



National Study on the IMPACT OF COVID-19 PANDEMIC ON OLDER PERSONS (Including those with disabilities) IN INDONESIA



FINAL REPORT

2022

National Study on the
**IMPACT OF COVID-19 PANDEMIC
ON OLDER PERSONS**
(Including those with disabilities)
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FOREWORD

Praise and gratitude to Allah SWT, God Almighty, for His mercy and grace, that **The National Study of the Impact of COVID-19 on the Older Persons Including Older Persons with Disabilities in Indonesia** has been completed.

The COVID-19 pandemic has been the fastest-spreading public health crisis this century, and it has caused a significant increase in the number of deaths and morbidity, and also has created social, economic and health challenges.

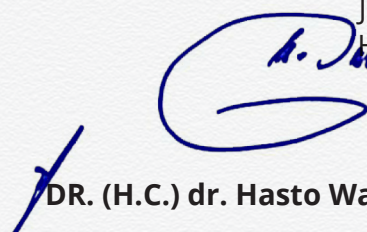
According to data from the 2021 Older Persons Population Statistics, the number of Older Persons people in Indonesia has increased and Indonesia has entered the phase of an aging population structure, which is indicated by the proportion of Older Persons people exceeding 10 percent of the total population, or 10.82 percent to be precise. The country has a total Older Persons population of 29.3 million, with 52.32 percent of them being women and 47.68 percent men, whereas 12.40 percent of them are Older Persons people with disabilities.

A National Study on the Impact of COVID-19 on the Older Persons including the Older Persons with Disabilities in Indonesia in the new normal situation, after the COVID-19 pandemic, is needed. The Older Persons, including those in the disabilities group, are amongst the most vulnerable to disease, particularly COVID-19, and require special assistance to access social and health services due to their physical condition. Therefore, this book will provide an understanding on the condition of Older Persons population from various aspects as a result of the impact of COVID-19. The findings can be taken into account in setting policies and assisting stakeholders to plan programs for the Older Persons in an effort to improve the quality of life of the Older Persons so they can remain healthy, independent, active, productive and dignified (SMART).

We would like to express our gratitude and highest appreciation to all of those who have contributed their thoughts and energy in the preparation of this book. Hopefully this book will be useful for the advancement of the Older Persons programs in Indonesia.



Jakarta, June 2022
Head of BKKBN RI


DR. (H.C.) dr. Hasto Wardoyo, Sp. OG(K)



FOREWORD

It seems that we are finally at the exit of prolonged COVID-19 pandemic, both globally and in Indonesia. We commend the efforts made by the Government of Indonesia, UN agencies and other stakeholders to bring this pandemic under control.

However, we lost so much during the past two and half years – the new virus claimed more than 6 million lives in the world, among which 150,000 are in Indonesia. It has also brought serious socio-economic impact on the whole society. The restriction of social activities has deprived people of opportunities for education and employment. People have faced various socio-economic and psychological challenges. Japan also severely suffered from this new virus, but nonetheless we have provided international assistance throughout the world, including for Indonesia, as no single country can overcome this transnational crisis alone. Japan has provided Indonesia with various medical supplies such as PCR test kits and personal protective equipment (PPEs) at the initial stage of the pandemic, and then vaccines and oxygen concentrators in the face of Omicron crisis. Japan has also provided technical cooperation in partnership with international organizations to enhance health capacity and response to pandemic. We also provided budget support for Indonesia's National Economic Recovery (PEN) program.

As part of these efforts, Japan contributed nearly US\$ 3 million to UNFPA to implement the “Leaving No One Behind” project. The pandemic has brought impact on people disproportionately, damaging vulnerable groups such as women, people with disabilities and the older persons more severely. As Japan promotes the concept of human security, we should focus on each individual, particularly protecting and empowering those individuals who face vulnerabilities. This is why our Government decided to contribute to this project that focuses on these vulnerable population.



I launched this project with Dr. Ir. Himawan Hariyoga Djojokusumo, MSc, Secretary of the Ministry of National Development Planning and Ms. Anjali Sen, UNFPA Representative in Indonesia, in June 2021. Since then the project has provided assistance for women with disabilities and older persons. This National Study on the Impact of COVID-19 Pandemic on Older Persons in Indonesia is a part of this project.

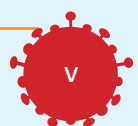
The disproportionality of the impact of COVID-19 pandemic I mentioned above is detailed in this report. Indonesia's population is regarded young, especially compared with aging Japan, but Indonesia does have aged population and has discussed the way to address the issue of aging (I once delivered presentation and joined discussion on aging at the BKKBN event in May 2021.). I hope that the national and local governments could make use of the findings and recommendations of this study in their policymaking. I am also sure that they are of use for other stakeholders for planning and implementing their activities.

As Indonesia maju, we should leave no one behind. And please rest assured that Japan is always with Indonesia.

Jakarta, June 2022

KANASUGI Kenji

Ambassador of Japan to the Republic of Indonesia



FOREWORD

Looking back on the past two years, the COVID-19 pandemic has been the fastest-spreading global public health crisis in a century, causing significant mortality and morbidity increase to daunting health and socioeconomic challenges. The Government of Indonesia has been taking unprecedented measures to limit the spread of the virus through the establishment of national coordination and response task forces at the country's highest level, and playing a role in executing the health sector response.

The pandemic is disrupting access to health services, and social systems are struggling to cope with rising caseloads, supply chain bottlenecks, movement restrictions, and economic strains. It is also compounding existing gender, economic, and social inequalities. Older persons, including and especially those with disabilities, are among the most vulnerable groups of the population. They need special assistance to access health and social services not only due to their physical condition and other disabilities but also multi-layered vulnerabilities to violence and discrimination.

Through the funding from the Government of Japan, the United Nations Population Fund (UNFPA) in collaboration with the National Population and Family Planning Board (BKKBN) provided technical assistance and conducted the National Study on the impact of COVID-19 Pandemic on Older Persons, including Those with Disabilities, in Indonesia. The study provides general background, characteristics, current status of older persons in Indonesia, and the challenges they face as well as social protection, existing policies, and rights-based legal framework. The study also; offers recommendations for safeguarding sustainable integrated access to health and social services for older persons, including those with disabilities, in Indonesia.



In determining the methodology, especially with respect to the sampling, we closely consulted with the BPS Statistics. We used the Golantang BKKBN web based application for the data collection process, which was carried out by 365 enumerators from BKKBN's Older Persons Family Development (BKL) cadres in 30 districts. Approximately a total of 9,000 respondents across 10 provinces in Indonesia were involved in the study. In its analysis, this study also includes secondary data reviews obtained from the Civil Registration and Vital Statistics (CRVS) data from the Ministry of Home Affairs, the BKKBN Family Data (PK) collection, Village Potency data from BPS-Statistics, and COVID-19 data from the National Disaster Management Authority (BNPB). The study also captures an overview of the government's policies, and the socioeconomic and health situations of older persons during the COVID-19 pandemic in Indonesia.

We hope that the results of this study provide an understanding of how COVID-19 affects the lives of older persons, including those with disabilities, in health, social, and economic aspects during the pandemic nationwide. Finally, we are hopeful that the study and its analysis provide valuable policy recommendations for strengthening the government's response to COVID-19, informing Indonesia's programme of inclusive growth and development, and ensuring that Indonesia's future policies will leave no one behind, especially older persons, including those with disabilities.

Anjali Sen

UNFPA Indonesia Representative

Acknowledgements

The publication of this report would not have been possible without the support of UNFPA Indonesia, and especially its Representative, Ms. Anjali Sen. We would like to thank Ms. Anjali Sen for her support in conducting the national study and ensuring its high quality. Thanks also go to Dr. Richard J. Makalew, Ms. Dian Safitri, Nur Arifina Vivinia, Mr. Narwawi Pramudhiarta, Iwan Kurniawan, Resnawati Kurniawan, Awalia Murtiana, and Jumita Siagian from UNFPA Indonesia, who provided valuable technical assistance in conducting the national study. Also, thanks to Mr. Erisman and BKKBN staffs, dr. Elsa Pongtuluran, M. Kes; Hartatik Sulistyoningsih, S. Kom, M. Eng; Sistha Atisomya, S. Psi, M.Si; Hemiliana Dwi Putri, S. Psi, Psi; Rany Widashanti, S. Sos, M. Si; Ema Florenta Sinuhaji, S. Gz, MHAPL; Erika Herry, S. Si; Salma Annisa Rahmadewi, SKM; Luthfiah, SKM; who provided the cadres and assisted in primary data collections using the GoLantang application.

We would like to extend our gratitude to the Government of Japan for providing the funds for the Project. Without their overall assistance, we would not have been able to see the impact of the pandemic on Indonesian older persons including those with disability in this report.

Many thanks go to Rintaro Mori, Ph.D. from UNFPA APRO (Asia-Pacific Regional Office), who reviewed the draft of this report and provided highly useful technical and substantive inputs to improve the quality of the report. Our gratitude also goes to UNFPA Indonesia, who carried out the final review of the report.

Finally, we would like to thank BPS-Statistics Indonesia for providing technical support on sampling selection and to the GoLantang developer. The dissemination of this report will support the government in developing precise and timely policy action to increase older persons' well-being, especially in a pandemic situation. In addition, it will empower the community and the family to support older persons increase their happiness and reduce their loneliness. Responsibilities for errors and omissions rest entirely with us. Comments and criticism are welcome and should be directed to us.



Jakarta, April 2022

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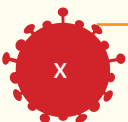
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List of Acronyms and Abbreviations

ASEAN	Association of Southeast Asian Nations
Bappenas	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
BKKBN	Badan Kependudukan dan Keluarga Berencana Nasional (National Population and Family Planning Board)
BKL	Bina Keluarga Lansia (older persons' family development)
BPJS	Badan Penyelenggara Jaminan Sosial (Social Health Insurance Administration Body)
BPS	Badan Pusat Statistik (Statistics Indonesia)
COVID-19	Coronavirus disease
CSR	Corporate Social Responsibility
DFLE	Disability-Free Life Expectancies
DTKS	Data Terpadu Kesejahteraan Sosial (Social Welfare Integrated Data)
ERIA	Economic Research Institute for ASEAN
FGDs	Focus Group Discussions
GDS	Geriatric Depression Scale
GOI	Government of Indonesia
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IPUMS	Integrated Public Use Microdata Series
Jamkesda	Jaminan Kesehatan Daerah (Regional Health Insurance)
Jamkesmas	Jaminan Kesehatan Masyarakat (Community Health Insurance)
JKN	Jaminan Kesehatan Nasional (National health insurance)
KIS	Kartu Indonesia Sehat (Healthy Indonesia Card)
LTC	Long-Term Care
MERS	Middle East Respiratory Syndrome
MSS	Minimum Service Standards
MOH	Ministry of Health
NAP	National Action Plan
NGO	Non-Governmental Organization
PBI	Penerima Bantuan Iuran (Premium Payment Assistance)

Peksos	Pekerja Sosial (Social worker)
PK	Pendataan Keluarga (Family Data)
PKH	Program Keluarga Harapan (Family Hope Program)
PLKB	Penyuluh Lapangan Keluarga Berencana (Family Planning Field Extension)
Posbindu PTM	Pos Pembinaan Terpadu Penyakit Tidak Menular (Health Integrated Services Post)
Posyandu Lansia	Pos Pelayanan Terpadu Lanjut Usia (Older Person Integrated Care Post)
PPKM	Pemberlakuan Pembatasan Kegiatan Masyarakat (Enactment of Community Activity Restrictions)
Progres LU	Program Rehabilitasi Sosial Lanjut Usia (Older Person Social Rehabilitation Program)
PSU	Primary Sampling Unit
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Centre)
RT	Rukun Tetangga (Neighborhood Association)
RW	Rukun Warga (Citizens Association)
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
Sembako	Sembilan Bahan Pokok (Nine Basic Staple Foods)
SILANI	Sistem Informasi Lansia (Older Persons Information System)
SOP	Standard Operational Procedure
SRH	Self-Rated Health
STRANAS	Strategi Nasional (National Strategy on Ageing)
Susenas	Survei Sosial Ekonomi Nasional (NSES: National Socio-Economic Survey)
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team for the Acceleration of Poverty Reduction, Republic of Indonesia)
UCLA	University of California, Los Angeles
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

A Glossary of Terms/definitions

Older Persons	Those aged 60 and over as of January 1, 2021
Not married / Unmarried	Never married, widowed and divorced
Low Education	Older persons with elementary school education or lower
Disability	Based on the Washington Groups' Short Set of Questions on Disability
Depression	Based on the Geriatric Depression Scale, scores higher than six
Loneliness	Based on the UCLA 3-item Loneliness Scale, scores higher than six
Falls	Unintentional event s older persons experienced in the past 12 months
Disability -free Life Expectancy	Computed using prevalence-based (Sullivan) method



Executive Summary

The COVID-19 pandemic has been the fastest spreading global public health crisis in a century, causing significant mortality and morbidity increases and daunting health and socioeconomic challenges. The Government of Indonesia (GOI) has been taking unprecedented measures to limit the spread of the virus, while health and social systems have been struggling to cope with rising caseloads, supply chain bottlenecks, movement restrictions, and economic strains. This pandemic also widened the social, gender, and economic inequality gap which has previously existed particularly, among vulnerable populations. Older persons, especially those with disabilities, are among the most vulnerable groups of the population because they need special assistance to reach out for health and social services due to their physical condition. A comprehensive national study adequately designed and with enough sample size is needed to understand the situation of older Indonesians during the pandemic.

The overall objective of a National Study on the Impact of COVID-19 Pandemic on Older Persons (including those with disabilities in Indonesia) is to understand how COVID-19 has been affecting the lives of the older population. The results of the study will be valuable in informing Indonesia's program of inclusive growth and development.

In order to achieve the study's objective, both quantitative and qualitative methods were used. For quantitative methods, primary data collection was conducted by utilizing GoLantang application for CAPI developed at BKKBN. Based on the estimated minimum sample size required for the national study, 9,000 sample households with at least one older person aged 60 and over were drawn from the household data provided by BKKBN using the multistage cluster sampling method. Face-to-face interviews with smart phone were conducted and data were obtained for 6,817 older persons in 360 locations in Indonesia. Based on the data collected, secondary data analyses, and focus group discussions, the current state of older persons and those with disabilities in Indonesia, in terms of their economic, physical, mental health, and social well-being was described.

Five research questions were set for the national study to assess the potential impact of COVID-19 on older persons. Findings for these questions and recommendations based on the findings are as follows:

1. “Did the COVID-19 pandemic affect the economic, physical, mental, and social well-being of older persons across different backgrounds?”

Findings

Results of the analyses indicated that the pandemic potentially affected the economic well-being of older persons. Before the pandemic started, about half of older persons aged 60 and over were working. As a result of the pandemic, older persons' work hours decrease over the period. Among working older persons, more than 60 percent reported that income from paid work decreased during the pandemic period. The perceived economic well-being of older persons also showed negative changes during the pandemic period. The percentage of older persons who reported at least some difficulty in meeting expenses increased from 46.3% before the pandemic started to 51.4% at the time of the survey. More than half of older persons aged 60 and over were struggling in meeting daily expenses. Particularly, older persons with lower levels of education and living alone continued to experience economic hardship.

The general health status of older persons was assessed through self-rated health before the pandemic started and at the time of the survey. On average, the percentage of older persons who answered being unhealthy increased during the pandemic period. Changes in the prevalence of chronic diseases showed mixed results during the pandemic. Heart disease and stroke showed slight increase in prevalence among older persons while prevalence of having high blood pressure and lung disease decreased. Although all falls did not cause injury, many falls were reported in the survey especially among female older persons and those aged 80 and over.

The impact of the pandemic on mental health status of older persons were assessed by examining prevalence of depression and dementia. Compared to the prevalence of both depression and dementia reported before the pandemic started, there was no significant change found in the survey results. However, social well-being of older persons as measured by loneliness and social isolation showed deterioration. This



could imply that the mental health status of older persons may be worsened in the future. In addition, even if the prevalence of depression and dementia stay at the same level in the future, the number of older persons with these mental health disorder will increase because of changes in population age structure.

Recommendations

Further financial assistance in meeting daily expenses should be provided to older persons. There is a need to specifically target older persons who are more vulnerable such as the less educated and those living alone.

Given that many older persons stay at home often during the pandemic and that falls commonly occur at home, it is better to consider fall prevention programs if no such programs are currently being implemented yet.

Support for mental health of older persons during the pandemic such as setting up hotlines and visits from cadres should be increased. In addition, there should be more mental health personnel and facilities as the number of older persons with mental health disorder are expected to increase. This should include increasing educational programs to foster mental health care professionals. In order to support older persons who are feeling lonely and socially isolated, programs should be developed to encourage them to engage in virtual or physical social interactions at a safe distance.

2. “Did the observed prevalence of disability among older persons in the survey increase compared to the prevalence of disability before COVID-19 pandemic started?”

Findings

As a measure of disability, the study used the Washington Group’s Short Set of Questions on Disability. Increasing trends in the prevalence of disability were observed based on data from the current study, the published data for the 2019 Susenas (TNP2K, 2020), and the 2010 Census. The prevalence rate of having at least one difficulty among six activities increased from 26.0% in 2010 to 56.2% and having at least one severe difficulty increased from 4.8% in 2010 to 13.9% in 2022. The huge

increases in the prevalence of disability needed to be investigated further. Awareness of disability among older persons as well as changes in policies for persons with disability may have affected the changes observed.

Recommendations

As the number of older persons with disability increases and the length of years with disability is expected to increase, personnel and facilities to care for older persons need to be increased as well. Also, programs to train formal care workers, as well as informal caregivers, need to be strengthened.

3. Did the policies to protect older persons including those with disability work effectively during the COVID-19 pandemic?

Findings

During the pandemic, the older persons' health program was directed at screening/early detection and conducted in primary health centers. The rate of vaccination among survey participants was about the same as the national figure. What this means was that, as of February, 2022, 34% of older persons were still not vaccinated. The reasons for non-vaccination include "health conditions", "not willing" and "did not know vaccination was necessary." The majority (69.2%) of those who were not vaccinated reported they had health conditions as the reason. The issue of comorbidity was also raised during the FGD.

Another 21.8% were not willing to be vaccinated partly because information conveyed to older persons about the pandemic and vaccination was sometimes unclear, imprecise, absurd, and untrue. A few older persons did not know that vaccination was necessary.

Recommendations

It is recommended that efforts should be made to re-assess individually those who are unvaccinated due to health reasons because many health experts have maintained that the vaccines are suitable for the vast majority of people, including those with comorbidity.

It is recommended that the information that will be disseminated is factually accurate and easy to understand for older persons. The information should be delivered to those who needed it, not just to disseminate to the general public.

4. Did the COVID-19 pandemic itself or the measures taken against the pandemic have effects on the health care utilization of older persons?

Findings

The results indicate that the impact of the pandemic on health care utilization was not serious. From the individual perspective, there were people who experienced serious problems accessing health care. However, for the overall population as a whole, only about three percent of older persons reported that they had some problems using health care services. Three-quarters of older persons did not have any delays or cancellations of health care services and 21.6% of older persons did not need to use health care services.

Among older persons needing medication, 15.5% of them experienced some kinds of difficulties receiving their medicine during the pandemic.

Recommendations

It is important that the core general health care services continue to be made available easily even as a bulk of health care resources is allocated to address the pandemic. In addition, there is a need to explore ways to deliver medicine to those who have difficulties obtaining them such as through satellite points, nodes in the community, village cadres to deliver, and postal/courier delivery.

Because of the pandemic, the use of telemedicine was explored. With improvement in internet technologies, use of telemedicine has been advancing quickly. The use of telemedicine should be expanded by promoting its use among health professionals and raising awareness of its use to the general public. This entails cooperation with several government ministries to ensure its successful implementation.

5. Did older persons receive the assistance they need during the COVID-19 pandemic?

Findings

Overall, the percentages of older persons reporting decrease in assistance and support were much higher than the percentages of those reporting increase of support from all sources. Among older persons who were receiving assistance from relatives/friends in the country and from those living abroad, about 35% and 42%, respectively, reported that the amount of assistance decreased. On the other hand, only about 4% and 2% of older persons reported increases in assistance received from relatives/friends in the country and from those living abroad, respectively. Support from the government and NGOs showed a little better picture. For older persons receiving support from the government, 29% reported decrease in support while 15% of them reported an increase. For NGOs and other organizations, 31% of older persons receiving support from them reported a decrease in support, while 11% reported an increase. More female older persons reported decreases in support and the percentages of decreases in support were lower for higher age groups.

Recommendations

The government and NGOs need to investigate the reported decreases in support and formulate ways to boost the support to vulnerable groups during the pandemic. In particular, women and the younger-old may need extra forms of support. While those aged 60-69 were more likely to report working at the time of survey, they experienced reduced income from paid work, thus, were affected more by the pandemic.



Chapter I

INTRODUCTION



INTRODUCTION

The COVID-19 pandemic triggered by SARS-CoV-2 has been the fastest-spreading global public health crisis in a century, causing significant mortality and morbidity increases and daunting health and socioeconomic challenges. The first case of COVID-19 infected person in Indonesia was announced by the government on March 6, 2020 (Tosepu, Effendy and Ahmad, 2020). Since then, the number of confirmed cases accumulated to more than six million, and the number of deaths from COVID-19 reached more than 155,000, as of April 4, 2022 (United Nations Office for the Coordination of Humanitarian Affairs, 2022). In order to fight against COVID-19, vaccination has been progressing. It was reported that more than 75% of the target population in Indonesia have received at least one dose of the vaccine, as of April 4, 2022 (United Nations Office for the Coordination of Humanitarian Affairs, 2022).

Although the pandemic has been affecting the entire population, older persons were particularly hit hard. As of March 15, 2022, 12% of the total confirmed cases were older persons aged 60 and over. However, almost half of the total number of deaths reported in the country came from the age group 60 years and over. There have been a couple of studies that examine the impact of the COVID-19 pandemic on the lives of Indonesian people. One of them focused on older persons living in three provinces in Indonesia, conducted in July 2020 by Economic Research Institute for ASEAN (ERIA) and the Ministry of National Development Planning/National Development Planning Agency (BAPPENAS), Republic of Indonesia (Komazawa, et. al., 2021). Another study conducted in October-November, 2020 assessed the impact of the pandemic on households with children and vulnerable people including those with disability. Both showed the significant impact of the pandemic on the lives of the targeted population (UNICEF, UNDP, Prospera and SMEUR, 2021).

Unfortunately, the pandemic wasn't over yet by the time these studies were conducted. The number of confirmed cases of COVID-19 by the end of November 2020 since the first confirmed case was reported was only 12.6% of the total number of confirmed cases at the end of March, 2022 (Bersatu Lawan Covid-19, 2022). This is because new variants of SARS-CoV-2 emerged, which had higher transmissibility and caused more severe consequences such as increased hospitalizations and deaths. In order to fight against the pandemic, vaccines for SARS-CoV-2 were successfully developed with unprecedented speed. Vaccination started in early 2021 in Indonesia. However, by mid 2021, the delta

variant of SARS-CoV-2 caused a surge in the confirmed cases and deaths. As a response, the government implemented the highest level of the Enactment of Community Activity Restrictions (PPKM: *Pemberlakuan Pembatasan Kegiatan Masyarakat*). Towards the end of 2021, the level of PPKM was lifted or downgraded depending on the COVID-19 situation in the regions but by early 2022, a new variant of SARS-CoV-2 virus started spreading in the country. The Government of Indonesia (GOI) has been taking unprecedented measures to limit the spread of the virus, while health and social systems are struggling to cope with rising caseloads, supply chain bottlenecks, movement restrictions, and economic strains.

With the ongoing exacerbating situation of COVID-19, older persons now become more prone to socioeconomic shocks. The MOH has prioritized vaccine rollout for older persons, but so far, vaccination coverage for this population sector has not been maximized. Some vaccination locations are not accessible for older persons. In addition, due to physical decline, older persons are disadvantaged because of their difficulty in accessing transportation, lack of or limited financial means to cover transportation costs, and the absence of a caregiver to provide them with assistance. Moreover, the lack of social protection made older persons more vulnerable to poverty. Physical distancing made them isolated from the outside world. This isolation could affect their mental well-being. Under such circumstances, it is important to urgently investigate how the pandemic has affected the well-being of older persons.



BACKGROUND



BACKGROUND

Based on the results of the 2020 population census, the number of older persons aged 60 and over in Indonesia was 27.2 million, or 9.8% of the total population (BPS Statistics Indonesia, 2021). This indicates that Indonesia can be considered almost an ageing population because a country where the share of the population aged 60 and over is between 10% and 20% is considered to be an ageing population (UNDESA, 2015). It is also recognized that Indonesia is experiencing rapid population ageing. Hayashi (2019) showed that the speed of ageing that Indonesia is expected to experience can be as fast as the one experienced in Japan. The percentage of older persons aged 65 and over is expected to double from 7% in 2025 to 14% in 2051. The estimated doubling time for Indonesia is 26 years compared to the 24 years it took for Japan to double the percentage of older persons 65 and over.

The increasing number as well as the increasing proportion of older persons caused by declining mortality have complex consequences. More older persons may need support economically for a longer period of time. The length of time that older persons may be needing long-term care is extended, too. Population projection published by UN (UNDESA, 2019) showed that an estimated life expectancy at age 60 in Indonesia increased by about one year from 2010 to 2020. However, the increased expected years to live at age 60 do not necessarily mean older persons could spend these years being healthy (Crimmins, Heyward and Saito, 1994; Jagger, 2006). Adioetomo and Mujahid (2014) reported that the prevalence of disability among older persons at age 60 and over was 26.0%. A study conducted by TNP2K (2020) reported that the prevalence of disability in 2019 was 44.4%. The health status of older persons seemed to have deteriorated tremendously in the 2010s in terms of functioning. The changes in the age structure of the population might have contributed to such condition. Nonetheless the prevalence of disability among older persons should be monitored carefully and paid attention to when the impact of the pandemic is examined.

As already well known, the impact of the COVID-19 pandemic on the lives of people differs significantly by age (e.g. Crimmins, 2021). As one becomes older, the higher is the risk of infection and death. Research also indicated that the pandemic affected people's lives differently by gender (e.g. Galasso, et al., 2020). Tadiri, et al. (2020) added that both "sex" as a biological attribute and "gender" as a complex social construct has an effect in acquiring the virus. In general, males were more likely to be infected by the virus and die.

Other studies also identified socioeconomic status as a factor associated with the pandemic (Liao, et al., 2021; Mena, et al., 2021; Yoshikawa and Kawachi, 2021). Hawkins, Charles and Mehaffey (2020) showed that socioeconomic factors played an important role in the prevalence and mortality of the COVID-19 disease. They also showed that “lower educational level has the strongest association with both cases and fatalities.” Differential impact of the COVID-19 pandemic on subpopulation suggests that the pandemic could create inequalities in society or widen inequalities if it already existed.

Statistics Indonesia (BPS: *Badan Pusat Statistik*) indicated that just before the pandemic started, income inequality increased significantly in many provinces in Indonesia (Brata, 2020). However, the increasing trend was only found in urban areas in provinces with more COVID-19 cases but not in rural area (Brata, et al., 2021). It was also reported that “Income inequality has risen during this pandemic as economic shocks have most strongly impacted the poorest and most vulnerable households” (UNICEF Indonesia, 2022).

The potential impact of the pandemic on the different aspects of health among older persons had been discussed. A few review studies were conducted to assess the impact of the pandemic on depression (Vahia, Jeste and Reynolds, 2020; Bueno-Notivol, et. al., 2021; Santomauro et al., 2021). These studies found that the pandemic affected the increased prevalence of depression among general population in the world. A study by Santomauro et al. (2021) found that the daily SARS-CoV-2 infection rates and reductions in human mobility were associated with increased prevalence of major depressive disorder. In addition, females were affected more than males and the younger age groups were more affected than the older age groups by the pandemic.

There was a concern about the worsening mental health among older persons because interaction was limited with friends, family, and caregivers in order to reduce the risk of being infected. Vahia, Jeste and Reynolds (2020) agreed with studies indicating that older persons as a whole, may be more resilient to depression compared to other age groups during the early stages of the pandemic.

The study of older persons living in three provinces in Indonesia (Komazawa, et al., 2021) at the early stages of the pandemic indicated that there was a tendency to worsen depression scores compared to scores before the pandemic. Older persons in Indonesia experienced massive increases in the number of infected people and the number of deaths by COVID-19 in 2021, as well as near lock-down in the cities during the time. Changes in the mental health status of older persons are needed to be carefully monitored.

Dementia is another mental health issue of global public health concern. Being confined at home or hospitalized for treatments could trigger worsening dementia or becoming demented among older persons. Dementia is regarded as a risk factor for mortality and in being infected by the virus (Saragih, 2021). This is partly because a person with dementia may not be able to understand or forget why they need to follow health protocol against the pandemic. If they become infected, they can be a spreader of the virus with them knowing it. Older persons with dementia are one of the most vulnerable groups of people and are needed to be protected.

Similarly, the social well-being of older persons could also be affected by the pandemic. Social isolation and loneliness are well known risk factors on social well-being of older persons (National Academy of Sciences, Engineering and Medicine, 2020). In addition, social isolation and loneliness are serious conditions affecting a significant number of older persons leading to dementia and other serious medical conditions.

A study conducted in the US during the pandemic found that among older persons with chronic conditions, having a spouse or a cohabiting partner, and more emotional support were associated with lower levels of loneliness while more worry about COVID-19 infection, and more financial strain because of the pandemic were associated with higher loneliness (Polenick, et al. (2021). Among community dwellers in Canada, being female, living alone, having poor health and having high concern for the pandemic were all associated with higher prevalence of feeling lonely, although the prevalence is found to decrease with advancing age (Savage, 2021).

In a study conducted in the Netherlands, results showed that feeling of loneliness among older persons increased during the pandemic although their mental health remained relatively stable. Health protocol such as physical distancing was not associated with increased social isolation but personal losses and concerns about the pandemic were associated with mental health problems (van Tilburg, et al., 2021).

Susanty, et al., (2022) conducted a study of loneliness among older persons in Kendari City in Indonesia. Using a single item question, results showed that 64% reported feeling lonely (Susanty, et al., 2022). However, because the study is not national sample and it used only a single question to measure loneliness, the result should be interpreted with caution and further study is warranted.

Wu (2020) emphasized that the social isolation and loneliness experienced by older persons during the pandemic not only impacted the current mental health state of older persons, these can also have lasting effects on social and mental well-being which in turn

affect physical health in the future. In order to deal with such negative consequences of the pandemic, Wu (2020) suggested strategies to be implemented such as “raising awareness of the health and medical impact of social isolation and loneliness across the health care workforce” and “community-based networks and resources that address social isolation and loneliness in older persons.”

In order to keep the well-being of older persons, the social security system plays a very important role. As people age, they all face health issues such as having a comorbidity and declining functional ability. Every older person should be covered by health insurance to ensure that they have some protection when they get sick. Medical expenses in old age could be a big burden not only for the older persons themselves but for their family as well. Based on the 2019 Susenas, TNP2K (2020) reported that about 70% of older persons are covered by JKN PBI, JKN Non-PBI, or private health insurance. The proportion of older persons who are covered by private health insurance is very small. Before the pandemic started, a similar proportion (65.5%) of older persons are covered by the national health insurance (Komazawa et al., 2021).

Older persons who are covered by JKN Non-PBI could be affected by the pandemic if they lose their job. However, as TNP2K (2020) showed, majority of older persons are covered by JKN PBI in which contributions are being paid by the government and are intended for the poor and underprivileged. In addition, among those who were working, 81.4% of men and 89.1% of women were working in the informal sector (TNP2K, 2020). The percentages of older persons who were working in the informal sector changed very little from 88.6% in 2010 (Adioetomo and Mujahid, 2014) to 84.3% in 2019 (TNP2K, 2020). Thus, the pandemic could have only limited impact on the health insurance status of older persons.

Similarly, changes in work status because of the pandemic could have effects on older persons' economic well-being. Over the last ten years, the percentage of older persons who were working has remained almost the same, 50.5% (69.4% for males and 34.5% for females) in 2010 (Adioetomo and Mujahid, 2014) and 54.3% (64.5% for males and 35.7% for females) in 2019 (TNP2K, 2020). Among working older persons, the percentage of older workers in the informal sector had not changed as mentioned above. The fact that more than 80% of older workers were in the informal sector was an indicator that they work just to meet their daily expenses. Older persons who were working in the informal sector could be heavily affected by PPKM because of the limited hours they could work. Reduced number of hours worked will directly affect their income. More than a half of older persons reported their income decreased even at the early stages of the pandemic (Komazawa, et al., 2021). Therefore, changes in work status of older persons, number of

hours worked as well as changes in income should be closely monitored to assess the impact of the pandemic.

Another social protection program for older persons that needed to be considered is the pension system. After the Madrid International Plan of Action on Ageing (United Nations, 2002) was declared in 2002, the GOI made continuous efforts to develop policies for older persons such as the National Plan of Action for Older Persons Welfare Guidelines in 2003 and the establishment of the National Committee for Older Persons through Presidential Decree No. 52 of 2004. In 2004, Law No. 40/2004 on National Social Security System was enacted to transform the existing social security system in Indonesia which included a pension scheme to ensure the economic well-being of older persons after retirement (Muliati, 2013). Unfortunately, the new social security system was just implemented and the pension scheme covered only a limited number of older persons in Indonesia so far. In 2019, only 10.1% of older persons were covered by the pension system in Indonesia (TNP2K, 2020). They were mainly former civil servants and retired military personnel. Because they receive the same amount of pension regularly, they may not be affected by the pandemic economically if the amount of pension they receive is enough to meet their daily expenses.

In addition to the social security system, there are several social protection/assistance programs in Indonesia. There are two types of such programs. One of them is BPNT (Non-Cash Food Aid: before 2020)/Program Sembako (Nine Staple Foods: after 2020) which provides recipients credit to purchase food commodities. The recipients of the program are families in poor economic conditions. The amount of credit was increased in April 2020 to take into account the effects of the pandemic (TNP2K, 2020). Another such program is Family Hope Program (PKH: *Program Keluarga Harapan*) that started in 2007. Initially, PKH covered only pregnant/breastfeeding women and children. However, since 2016, PKH included persons with disability and older persons as beneficiaries (TNP2K, 2020). PKH is a cash transfer program for underprivileged and vulnerable families (TNP2K, 2020). It is worth mentioning that the eligible age of older persons for PKH changed from time to time between 2016 and 2020. Between 2016 and 2018 and 2020, only older persons aged 70 and over were covered by the program but in 2019, older persons aged 60 and over were covered (TNP2K, 2020). This means that older persons aged 60-68 in 2019 might have experienced a reduction in the assistance they received.

The Progres LU (*Program Rehabilitasi Sosial Lanjut Usia*) or Older Persons Program is another type of social protection program that specifically targets individual older persons. It aims to keep the well-being of older persons and covers mainly those who live

alone or only with their spouse, those who are not able to work or take care of their daily activities. The recipients are determined by the Ministry of Social Affairs based on certain conditions (TNP2K, 2020). Each older persons under the program receives Rp 2,700,000 (about 180USD) a month in 2020

In addition to these assistance from the central government, there are programs offered in several provinces such as DKI Jakarta, DI Yogyakarta and Bali, and also from local municipalities. Therefore, the amount and kinds of assistance could vary according to the places that the older person lives.

A survey conducted before the pandemic indicated that 24.7% of older persons received assistance from Program Sembako and 11.3% of them from PKH (TNP2K, 2020). Because of the impact of COVID-19, older persons who received assistance from these programs could have increased especially after a surge in the infected cases and the implementation of PPKM. This information served as bases for the study.

1. Objectives

The overall objective of a National Study on the Impact of COVID-19 Pandemic on Older Persons (including those with disabilities) in Indonesia is to understand how COVID-19 has been affecting the lives of the older population group. The results of the study will be valuable in ensuring Indonesia's program of inclusive growth and development.

In order to achieve the study objective, both quantitative and qualitative methods were used. For quantitative methods, first, primary data collection was conducted by utilizing GoLantang application developed by the National Population and Family Planning Board (BKKBN: Badan Kependudukan dan Keluarga Berencana Nasional). Based on the data collected, the current state of older persons including those with disabilities in Indonesia in terms of their economic well-being, physical and mental health status, and social well-being were described.

Second, existing data on older persons in Indonesia were analyzed. The secondary data analysis was compared with the results of the primary data analysis to cross-validate observations on patterns and changes in the status of older persons.

The qualitative component of the study included the conduct of two focus group discussions (FGDs). The FGDs provided more nuances on the results of the quantitative analyses.

2. Research Questions

1. Did the COVID-19 pandemic affect the economic, physical, mental, and social well-being of older persons across different backgrounds?
2. Did the observed prevalence of disability among older persons in the survey increase compared to the prevalence of disability before COVID-19 pandemic started?
3. Did the policies to protect older persons including those with disability work effectively during the COVID-19 pandemic?
4. Did the COVID-19 pandemic itself or the measures taken against the pandemic have effects on the health care utilization of older persons?
5. Did older persons receive the assistance they need during the COVID-19 pandemic?





Chapter III

METHODOLOGY

Methodology

1. Quantitative Methods

a) Primary data source: Interview Survey Data

Survey Design

We defined the target population as those who were aged 60 and over as of January 1, 2021, because of the sampling frame available to us. A national face-to-face interview survey of those aged 60 and over was conducted for the project by using GoLantang application developed by the National Population and Family Planning Board (BKKBN). Interviews were conducted by the older persons' family development cadres (BKL: *Bina Keluarga Lansia*, and PLKB: *Penyuluh Lapangan Keluarga Berencana*). For older persons who could not participate in the survey, proxy responses were allowed.

Survey design: First we estimated the minimum sample size by using the following equation suggested by BPS (*Badan Pusat Statistik*).

$$n = \frac{N (Z_{\alpha/2})^2 p (1-p)}{N (ep)^2 + (Z_{\alpha/2})^2 p (1-p)} \times \frac{deff}{rr}$$

where:

n = minimum sample size

N = Household of those aged 60 and above based on the National Socio-Economic Survey (NSES) or *Survei Sosial Ekonomi Nasional* (SUSENAS) 2020 = 20,734,758

$Z_{\alpha/2}$ = confidence interval = 1.96

e = relative margin of error = 0.0813

p = proportion of event = the proportion of households that have social security based on NSES 2020 = 0.1384

$deff$ = design effect = 2

rr = expected response rate = 0.85

Based on the above formula, the estimated minimum sample size was 8,512. However, we set the sample size of the survey to 9,000 considering the availability of the project's budget as described later. In addition, we selected five reserve samples for each village selected by following the suggestion from BPS.

Multistage cluster sampling method was employed for sample selection. The primary sampling unit (PSU) is the provinces and 10 out of 34 provinces were selected using probability proportional to size according to the number of households with at least one older adult aged 60 and over. Six provinces were selected from the West region (Sumatera Utara, Jawa Barat, Jawa Tengah, DI Yogyakarta, Jawa Timur, and DKI Jakarta), three provinces were selected from the Central region (Bali, Kalimantan Timur, Sulawesi Selatan), and Maluku was selected from the East region.

The secondary sampling units are cities and districts. Among 198 cities and districts within the 10 selected provinces, 19 cities and 21 districts were selected using again the probability proportional to size. Then, three sub-districts from each city and district were selected as the tertiary sampling units based on the household data (PK: Pendataan Keluarga) provided by BKKBN. Within 120 sub-districts, three villages were selected according to the probability proportional to size method and the family data provided by BKKBN. In total, we had 360 villages to collect survey data from households with at least one older adult. In theory, we had to sample 23 or 24 households from each village ($23.64 = 8512/360$). However, considering the project's budget and making it easy for the administrative process, it was recommended to select 25 households from each village. In total, we have 9,000 sample households with at least one older adult aged 60 and over (plus an additional 5 reserve sample households from each village). We interviewed only one older adult from each sample household. After the survey was completed, sampling weights adjusting for non-response, death, and number of older persons in a household were estimated.

While sample selection was on-going, a questionnaire was developed for the survey to be incorporated into the GoLantang application. A pretest was conducted using the GoLantang application on smartphones. Based on the results, questions were revised and finalized for the interview survey. The main interview survey was conducted between February 10 and 16. Before the pretest and the main survey, training workshops were conducted to make sure that the

interviewers and supervisors understand the questionnaire and how to use the GoLantang application on smartphone and the survey procedures.

Prior to conducting the main interview survey, we obtained approval of the survey protocols from the Research Ethics Commission of the Atma Jaya Catholic University of Indonesia. Written consent was obtained from older persons and proxy respondents in sampled households.

The face-to-face interview survey was conducted between February 10 and 16, 2022 by the members of Cadre. The total number of sample persons were 9,000 including reserved sample persons. As shown in Table 1.1, of these 9,000, 413 sample persons had moved from the address reported at the time of sampling and 604 sample persons have died by the time the fieldwork was conducted. Another 102 sample persons refused to participate in the survey. Because the server which stored survey data crashed on February 15, 2022, data for 1,064 sample persons were lost. Therefore, the analytical sample is 6,817 and the response rate is 75.7%.

Table 3.1. Response to the Interview Survey

	Unweighted N	Unweighted %
Self-Response	6,312	70.1
Proxy Response	505	5.6
Moved	413	4.6
Deceased	604	6.7
Refused	102	1.1
Data lost because of data server accident	1,064	11.8
Total	9,000	100.0

Source: 2022 National Study data processing

Measures Used

In order to understand the situation of older persons in Indonesia during the COVID-19 pandemic, a questionnaire was developed to be used in the survey. The questionnaire was incorporated into the GoLantang application developed by BKKBN for the field work. At first, standard demographic information such as age, sex, marital status, education and living arrangements were asked.

The direct and indirect impacts of COVID-19 on older persons as well as their family members, relatives, friends and neighbors were assessed by asking questions whether they had been infected by COVID-19 and had family members, relatives and friends who died of COVID-19. In addition, they were also asked on how seriously they followed measures taken against the virus requested by the government.

Following the COVID-19 related questions, sets of questions regarding older persons' physical and mental health status, health care utilization, health related behavior, social well-being and economic well-being were asked. In the section on physical health status, self-rated health (SRH) was asked to indicate general health status of older persons. Changes in SRH from the time the pandemic started was explored. Current chronic disease conditions such as heart disease and diabetes were also asked.

The concept of healthy ageing is first introduced by the World Health Organization (WHO) in 2015 and defined as “the process of developing and maintaining the functional ability that enables well-being in older age, with functional ability determined by the intrinsic capacity of the individual, the environment they inhabit and the interaction between them” (World Health Organization, 2015). Healthy ageing is a person-centered approach that departs from WHO's traditional disease-based model in the process of ageing and focused on functional ability as the essential factor to maintain well-being of older persons. Functional ability or disability is precisely defined by the International Classification of Functioning, Disability and Health (World Health Organization, 2001). Considering this definition, the United Nations' City Group, Washington Group developed a Short Set of Questions on Disability to measure the level of disability being administered in surveys (Madans, Loeb and Altman, 2011).

As the title of the project indicates, disability among older persons was given special attention in this study. Disability, thus, was measured using the Washington Group's Short Set of Questions on Disability. Questions asked were:

- 1) Do you have difficulty seeing, even if wearing glasses?
- 2) Do you have difficulty hearing, even if using a hearing aid?
- 3) Do you have difficulty walking or climbing steps?
- 4) Do you have difficulty remembering or concentrating?
- 5) Do you have difficulty (with self-care such as) washing all over or dressing?
- 6) Using your usual (customary) language, do you have difficulty communicating, (for example understanding or being understood by others)?

There were four response categories for each question: (1) No, no difficulty, (2) Yes, some difficulty, (3) Yes, a lot of difficulty, and (4) Cannot do it at all. Disability status can be assessed using each item but is often assessed by composite measures based on answers to these questions. Two composite measures of disability were constructed by using the answer to six questions: (1) at least one item with some difficulty, a lot of difficulties or cannot do it at all (disability) (Tareque, Begum and Saito, 2014), and (2) at least one item with a lot of difficulties or cannot do it at all (severe disability) (Madans, Loeb and Altman, 2011).

Mental health is becoming a serious public health concern during the pandemic period partly because of economic hardship and restricted social interaction among people. Depression, one of the mental health disorders was assessed by using the 15-item version of the Geriatric Depression Scale (GDS). The 15-item version of GDS was translated into Bahasa Indonesia and had been validated in 1995 (Ministry of Health, 2017).

- 1) NO: Are you basically satisfied with your life?
- 2) YES: Do you give up many of your activities and interests/fun?
- 3) YES: Do you feel your life is empty?
- 4) YES: Do you often feel bored?
- 5) NO: Are you excited most of the time?
- 6) YES: Are you afraid that something bad will happen to you?
- 7) NO: Have you been happy most of your life?
- 8) YES: Do you often feel helpless?
- 9) YES: Would you rather stay at home than go out and do something new?
- 10) YES: Do you feel you have more problems with your memory than most people?

- 11) NO: Do you think now is a wonderful time to live?
- 12) YES: Do you feel less valuable?
- 13) NO: Do you feel energized?
- 14) YES: Do you feel that your situation is hopeless?
- 15) YES: Do you think that other people are better off than you?

Indicated responses for each item of the scale take 1 and 0 otherwise. GDS scores range from 0 to 15. The cut-off point used to classify the survey participants into potentially depressed is 6 and higher. Those with a GDS score of 10 or higher can be considered as depressed.

Although the 15-item version of GDS had been validated in Indonesia, another composite measure was constructed by considering the measures taken against the pandemic. The 9th item of the GDS reads "Would you rather stay at home than go out and do something new?" As the previous study indicated, this question may not appropriately assess the mental status of older persons during the pandemic. Therefore, an additional composite measure of depression was constructed with only 14 items of the GDS. However, the same cut-off point was applied to group survey participants into depressed and not depressed.

A measure of internal consistency, Cronbach's Alpha obtained based on 15 items GDS was 0.71 and 0.74 for 14 items GDS. Both sets of questions on depression can be considered acceptable.

In the section on health care utilization, questions regarding access to health care and health insurance were asked. As one health-related behavior, the experience of falls was also included. This is because falls among older persons could cause serious health problem. Majority of falls were reported to happen at home and during the pandemic, older persons were confined at home.

In order to assess the social well-being of older persons, questions on feeling lonely and social interaction were asked. Loneliness can be defined as, among others, the sense of distress that derives from the lack of social relationships and interactions one desires to maintain (de Jong Gierveld 1998). It is well-known that the feeling of loneliness has various negative effects on the health status of older persons such as self-rated health and physical functioning (Mulhotra, et. al., 2021), especially for those aged 80 and over (Dykstra, 2009). Among

ageing countries, loneliness has become a social and public health concern as represented by the emerging new post of Minister dealing with loneliness in the UK and Japan.

Because the time for the fieldwork was limited, the UCLA 3-item loneliness (Hughes, 2004) scale was adopted to measure loneliness in the survey even though there is no validation study conducted in the country. Question wordings for the scale were:

- 1) How often do you feel that you lack companionship?
- 2) How often do you feel left out?
- 3) How often do you feel isolated from others?

Response categories of each item are 1) hardly ever (assigned 1 point), 2) some of the time (assigned 2 points) and 3) often (assigned 3 points). By summing the 3 items score, loneliness scores range from 3 to 9. Those survey participants with a score of 3 to 5 are considered to be not lonely and those with 6 points and higher can be considered as feeling lonely. Cronbach's Alpha for the UCLA 3-item Loneliness Scale was 0.76 and is considered acceptable.

Often in social surveys, questions regarding economic conditions such as household income tended to be asked toward the end of the surveys. In the questionnaire developed for the project, questions on economic condition of older persons and their family were asked at the end of the survey following the usual practice. This is done to prevent potential withdrawal from the survey. In the section on economic conditions of older persons, questions include changes in work hours, income and support from various sources.

b) Secondary Data:

In addition to the survey data, we analyzed secondary data available to us to examine conditions of older persons before the COVID-19 pandemic started as well as to understand the direct effects of COVID-19 on the health status of older persons. Secondary data are valuable sources of information to assess changes in status of older persons in terms of economic well-being, physical and mental health, and social well-being. Although the changes observed may not be attributable to the effect of COVID-19, the findings from the primary and secondary data analyses could suggest future direction of policies to be taken to

support older persons including those with disabilities. Secondary data used for the study include:

- 1) Population Census 2010 10% sample from IPUMS International (Individual data)
- 2) Number of confirmed cases of COVID-19 infection and death (Published data)
- 3) National Socio-Economic Survey/ *Survei Sosial Ekonomi Nasional* (SUSENAS) 2020 (Published data)
- 4) Analysis of the Social and Economic Impacts of COVID-19 on Households and Strategic Policy Recommendations for Indonesia (Publish data)
- 5) *Older People and COVID-19 in Indonesia* (Komazawa, et al. 2021, Published data)

c) **Statistical Analyses:**

We conducted descriptive analyses based on cross tabulations and comparison of means of variables of our interest to examine the economic, social, and health status of older persons. Differences in means and proportions by older persons' age and gender, if applicable by socioeconomic status and disability status were tested by applying appropriate descriptive statistical methods such as the t-test and chi-square test.

2. Qualitative Methods

In order to confirm the results from the interview survey and obtain a deeper understanding of the current situation of older persons, two Focus Group Discussions (FGD) were held.

a) **Focus Group Discussion with Older Persons**

Participants: Four persons, with the following inclusion criteria:

- 1) Aged 60 years old and older;
- 2) Male (2 persons) and female (2 persons) older persons who can participate in an online discussion;
- 3) Older persons from academic or professional groups and community leaders;
- 4) Strategic issues are taken from online survey results.

Time : March 18, 2022
Place : Hybrid online and offline
Theme : Strategic issues obtained from survey results using the GoLantang application, the impact of the COVID-19 pandemic on the older persons (including the older persons with disabilities)
Goal : To carry out a need assessment and to collect further information to support the survey results

Key points of discussions:

- 1) Impact of the COVID-19 on health, social well-being and economic well-being of older persons
- 2) Coping mechanism to overcome the impact of the COVID-19 pandemic
- 3) Access to health care facilities
- 4) The assistance needed and received

b) Focus Group Discussion with Government Officials

Participants: Seven officials from relevant ministries/governmental institutions concerning the current situation of older persons

- 1) Coordinating Ministry for Human Development and Cultural Affairs
- 2) Ministry of National Development and Planning
- 3) National Population and Family Planning Board
- 4) Ministry of Health
- 5) Ministry of Social Affairs
- 6) Ministry of Communication and Information
- 7) Ministry of Home Affairs

Time : March 17-18, 2022
Place : Hybrid online and offline
Theme : impact of the COVID-19 pandemic, programs, and challenges in implementation.
Goal : to complete the information obtained from the results survey and to get more information about decision-making for older person services (including the older person with disabilities) during and after the pandemic.

Key points of discussions:

- 1) Interventions implemented to provide social protections to older persons
- 2) Challenges during implementation

c) Analysis

The transcripts of the FGD were analyzed in order to identify themes. Furthermore, an analysis was carried out that aims to know the impact of the COVID-19 pandemic on the older person (including the older person with disability).

3. Challenges and Study Limitations

It was a big challenge to conduct the interview survey for primary data collection in two ways. First, it was the first time to use the GoLantang application on mobile devices to conduct a national survey. We did not have enough information on how the GoLantang application worked during the interviews and how the questionnaire we prepared for the survey was incorporated. There were issues with questions with multiple answers. Skip patterns in the questionnaire were not fully incorporated into the application. Later we also found that it needed time to make changes in questions and question wordings. Second, partly because of the pandemic, we had to organize training workshops for the interviewers online. Although interviewers had to understand the background of the questions asked and learn how to operate the GoLantang application on mobile devices, online training workshops and time constraints for the project forced many of the interviewers to go into the fieldwork without fully understanding the survey.

Because of an accident on the data server as described earlier, some of the survey data were lost. Examination of the remaining data does not seem to be biased. However, as shown later, distributions of some demographic variables from the current survey deviate from those in other national surveys. Therefore, we need to be cautious about the interpretation of the results.

In addition, the number of questions asked in the survey was limited because the scheduled duration of the fieldwork was very short, and we avoided forcing a heavy burden on both interviewers and older persons. Therefore, analyses based on the survey data were somewhat limited.



DATA ANALYSIS AND FINDINGS



Data Analysis and Findings

1. Basic demographic information of survey participants

The distribution by sex, age group, level of education and marital status of the respondents is shown in Table 4.1 with data from Susenas 2020 as reference. As can be seen, both the number and percentage of males are larger than that of females'. The percentages by sex and education deviate from the Susenas 2020 results. For the survey participants, more males and more older persons with middle school or higher education were selected. One of the reasons why educational levels of the survey participants are higher is because of the secondary sampling unit we used which is "city/district." Those who live in "city" are basically all urban residents but those who live in "district" are not necessarily rural residents.

Table 4.1. Characteristics of sampled older persons and comparison with Susenas 2020 results

		Unweighted N	Weighted %	Susenas 2020 %
Sex	Male	4,082	59.54	47.71
	Female	2,735	40.46	52.29
	Total	6,817	100.00	100.00
Age	60-69	4,359	63.50	64.29
	70-79	1,890	28.86	27.23
	80+	565	7.64	8.48
	Total	6,814	100.00	100.00
Education	No school/Elementary School	3,188	65.00	78.22
	Middle School or higher	2,630	35.00	21.78
	Total	6,817	100.00	100.00
Marital Status	Married	3,830	55.93	52.92
	not married	2,987	44.07	47.08
	Total	6,817	100.00	100.00

Sources: 2022 National Study data processing and 2020 SUSENAS data



It is worth mentioning that the distributions of the level of education, marital status and living arrangements are significantly different by sex and age among older persons in Indonesia. As can be seen in Table 4.2, 41.0% of male older persons have middle school education or higher but only 26.1% of female older persons have the same level of education. In addition, while 39.2% of older persons aged 60-69 have middle school education or higher, only 18.1% of those aged 80 and above have the same level of education. All percentages reported in this report are weighted percentages.

Marital status also exhibits differences in distributions by sex and age. More than 80% of male survey participants are married whereas the same percentage of their female counterparts are not married, but are mostly widowed. The percentage of those who are married decreased from 64.9% for those aged 60-69, to 44.8% for those aged 70-79, and to 23.6% for those aged 80 and over. These differences are also reflected in their living arrangements. Less than 5% of male older persons and 8.4% of older persons aged 60-69 live alone while 18.9% of females and 13.6% of older persons aged 80 and above reported they live alone. These differences can be mostly attributed to the differences in mortality and mean age at marriage by sex.

Tabel 4.2 Pendidikan, Status Pernikahan, dan Pilihan Tempat Tinggal menurut Jenis Kelamin dan Umur

(%)

		Total	Sex		Age		
			Male	Female	60-69	70-79	80+
Education	No education/elementary education	65.00	58.96	73.88	60.82	69.70	81.88
	Middle school or higher	35.00	41.04	26.12	39.18	30.30	18.12
	Total	100.00	100.00	100.00	100.00	100.00	100.00
Marital Status	Married	55.93	81.53	18.25	64.87	44.85	23.60
	Not married	44.07	18.47	81.75	35.13	55.15	76.40
	Total	100.00	100.00	100.00	100.00	100.00	100.00
Living Arrangements	Live alone	10.17	4.22	18.93	8.39	13.16	13.58
	Spouse only	19.71	28.74	6.42	21.29	19.26	8.35
	Spouse and others	31.15	45.13	10.58	37.91	20.83	14.09
	Child's family and others	32.23	17.46	53.97	27.73	36.57	53.12
	Others	6.74	4.45	10.11	4.68	10.17	10.85
	Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2022 National Study data processing

2. Impact of COVID-19 on family, friends, and neighbors of older persons

As mentioned above, older persons are the most vulnerable group of people to infection. The number of deaths has been disproportionately large among older persons aged 60 and over in Indonesia, as also observed in the world. Vaccination is the most effective way to prevent older persons from becoming seriously ill and dying. In the survey, older persons were asked whether they had been vaccinated against COVID-19. By February 15, 2022, it was reported that about 69% of the eligible population were at least vaccinated once. When the survey was conducted in February, survey results indicated that about 66% of older persons were at least vaccinated once. The vaccination rate among survey participants was about the same as the national figure. This means that 34% of older persons were not yet vaccinated by February 2022. The reasons for non-vaccination include "health conditions," "not willing," and "did not know vaccination was necessary." The majority, 69.2% of those

not vaccinated, reported they had health conditions that did not allow them to be vaccinated. Another 21.8% were not willing to be vaccinated. Some did not know that vaccination was necessary.

There were differences in the rates of vaccination by sex and age group. The rate of vaccination among male older persons was higher than for female older persons, and the higher the age, the lower the rate of vaccination. More than 50% of older persons aged 80 and over reported not being vaccinated compared to about 30% of those aged 60 to 69.

The direct impact of COVID-19 on the health of older persons as well as family members, relatives, friends, and neighbors were assessed by asking whether they were infected and know someone who died of COVID-19. COVID-19 infected less than 5% of the survey participants but only less than 1% were treated. The number seems to be a little lower than the national figure but maybe partly because those infected might have died by the time the survey was conducted. The survey participants were selected from the sampling frame dated January 1, 2021. Thirty-four sampled older persons were reported to have died when interviewers visited them for the survey.

About one in ten older persons reported that COVID-19 infected their family members, including relatives living outside of their houses, and 2.5% of survey participants said that they lost family members due to COVID-19. For older persons, knowing that family members were infected or have died during the pandemic might have affected their mental health. The economic well-being of older persons could have been affected by these events, too.

Although older persons might not have been impacted economically by knowing their friends or neighbors were infected or losing them, such events might have affected their emotional status and, in turn, their mental health. The differences in mental health status between those who had such experiences and those who did not have should be monitored in the future.

To understand the awareness of measures against the infection by older persons, questions were asked about how seriously older persons followed steps taken by the government to address the pandemic. As shown in Table 4.3, results indicated that the majority of older persons followed preventive measures recommended by the government. There were slight differences between males and females. Although the percentages are minimal, female older persons tended to report that they rarely

or have not taken preventive measures. Surprisingly, as the pattern suggests, older ages are not obedient in following preventive measures.

Table 4.3. After the government announced the health protocols for COVID-19, how obedient were you to follow the protocols?

	Total	Sex		Age		
		Male	Female	60-69	70-79	80+
Very obedient	30.93	30.43	31.69	32.37	28.88	26.75
Obedient	43.49	45.39	40.68	45.07	42.12	35.53
Obedient enough	21.42	21.48	21.33	19.92	23.06	27.69
Less obedient	3.27	2.38	4.58	2.08	4.63	7.94
Disobedient	0.89	0.32	1.72	0.56	1.31	2.09
Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2022 National Study data processing

3. Economic Well-being of Older Persons

The economic well-being of older persons has been a concern during the pandemic because economic activities have been restricted for quite some time. To examine the impact of the pandemic on the economic well-being of older persons, several questions were asked in the survey. At first, the working status of older persons was asked, as shown in Table 4.4. Based on the results, the percentage of older persons working before the pandemic started was 45.8%. Many of those who answered "Others" reported that they were farming and selling small items. Thus, about half of people aged 60 and above were working when the pandemic started. TNP2K (2020) report showed that 49.4% of older persons were working in 2019. Although the results from the survey were collected retrospectively, numbers were very similar to what was reported in 2019.

Among male older persons, 52.9% and 35.3% of female older persons were working. About one-third of older persons aged 80 and above also reported they were working. The percentage of older persons who were not working for health reasons and no desire to work increased with age.

Table 4.4. Work Status Before the Pandemic among Survey Participants (%)

	Total	Sex		Age		
		Male	Female	60-69	70-79	80+
Doing Business Independently	23.17	23.23	23.07	26.38	17.68	17.25
Doing Business and Getting Help from Unpaid Worker	1.37	1.69	0.89	1.57	0.79	1.83
Doing Business and Getting Help from Paid Worker	1.54	2.25	0.49	1.95	1.05	0.00
Paid Worker/ Employee	6.57	9.71	1.96	7.38	6.18	1.38
Freelance Worker	10.66	13.34	6.73	13.23	7.08	2.88
Family Worker/ Unpaid	2.48	2.72	2.14	2.30	1.45	7.84
Not working because of health reasons	4.39	4.92	3.61	3.52	5.70	6.64
Not working (not looking for work and not willing to work)	5.74	3.16	9.53	3.31	9.12	13.11
Not working but looking for job	0.49	0.21	0.91	0.15	1.34	0.08
Retired with pension	14.39	15.08	13.37	13.67	14.25	20.86
Retired without pension	16.20	11.60	22.97	14.12	20.35	17.82
Lost job	1.88	1.53	2.39	1.56	2.48	2.28
Others	11.12	10.56	11.94	10.86	12.52	8.03
Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2022 National Study data processing

Those who reported working before the pandemic were asked whether their work hours decreased when the survey was conducted (Figure 4.1). Almost half of them said that their work hours declined, although they did not lose their job. Measures taken against the pandemic, such as the Enactment of Community Activity Restrictions (PPKM: Pemberlakuan Pembatasan Kegiatan Masyarakat), must have affected their work hours. Reduced work hours could have affected sources of income for older persons themselves and support from their family members or relatives.

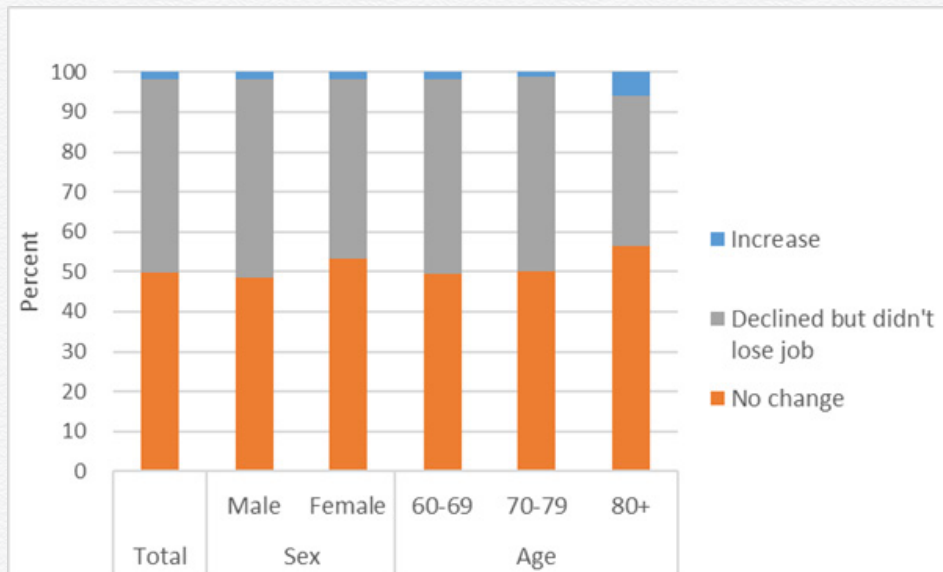


Figure 4.1 Changes in Work Hours
Source: 2022 National Study data processing

To assess the impacts of changes in work hours, changes in income from paid work were asked. As shown in Figure 4.2, more than 60% of working older persons reported that their income declined during the pandemic. The differences in the percentage of reduced income from paid work were observed between the sexes and age groups. However, these differences were not statistically significant. The percentage of older persons reporting reduced income decreased gradually by age. Some older persons reported an increase in their income from paid work, but the percentage of those who reported an increase was negligible. Although results are not shown here, changes in income from paid work were significantly different by the level of education. Older persons with middle school or more showed a higher percentage of no change and a lower percentage of decreased income from paid work.

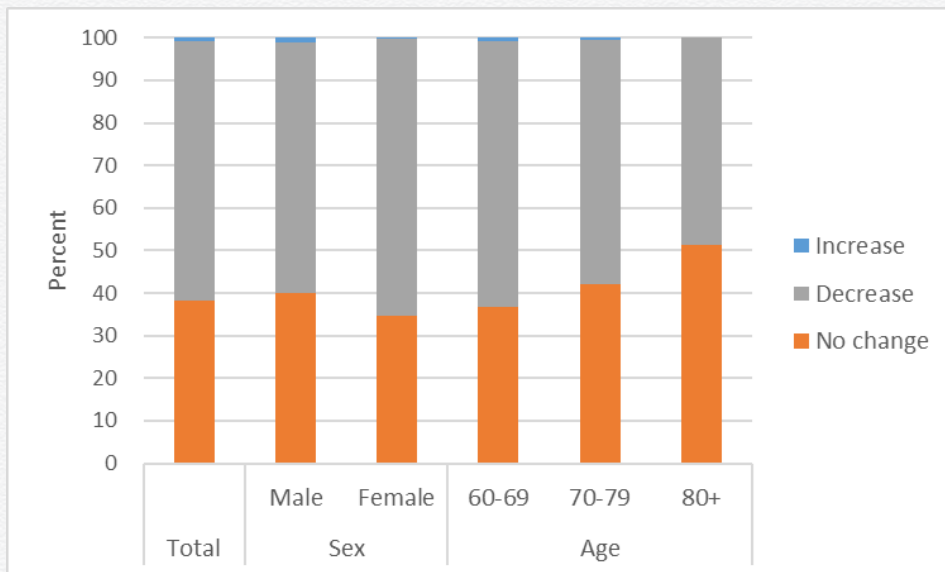


Figure 4.2 Changes in Income from Paid Work During the Pandemic Period

Source: 2022 National Study data processing

Questions on changes in support, including money and goods that older persons were receiving before the pandemic and at the time of the survey were asked from four different sources. First, a change in assistance from relatives/friends during the pandemic was asked. As shown in Figure 4.3, majority of older persons reported no change in assistance from relatives/friends. However, a little over one-third of older persons reported that received aid from relatives/friends decreased. Patterns of differences in reduced assistance from relatives/friends were similar to one observed in the reduced income from paid work. A small percentage of older persons reported that assistance from relatives/friends increased during the pandemic period. The

observed difference in assistance from relatives/friends by sex was statistically significant but not significant by age group.

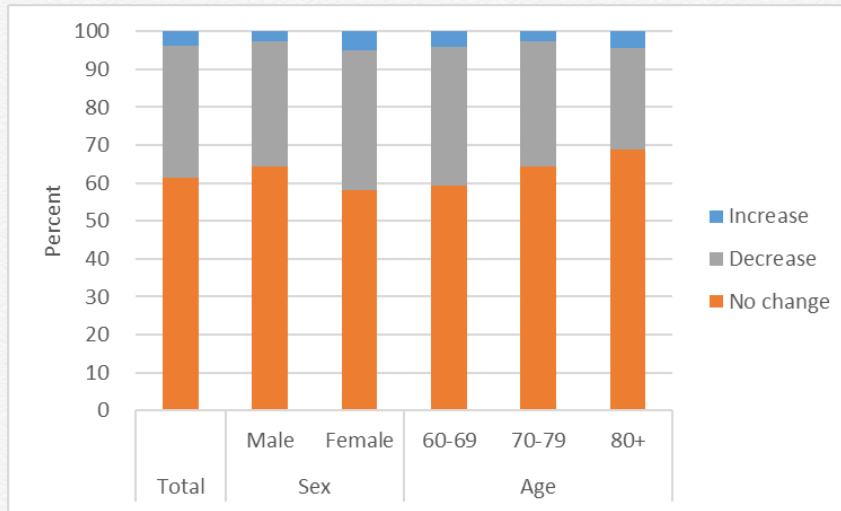


Figure 4.3 Changes in Assistance from Relatives/Friends During the Pandemic Period
 Source: 2022 National Study data processing

Overall, changes in assistance received from relatives/friends living abroad by sex and age group were shown in Figure 4.4. Results were very similar to observed changes in assistance received from relatives/friends living within the country. More female older persons reported decreased amount of assistance. Among those who reported no change in assistance from relatives/friends living in abroad, the percentage is higher in older age groups. Very few older persons reported that the assistance they received from abroad increased.

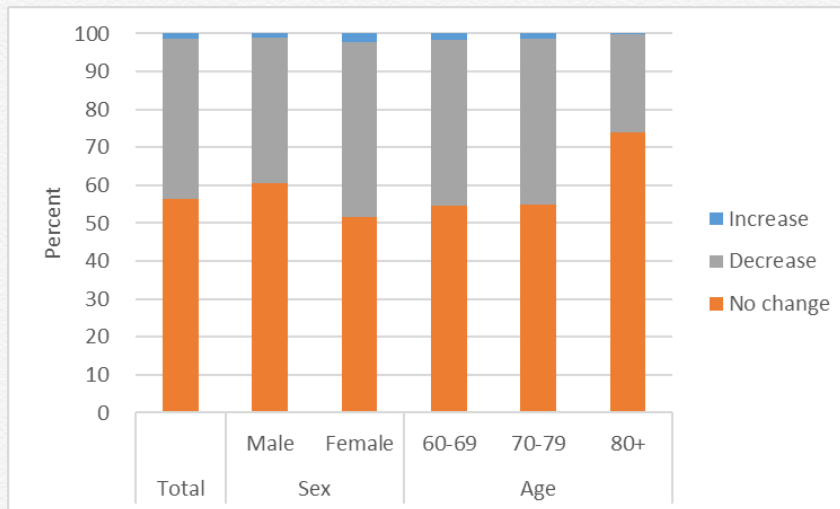


Figure 4.4 Changes in Assistance from Relatives/Friends Living in Abroad During the Pandemic Period
 Source: 2022 National Study data processing

Figure 4.5 shows changes in support from the government. At the time of the survey, about 50% of older persons were receiving support from the government. There is a sizable percentage who reported an increase in support from the government. At the same time, about thirty percent of older persons reported that support from the government decreased. Differences in support from the government by sex were not significant but the differences by age group were statistically significant. The percentage of those who reported a reduction in support from the government decreases as age increases. For older persons aged 80 and over, the percentage of those who reported increases in support from the government was higher than those who reported decreases in support.

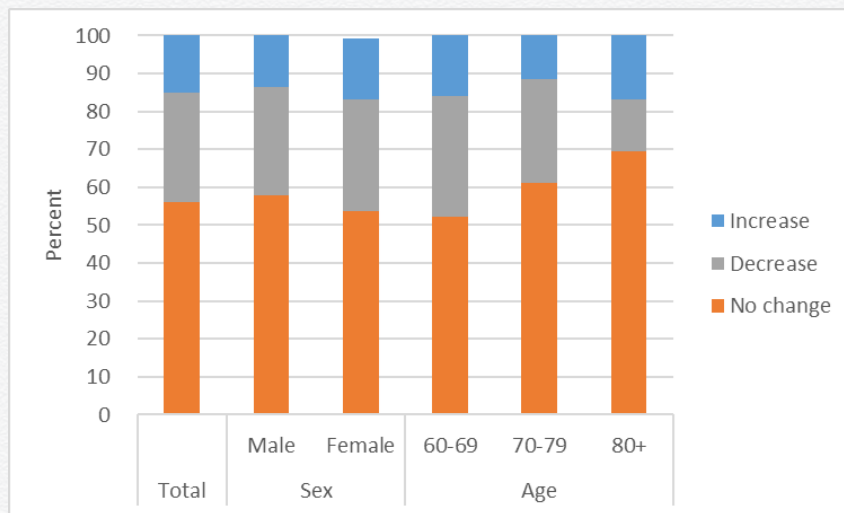


Figure 4.5 Changes in Support from the Government During the Pandemic Period
Source: 2022 National Study data processing

Patterns of changes in support that older persons were receiving from NGOs and other organizations during the pandemic period were similar to the patterns observed for support from the government. About 30% of older persons were receiving support from NGOs and other organizations. Interestingly, most older persons who received support from NGOs were also receiving support from the government. Very few older persons were receiving support only from NGOs and other organizations. About ten percent of older persons reported they received more support from NGOs, while about thirty percent reported less support from NGOs during the pandemic period. Female older persons reported a higher percentage of increased support and a higher percentage of decreased support than their male counterparts. However, the difference was not significant. On the

other hand, the difference by age group was statistically significant. More than eighty percent of older persons aged 80 and above reported no change in support from NGOs, and about ten percent each for those who reported an increase and decrease in support from NGOs.

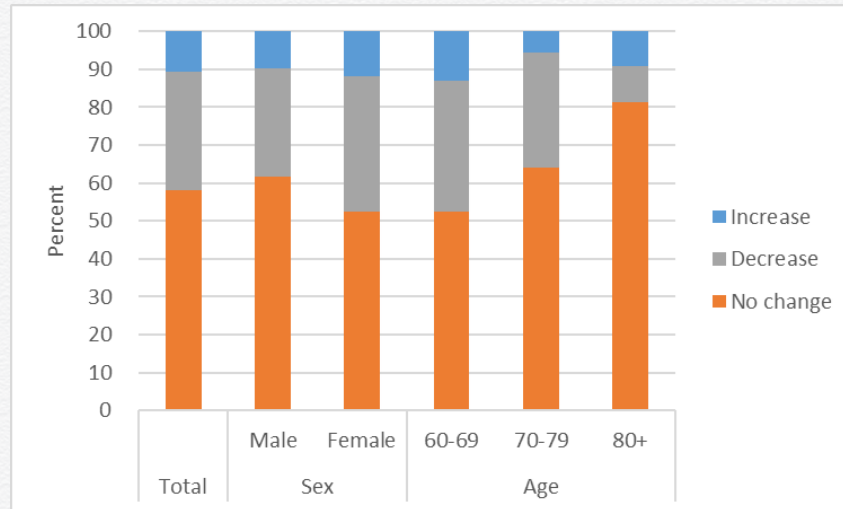


Figure 4.6 Changes in Support from the NGOs and Other Organizations During the Pandemic Period
 Source: 2022 National Study data processing

Overall, the percentages of older persons reporting decreases in assistance and support were much higher than those reporting increase for all sources. Women reported higher percentages of reduction in support. The percentages of reduced support were lower for higher age groups. One observation that may be worth mentioning is the observed patterns for older persons aged 70-79. The percentages of those aged 70-79 reporting increases in support were the lowest, although the magnitude of the percentages is low. In addition, the differences in receiving assistance from relatives/friends are statistically significant by sex but not by age group, while the differences in support from the government and NGOs are statistically significant by age group but not by sex. These differences may be because of the differences in marital status and living arrangements by sex.

Questions on the perceived economic well-being of older persons before the pandemic started and at the time of the survey were also asked. Figure 4.7 shows the perceived economic well-being of older persons before the pandemic. Overall, 46.3% of older persons reported they had some difficulty in meeting expenses. The percentages do not vary much by sex and age group. As mentioned previously

about the peculiar patterns of older persons aged 70-79, they reported the highest percentages of economic hardship even before the pandemic started.

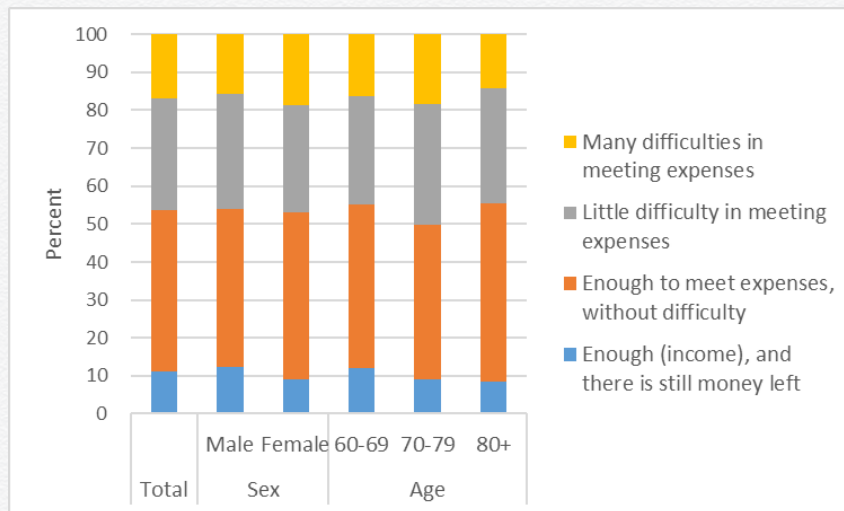


Figure 4.7 Perceived Economic Well-being by Older Persons Before Pandemic
 Source: 2022 National Study data processing

The status of perceived economic well-being of older persons at the time of the survey is shown in Figure 4.8. The percentage of older persons who reported at least some difficulty in meeting expenses increased to 51.4% from 46.3% at the time of the survey. The percentage of older persons that reported many difficulties in meeting expenses exceeded 20%. The differences in perceived economic well-being between sexes and age groups seem to be similar. Economic conditions of older persons aged 70-79 seem to exacerbate during the pandemic.

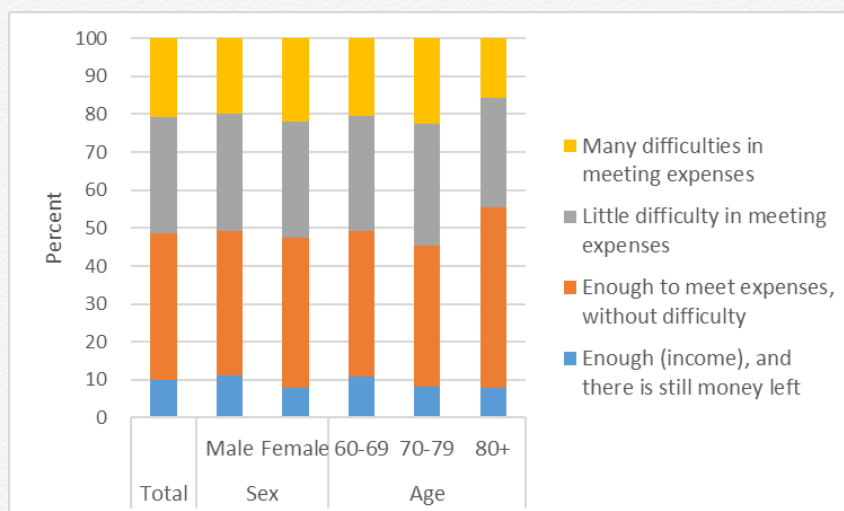


Figure 4.8 Perceived Economic Well-being by Older Persons at the Time of Survey
 Source: 2022 National Study data processing

Table 4.5 shows factors associated with the perceived economic well-being of older persons at the time of the survey. Results indicated that 32.1% of the older person with more than middle school education reported at least some difficulty in meeting expenses, while 63.3% of older persons with elementary school or less reported economic hardship. The percentages of having difficulty meeting expenses among “married” older persons living in “city” were lower than their counterparts. In addition, more than 70% of older persons living alone reported that they had little or many difficulties in meeting expenses. It is worth mentioning that these results are based on bivariate analyses. All these factors are closely interwoven with each other and age and sex. Detailed analyses of factors affecting the lives of older persons are needed.

Table 4.5. Factors Associated with Perceived Economic Well-being by Older Persons at the Time of the Survey (%)

	Low Education**		Married**		Place of Residence**		Live Alone**	
	No	Yes	No	Yes	District	City	No	Yes
Enough (income), and there is still money left	17.82	4.89	7.02	11.91	7.47	12.49	10.22	6.50
Enough to meet expenses, without difficulty	50.07	31.82	39.23	38.48	33.00	45.33	40.60	22.94
Little difficulty in meeting expenses	20.62	36.98	30.01	31.26	35.36	25.50	30.61	31.78
Many difficulties in meeting expenses	11.50	26.31	23.75	18.36	24.17	16.68	18.57	38.78
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Note: ** indicates statistically significant at 0.01 level.

Source: 2022 National Study data processing

Those mentioned above as perceived economic well-being of older persons were based on the responses of the survey participants. Individual changes in the perceived economic well-being of older persons were examined by comparing perceived economic well-being before the pandemic and the time of the survey. About eighty-five percent of older persons responded to the same response categories in two questions on perceived economic well-being (Figure 4.9). Only 3.3% of older persons indicated improvement in perceived economic well-being, while 11.9% of older persons responded to a worsening perceived economic well-being. The percentage of older persons with worsening perceived economic well-being may not be high. However, more than half of older persons reported that they had at least some difficulty meeting their daily expenses.

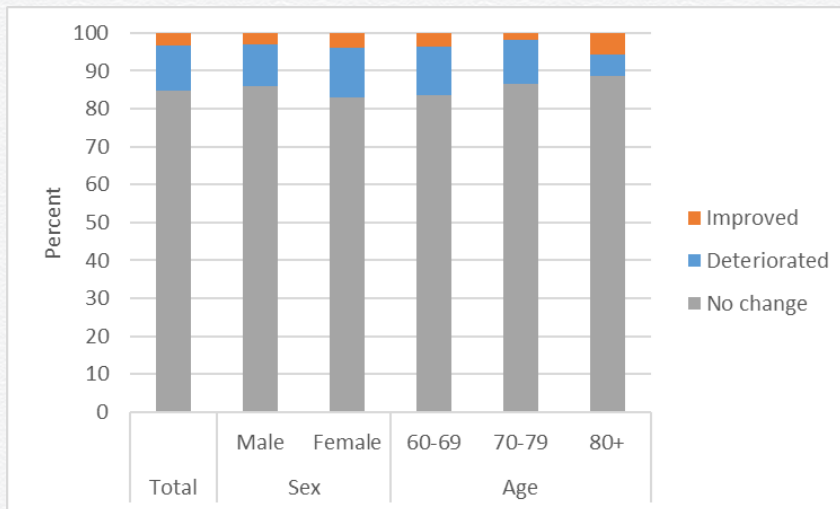


Figure 4.9 Changes in Perceived Economic Well-being by Older Persons During Pandemic Period

Source: 2022 National Study data processing

Worsened economic conditions were certainly affected by the pandemic. In addition, measures taken to combat the pandemic such as PPKM made it hard for older persons to undertake economic activities. Older persons were asked about their economic perspectives under a hypothetical situation. Almost forty percent of older persons responded they would have difficulties to pay for expenditure of basic need if PPKM is reinstated (Figure 4.10). Another 20% indicated potential difficulty with the next round of PPKM. These results suggest that if the government decide to reinstate PPKM, they should have enough safeguard for older persons in economic hardship.

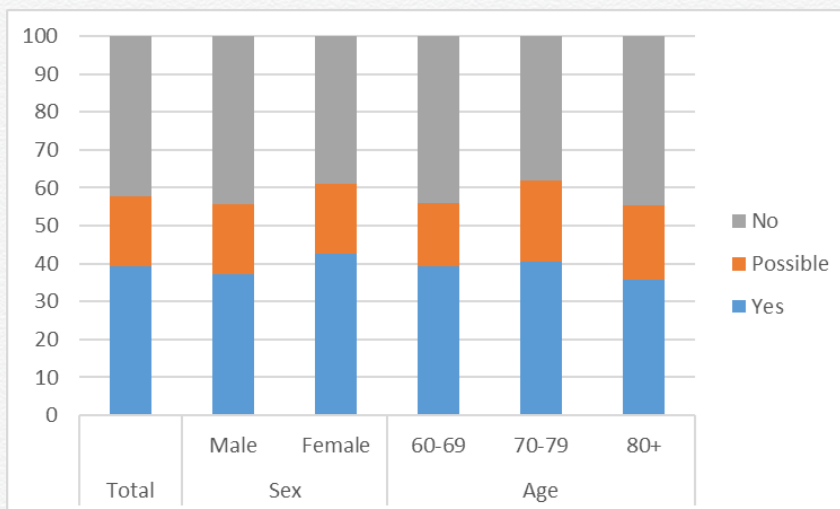


Figure 4.10 Perceived Difficulties to Pay for Expenditure of Basic Need If PPKM is Reinstated

Source: 2022 National Study data processing

Because many older persons were struggling with their lives, understandably, almost 70% of older persons reported they need help to live a life like what they had before the pandemic (Figure 4.11). Although there is no certainty of this occurring, results seem to suggest that many older persons are needing help to recover from the impact of the pandemic. There are more women than men who indicated that they need help to “live a life like it was before the Covid-19 pandemic”. There is no significant differences among age groups in needing help. As shown in Figure 4.12, the help needed the most by older persons is financial support followed by groceries and goods.

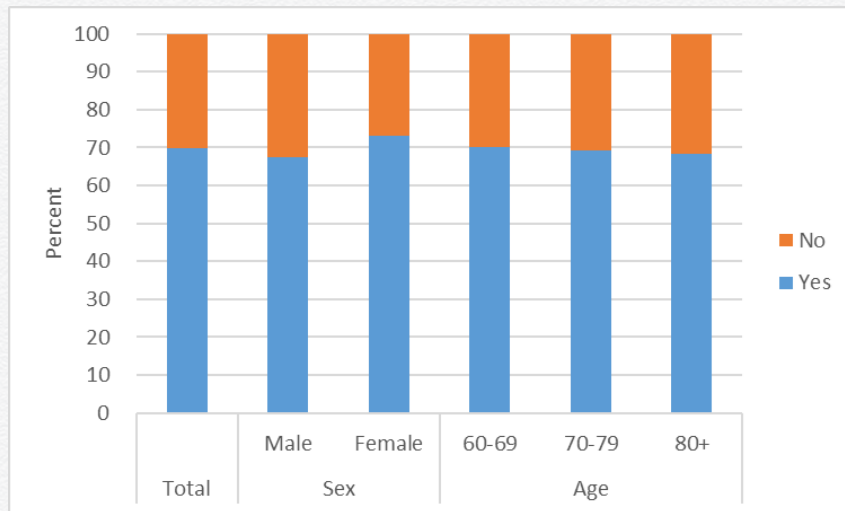


Figure 4.11 Need Help to Live Life as it was before the Pandemic
 Source: 2022 National Study data processing

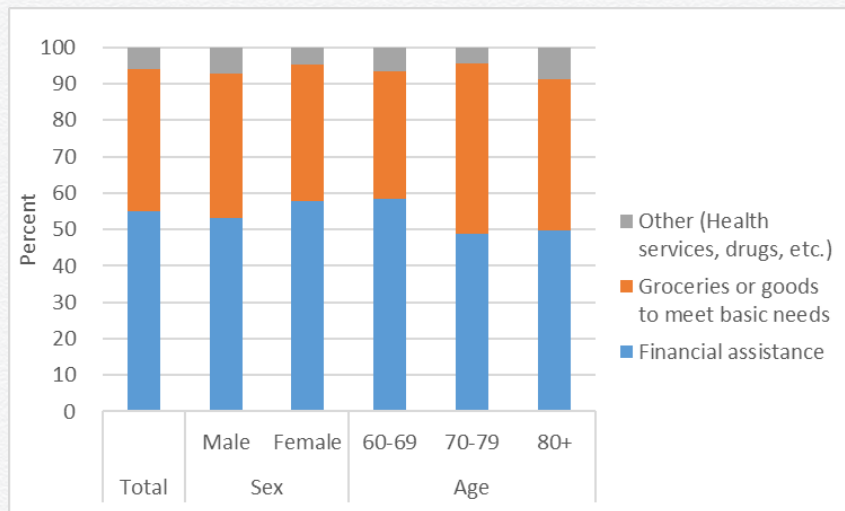


Figure 4.12 Kind of Assistance Needed
 Source: 2022 National Study data processing

4. Health (include physical and mental) Status of Older Persons

a) General Health Status

Using cross-sectional survey data, it is difficult to identify or quantify the effect of the COVID-19 pandemic on older persons. However, at least by asking their health status at the time of the survey and their health status before the pandemic started, the potential effects of the pandemic on the health of older persons can be understood. Self-rated health (SRH) at the time of the survey and retrospectively, before the pandemic started as representing the general health of older persons was asked in the study. Figure 4.13 shows that the percentage of older persons who reported positively on their health status decreased compared to before the pandemic started. The difference in the percentage by sex was not significant, but it was statistically significant by age group.

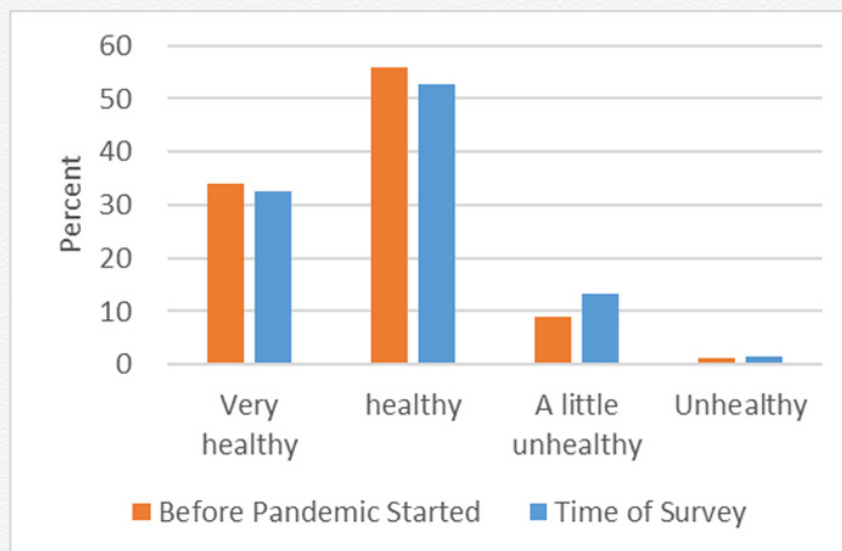


Figure 4.13 Self Rated Health of Older Persons before the Pandemic and at the Time of Survey

Source: 2022 National Study data processing

In addition, the observed differences in SRH by the level of education, marital status, and city/district were examined. As shown in Table 4.6, these factors were significantly associated with self-rated health at the survey time. More older persons with a lower level of education, not married, and residing in the district reported being in unhealthy health states.

Table 4.6. Factors Associated with Self-rated Health at the Time of the Survey (%)

	Low Education**		Married**		Place of Residence**	
	No	Yes	No	Yes	District	City
Very healthy	42.77	26.80	28.06	35.79	26.22	40.62
Healthy	47.07	56.03	53.66	52.19	56.99	47.46
A bit unhealthy	9.53	15.45	15.87	11.47	15.19	10.92
Unhealthy	0.62	1.73	2.41	0.56	1.60	0.99
Total	100.00	100.00	100.00	100.00	100.00	100.00

Note: ** indicates statistically significant at 0.01 level.

Source: 2022 National Study data processing

Individually, improvements and deterioration of health among older persons were observed, but the percentage of older persons who experienced deterioration of their health was larger than the one for improvement, as shown in Figure 4.14. Older persons who did not experience change over the same period were excluded from the figure. About 88% of older persons aged 60-69 and about 95% of older persons aged 80 and over reported no change in SRH in two-time points.

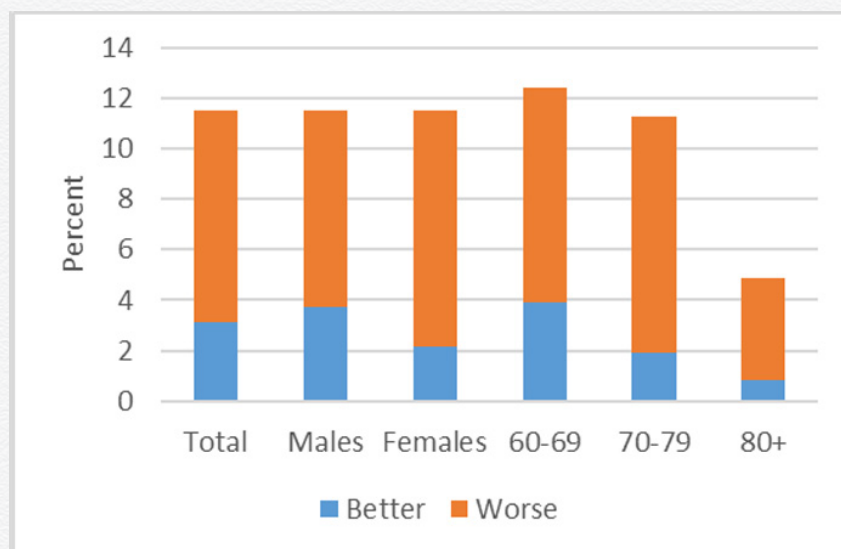


Figure 4.14 Changes in Self Rated Health of Older Persons

Source: 2022 National Study data processing

b) Chronic Conditions

Table 4.5 compares the prevalence rates of having chronic conditions among older persons at two-time points before the current survey. Because the previously reported prevalence rates were based on older persons mainly living in cities, results from the recent survey for the whole sample and only those living in cities (Kota) are shown in the table. Comparing the prevalence rates among older persons living in cities, heart disease and stroke seemed to increase during the pandemic period. However, the prevalence rate for reporting high blood pressure is lower than before the pandemic but higher than the rate observed in July 2020. The prevalence rate of reporting diabetes showed a declining trend over time while older persons having lung disease and kidney disease somewhat increased from the early period of the pandemic but decreased from the time before the pandemic started among those living in cities. One factor in helping improve lung disease among older persons is the improvement of air quality, and during the pandemic, with less mobility and road congestion, this might have happened.

Table 4.7 Comparison of Prevalence Rates for Selected Chronic Conditions (%)

Kondisi Kronis	Sebelum Pandemi COVID-19	Survei lewat Telepon pada Juli 2020	Survei wawancara pada Februari 2022**	
			Seluruh sampel	Hanya kota
Tekanan Darah Tinggi	36.33	26.93	31.05	29.07
Sakit Jantung	8.53	6.66	8.30	10.04
Diabetes	12.79	11.21	9.73	10.49
Sakit Paru-Paru	4.32	2.34	7.17	3.93
Sakit Ginjal	2.22	1.14	3.13	1.98
Stroke	4.50	3.07	6.34	4.83

Note: **Weighted prevalence

Sources: Komazawa et. al., 2021. "Older People and COVID-19 in Indonesia" 2022 National Study data processing

Questions on conditions also include dementia/senility. The percentage of older persons reported with dementia was 6.7%. Hogervorst, et. al. (2021) reported the prevalence of dementia among older persons aged 60 and over in Indonesia varied between urban (3%) and rural sites (7–16%) (Hogervorst et. al., 2011). However, the recently conducted study in Yogyakarta showed higher prevalence

rate of 20.1% (Suriastini, et. al., 2020). Results from the survey indicated that the prevalence rate for older men (5.2%) was lower than one for older women (9.0%) and the difference was significant. Older persons aged 80 and over showed much higher prevalence rate of dementia (25.4%) compared to older persons aged 60-69 (4.0%). The differences across age group were also statistically significant.

c) **Functional Disability**

Using the 10% sample of 2010 Population Census of Indonesia provided by IPUMS International (Minnesota Population Center, 2020)¹ and the published data for the 2019 Susenas (TNP2K, 2020), prevalence rates of disability were compared with the results from the current study. Two composite measures of disability were constructed based on the 2010 Population Census data and the current survey and compared the prevalence of disability in three time points by sex. First one is “having at least one difficulty among six activities.” Second one is “having at least one SEVERE difficulty among six activities.” The latter composite measure could be an indicator of older persons who may need long-term care (LTC).

The percentage of older persons who had at least one functional difficulty increased from 26.0% in 2010, to 44.8% in 2019 and to 56.2% in 2022 (Figure 4.19). The observed increases in the prevalence of disability were 18.8 percentage points between 2010 and 2019 and 11.4 percentage points between 2019 and 2022. The prevalence of disability increased 2.1 percentage points every year on average between 2010 and 2019, and 3.8 percentage points between 2019 and 2022. The increase between 2019 and 2022 was higher than one for between 2010 and 2019. The differences could be caused by the pandemic although the difference may not be attributable to the pandemic entirely. The observed changes in the disability prevalence could be also caused by the changes in the age structure among older persons. Nevertheless, the large increases in the prevalence of disability needed to be investigated more in detail.

The pattern observed in changes in the prevalence of disability by sex was similar to the total. For male older persons, the prevalence increased from 23.3% in 2010 to 51.1% in 2019, and for female older persons, it increased from 28.2% to 63.7% over the same period. The increases in the prevalence were higher for older female persons and the difference by sex was statistically significant.

¹ The author wishes to acknowledge BPS Statistics Indonesia that provided the 10% sample data of 2010 Population Census making this study possible.

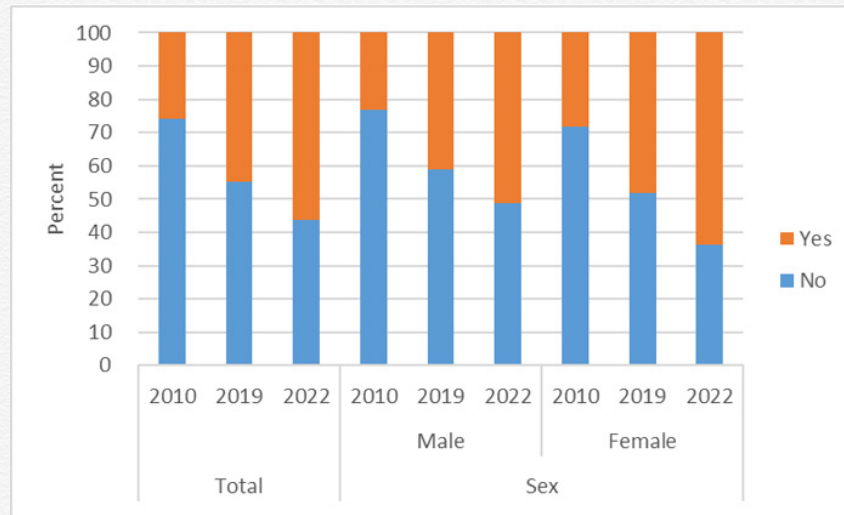


Figure 4.15. Changes in Prevalence of Having at Least One Functional Difficulty among Older Persons by Sex: 2010, 2019 and 2022

Sources : 2010 Population Census; *The Situation of the Elderly in Indonesia and Access to Social Protection Programs: Secondary Data Analysis*; 2022 National Study data processing

Changes in the second composite measure of disability among older persons with having at least one severe functional difficulty by sex were shown in Figure 4.16. Although the magnitude of numbers was not as large as one based on the first composite measure, the increase in the prevalence was observed mainly between 2010 and 2019. The majority of older persons with at least one severe functional difficulty increased from 4.8% in 2010 to 14.4% in 2019 and 13.9%. The prevalence of disability slightly decreased between 2019 and 2022. This is because the prevalence of severe disability declined from 12.4% in 2019 to 11.1% in 2022 for male older persons. The prevalence of severe disability for female older persons increased from 16.3% in 2019 to 18.1% in 2022. Older persons with at least one severe disability were potentially needing long-term care. The changes in the prevalence of severe disability especially among female older persons should be carefully monitored even after the pandemic is under control.

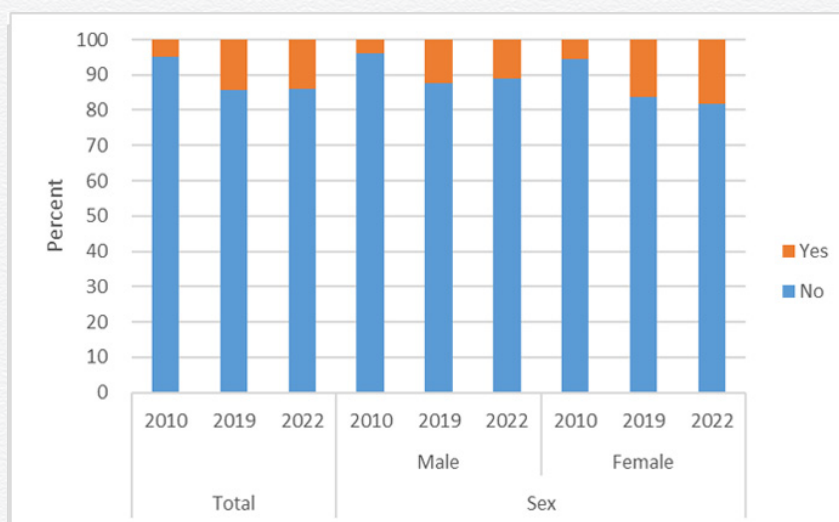


Figure 4.16. Changes in Prevalence of Having at Least One Severe Functional Difficulty among Older Persons by Sex: 2010, 2019 and 2022

Sources: 2010 Population Census; *The Situation of the Elderly in Indonesia and Access to Social Protection Programs: Secondary Data Analysis*; 2022 National Study data processing

Changes in the prevalence of disability among older persons by age group are shown in Figure 4.16. Considerable increases in the prevalence of disability among older persons were observed for all age groups. The prevalence rates of disability were higher for older persons aged 80+ compared to other age groups both in 2010 and 2022. However, rates of increase in the prevalence rates were higher for older persons aged 60-69 (changed from 18.0% in 2010 to 50.3% in 2022) compared to other age groups (33.0% to 61.9% for 70-79 and 51.7% to 83.6% for 80+).

Changes in the prevalence of severe disability among older persons by age group were also shown in Figure 4.16. Compared to the prevalence of disability, changes were not substantively large. However, the change in the prevalence rates was much higher for older persons with severe disability. The prevalence rates increased from 2.3% in 2010 to 9.3% in 2022 for older persons aged 60-69, from 6.0% to 18.7% for older persons aged 70-79 and 15.2% to 34.0% for older persons aged 80+. It is important to remember that these observed changes might have occurred between 2010 and 2019 as described before.

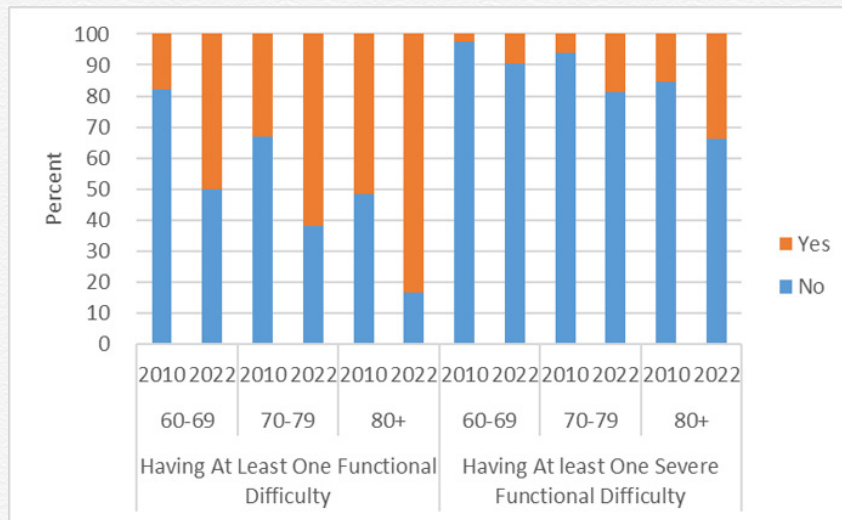


Figure 4.17. Changes in Prevalence of Having at Least One Functional Difficulty and at Least One Severe Functional Difficulty among Older Persons by Age: 2010 and 2022

Sources: 2010 Population Census and 2022 National Study data processing

In addition to age and sex, education and marital status were significantly associated with having at least one functional difficulty among older persons, as shown in Table 4.8. Older persons with lower education and not married had a higher prevalence of disability. The difference in disability by District/City was not significant at 0.01 level but nearly significant at 0.05 level.

Table 4.8. Prevalence Rates of Older Persons with at Least One Difficulty (%)

	Low Education**		Married**		Place of Residence	
	No	Yes	No	Yes	District	City
No	56.18	37.15	35.29	50.52	37.22	52.24
Yes	43.82	62.85	64.71	49.48	62.78	47.76
Total	100.00	100.00	100.00	100.00	100.00	100.00

Note: ** indicates statistically significant at 0.01 level.

Source: 2022 National Study data processing

Having functional difficulties and receiving help for daily activities at home are two different things. Older persons with functional difficulties may not be able to receive support or assistance if they are living alone. On the other hand, older

persons who have only some difficulties performing daily activities may rely on family members if they can ask for help easily. As shown in Figure 4.21, one-third of older persons were receiving help at home. The difference in receiving help for daily activities at home by sexes was not significant, but it was significant by age group. The percentage of older persons aged 80 and above receiving help at home was much higher than those aged 60-69, 57.0% vs. 33.1%, respectively.

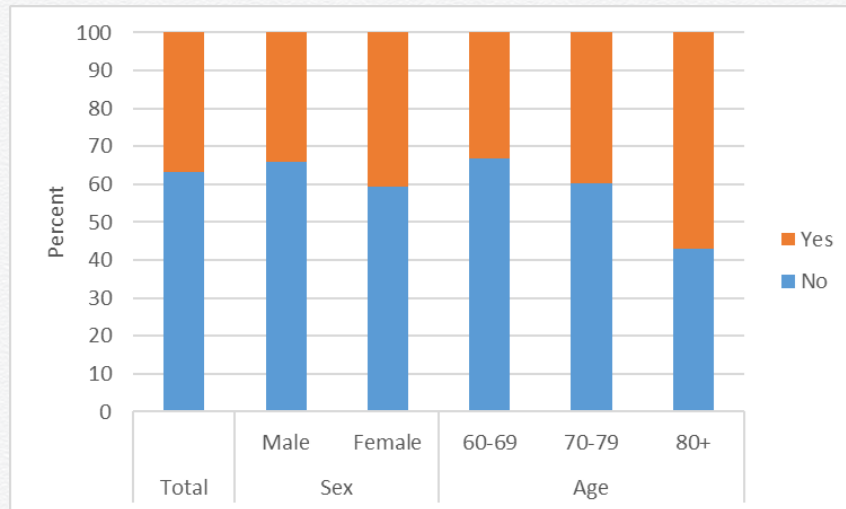


Figure 4.18 Receiving Help for Daily Activities
 Source: 2022 National Study data processing

d) Depression among Older Persons

As explained previously, the 15-item and 14-item versions of GDS were used to assess depression among older persons. As shown in Table 4.6, older persons who answered “yes” to the question “Would you rather stay at home than go out and do something new?” was very high, 73.9%. Therefore the 14-item version of GDS with the cut-off point of 6 was used to discuss depression among older persons. This is because the prevalence of depression based on 14-item GDS is the most conservative estimate of depression prevalence. The overall prevalence rate of depression among older persons was 6.9% on 14-item scale and 9.2% on 15-item scale. Therefore, the actual value of the depression prevalence lies somewhere between these two values if the scale measures depression as intended. There are studies on the prevalence of depression among older persons using GDS in Indonesia, and the level of depression reported ranges from 33.8% (Wada et. al., 2005) to 53.6% (Kurniawidjaja et. al., 2022). A prevalence rate of 42.5% was reported for older persons in a nursing home in Indonesia (Pramesona and Taneepanichskul, 2018). Compared to these existing studies, the results from the

current study seem to be very low. However, these studies are limited in sample size and scope. There is another study of depression among older persons in Indonesia using a different instrument to assess the depression prevalence. Using Mini-International Neuropsychiatric Interview (MINI) version 6, Idaiani and Indrawati (2021) reported a prevalence rate of 7.7% based on a large national sample survey.

Table 4.9. Depression among Survey Participants (%)

	Yes	No	Total
Would you rather stay at home than go out and do something new?	73.90	26.10	100.00
Depressed: 15 item version of GDS	9.22	90.78	100.00
Depressed: 14 item version of GDS	6.92	93.08	100.00

Sumber: Pengolahan data Studi Nasional 2022

Figure 4.22 shows prevalence of depression by sex and age group for both the 14-item GDS and the 15-item GDS. However, the following discussion is based on the 14-item GDS prevalence. Women had a little higher prevalence rate of depression, 7.2% compared to men, 6.7%. The difference between both sexes is not statistically significant based on chi square test. A clear pattern was observed by age group: the higher the age the higher is the prevalence rate. For those aged 80 and above, the prevalence rate was 17.7%. The difference across age group is statistically significant.

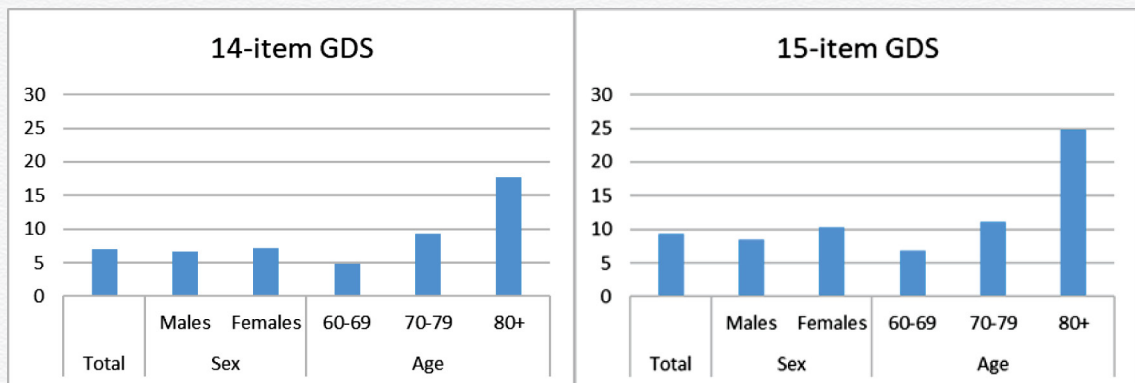


Figure 4.19 Prevalence of Depression by Sex and Age

Sumber: Pengolahan data Studi Nasional 2022

The differences in prevalence of depression among older persons were statistically significantly across different levels of education and marital status (alpha=0.01 level). Older persons with lower education and not married had a higher prevalence of depression. Older persons living in a city showed lower levels of depression compared to those living in a district region. Older persons living alone also exhibited a higher prevalence of depression, which is also significant at 0.1 level.

Table 4.10. Factors Associated with Depression among Older Persons at the time of the Survey (%)

	Low Education**		Married**		Place of Residence*		Live Alone	
	No	Yes	No	Yes	District	City	No	Yes
No	96.95	90.90	90.33	95.07	91.11	95.60	93.44	89.65
Yes	3.05	9.10	9.67	4.93	8.89	4.40	6.56	10.35
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Note: ** indicates statistically significant at 0.01 level.

* indicates statistically significant at 0.05 level.

Source: 2022 National Study data processing

5. Health Service Utilization

Table 4.7 shows the impact of the COVID-19 pandemic on health care utilization among older persons. The results indicate that the impact on health care utilization was not that serious. From the individual perspective, some people experienced serious problems accessing health care. However, overall, only about three percent of older persons reported that they had some issues using health care services. Three-quarters of older persons did not have any delays or cancellations of health care services, and 21.6% of older persons did not need to use health care services. There were no significant differences in health care utilization between the sexes and age groups.

Table 4.11. Impact of the Pandemic on Health Care Utilization

	Total	Sex		Age		
		Male	Female	60-69	70-79	80+
Postpone or cancel the use of essential health services as needed	1.35	1.23	1.54	1.43	1.33	0.77
Postpone or cancel the use of necessary non-essential health services	0.77	0.81	0.71	0.67	1.06	0.49
Postpone or cancel the use of preventive health services	1.02	0.84	1.27	0.93	0.97	1.86
No delays or cancellations of health services	75.22	74.08	76.89	73.77	78.00	76.72
No need for health services	21.65	23.04	19.59	23.19	18.64	20.16
Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2022 National Study data processing

Among older persons needing medication, 15.5% of them experienced difficulties receiving medicine during the pandemic, as indicated in Figure 4.23. Differences in the percentage of having difficulty receiving medicine by age group were observed, but the differences were relatively small and were not statistically significant. The percentages observed by sex were almost identical.

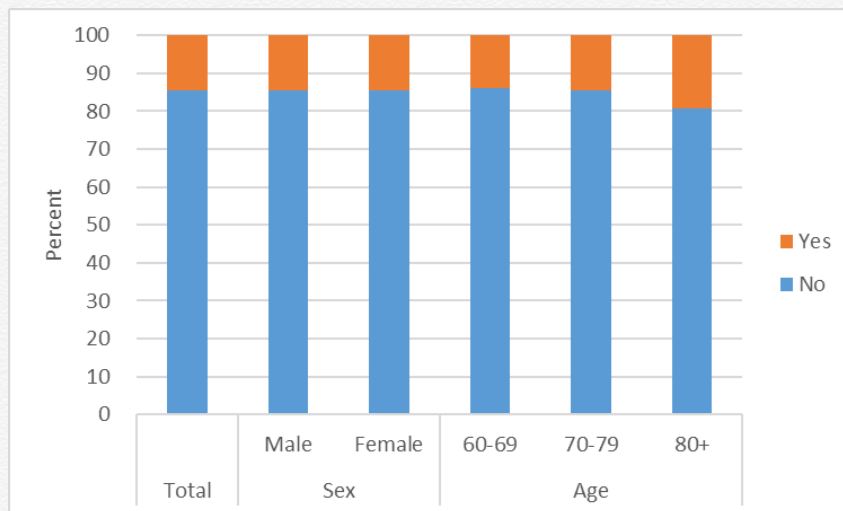


Figure 4.20 Having Difficulty Receiving Medicine During the Pandemic

Source: 2022 National Study data processing

Health care utilization could be affected by the pandemic and health insurance. Whether older persons have their health insurance was asked in the survey. Overall, as shown in Figure 4.24, 70% of older persons had health insurance. The percentage matches the number shown in the report by TNP2K (2020). More than 40% of older persons were covered by BPJS PBI type of insurance (the Government-financed health insurance program for the poor and near-poor), and 26.0% of older persons were covered by BPJS Non-PBI type insurance. Yet, about 30% of older persons were not covered by any health insurance schemes. Many of them seem to be working in the informal sector. Private insurance is available, but those with such health insurance are very small, 3.0%. The patterns of having health insurance between males and females were not different, while the patterns by age groups were statistically significant. The percentage of having BPJS PBI type of health insurance was the lowest among older persons aged 70-79.

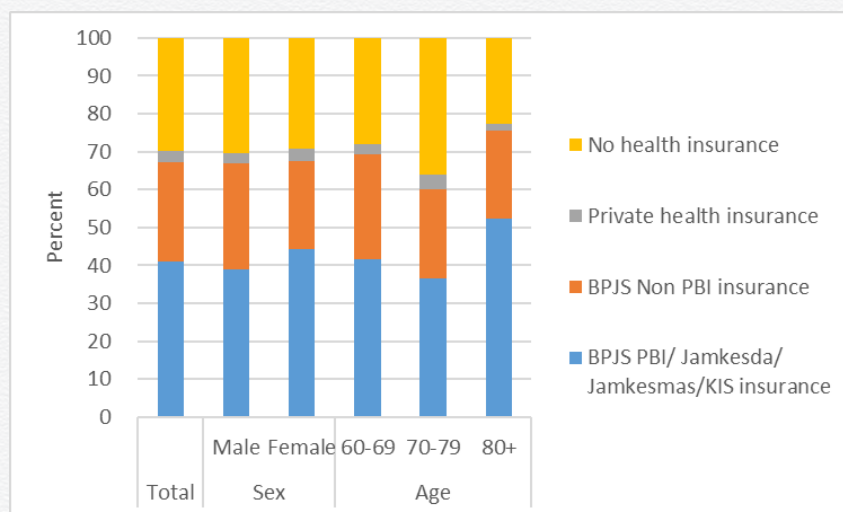


Figure 4.21 Health Insurance
 Source: 2022 National Study data processing

6. Falls

Falls are another global public health concern. As reported by the World Health Organization (2021), “falls are the second leading cause of unintentional injury deaths worldwide,” and “adults older than 60 years of age suffer the greatest number of fatal falls.” In addition, injurious falls could cause hospitalization and disability. Hospitalization of older persons may, in turn, eventually results in mental disorders. Because most falls (67%) among older persons occur within the home environment (Ministry of Health Republic of Indonesia, 2018), and older persons spend more time at home during the pandemic period, it is better to monitor such events among older adult persons.

The overall prevalence of falls among survey participants was 15.4%. A recently conducted study on falls in ASEAN countries reported that the prevalence rate of falls among older persons in the Philippines was 17.7% and 7.3% in Viet Nam (Mgabhi et al., 2021). The prevalence rate for Indonesia seems to be comparable to one for the Philippines.

Studies on falls have been conducted in Indonesia to examine the prevalence and correlates of falls. Susilowati et al. (2020) reported a prevalence rate of 29.0% using a small regional sample including an institutionalized population. The reported prevalence of falls among those aged 55 and over by Nugraha et al. (2021) was 19.0%, based on survey data from West Java. They also reported that among those who fell, 67.2% did so once, and the rest fell more than twice. Pengpid and Peltzer (2018) examined falls using data from the Indonesian Family Life Survey conducted in 2014-2015. However, their focus was on injurious falls and reported a 12.8% prevalence rate.

The prevalence of falls among older persons by sex and age group is shown in Figure 4.25. Females had higher prevalence rates (19.5%) than males (12.6%), and the difference is statistically significant. The difference in prevalence rates of falls by age group is also substantial and increases as age increases. Among those who fell, 37.9% of them were injured. The rate of injury was higher for males (44.8%) than for females (31.2%), and the difference was significant. As can be expected, older persons with a higher frequency of fall experiences or who were injured tended to report that they walk slower or make adjustments for fear of falling while doing daily activities.

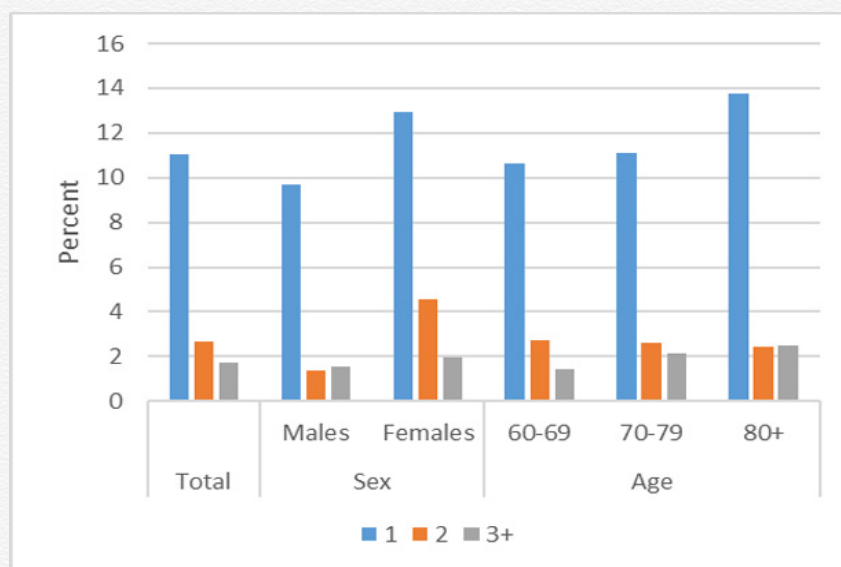


Figure 4.22 Experience of Fall over the Last 1 Year
 Source: 2022 National Study data processing

7. Social well-being of older persons

As mentioned by WHO, loneliness and social isolation are “increasingly being recognized as a priority public health problem and policy issue for older people” (World Health Organization, 2021). These issues will undoubtedly be dealt with through the UN Decade of Healthy Ageing by countries with an increasing number of older persons. Loneliness and social isolation are distinct concepts. Loneliness is the subjective perception of discrepancy between one’s desired and actual social relationship (Shiovitz-Ezra and Leitsch, 2010) or “the sense of distress deriving from the perceived deficiency in social relationships one wants to maintain (de Jong Gierveld et al., 2015). On the other hand, social isolation is the objective of having few social relationships or infrequent social contact with others (National Academies of Sciences, Engineering, and Medicine, 2020). Both loneliness and social isolation could shorten the lives of older persons and negatively impact their health and quality of life (World Health Organization, 2021).

As described above, the UCLA 3-item loneliness scale assessed feeling lonely among older persons in the survey. Older persons who scored six or more are considered to be those who are lonely, and the results are shown in Figure 4.26. The overall prevalence of loneliness among survey participants was 10.3%, and females had a higher prevalence rate of loneliness than males. However, the difference was not

statistically significant. On the other hand, across age groups, significant differences were observed: as age increases, the prevalence of feeling lonely also increases. Dykstra (2009) pointed out that the prevalence rate of feeling lonely among those aged 80 and over is more than three folds of older persons aged 60-69.

Peltzer and Pengpid (2019) assessed the prevalence of loneliness among the Indonesian population aged 15 and over. It used the 5th round of the Indonesian Family Life Survey conducted in 2014-2015. The results indicated that the overall prevalence of loneliness was 10.6%, although the measure used for the study was not the same as the one used in the current study. Because only plots by age group without observed prevalence rates were shown in the article, the exact rates among the older population were not known. However, plots of prevalence rates by age group indicated that the rates ranged from about 11% for age group of 60-64 to 15% for age group 80 and over. Their results suggest that the prevalence rate of loneliness among older persons aged 80 and over is higher in 2022 although the potential causes of the difference are not known.

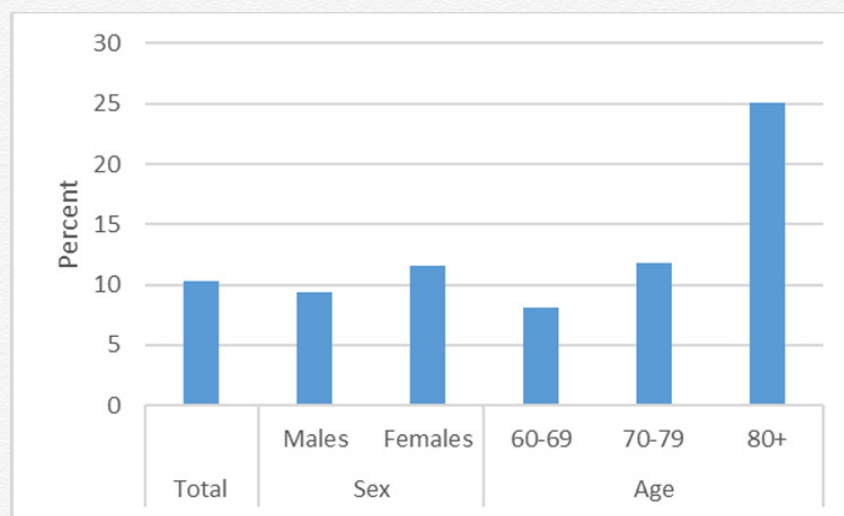


Figure 4.23 Prevalence of Feeling Lonely
 Source: 2022 National Study data processing

The overall prevalence of loneliness was relatively low among older persons as shown above. However, a few factors significantly associated with loneliness were found. More older persons with lower education reported feeling lonely, while lower percentage of older persons who are married said they felt lonely. Older persons residing in the district had a much higher prevalence of loneliness and the difference between city/district was statistically significant. As can be expected, older persons living alone showed a very high prevalence rate of loneliness. However, as mentioned

above, the results were based on bivariate analyses, thus interpretation of results should be cautious.

Table 4.12. Factors Associated with Feeling Lonely among Older Persons at the time of Survey (%)

	Low Education**		Married*		Place of Residence*		Live Alone**	
	No	Yes	No	Yes	District	City	No	Yes
No	94.45	87.07	86.75	91.88	86.26	94.15	90.83	79.54
Yes	5.55	12.93	13.25	8.12	13.74	5.85	9.17	20.46
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Note: ** indicates statistically significant at 0.01 level.

* indicates statistically significant at 0.05 level.

Source: 2022 National Study data processing

Changes in feeling lonely during the pandemic period were also asked to examine the potential impact of the COVID-19 pandemic. As shown in Figure 4.27, about one-third of older persons reported they were somewhat lonelier at the time of the survey compared to the time the pandemic started. The percentage of older persons who said feeling lonelier at the time of the survey by sex are almost the same. However, differences were observed by age group. Somehow, older persons aged 70-79 reported a much higher percentage of feeling lonelier than other age groups. It is essential to keep in mind that feeling lonelier now does not mean they are in the state of loneliness measured by the UCLA 3-item Loneliness Scale. Of course, feeling lonely affects the quality of life of older persons and may be caused by the pandemic and measures taken to address the pandemic. More importantly, how the life of people feeling lonely at the time of the survey needs to be studied.



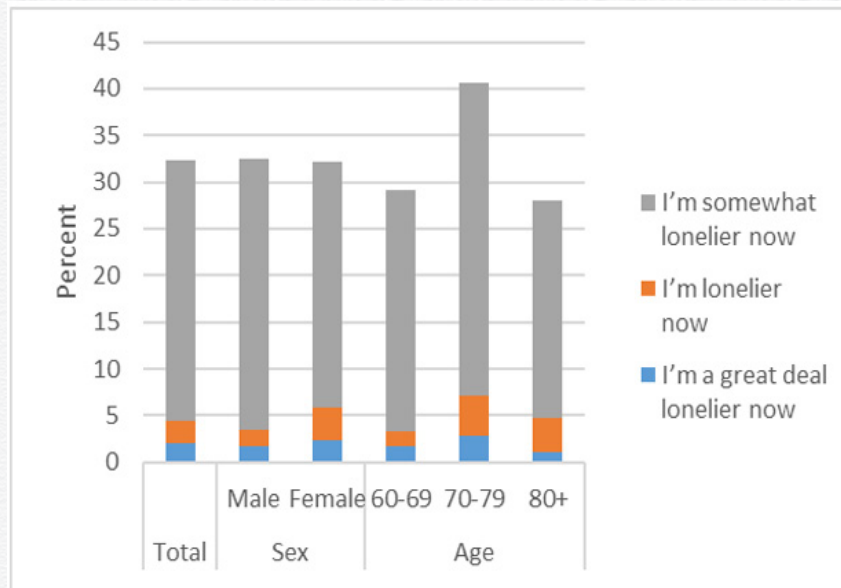


Figure 4.24 Changes in Feeling Lonely
 Source: 2022 National Study data processing

Although there are sets of questions that have been available to measure the concept of social isolation, due to the limited space in the questionnaire, only one question regarding social interaction was asked in the survey. Older persons were asked how often they interact with close friends and family before the COVID-19 pandemic. Response categories are “less than before,” “same as before,” and “more than before.” Results are shown in Figure 4.28. More than 10% of older persons were interacting with their close friends and family members more often than before the pandemic. In comparison, 47.5% of the survey participants reported “about the same,” and 41.8% reported “less often than before the pandemic.” More male participants reported “less often than before” interacting with friends and family members and the difference between the sexes was statistically significant. The differences by age group were also significant, the higher the age, the lower the percentages of answering “more often than before” the pandemic.

Living alone can be also an indicator of social isolation. However, older persons who are living alone do not necessarily mean they are lonely. There were also cases reported in the other surveys that the response to the question on living arrangements was “living alone” but family members of older persons are living in very close proximity. Social isolation independent of loneliness should be monitored and examined for its potential effects on the health status and quality of life of older persons.

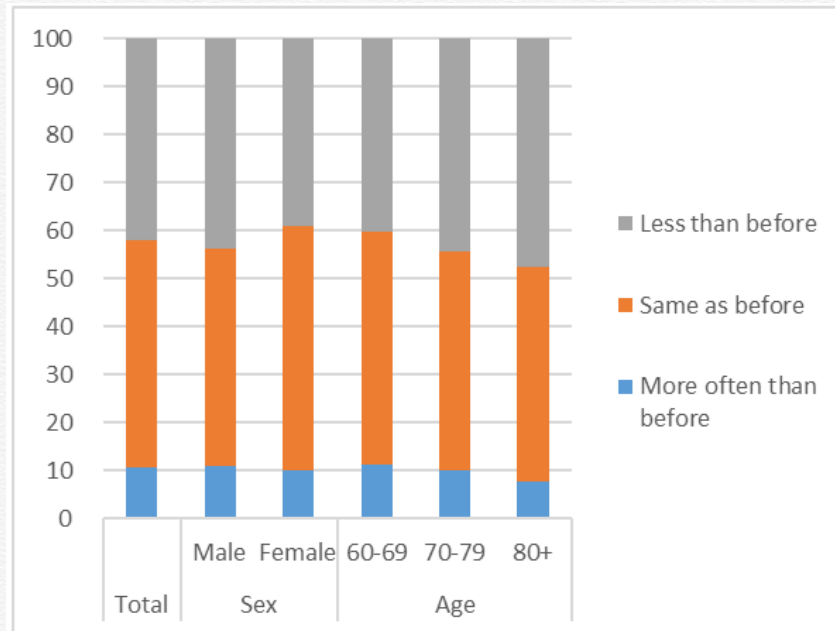


Figure 4.25 Changes in Social Interaction

Source: 2022 National Study data processing

The government of Indonesia requested people to stay at home and keep physical distance from other people during activities in the community in order to fight against the COVID-19 pandemic. The survey results indicate that older persons seemed to follow the order as shown in the earlier section of this report. A sizable proportion of older persons reported that they were more feeling lonely compared to the time before the pandemic started. Under such a situation, the survey also asked about older persons' activities to cope with the pandemic. The question was: "What were the main activities carried out to cope with the COVID-19 pandemic?" Results are shown in Table 4.13.

Almost one-third of older persons reported that they were spending more time on hobbies and activities. Older men and those aged 60-69 were more likely to report spending time on hobbies and activities than their counterparts. Watching TV is the second most common activity reported by older people during the pandemic, followed by physical activity. Older women reported to spend more time watching TV, while men reported spending more time doing physical activity. Not many older persons reported using ICT to cope with isolation during the pandemic. About 10% of older persons reported not taking any specific action to cope with isolation during the pandemic. Many of those who reported other activities as dealing with the pandemic included farming, gardening, spending more time with grandchildren, and listening to the radio.

Table 4.13. Main Activity Taken by Older Person to Cope with the Pandemic

	Total	Sex		Age		
		Male	Female	60-69	70-79	80+
Making more time for hobbies and activities	32.00	36.55	25.30	34.89	29.36	17.99
Watching television	27.87	23.76	33.93	25.17	35.02	23.41
Doing physical activity	19.43	22.82	14.45	20.30	15.51	26.97
Talk to close friends and family by phone or zoom	0.93	1.05	0.75	1.05	0.72	0.73
Sending written messages (SMS/WA) to close friends and family	0.64	0.42	0.95	0.66	0.62	0.50
Using social media and other forms of online entertainment	0.84	1.05	0.54	0.81	0.63	1.92
Others	9.85	8.34	12.07	11.19	7.37	8.07
There was none	8.43	6.01	12.00	5.92	10.77	20.42
Total	100.00	100.00	100.00	100.00	100.00	100.00

Source: 2022 National Study data processing

The provision of social support to older persons during the pandemic was also explored in the survey. The question asked was: “Who provides social support (such as giving attention, affection, services, advice) to you during the COVID-19 pandemic?” Multiple choices were allowed as response/s to this question. Almost all respondents reported that they received social support from their family members (Table 4.14). This was probably the expected result considering that the teaching of Islam stressed filial piety (Tanggok, 2017). However, some older persons also reported that they did not get social support, although the percentage was very small.

More than one in ten older persons reported that they were given social support by Cadre (organized volunteers for helping older persons in the community in Indonesia). It must be good for older people to know that they have someone to rely on when needed. In a country like Indonesia with enormous land areas, a system like Cadre is required to support older persons. Other sources of support include the neighbors.

Table 4.14 People Who Provide Older Persons Social Support During the Pandemic

	Total	Sex		Age		
		Male	Female	60-69	70-79	80+
Family members	97.05	97.94	95.73	97.25	96.48	97.55
Cadre	11.35	11.21	11.55	11.22	11.11	13.31
Special assistant for older persons	1.34	1.43	1.22	1.28	1.65	0.7
No social support	1.03	0.84	1.3	1.31	0.35	1.21
Others	3.53	2.32	5.32	3.47	4.18	1.61

Source: 2022 National Study data processing

Talking with someone is also essential for dealing with social isolation when people are confined at home. Older persons could talk with co-residing family members. However, they may not be able to speak with their children and grandchildren living outside the home as frequently as before. Therefore, a question was asked, "If you use communication tools to contact friends or family, what is the main (most frequent) tool used?" As shown in Table 4.15, most older persons answered that they use mobile phones to talk with family members and friends. Nowadays, people rarely use their house phone. One third of older persons do not use technological tools to speak with family members or friends. The reasons for not using tools were not asked in the survey. However, if the reason is that they do not know how to use technological tools, even if they want to, ways to teach them how to use ICT tools must be considered. Some said they did not use any tools because they could not afford to buy the gadgets or devices. Other older persons mentioned that they borrow someone else's mobile phone to talk to their friends.

Tabel 4.15 Metode Komunikasi, jika Ada

	Total	Jenis Kelamin		Usia		
		Laki-laki	Perempuan	60-69	70-79	80+
Telepon Rumah	1,15	1,17	1,12	1,10	1,45	0,50
Telepon Genggam	61,61	65,94	55,23	67,50	53,67	42,70
Tidak menggunakan perangkat teknologi	34,09	29,56	40,77	29,03	39,77	54,62
Lainnya	3,14	3,33	2,87	2,37	5,11	2,18
Total	100,00	100,00	100,00	100,00	100,00	100,00

Sumber: Pengolahan data Studi Nasional 2022

8. Results from Focus Group Discussions

a) With Older Persons

- 1) Impact of the COVID-19 on health, social and economic well-being of older persons

From a health perspective: Many older persons have died from COVID-19 and experienced various psychological impacts. The absence of social support or inaccurate information can cause anxiety or overprotection among older persons.

Some older persons do not know (have not received information), do not believe, and do not care about the COVID-19 pandemic because they feel healthy.

Information about the COVID-19 pandemic is sometimes unclear and imprecise, and there is even information that is unrealistic and untrue (hoax). Policies from the government, which may be inconsistent, especially at the beginning of the pandemic, resulted in confusion among the general public in dealing with the situation of the COVID-19 pandemic.

Most of the time, older persons who are community members obtain information from their cadres and/or companions. While among older people who are not community members, their main source of information depends on general knowledge of family members on the pandemic, which is mostly acquired from the community and social media.

In terms of vaccination for older persons, there were still many who refused to be vaccinated. One of the reasons was that there were cases where they still got positive results after being vaccinated with a booster (third vaccination) when compulsory swab testing was done.

The main reason why other older persons have not been vaccinated was due to their comorbidities or difficulties in accessing the vaccination hubs. Older persons who live in areas that are difficult to reach, have no one to accompany them, or are not invited to the vaccination site should be given more options to be vaccinated.

From the economic perspective: In general, older persons remained active in

maintaining their livelihood, but their financial involvement has drastically decreased during the years that followed the COVID-19 pandemic. Most of the affected older persons are in the lower-middle-income group with limited literacy and income-generating capacity.

From a social perspective: There are still many older persons who have not been covered by the social assistance program, such as those abandoned, living in the middle of the forest, or living alone in uninhabitable houses. In addition, measures taken against the pandemic, such as staying at home, are potential risk factors affecting older persons' mental health. The older persons who have access to services and are digitally literate have access to social media communication such as zoom, Whatsapp, video calls, or other means of communication. Older persons without such tools are needed to be covered by government programs.

- 2) Coping mechanism to overcome the impact of the COVID-19 pandemic
Efforts for older persons to overcome the COVID-19 pandemic include increasing the dissemination of appropriate and reliable information related to the COVID-19 pandemic and vaccination. There needs to be a strategy to encourage older persons with comorbidities and immuno-compromised to comply with health protocol, vaccinations, and other self-care initiatives.

Socialization on COVID-19 control and prevention can be done through older person groups. Older persons who are not digitally literate can be assisted by their community cadres and/or informal caregivers. In addition, the neighborhood (RT: Rukun Tetangga) or community (RW: Rukun Warga) heads must be optimized as liaisons/ contact persons and show their concern and facilitate assistance to an older person in their designated environment.

The implementation of this older person sustainability program needs to increase the role of women, for example, in socializing programs and assisting older persons in having access to these programs. In addition, it is also necessary to pay attention to the older persons from various groups, including the older persons in correctional institutions and other often neglected marginal groups.

- 3) Access to health care facilities
Health care access has generally improved, especially in urban areas. But for remote and challenging to reach places, access to health services still needs innovative health care programs. Therefore, in providing services to older persons, attention should be paid to ensure that it will make it easy for them to

come for health consultations and receive social benefits during the pandemic. This includes short waiting time, no queues, and keeping a schedule. Health services should be accessible to all groups of older persons and those with special needs.

4) The assistance needed and received

Government assistance program for older persons already exists, but the programs do not cover all older persons in need. The most prominent sustainability programs are health services through community health centers (puskesmas: pusat kesehatan masyarakat) and older person-integrated healthcare posts (posyandu: pos pelayanan terpadu) from the Ministry of Health, and social assistance from the Ministry of Social Affairs.

There are still many older persons who need support not only during the COVID-19 pandemic but especially for those who do not work and do not have family or community support. Regarding assistance and access, retired older persons can still obtain health insurance.

Ownership of old-age insurance and pension is necessary for older persons to be financially independent. Health insurance needs to be extended to retirement age, not only when actively working.

To reach the majority of the older person, it is necessary to increase the role of the community, including universities or private sectors. For example, local government programs related to age-friendly homes. Another activity is to increase or revitalize the role of the Older Person Posyandu or Health Integrated Services Post (Posbindu PTM: Pos Pembinaan Terpadu Penyakit Tidak Menular), which has great potential in community development. Activities that can empower older persons who are still active include hobbies and activities according to their abilities and personal interests, such as gardening (integrated farming), making handicrafts, and cooking. This effort, if managed properly, can motivate the older person to help increase their income and become a source of pride and inspiration for the older person themselves.

Support from family and their surrounding environment is vital, especially during the COVID-19 pandemic, to avoid loneliness, stress, and suicide.

The National Strategy on Ageing (STRANAS: Strategi Nasional Kelanjutan Usia)) issued by the Presidential Regulation number 88 year 2021 faces an enormous

challenge in its integrated implementation. The current condition of older people in Indonesia still shows that the implementation of Law Number 13 of 1998 concerning the Welfare of Older Person has not been carried out comprehensively. It formerly focused on nursing homes then shifted its focus on ageing in place and supported by age-friendly communities and environment.

In the implementation of STRANAS, the role of institutions needs to be revitalized at both the central and regional levels, from its laws and regulations as well as the organizational structure. Cross-sectoral, cross-program, and its various related stakeholders require coordination and synergy and collaboration between three entities: community organizations, private sector, and government, both local (regional) and central. The main key in its implementation is spearheaded by initiatives originating from the grassroots community and supported by the local government both in program and funding.

b) With Government Officials

- 1) Interventions implemented to provide social protections to older persons. The current sustainability program refers to Presidential Regulation Number 88 of 2021 on the National Strategy for Ageing. Program implementation begins with a coordination process between sectors and various stakeholders at the central and regional levels. Socialization has begun in the provincial ministries at the central and regional government levels. As one of the mandates of the National Strategy, a monitoring and evaluation guide for implementation will be prepared. Regarding the financing that is budgeted to the state budget, Regional Revenue and Expenditure Budget, and support from CSR (Corporate Social Responsibility) programs from the private sector.

It is hoped that all sectors that have the authority (central and regional) can carry out these activities. The Ministry of Health carries out older persons' health profiles by name and address, and BKKBN reaches out to active older persons based on the seven dimensions of resilience. The Ministry of Social Affairs identifies older persons who need social assistance. At the regional level, studies on the Minimum Service Standards (MSS) have already been conducted in the respective sectors. For example, there is already a nomenclature for regions in the health sector. In addition, there needs to be a synchronization between MSS in the health sector with other sectors in the central policies to be integrated into the community with budgetary support of the Regional Revenue and Expenditure Budget.

The main responsible persons/agencies for the National Strategy for Ageing are BAPPENAS and the coordinating minister for Human Development and Culture. Its implementation coordinates with three relevant ministries, namely the Ministry of Health, the Ministry of Social Affairs, and the BKKBN. However, other ministries also play an important role in implementing the National Strategy.

In implementing the National Strategy, BAPPENAS developed a long-term care system supported by the Older Persons Information System (SILANI: Sistem Informasi Lansia). Related to system development, data collection was carried out at three pilot project locations in three provinces in 2019. Through SILANI, data collection was carried out on a digital platform and categorizes the older person according to their conditions, such as active older persons and those who need LTC. The LTC program requires human resources (companion/service officer) to collaborate. However, this collaboration has not materialized yet, because they are still not working collaboratively. From the evaluation results, the burden of the average companion workload is quite heavy, such as BKL (Bina Keluarga Lansia), Peksos (Pekerja Sosial), and Puskesmas staffs have their output to be achieved.

It is further necessary to provide technical assistance to support companions in the field. For example, the Standard Operational Procedure (SOP) for active older person services is by providing training to non-professional older person companions.

Still in process, there is already coordination for training from the results of case management in the community such as BKL, Posyandu and Puskesmas. For case management, it is expected to use family data and SILANI data as an integrated service targeting database.

In SILANI project, application usage and case management guides are available. However, to use the application would require sufficient digital literacy from each case manager. In the future, preparations are being made so that the older persons can be digitally literate in meeting their needs, such as requesting a caregiver and transportation assistance to health facilities. From this study, the older persons who are economically vulnerable can be supported by social rehabilitation from the Ministry of Social Affairs, while the middle-upper class through their own initiative will be accommodated.

The Ministry of Health provides health services for older persons. Activities carried out are in the form of compiling and socializing guidelines for older persons' health services in the era of the COVID-19 pandemic such as IEC (Information, Education, and Communication) media, older person vaccinations, and guidelines for preventing COVID-19 and self-isolation. In addition, it organizes integrated Posyandu for the older persons and integrated Posbindu PTM; prevention and management of dementia in the community (which is the scope of mental health) in collaboration with related parties; development of an integrated model for the older persons (Posyandu) across sectors and across programs.

During the pandemic, the older persons' health program is directed at screening/ early detection, which is conducted in primary health centers. The Ministry of Health has a program of empowerment of older persons, integrated geriatric services, and harmonization of the referral system. In addition, the development of the older persons' health e-cohort was carried out; long-term care by strengthening informal care providers and developing minimum health services for the older persons in disaster/health crisis situations. Most importantly, vaccination became a crucial effort in preventing the spread of the infection.

The sustainability program is directed at integrated services, including social assistance from the Ministry of Social Affairs (such as the Family Hope Program) and health services from the Ministry of Health.

The Ministry of Social Affairs has a social assistance program that includes older persons and all families who have lost their jobs and experienced layoffs. The Food Distribution Program and assistance for PPKM also include older persons. Social assistance, such as Family Hope Program and Non-Cash In-kind Food Assistance, will be integrated into its implementation. For single older persons, Family Hope Program provides packages of basic food cards.

Regarding the pandemic and handling of older persons, all residentials of the Ministry of Social Affairs are required to carry out multiple services. Previously, only three residentials of the Ministry of Social Affairs were serving specifically the older persons, namely Balai Budhi Dharma Bekasi, Gau Mabaji Makassar, and Loka Minaula Kendari. After the program changed from single to multiple services, all the residentials were merged. There are 31 residentials of the Ministry of Social Affairs for all people with social welfare problems, including older people.

Local governments also provide social services for older persons in accordance with Minister of Social Affairs Regulation Number 9 of 2018 concerning Basic Service Technical Standards on Minimum Service Standards in the Social Sector. In addition, social services are provided by the community, such as through social welfare institutes.

As an effort to provide integrated services, an Integrated Posyandu will also be carried out according to the Minister of Social Affairs Regulation Number 7 of 2021 concerning Social Rehabilitation Assistance. In addition to the regular services provided at the Posyandu, social assistance will also be provided.

Although there are already several programs for older persons, there are still older persons who have not been reached. To cover all older persons who need assistance, the government is carrying out social protection reforms. However, this needs to be supported by target data; for example, social welfare integrated data (DTKS: Data Terpadu Kesejahteraan Sosial) from the Ministry of Social Affairs or family data from BKKBN.

The BKKBN program targets the seven dimensions of the older persons' resilience, as well as the GoLantang application. In addition, to support the implementation of the National Strategy, an older person's school was developed as an application of the seven dimensions. At present, only older persons' schools have been conducted in three provinces (DKI Jakarta, DI Yogyakarta, and West Java). Efforts are being made to expand it to other provinces.

During the pandemic, older person groups such as the BKL group and older person posyandu group in some areas still carry out activities but online.

The Ministry of Communication and Informatics has carried out the development of ICT (Information and Communication Technology) infrastructure and ecosystem, especially in remote areas, so as to facilitate internet access. For example, it is helping health service facilities and BKKBN, especially in remote areas. The Ministry of Communication and Informatics takes both preventive and corrective approaches. Prevention activities include the socialization of countermeasures against disseminating fake news to various parties, local governments, and the public. From a corrective perspective, it blocks media and portals that spread fake news.



Chapter V

DISCUSSION AND RECOMMENDATIONS

Discussion and Recommendations

We started the study with five research questions to assess the potential impact of COVID-19 on older persons. We have some answers to these questions based on analyses of data collected for the study.

“Did the COVID-19 pandemic affect the economic, physical, mental, and social well-being of older persons across different backgrounds?”

Results of the analyses indicated that the pandemic potentially affected the economic well-being of older persons. Before the pandemic started, about half of older persons aged 60 and over worked. As a result of the pandemic, older persons' work hours decreased over the period. More than 60 percent of working older persons reported that income from paid work decreased during the pandemic period. The perceived economic well-being of older persons also showed negative changes during the pandemic. The percentage of older persons who reported at least some difficulty meeting expenses increased from 46.3% before the pandemic started to 51.4% at the time of the survey. More than half of older persons aged 60 and over were struggling to meet daily expenses. Percentages of reporting economic hardship vary by sex and age group, but the difference was not significant. However, older persons with lower levels of education, not married, residing in the district, and living alone reported more economic hardship than their respective counterparts.

The general health status of older persons was assessed through self-rated health before the pandemic started and at the time of the survey. Similar to changes observed in perceived economic well-being, the percentage of older persons who answered being unhealthy increased during the pandemic period. The difference in the percentage by sex was not significant, but it was statistically significant by age. In addition, the observed differences by level of education, marital status, and city/district were significant. More older persons with a lower level of education, not married, and residing in the district reported that they are in unhealthy health states.

Because most falls (67%) among older persons occur within the home environment (Ministry of Health Republic of Indonesia, 2018), and older persons spend more time

at home during the pandemic period, it is better to monitor such events among older persons. The overall prevalence of falls among survey participants was 15.4%. Females had higher prevalence rates (19.5%) than males (12.6%), and the difference is statistically significant. The difference in prevalence rates of falls by age group is also significant; it increases as age increases.

The mental health status of older persons was assessed by using the 14-item version of the Geriatric Depression Scale (GDS). With the previously used GDS score cut-off point of 6, the overall prevalence of depression among older people was 6.9%. Compared to previous studies, results showed a lower prevalence rates, although sample sizes and instruments used to measure depression were not the same. As previous studies have shown, age is significantly associated with depression. The prevalence of depression is higher as age increases. Moreover, the prevalence rates were higher for older persons with elementary level of education or less, not married and city resident.

Previous study indicated that the effects of experiencing a disaster on mental health of people lasted for half a year to one year. The pandemic can be considered as a disaster and the huge increases in the number of deaths during the second wave of the pandemic in mid-2021 could have impacted mental health of older persons. The pandemic is not over yet, and the incidence of depression among older persons may increase in the near future. In addition, if the observed prevalence rate of depression is applied to the projected number of population (UN, 2019) for 2050, the number of older persons with depression will increase from about 1.6 million people to almost 6 million people. This big change is caused by the changes in population age structure. Quality of life among older persons with depression as well as their family members are known to be very low. Efforts to prevent people becoming depressed are needed.

In the survey, 6.7% of older persons reported they had dementia and the differences in prevalence rates by sex and age group were significant. Female older persons were more likely to report having dementia and older persons aged 80 and above showed a very high prevalence rate of dementia as expected. Comparing the results with previous studies, changes in the prevalence of dementia was inconclusive. However, by applying observed prevalence of dementia among older persons to the projected population by the United Nations (2019) for 2050, the estimated number of older persons with dementia will increase from about 1.6 million to more than 6 million. The projected numbers of older persons with depression and dementia are almost the same, mainly because the observed prevalence of dementia and the conservative prevalence rate of depression are almost identical. What this suggests is the big challenge that the Indonesian society will face in taking care of 12 million older persons with depression or dementia by 2050.

Prevention effort needs to be made, and a caring system in the society needs to be established.

The social well-being of older persons was examined using two indicators, i.e., the UCLA 3-item loneliness scale and changes in the frequency of social interaction during the pandemic period. The overall prevalence rate of loneliness for the current study was 10.3%. Results shown in the study by Peltzer and Pengpid (2019) indicated that the percentages of feeling lonely among older persons were slightly lower than in the current study except for older persons aged 80 and above. Age is significantly associated with loneliness, and the prevalence of feeling lonely increases as age increases. About one in four older persons showed loneliness based on the instrument used. Other factors significantly associated with a higher prevalence of loneliness were a lower level of education, residing in a district, not married, and living alone.

The potential impact of the COVID-19 pandemic was explored by looking at whether there was a change in the reported feeling of loneliness during the pandemic. Overall, about one-third of older persons said they were somewhat lonelier at the time of the survey than when the pandemic started. The percentages of older persons who reported being lonelier at the time of the survey by sex are almost the same. However, differences were observed by age group.

The study found that only about 10% of older persons were interacting with their close friends and family members more often than before the pandemic, while 47.5% of the survey participants reported “about the same,” and 41.8% reported, “less often than before the pandemic.” These results could be expected because they were supposed to stay at home during the pandemic. More male participants reported “less often than before” interaction with friends and family members, and the difference between the sexes was statistically significant. The differences by age group were also significant: the higher the age, the lower the percentage of answering “more often than before” the pandemic.

Recommendations

- Provide further financial assistance for meeting daily expenses. Financial schemes could target older persons who need more support, such as the less educated, unmarried, and single.
- Given that many older persons stay at home often during the pandemic and that falls commonly occur at home, initiate programs and outreach efforts (e.g., public broadcasts, leaflet distribution) to educate on fall prevention at home.

- More support for older persons' mental health during the pandemic, including setting up hotlines and visits from cadres.
- Increase mental health personnel and facilities as the number of older persons with mental health disorders increases. This should include increasing educational programs to foster mental health care professionals.
- Encourage those who feel lonely to engage in virtual or physical social interactions at a safe distance. The government should also promote increased interaction with older persons within a family. More attention should be paid to older persons aged 80 and above as a higher proportion reported feeling lonely during the pandemic.
- Where feasible, to support technology aids in bridging the technology divide (e.g., provide equipment and educating older persons on their use.). ICT could help alleviate feelings of loneliness among older persons and can be used to obtain accurate information on the pandemic and vaccination.

“Did the observed prevalence of disability among older persons in the survey increase compared to the prevalence of disability before the COVID-19 pandemic started?”

As a measure of disability, the study used the Washington Group's Short Set of Questions on Disability. Increasing trends in the prevalence of disability were observed based on data from the current study, the published data for the 2019 Susenas (TNP2K, 2020), and the 2010 Census. The prevalence rate of having at least one difficulty among six activities increased from 26.0% in 2010 to 56.2%, and having at least one severe difficulty rose from 4.8% in 2010 to 13.9% in 2022. The prevalence rates vary by sex and age, and the differences are significant. In addition, level of education and marital status showed significant differences in prevalence rates of having a disability.

Based on results obtained from the survey and life tables published by the United Nations (2019), disability-free life expectancies (DFLE) by sex were computed for 2010, 2022, and 2050 and shown in Table 5.1 for ages of 60 and 80. DFLE is a summary measure of population health and indicates population health structure (Saito, Robine & Crimmins, 2014).

In 2010, at age 60, older men were expected to live another 15.8 years while older women, 18.6 years. Within these expected years to live, on average, men only spend 0.7 years with at least one severe functional difficulty and another 3.2 years with at least one functional difficulty. More than three-quarters of the remaining life could have been in disability-free years. For older women, of the expected remaining life of 18.6 years, they

could, on average, expect to live 1.1 years with severe functional difficulty and 4.5 years of functional difficulty. About 70% of the remaining life were disability-free years.

Changes were observed in the years with and without disabilities by 2022. Older men were expected to live another 17.1 years, about one year increase from 2010. Of those remaining years, 2.4 years with severe functional difficulty and 7.0 years with some functional difficulty. Only about 45% of the remaining life for men were expected to be disability-free years. The percentage of disability-free life expectancy to life expectancy decreased by 30 percentage points over the 12 years period. For older women, the decrease was larger, from 69.6% to 33.5%. Older persons were spending more time with disabilities in 2022.

With the observed prevalence of disability, the expected gain in life expectancy for older men and women will be from expected years with disability. The WHO's Decade of Health Ageing emphasizes the importance of functioning as the key to ageing society. The estimated results indicated the opposite pattern, though a caveat must be stated. These results were based on a population projection published by the UN in 2019 before the pandemic started. Therefore, the effects on mortality caused by the pandemic were not considered.



Table 5.1. Life Expectancy and Disability-free Life Expectancy by Sex in Indonesia in 2010, 2022 and 2050

Males						
Year	Age	Life Expectancy	Disability-free Life Expectancy	At Least 1 Difficulty	At Least 1 Severe Difficulty	% Disability-free Life Expectancy
2010	60	15.80	11.91	3.21	0.68	75.37
	80	5.37	2.82	1.90	0.65	52.49
2022	60	17.10	7.67	7.00	2.43	44.88
	80	6.00	1.26	2.78	1.96	21.04
2050	60	19.70	8.45	8.18	3.07	42.88
	80	7.12	1.39	3.39	2.34	19.58

Females						
Year	Age	Life Expectancy	Disability-free Life Expectancy	At Least 1 Difficulty	At Least 1 Severe Difficulty	% Disability-free Life Expectancy
2010	60	18.62	12.95	4.52	1.14	69.58
	80	4.53	2.95	2.35	1.02	46.69
2022	60	20.04	6.71	9.19	4.14	33.48
	80	6.96	0.83	3.42	2.71	11.87
2050	60	22.89	7.27	10.45	5.17	31.75
	80	8.39	1.02	3.92	3.46	12.09

Source: Authors' calculations

Recommendations

- As the number of older persons with disability increases and the length of years with a disability is expected to increase, personnel and facilities to care for older persons need to be increased.
- Increase programs to train formal care workers as well as informal caregivers
- Assistance for older persons with disability should not be the same for all age groups. For those aged 60-69, assistance to recover or rehabilitate from a disability should be sought. For those aged 70-79, assistance to keep them in the same level of disability and not to an advanced level of disability should be provided. For those aged 80 and over, quality of life should be the main focus for assistance.

Did the policies to protect older persons, including those with disability, work effectively during the COVID-19 pandemic?

The Ministry of Health implements several older person's health programs during the pandemic. These programs include 1) health screening conducted at the puskesmas as an early detection; 2) older person empowerment; 3) integrated geriatric services, 4) harmonization of the referral system; 5) development of the older person health e-cohort; 6) Long-term care by strengthening informal care providers; 7) developing minimum health services for the older persons in disaster/health crisis situations, and 8) vaccination as COVID-19 prevention.

Empowerment of the older person is an activity or process of increasing the knowledge, skills, and abilities of the older person. Empowering the older persons based on the Republic of Indonesia's Law No. 13/1998 means that the older person can still carry out their social functions and play an active role naturally in the life of society, nation, and state. The empowerment of the older person also means an effort to improve family health. Through empowerment activities, it is expected to encourage the older person to behave in a healthy manner and participate in developing healthy behavior. So that the older persons can provide solutions when needed in the family and community. Older person empowerment is one of the strategies in the 2020-2024 National Action Plan (NAP) for Older Person Health which also refers to the National Strategy on Ageing. (from FGD)

The study found that the vaccination rate among survey participants was about the same as the national figure. This implies that a substantial proportion (34%) of older persons were still not vaccinated as of February 2022. The reasons for non-vaccination include

“health conditions”, “not willing” and “did not know that vaccination was necessary.” The majority, 69.2% of those who were not vaccinated, reported they had health conditions which prevented them from getting the vaccine. Another 21.8% were not willing to be vaccinated.

There were differences in the rates of vaccination by sex and age group. The rate of vaccination among male older persons was higher than that for female older persons and the older the age, the lower the vaccination rate. More than 50% of older persons aged 80 and over reported not being vaccinated compared to about 30% of those aged 60 to 69.

The issue of comorbidity was raised during the FGD. Older persons with co-morbidity are the most vulnerable group of people and need to be given more attention. In addition, the issue of disseminating correct information regarding the COVID-19 virus and the vaccination were also discussed during the FGD.

Information about the COVID-19 pandemic is sometimes unclear and imprecise, and there is even information that is absurd and untrue (hoax). Policies from the government, which may be inconsistent, especially at the beginning of the pandemic, resulted in confusion among the general public on how to deal with the COVID-19 situation.

There are still many older persons who have not been covered by the social assistance program, such as those abandoned and are either living in the middle of the forest, or living alone in uninhabitable houses. (from FGD)

Recommendations

- Ensure that information is factually accurate and easy to understand (e.g. vetted by experts only; promote the use of information from official sources only; swiftly rebut and remove inaccurate information; use simple infographics; large, impactful prints). Information should be delivered to those who needed, not just disseminate the accurate information to the public.
- Improve the dissemination of information (e.g. use of a variety of channels that older persons tend to use such as TV, radio, public broadcasts, pamphlets, and social media).
- Focus more efforts on reaching out to older persons who are unvaccinated (e.g. step up on outreach; use ambassadors and village cadres to provide information, clarifications and support; form mobile vaccination teams to go to their homes, provide doctor-consultations at vaccination centers, etc.).

- Explore re-assessing older persons who are unvaccinated due to health reasons. Older persons can be assessed individually by a qualified medical doctor before taking the vaccine (Many health experts have maintained that the vaccines are suitable for the majority of people, including those with comorbidity).
- Improve public communication of policies and measures to ensure clarity and consistent messaging. Reiterate messages as often as necessary.

Did the COVID-19 pandemic itself or the measures taken against the pandemic have effects on health care utilization of older persons?

The results indicate that the impact on health care utilization was not serious. From the individual perspective, there were people who experienced serious problems accessing health care. However, in the overall population as a whole, only about three percent of older persons reported that they had some problems using health care services. Three-quarters of older persons did not have any delays or cancellations of health care services and 21.6% of older persons did not need to use health care services. There were no significant differences in health care utilization between the sexes and age groups. In addition, among older persons needing medication, 15.5% of them experienced some kinds of difficulties receiving their medicine during the pandemic.

Recommendations

- Ensure that the core general health care services continue to be made available easily even as health care resources are allocated for the pandemic.
- Explore ways to deliver medicine to those who had difficulties obtaining them during the pandemic (e.g., through satellite points, nodes in the community, village cadres to deliver, and postal/courier delivery).
- Because of the pandemic, the use of telemedicine was explored. With the improvement of internet technologies, the use of telemedicine has been advancing quickly. During the online “Workshop on Telemedicine in the Asia-Pacific Region: Network Architecture, Capacity, and Feasibility” held in March 2022, a participant from Indonesia presented the actual use of telemedicine in Indonesia. Such use of telemedicine should be expanded by promoting telemedicine among health professionals and informing the general public about its use. The Ministry of Health, Ministry of Communication and Information and Ministry of Social Affairs have to work closely to make this successful.

Did older persons receive the assistance they needed during the COVID-19 pandemic?

Although most older persons reported no change in assistance from relatives/friends living within the country, a little over one-third of older persons reported that assistance received from relatives/friends decreased. Only a small percentage of survey participants reported that they received assistance from relatives/friends living abroad. More female older persons reported a reduction in the amount of assistance and those who reported no change in assistance from relatives/friends living in abroad are higher in the older age groups.

In terms of support from the government, about 15% of older persons reported increases in support from the government. At the same time, about 30% of older persons reported that support from the government decreased. Differences in support from the government by sex were not significant but the differences by age group were statistically significant. The percentage of those who reported decrease in support from the government decreases as age increases.

About ten percent of older persons reported they received more support from NGOs while about 30% of older persons reported less support from NGOs during the pandemic period.

Overall, the percentages of older persons reporting a decrease in assistance and support were much higher than the percentages of those reporting an increase from all sources. Higher percentages of female older persons reported a decrease in support. The percentages of decreases in support were lower in higher age groups.

Recommendations

- The government and NGOs should encourage people to help each other out during difficult times; promote a cohesive community spirit.
- The government and NGOs need to investigate the reported decrease in support and formulate ways to boost the support to vulnerable groups during the pandemic.
- In particular, women and the younger old may need extra forms of support. Those aged 60-69 were more like to report working at the time of survey and affected more by the pandemic with reduced income from paid work.





Chapter VI

CONCLUDING REMARKS

Concluding Remarks

Older persons are not a homogeneous population. Policies targeting older persons may need to reconsider moving from treating older persons as a whole to focus more on differences by the characteristics of older persons such as by age group as previously mentioned. Living arrangements should be paid more attention, too. As described above, a high proportion of older women are widowed. Among survey participants, more than 80% of men had spouses while the same percentage of women were unmarried. This difference is attributed to differences in mortality and age at marriage between sexes. Women on average, tend to traditionally marry older partners in Indonesia. Therefore, a social system that will provide care for older widowed women needs to be considered. Indonesian society is presently still upholding traditional values, the religious teaching of Islam conveys to people the importance of filial piety, and current fertility rate is still above replacement level. These conditions may not change overnight. However, there is no guarantee such conditions remain forever. As a matter of fact, there seems to be showing changes in the relationship between parents and children. Some news article reported that older parents in Indonesia prefer to live independently at homes for older persons although the number is still very small.

Promoting lifelong learning is an excellent program that was already initiated by the government using ICT during the pandemic. Unfortunately, the very old, such as those who are aged 80 and over may not benefit from the program, but old people in the younger age groups may be more accustomed to the use of ICT and will benefit from this when they reach older ages. In order to push for such program faster, efforts to improve digital literacy among older persons need to be made by the government.

The world has already experienced three pandemics in the twenty-first century - severe acute respiratory syndrome (SARS) in 2002, Middle East respiratory syndrome (MERS) in 2012, and presently the COVID-19 pandemic. The world had also suffered from the 1918-1920 Influenza pandemic, so-called "Spanish Flu." The number of deaths has been disproportionately large among older persons by the COVID-19 pandemic. However, many young people were also killed by the Spanish Flu (Richard, et. al., 2009). The number of infected people surged because of the new COVID-19 variants. Even after the current COVID-19 pandemic is over, we may see another in the future. It is unpredictable who would be affected the most by pandemics - young or old, men or women. In order to

control and prevent the spread of the pandemic within the country, social environments have to be prepared including internet access for all including older persons living across this large island archipelago nation-state. To improve older persons' well-being (including those with disabilities), there is a need for government to collaborate with various stakeholders in providing integrated health and social services in accordance with the strategies in the National Strategy on Ageing (Presidential Regulation No. 88 the Year 2021).



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