

COVID-19 IMPACTS ON PEOPLE WITH DISABILITIES IN INDONESIA: AN IN-DEPTH LOOK



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**Direktorat Penanggulangan Kemiskinan dan Pemberdayaan Masyarakat,
Badan Perencanaan Pembangunan Nasional Republik Indonesia**
with Support from **Mahkota** and **Kompak**

Authors: Sinta Satriana, Karishma Huda, Nurul Saadah, Diah Hidayati, Ari Zulkarnaen

Editors: Maliki, Adhi Rachman Prana, Ratna Fitriani, Annissa Sri Kusumawati, Emmy

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AUTHORS:

SINTA SATRIANA, KARISHMA HUDA, NURUL SAADAH, DIAH HIDAYATI, ARI ZULKARNAEN

**DIREKTORAT PENANGGULANGAN KEMISKINAN DAN PEMBERDAYAAN MASYARAKAT,
BADAN PERENCANAAN PEMBANGUNAN NASIONAL REPUBLIK INDONESIA**

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FOREWORD

As the world is dealing with the impacts of the COVID-19 pandemic, it is important for policy makers to understand that the impacts are even more profound in the lives of people with disabilities. Existing barriers faced by people with disabilities, including limited access to services, low education attainment, discrimination in the labour market, and higher cost of living, provide them with limited resources to cope with crisis situations.

This study, an In-Depth Look at COVID-19 Impacts on People with Disabilities in Indonesia, has provided us with important evidence on the impacts of the COVID-19 crisis on people with disabilities in Indonesia, and how the barriers they face contribute to their vulnerability to shocks. The study provides comprehensive analyses on the different aspects of the COVID-19 impacts including income, employment, access to health services and access to education. Beyond the impacts of the crisis, the study shed lights on the extent to which Indonesia's social protection system have reached and helped people with disabilities during the COVID-19 pandemic.

The Government of Indonesia realizes the importance of reducing barriers for people with disabilities by creating inclusive development policies in all sectors. The Government of Indonesia has stipulated the Master Plan on People with Disabilities (Rencana Induk Penyandang Disabilitas—RIPD), embedded in the Government Regulation No. 70 Year 2019. The RIPD provides guidance to relevant Ministries and all Local Governments in Indonesia in designing inclusive development policies to fulfill the rights of People with Disabilities. The RIPD also aims to synchronize policies at the Central Government and Local Government levels, and ensure the implementation of the human right based approach. RIPD mandates 7 strategic targets which include data on people with disabilities, inclusive environment, employment, justice, education, inclusive economy, and health.

In light of these regulatory developments, the Ministry of National Development Planning/BAPPENAS is delighted to welcome this collaborative study, carried out jointly with MAHKOTA, KOMPAK, AIPJ2 and the Organization of People with Disabilities (OPD) Network for a More Inclusive COVID-19 Response in Indonesia. Findings of the study provides crucial empirical data on the barriers faced people with disabilities in Indonesia and the ensuing vulnerabilities to crises—an important consideration in policy designs.

I hope this study will serve the utmost benefit to support the effort of the Government of Indonesia to set inclusive development policies for People with Disabilities on years ahead.

Jakarta, 28 September 2021

Director for Poverty Alleviation and Community Development

Ministry of National Development Planning / BAPPENAS



Maliki, ST, MSIE, Ph.D

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EXECUTIVE SUMMARY

This report analyses the impacts of the COVID-19 crisis on people with disabilities in Indonesia and the extent to which the country's social protection system and COVID-19 economic response measures have strengthened their ability to cope. It also aims to understand the implications that Indonesia's COVID-19 response may have in shaping Indonesia's social protection policies in the long term and how policy lessons from the pandemic can be used to improve the social protection system for people with disabilities.

Disability and Its Multiple Layers of Vulnerability

The COVID-19 pandemic has had severe and lasting impacts on the Indonesian economy. The country's economy contracted by 5.32 per cent in the second quarter of 2020 while, in the third quarter of 2020, over 5 million people lost their jobs, and 24 million individuals were working reduced hours.

While these economic impacts brought hardships across the population, they are even more profound for the lives of people with disabilities. People with disabilities tend to have: (i) lower education levels; (ii) less access to the labour market; (iii) higher costs; and (iv) lower income compared to people without disability. Such vulnerabilities are gendered, with women carers and women with disabilities experiencing greater deprivations compared to their male counterparts.

Education

People with disabilities are faced with physical, geographic, and social barriers to education. Few specialised education institutions exist and, while there are some mainstream schools that enrol students with disabilities, many schools are not equipped to provide quality inclusive education. The COVID-19 pandemic has disproportionately impacted students with disabilities. In a survey taken since the outbreak of COVID-19 (BPS 2020), 31 per cent of children with disabilities between the ages of 13 to 15 had dropped out of school—compared to only 7 per cent of children without a disability in the same age group.

Labour

Low education attainment poses significant barriers to the labour market and consequently a low rate of labour force participation. Barriers to employment are particularly high among women with disabilities. Those who do find employment end up in predominantly informal work, earning a poor and irregular income. By April 2020, 81 per cent of workers with disabilities had reported experiencing reduced income due to the COVID-19 crisis while more people with disabilities claimed to have stopped working (68 per cent) compared to respondents in the general category (55 per cent) (J-PAL 2020). As of April 2020, up to 69 per cent of respondents had become poor or fallen deeper into poverty after the COVID-19 pandemic.

Higher Costs

Poor individual and household income is reflected in the high poverty rate of people with disabilities and their households, but this underestimates the deprivations experienced by people with disabilities. Poverty lines are set at a level of income that is considered sufficient to meet a minimum standard of living, but the minimum needs of people with disabilities can be much higher because they incur extra costs due to both disability-specific spending (such as assistive devices, rehabilitation services) as well as extra spending on regular items given the barriers of inaccessible environments (for example, the cost of private transport due to inaccessible public transport). People with disabilities may, therefore, appear to live above the poverty line, while, in reality they do not have adequate income to meet a basic minimum standard of living.

Gender

Gender is an important consideration in assessing the deprivations and vulnerabilities that people with disabilities and their caregivers face. Women with disabilities must often confront additional disadvantages, making them more likely to experience marginalisation, poverty, neglect, and abuse. Women in households with members with disabilities experience more significant barriers to employment and are more likely to take on the role of caregiving for people with disabilities—with fewer in paid work as a result—leading to higher physical and mental strain and lower economic opportunity.

Health

Aside from the direct epidemiological effects of the COVID-19 disease, the pandemic has had dire consequences on people's health through indirect secondary effects from disruption to essential health services, limited social and care networks, and heightened stress levels. People with disabilities are particularly susceptible to negative health outcomes in this situation, as many of them have underlying health conditions and have higher needs for health care.

Like many countries, Indonesia is experiencing health service disruptions due to the COVID-19 pandemic. This includes suspension of rehabilitation services, outpatient services, inpatient services, community-based care, and even emergency services—with potentially harmful health impacts in the short, medium, and long term. Such disruptions are particularly detrimental to people with disabilities, many of whom require regular rehabilitation service.

With the discontinuation or interruption of regular rehabilitation services, people with disabilities may face deteriorating health conditions that, in turn, require more serious medical attention. Across Indonesia, hospitals and clinics have seen a drop in non-COVID patient numbers—both for inpatient and outpatient visits. Many people, including people with disabilities who regularly need medical attention, are reducing their visits to clinics due to fear of exposure to COVID-19, as well as difficulties reaching health facilities due to movement restrictions.

Challenges for People with Disabilities in Accessing the Social Protection System

Despite their high vulnerability, people with disabilities in Indonesia have historically received little social protection from the national government. Prior to the pandemic, social protection programs targeted to people with disabilities covered only 5 per cent of people with severe disabilities, leaving the vast majority without protection.

Indonesia started implementing a cash transfer program for people with severe disabilities in 2006 under the Social Insurance for People with Severe Disabilities (*Jaminan Sosial Penyandang Cacat Berat*: JSPACA) Program. JSPACA was subsequently renamed Social Assistance for People with Severe Disabilities (*Asistensi Sosial Penyandang Disabilitas Berat*: ASPDB) and later again as Social Assistance for People with Disabilities (*Asistensi Sosial Penyandang Disabilitas*: ASPD). Currently, ASPD offers 2,000,000 IDR/year to 22,500 people with a severe disability.

Regular social assistance for people with disabilities in 2021 mainly consists of two cash transfer programs—ASPD and the Family Hope Program (*Program Keluarga Harapan*: PKH). There are also some social insurance schemes for workers under the Social Security Agency for Employment (*Badan Penyelenggara Jaminan Sosial-Ketenagakerjaan*: BPJS-TK) Program.

PKH is a cash transfer program for families, conditional on utilisation of health and education services. Families are eligible for the benefit if they have children or a pregnant woman and are ranked as being in 'the very poor' category in the national poverty-targeted social registry (*Data Terpadu Kesejahteraan Sosial*: DTKS). The program added a disability component and an elderly component in 2016. Currently, 108,863 PKH beneficiaries who have a person with disability within their households are receiving an additional benefit of 2,400,000 IDR/year.

Social Protection for People with Disabilities in the COVID-19 Crisis is An Opportunity to Build Back Better

Evidence is emerging that the Indonesian Government's robust response to the crisis has already begun to mitigate the pandemic's devastating impact on poverty, particularly for children. There is, however, little knowledge so far on how such responses have impacted people with disabilities who, pre-pandemic, had been receiving a very small share of social protection despite the apparent need.

Faced with the urgency of protecting the incomes of millions of vulnerable citizens, the Government of Indonesia responded decisively by expanding existing schemes and rolling out new programs at an unprecedented scale. These have been implemented since April 2020, with plans to continue benefits until April 2021 (except for temporary cash top-ups to PKH and *Program Sembako* beneficiaries). The size, delivery mechanisms, and targeting methods for these COVID-19 response programs may well have a lasting impact on Indonesia's social protection system.

As social protection programs expanded, so did the coverage for people with disabilities

There has been a significant increase in social protection coverage among people with disabilities with the implementation of COVID-19 response programs. By July 2020 most survey respondents received some form of social assistance, although in varying amounts and frequency, ranging from one-off food donations to the more substantial periodic cash transfers. *Bantuan Sosial Tunai* (BST), *Bantuan Langsung Tunai* (BLT) *Dana Desa*, Electricity Subsidy, and *Program Sembako* had the greatest coverage among respondents, while PKH constituted more limited coverage.

Social protection expansion was made possible through a combination of national, local, and village-level programs, and the adoption of new targeting methods

Unlike PKH and *Program Sembako* that used DTKS data to expand beneficiary lists, the village fund cash transfer program (*BLT Dana Desa*) used a community-based targeting mechanism. The new unconditional cash transfer program (BST) used a combination of DTKS and new data submitted by local governments. BST also has a specific allocation for people with disabilities that uses the disability registry (SIMPDP) as a source of beneficiary data.

The use of the SIMPDP disability registry was essential in expanding social protection coverage among people with disabilities

Following the launch of the BST Program at the start of the crisis, MoSA specifically allocated a portion of the program for people with disabilities and decided to use SIMPDP for targeting these beneficiaries. The decision led to significant inclusion of people with disabilities within BST in a relatively quick timeframe, something that could not have been achieved without a readily available disability registry.

Villages can play an important role in the implementation of social protection programs and policies for people with disabilities

A complete overview of social protection beneficiaries is only available at village level, giving the village administration a unique position to fill the gaps

The smorgasbord of social protection programs on offer can be overwhelming to manage and monitor. Implementers in one ministry (or one directorate within a ministry) may not be aware of the scope of programs implemented by another, regardless of their complementarity. Likewise, programs initiated by provincial governments are independent of those coming from the central government or district governments, making it very difficult to synchronise benefits and coverage. This gives the village a very important role as a gatekeeper to identify errors, overlaps and gaps in program coverage.

BLT Dana Desa allows communities to cover people who are missing out on programs, providing much-needed assistance to people with disabilities

The villages' oversight complements their new role as the implementers of *BLT Dana Desa*—allowing them to fill the gaps and cover residents who are otherwise missed by other programs. This has helped to improve levels of inclusion of people with disabilities and other vulnerable groups who are often missed by central government programs. Many villages have prioritised people with disabilities as they acknowledge their vulnerabilities during the crisis and their possible exclusion from other schemes.

The use of the Village Information System (*Sistem Informasi Desa: SID*) could significantly improve social protection coverage but could benefit from more guidance from the central government in collecting standardised data

The massive expansion of social protection programs, including those for people with disabilities, relied heavily on new data provided by village governments. Village-level data, whether originating from existing village databases or spontaneously collected for the COVID-19 programs, has proven crucial in reaching people in need of assistance. Most of the villages interviewed in this study held data on people with disabilities prior to COVID-19 which then proved very useful during the crisis.

The last few years have seen advancements in the village data system through the development of the electronic village information system (SID). While the system is not yet in place in all villages in the country, it promises a comprehensive and interoperable data system for social protection (as well as other purposes). SID generally includes data on people with disabilities which may cover those beyond the poor category.

Social assistance, particularly cash transfer programs, had a significant impact on people with disabilities in dealing with the crisis

The frequency and continuity of the COVID-19 social protection programs play an important role in helping beneficiaries mitigate negative impacts of the crisis. World Bank simulations show that Indonesia's COVID-19 package may have prevented millions of individuals from falling into poverty. At a micro level, experiences of our respondents show the difference social protection benefits make in their ability to cope with the crisis.

Cash transfer programs are felt to have the most significant impact, providing a lifeline to many beneficiaries who lost their income

While most respondents expressed that any assistance would help in coping with the crisis, significant impacts were particularly reported by those receiving the COVID-19 cash transfers programs (BST and BLT-DD). While one-off food transfers were appreciated, respondents receiving them felt that the impacts were short lived and did not necessarily respond to their needs. They felt that cash assistance, on the other hand, would have helped them cover the extra transportation cost or special food supplements that have been more difficult to afford during the crisis.

Cash can accommodate a much wider range of needs, particularly those related to disability. Cash assistance provided through BST and BLT-DD also tended to be higher in value compared to existing in-kind assistance. The majority of workers with a disability earn less than IDR 1 million per month and are losing more than 50 per cent of their income in the crisis. For these individuals, the IDR 600,000 per month that they receive in assistance is a significant income boost that can save their families from being hungry or indebted.

Cash transfer benefit levels for people with disabilities are inadequate as they do not compensate their higher costs of living. Recent changes to PKH and ASPD benefit levels further undermine their adequacy.

While this study did not explore in detail the adequacy of existing social assistance benefits, it is worth noting that the benefit value for households with disability tends to be relatively low—particularly given the higher cost of living that they must bear. Recent policy changes in the disability benefits under ASPD and PKH are an additional setback in terms of benefit adequacy and fairness. In 2020, ASPD reduced its benefit amount from IDR 3,600,000 per person per year to IDR 2,000,000 per person per year, while PKH applied a cap of one person with disability receiving PKH benefits per household.

Continuation and adjustments in program approaches indicate potential for more sustainable impacts

One noteworthy sustainability feature is the government's ability to shift from in-kind to cash transfers in 2021. In the current context, the benefits of cash over in-kind include minimising human contact as cash can be distributed safely through bank accounts or post services. Cash transfers are also cheaper and more efficient to administer (quicker, limited leakages, and wastage). While food may benefit the beneficiaries, cash strengthens local economies through 'multiplier effects' and helps keep businesses afloat.

Conclusions

A number of conclusions can be drawn from the research conducted for this study:

Expansion of social protection programs can be achieved, quickly and inclusively.

Through the COVID-19 crisis, one clear and valuable lesson to take forward is that the massive expansion of social protection programs, including to previously hard-to-reach groups such as people with disabilities, is possible and can be done quickly.

Social protection has proven to stimulate the economy and protect the vulnerable in the face of crisis.

Social protection interventions in the COVID-19 pandemic have been acknowledged by the Government of Indonesia and academic institutions as an effective strategy in preventing a much worse outcome from the crisis.

Poverty-based social registries are not accurately capturing poverty and vulnerability in the face of a crisis.

The COVID-19 crisis has confirmed the highly dynamic nature of poverty—particularly for groups with higher vulnerability such as people with disabilities, where economic uncertainties are more prominent and impacts of shocks tend to be deeper and long lasting.

A disability registry that covers all people with disabilities is critical.

The SIMPD disability registry was developed in 2018 by MoSA and was used to target people with disabilities for unconditional cash transfer schemes rolled out during the crisis. Although not perfect, the SIMPD proved to be a more comprehensive database on people with disabilities compared to the DTKS.

Community targeting and self-registration mechanisms have filled targeting gaps.

The Government of Indonesia has employed a combination of new and innovative targeting mechanisms, including community-based targeting (for example, in *BLT Dana Desa*). This has been particularly helpful in identifying beneficiaries with disability who have a higher tendency to be excluded from the DTKS due to limited participation, lower access to documentation, stigma, and other barriers.

Cash transfers have proven to be useful, convenient, and safe for beneficiaries with disabilities.

In the COVID-19 crisis, cash transfers have once again shown to be more beneficial and more practical than in-kind transfers. Some of the well-known advantages of cash over in-kind assistance include: (i) the flexibility to cover different needs; (ii) cost-efficient distribution mechanisms and easier oversight; (iii) economic “multiplier effects” where impacts go beyond the direct beneficiaries (noteworthy during the crisis when local economies came to a halt); and (iv) no crowding at distribution points—a serious concern for COVID-19 transmission.

Recommendations

The recommendations in this report have been divided into three policy areas and prioritised into short-term and medium-term initiatives.

Policy Area One: Access to Social Protection for People with Disabilities

1. Short-term Recommendations:

- **Recommendation One:** Reinstate adequate benefit levels for national social protection programs for people with disabilities (PKH and ASPD).
- **Recommendation Two:** Improve communications campaigns and registration mechanisms for social protection schemes so that people with disabilities are aware of programs they are entitled to and how to enrol.

2. Medium-term Recommendations:

- **Recommendation Three:** Introduce a three-tiered social protection system for people with disabilities:
 - mainstream social protection programs and COVID-19 response programs for households with a person with disability;
 - cash transfers for people with severe disabilities; and
 - concessions for everyone registered with a disability.
- **Recommendation Four: Enhance Indonesia’s disability registry by including ALL people with a disability and linking it to a needs assessment (so that the severity of disability can be captured).**
- **Recommendation Five:** Ensure that complementary interventions (e.g., Skills Enhancement schemes, such as *Kartu Prakerja*) are accessible and advocated to people with a disability.

Policy Area Two: Enhance access to health care and rehabilitation for all people with disabilities.

1. Short-term Recommendations:

- **Recommendation Six:** Expand coverage of the national health insurance programme (JKN) and ensure better access to assistive devices.

2. Medium-term Recommendations:

- **Recommendation Seven:** Improve community-based rehabilitation (CBR) to reduce reliance on institutions-based services.

Policy Area Three: Improve accessibility in remote learning and make mainstream education more inclusive.

1. Short-term Recommendations:

- **Recommendation Eight:** Improve remote learning accessibility for students with disabilities through the provision of smart devices and enhanced teacher training.
- **Recommendation Nine:** Prioritise students with disabilities in transitioning back to school and improve teachers' capacity to address learning loss (this applies to all children, but especially children with disabilities).

2. Medium-term Recommendations:

- **Recommendation Ten:** Make mainstream schools more inclusive so there is less reliance on 'special schools' for children with disabilities

ABBREVIATIONS AND ACRONYMS

AIPJ2	: Australia-Indonesia Partnership for Justice
ASPD	: <i>Asistensi Sosial Penyandang Disabilitas</i> (Social Assistance for People with Disabilities)
ASPDB	: <i>Asistensi Sosial Penyandang Disabilitas Berat</i> (Social Assistance for People with Severe Disabilities)
<i>Banpres</i>	: <i>Bantuan Presiden</i> (Presidential Assistance)
BLT	: <i>Bantuan Langsung Tunai</i> (Cash Transfer Assistance)
BPJS-TK	: <i>Badan Penyelenggara Jaminan Sosial-Ketenagakerjaan</i> (Social Security Agency for Employment)
BPNT	: <i>Bantuan Pangan Non Tunai</i> (Non-cash Food Assistance)
BPS	: <i>Badan Pusat Statistik</i> (Statistics Indonesia)
BSS	: <i>Bantuan Sosial Sembako</i> (Food Social Assistance)
BST	: <i>Bantuan Sosial Tunai</i> (Cash Social Assistance)
CFW	: Cash for Work
DFAT	: Department of Foreign Affairs and Trade (Australia)
<i>DinSos</i>	: <i>Dinas Sosial</i> (Social Affairs Office at district level)
DTKS	: <i>Data Terpadu Kesejahteraan Sosial</i> (Integrated Social Welfare Database)
EAP	: East Asia and the Pacific
HH	: Household
JHT	: <i>Jaminan Hari Tua</i> (Old Age Provident Fund)
JKK	: <i>Jaminan Kecelakaan Kerja</i> (Work Injury Insurance)
JKN	: <i>Jaminan Kesehatan Nasional</i>
JKN-PBI	: <i>Jaminan Kesehatan Nasional - Penerima Bantuan Iuran</i>
KOMPAK	: <i>Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan</i>
MAHKOTA	: <i>Menuju Masyarakat Indonesia yang Kokoh Sejahtera</i>
MoSA	: Ministry of Social Affairs
OPD	: Organisation of People with Disabilities
PKH	: <i>Program Keluarga Harapan</i> (Family Hope Program)
PMT	: Proxy Means Test
PPD	: <i>Pendamping Penyandang Disabilitas</i> (Companion for People with Disabilities)
SIMPD	: <i>Sistem Informasi Manajemen Penyandang Disabilitas</i> (Information Management System for People with Disabilities)
TPD	: <i>Tenaga Pendamping Disabilitas</i> (Support Worker for People with Disabilities)
TKSPD	: <i>Tenaga Kesejahteraan Sosial Penyandang Disabilitas</i> (Social Welfare Workers for People with Disabilities)

1. INTRODUCTION

1.1. Background

As the world grapples with an unprecedented pandemic, numerous studies have been conducted to assess its impacts on people's lives. Little analysis has been done, however, on its impacts on people with disabilities. Given their vulnerability profile, people with disabilities have limited means to respond to shocks and are likely to face more severe outcomes of the crisis. A closer look at the impacts of the COVID-19 pandemic on people with disabilities is essential as it provides an important opportunity to better understand the barriers and inequalities experienced by people with disabilities and how they interact with shocks in times of crisis. The information will help policy makers in designing more suitable interventions for people with disabilities, not only as a crisis response but also in their long-term social protection strategies.

In this report, we analyse the impacts of the COVID-19 crisis on people with disabilities in Indonesia and the extent to which the country's social protection system and COVID-19 economic response measures have strengthened their ability to cope. We also aim to understand the implications that Indonesia's COVID-19 response may have in shaping Indonesia's social protection policies in the long term and how policy lessons from the pandemic can be used to improve the social protection system for people with disabilities in Indonesia.

The report is structured into six chapters. Chapter Two lays the foundation by describing the barriers and inequalities experienced by people with disabilities in Indonesia. Chapter Three assesses the economic impacts of the pandemic on people with disabilities and how these impacts exacerbate the multiple vulnerabilities that they face. Chapter Four discusses how the COVID-19 pandemic affects access for people with disabilities to health and education services and the implications for their long-term health and wellbeing. Chapter Five describes the social protection system for people with disabilities before the COVID-19 crisis while Chapter Six analyses the changes within this system during the pandemic, highlighting how the crisis has altered access to social protection for people with disabilities. Chapter Seven concludes with key policy lessons and recommendations for improving the future social protection system for people with disabilities in Indonesia.

Throughout the analysis, attention is paid to how people with disabilities fare in comparison to people without disability and how the inequalities they experience influence the outcomes.

1.2. Methodology

This report utilises both quantitative and qualitative methodologies for an in-depth and triangulated interpretation of results. The primary data collected from a qualitative study in July-August 2020 provides a 'deep dive' into the experiences of people with disabilities, caregivers, rehabilitation centres, and local governments. The study also draws on a preceding quantitative survey conducted in April 2020¹, and references secondary data from other relevant studies. A detailed description of the data sources is provided below:

Quantitative Survey

The Organisation of People with Disabilities (OPD) Network for a More Inclusive COVID-19 Response in Indonesia carried out a quantitative survey on the impact of COVID-19 on people with disabilities between 10-24 April 2020. The survey was supported by Australian Government development cooperation programs working on social protection (MAHKOTA), decentralised governance (KOMPAK), access to justice (AIPJ2) and social inclusion (PEDULI). These programs operate under a development cooperation partnership between Australian and Indonesian governments. KOMPAK works with Government of Indonesia (GoI) at the national and the sub-national levels to help strengthen Indonesia's decentralised governance system. MAHKOTA works with GoI at the national level to help strengthen Indonesia's national social protection system. AIPJ2 partners with GoI and civil society organisations to improve access to Indonesia's justice and law system, while PEDULI works to promote social inclusion to reduce poverty among marginalized groups. Data collection was mainly conducted via online survey platforms although a small number of phone interviews were conducted to accommodate respondents with limited access.

¹ For earlier publications using the April 2020 quantitative survey data, see OPD Network for Inclusive COVID-19 Response (2020) and Satriana (2020).

The survey covered a range of indicators on social and economic factors as well as access to services. Using snowball sampling through OPD’s personal networks, the survey received 1,683 responses across Indonesia². Findings from this quantitative analysis helped us to identify research gaps and remaining questions to further explore in the qualitative survey (below).

Qualitative Study

Qualitative data collection was conducted between July and August 2020 to provide more in-depth information on the impacts of COVID-19 on people with disabilities and the role of social protection in mitigating these impacts. The survey focused on the perspectives of people with disabilities, caregivers, rehabilitation centres, Social Affairs Offices (*Dinas Sosial: DinSos*) at the district level, and village governments to understand the lived realities of people with disabilities and their families, the COVID-19 response programs available to them, and their accessibility to such programs.

Additional interviews were also conducted with a physician in one of the health centres (*Pusat Kesehatan Masyarakat: Puskesmas*), a psychiatry specialist in Jakarta, and two social workers. The development of research instruments, selection of research areas, identification of respondents, and the interviews were carried out jointly by the DFAT-supported programs MAHKOTA and KOMPAK, and representatives of OPDs in the respective regions. The design of the survey also received significant inputs from disability advisors within the DFAT-supported program, AIPJ2. Interviews were conducted by phone and video call.

The study was conducted in seven provinces, selected purposively to represent Eastern, central, and Western Indonesia as well as urban and rural settings. They include Nanggroe Aceh Darussalam, DKI Jakarta, Central Java, East Java, South Sulawesi, West Nusa Tenggara (NTB), and Papua (Figure 1.1). Data was collected in one district per province, except for Central Java where two districts were covered.

Figure 1-1: Quantitative and Qualitative Study Areas



Source: KOMPAK and MAHKOTA 2021.

The eight districts represent urban and rural locations as well as COVID-19 “red zones” (areas with a very high number of positive cases at the time of data collection) and non-red zones. Each district was represented by one to two villages, depending on the number of households with a member with disability found in the respective village. In-depth interviews were carried out with respondents and selected purposively to consider gender, type of disability, and geographic location (Tables 1.1 and 1.2).

² A statistically representative sample is not possible because the population is unknown.

Table 1-1: Respondents of Qualitative Interviews

Respondents	No. of interviews
People with Disabilities	34
Carers	13
Staff of Rehabilitation Centres	8
DinSos	10
Village Governments	9
Social Workers	2
Psychiatry specialist	1
Puskesmas doctor	1
TOTAL	78

Table 1-2: People with Disabilities Interviewees (by Type of Disability and Gender)

Type of Disability	Male	Female	Total
Physical	8	6	14
Sensory	7	7	14
Psychosocial	2	1	3
Cognitive	0	0	0
Multiple	1	2	3
Total	18	16	34

Of the 13 carers interviewed, 12 are family members of people with disabilities and one person is a volunteer assisting several members of a disability self-help group in a village in Sukoharjo. Among the 12 family carers, 10 are female (mother, sister, and sister in-law of people with disabilities) and two are male (a father and a husband of people with disabilities).

Desk review

2. DISABILITY AND ITS MULTIPLE LAYERS OF VULNERABILITY

The COVID-19 pandemic has had severe and lasting impacts on the Indonesian economy. The country's economy contracted by 5.32 per cent in the second quarter of 2020—its sharpest economic downturn since the 1998 Asian financial crisis (Bank Indonesia 2020). Statistics Indonesia (*Badan Pusat Statistik: BPS*) found that, in the third quarter of 2020, over 5 million people lost their jobs, and 24 million individuals are working reduced hours due to COVID-19 (BPS 2020a).

While these economic impacts brought hardships across the population, they are even more profound in the lives of people with disabilities. The disproportionate outcomes are attributed to the greater vulnerabilities of people with disabilities, translating to their inability to weather economic shocks. People with disabilities (approximately ten per cent of the Indonesian population)³ tend to have lower education levels, less access to the labour market, and lower income compared to people without disability. Such vulnerabilities are gendered, with women carers and women with disabilities experiencing greater deprivations compared to their male counterparts.

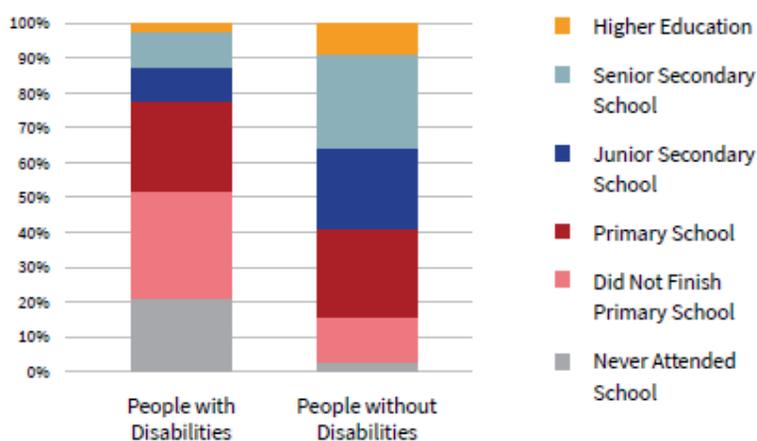
2.1. Economic vulnerability: beyond poverty numbers

As in other parts of the world, people with disabilities in Indonesia are more likely to be poor compared to people without disabilities. While the national poverty rate in 2019 was 9.2 per cent, the poverty rate of households with a member with higher threshold disability was much higher at 16.3 per cent (Prospera 2020). Although existing poverty indicators are useful measurements, they do not provide a complete picture of the deprivations that people with disabilities experience.

2.1.1 Low education attainment

People with disabilities have poorer education outcomes compared to the rest of the population. In 2019, more than one-half (52 per cent) of people with disabilities in Indonesia had not attended/completed primary school. This compared to only 15 per cent of the population without disabilities (Figure 2.1). Attainment of higher education was 2.8 per cent among people with disabilities compared to 9.5 per cent among people without disabilities (BPS 2019a). The 2018 education statistics also showed that, while 5.36 per cent of people without disabilities participated in vocational training or courses, the figure was only about 0.8 per cent among people with disabilities (BPS 2018). These figures show the limited access that people with disabilities experience in education.

Figure 2-1: Educational Attainment of People with Disabilities Compared to People Without Disabilities



Source: Susenas 2019.

Although the problem is more pronounced in rural areas and among people with severe disabilities, respondents across the board are faced with physical, geographic, and social barriers to education. Few specialised education institutions exist and, while there are some mainstream schools that enrol students with disabilities, respondents report that many schools are not equipped to provide quality inclusive education. Respondents report that special needs students must often comply with general learning methods and academic standards, leading to frustration and a feeling of incompetence in school. In other cases, public stigma about disability and lack of awareness among family and community members prevent people with

³ People with disabilities five years of age and above (Bureau of Statistics, Susenas, 2019).

disabilities from obtaining an education. For many, going to school was not considered an option by their families or communities, based on the assumption that people with disabilities simply do not belong within the education system. Box 2.1 illustrates these challenges with respondents' experiences.

Box 2-1: Barriers to Education for People with Disabilities

Respondent of short stature, East Lombok: "I studied engineering in [a well-known state university]. But during the practical work, the machines and equipment were too big for my body so I couldn't participate. I quit university and took a few years off."

Respondent with paraplegia, Jayapura: "I never went to school. I learned to read on my own. I could go to school, but my mother didn't let me. I don't know why. Maybe she was worried about the transportation to school. I didn't have a wheelchair at that time."

Brother and translator of a person with hearing impairment, East Lombok: "When he was small, a teacher from school came here and asked him to join the school. It was a public school. But he was hiding from the teacher because he was too afraid to go to school."

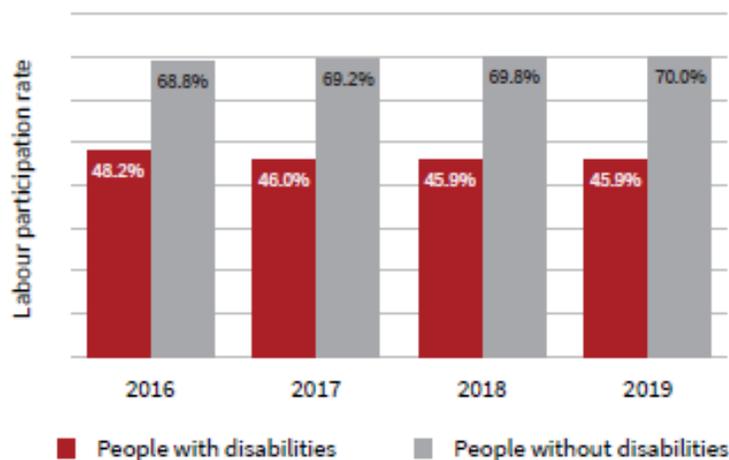
A caregiver and mother of a child with physical disability, Trenggalek: "My son is 14 years old, he hasn't been in school. He is very shy, so he doesn't want to go to school. There are schools close by, but there is no special school in this area."

Mother and caregiver of a child with multiple (intellectual and physical) disabilities, East Lombok: "My daughter attended a public primary school in the village. She failed to pass the first grade for four years in a row. After four years she refused to go to school."

2.1.2 Barriers to Labour Market Access

Low education attainment, along with the discrimination and stigma that many people with disabilities experience, pose significant barriers to the labour market and consequently a low rate of labour force participation (Cook 2006; Kaye et al. 2011; Potts 2005). While the labour force participation rate for people without disabilities increased between 2016 and 2019 (from 68.8 per cent to 70.0 per cent), it fell for people with disabilities (from 48.2 per cent to 45.9 per cent) in the same period (Figure 2.2). Barriers to employment are particularly high among women with disabilities (WHO and World Bank 2011).

Figure 2-2: Labour Force Participation (2016-19)



Source: Katadata 2020a (based on Susenas 2019).

Those who do find employment end up in predominantly informal work, earning a poor and irregular income. Seventy-two per cent of workers with disability were in informal employment, compared to 53 per cent for workers without disability (Bappenas 2020a; BPS 2019b). Informal employment among people with disabilities comes with poor and irregular income, providing very little income security (Figures 2.3 and 2.4).

Figure 2-3: Monthly Income Level Among Workers with Disabilities (IDR per Month)

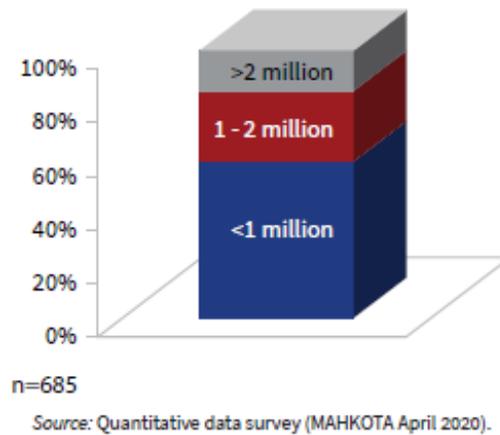
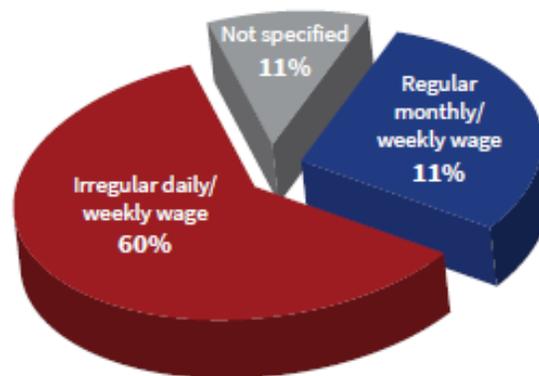


Figure 2-4: Regularity of Income for Workers with Disabilities

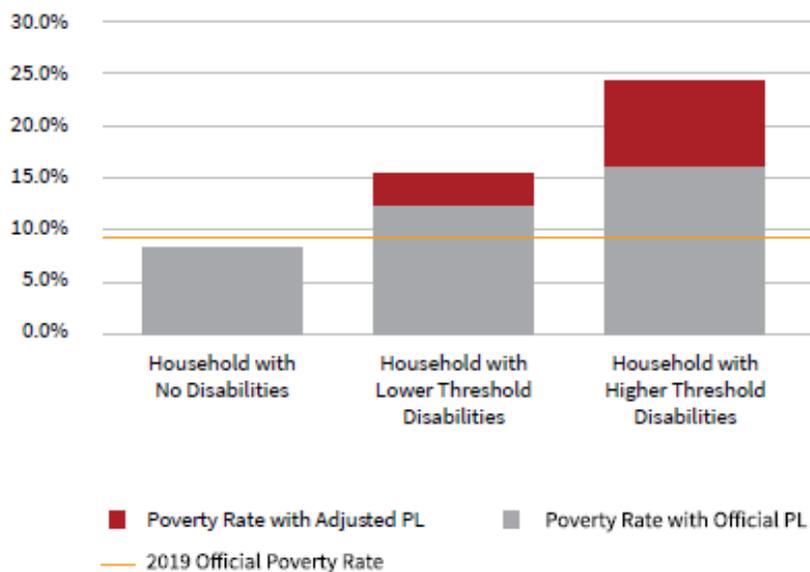


The impact of constraints on income-generating capacity extends beyond the individuals with disability. Households that have family members with disability also tend to have lower income as other family members must often forego income-generating opportunities to care for the people with disabilities within their household. One in 10 households with a person with a mild disability lost their job due to COVID-19, and eight out of 10 saw their income fall as a result of the pandemic (UNICEF et al 2021). Caregivers often quit their jobs or reduce their working hours to provide care to the person with disability, with significant consequences on household income (UNPRPD 2020; Feinberg and Choula 2012).

Poor individual and household income is reflected in the high poverty rate of people with disabilities and their households, but this underestimates the deprivations experienced by people with disabilities. Poverty lines are set at a level of income that is considered sufficient to meet a minimum standard of living, but the minimum needs of people with disabilities can be much higher because they incur extra costs due to having a disability. People with disabilities and their families face higher costs of living due to both disability-specific spending (such as assistive devices, rehabilitation services) as well as extra spending on regular items given the barriers of inaccessible environments (for example, the cost of private transport due to inaccessible public transport). People with disabilities may, therefore, appear to live above the poverty line, while, in reality, they do not have adequate income to meet a basic minimum standard of living.

on type and severity of disability⁴. Households with a member who has a higher-threshold disability⁵ experienced a poverty rate of 16.3 per cent in 2019, but when their extra costs were taken into account, the rate of poverty among these households jumped to 24.3 per cent—nearly three times the poverty rate of households with no member with disability (Figure 2.5).

Figure 2-5: Poverty Rate by Disability Status (2019)



2.2. Intersectionality of Gender and Disability

Gender is an important consideration in assessing the deprivations and vulnerabilities that people with disabilities and their caregivers face. Women with disabilities often must confront additional disadvantages, making them more likely to experience marginalisation, poverty, neglect, and abuse (UNICEF 2013). As discussed previously, women in households with members with disability experience more significant barriers to employment and are more likely to take on the role of caregiving for people with disabilities, leading to higher physical and mental strain and lower economic opportunity. Despite this, the intersectionality of gender and disability has not been featured strongly in policy discussions about people with disabilities in Indonesia.

2.2.1 Women with disabilities face multiple barriers

Our quantitative survey found that only 40 per cent of women with disabilities reported being in paid work—compared to around 50 per cent of male respondents. Among respondents who are in paid work, women are reporting significantly smaller wages compared to men (Figure 2.6). These differences have an important implication for their economic vulnerability. When the crisis hit, women respondents were more likely to fall into poverty compared to men due to their low baseline income. Our analysis shows that 45.1 per cent of women respondents who work are categorised as highly vulnerable compared to 37.8 per cent among men who work (Table 2.1)⁶.

⁴ The extra cost is expressed as a percentage of the conventional standard of living used to determine the national poverty line. In this case, the monetary amount of the extra cost can be calculated as a percentage of the poverty line.

⁵ For this calculation, Prospera used a higher threshold of disability that includes respondents who answer: “a lot of difficulties” and “cannot do at all”; but excludes those answering “some difficulty” in the Washington group questions used in *Susenas*.

⁶ “Highly vulnerable” respondents are those whose post-pandemic income would have certainly put them under the poverty line of IDR 454,652 (approx. USD 32.00). The income range of the “vulnerable” group, post-pandemic, would have positioned them under or just above the poverty line.

Figure 2-6: Gender Disaggregation of Monthly Income Levels for People with Disabilities

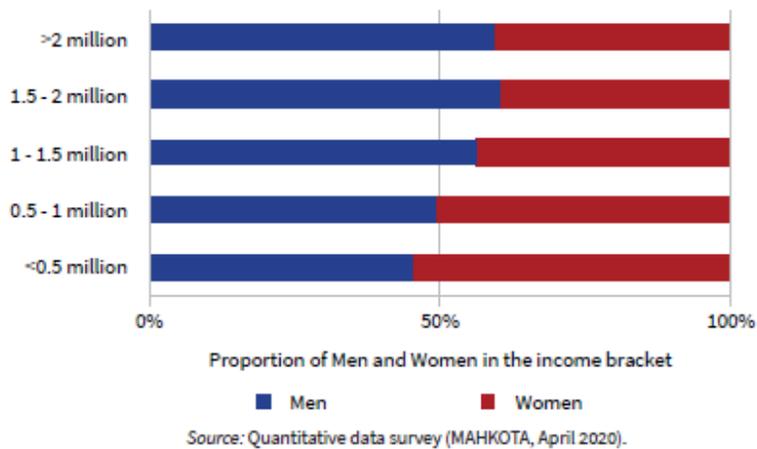


Table 2-1: Lower Income Level Among Women with Disabilities Leads to Higher Economic Vulnerability

Gender	Not Vulnerable (%)	Vulnerable (%)	Highly vulnerable (%)
Men	33.0	29.2	37.8
Women	28.4	26.5	45.1
Total	31.0	28.0	41.0

Source: Quantitative data survey (MAHKOTA, April 2020).

2.2.2 Caring roles for people with disabilities are disproportionately filled by women

⁷ The male caregivers in our qualitative study (two out of 13 caregivers) only play this role part-time and have taken on this responsibility because there were no women within their households available for the task. In households where a female member is available, even when she is not a direct relative of the person with disability, the caregiving role is likely to be given to her rather than a male member who is the direct relative of the person with disability.

Box 2-2: Demands for Single Caregivers: Juggling Long Working Hours and Full-time Caregiving

“I actually don’t want to leave him at home. He can move around the house, he can clean himself and eat by himself. But I always worry that something may happen to him. When I work, sometimes I leave him at home and I try to be home as soon as I can. Sometimes I take him to work so he stays during the day at my workplace.”

When the person with disability requires full-time support, the caregiver must allocate most of her time to care for the person with disability and is presented with few options to earn a livelihood to support herself and the person she is caring for. Some take on a full-time job while also being a full-time caregiver (either performing work from home or bringing the person they are caring for to their workplace). Some manage to work part-time, and others struggle to find a job that can be combined with caring work. In all cases, the caregivers experience significant financial, physical, and psychological stress

⁷ More discussion on gender dynamics in caregiving roles is presented in Chapter 5.

due to the heavy burden. Many must rely on handouts or loans from relatives or limit their expenses to the bare minimum to survive (Boxes 2.2 and 2.3).

Box 2-3: Livelihood 'Trade-offs' for Female Caregivers

A difficult choice between employment and caregiving responsibilities

Rima is the sole caregiver for her younger brother who has intellectual disability. The two of them live in a house they inherited from their parents who have passed away. She graduated from university in 2018 and would like to work to financially support her brother. She had a few job offers, but none of the potential employers were willing to negotiate for flexible working hours so she could help her brother before and after school.

“I applied for jobs and received a few job offers. But I couldn’t negotiate for flexible working hours, so I had to decline. My brother needs me to drop him at school, pick him up from school and eat lunch with him. He doesn’t eat his meals if I’m not with him. The schedule clashes with the office hour.”

Because their late mother was a civil servant, the siblings currently receive a monthly family pension, which is available until the youngest child reaches the age of 21. Rima feels lucky that they have the pension of IDR 1,200,000 (approx. USD85.00) per month, and it covers their basic expenses. The pension will expire as her brother grows older, however, and Putri will have to earn some income to cover their expenditure. She is still applying for jobs but is becoming less hopeful of finding one that fits her time constraints as a caregiver.

3. ECONOMIC IMPACTS OF COVID-19: LIVELIHOOD DYNAMICS AMONG PEOPLE WITH DISABILITIES DURING THE CRISIS

This chapter analyses the economic impacts of the COVID-19 crisis on people with disabilities, highlighting the changes that the pandemic brought to their livelihood activities, income, and expenses. Although our analysis focuses on income shocks, people with disabilities also bear increased expenditure due to the crisis. These expenditure shocks add to the already high cost of living borne by people with disabilities.

3.1. Disproportionate job loss and severe income reductions further escalate poverty levels of people with disabilities

While the COVID-19 impact on income and employment is prevalent across the board, the situation is exacerbated among people with disabilities. By April 2020, 81 per cent of workers with disabilities reported experiencing reduced income after the COVID-19 crisis. A large proportion of these experienced a severe income drop between 50 and 80 per cent (OPD 2020; Satriana 2020). In the same period, a survey conducted by J-PAL (2020) showed that a higher percentage of people with disabilities claimed to have stopped working after the COVID-19 crisis (68 per cent) compared to respondents in the general category (55 per cent).

Given their low baseline income, such a severe income drop is likely to leave households with disability in an untenable economic situation. As of April 2020, up to 69 per cent of respondents had become poor or fallen deeper into poverty after the COVID-19 pandemic (OPD 2020; Satriana 2020). Against the national poverty line of IDR 440,538 (approx. USD 31.00) per person per month, 41 per cent of respondents had a post-pandemic income that falls under the poverty line and another 28 per cent had an income level at or just slightly above the poverty line (Table 3.1). Given that this analysis is based on the national poverty line (without considering the extra disability-related costs), the economic hardships experienced are, in fact, underestimated.

Table 3-1: Respondents Reporting COVID-19-related Income Change

Income before COVID-19 pandemic	Income changes after COVID-19 pandemic		
	10-30% reduction	30-50% reduction	50-80% reduction
> IDR 2 million	1.6%	1.6%	4.2%
IDR 1.5 - 2 million	1.4%	4.2%	4.9%
IDR 1 - 1.5 million	1.3%	1.4%	4.8%
IDR 500,000 - 1 million	4.0%	7.3%	10.9%
< IDR 500,000	11.0%	8.1%	22.0%
41% Under poverty line		28% At or slightly above poverty line	

Source: Satriana, 2020

The income reduction has led to an overwhelming majority of respondents (81 per cent) reporting difficulty in affording food (*sembako*) since the pandemic started. As expected, this income effect on staple food is most pronounced among respondents with lower post-pandemic income. Fifteen per cent of households with a person with a disability said they had experienced 'moderate or severe' food insecurity since April 2020, compared to the national average of 11.7% (UNICEF et al 2021). Difficulty in purchasing staple food far exceeds that of other expenses such as phone/internet (36 per cent), electricity/water (38 per cent) and credit/debt payment (37 per cent).

Economic difficulties are also experienced by people with disabilities who live in institutions. Our respondents from non-profit disability institutions in Jakarta, Central Java, and East Java mentioned that their organisations were getting less funding since they stopped receiving visitors who normally come to give donations. Institutions are also losing income because their income-generating activities are affected by the pandemic. This was the case for an institution in East Java which has a catering and confectionery business. Sales have been very low and they had to reduce expenditures including that on food and vitamins.

3.1.1 Informal occupations among people with disabilities exacerbate their susceptibility to income shocks

The informal nature of the jobs taken up by people with disabilities is known to have a major contribution to their susceptibility to income shocks. Ninety-seven per cent of respondents with informal employment experienced a reduction in income compared to 67 per cent of those in formal employment. Furthermore, informal jobs do not provide social insurance or severance pay in case of unemployment, and low and unpredictable income means they cannot build sufficient savings to buffer their expenditures in times of hardship.

With low education attainment, many people with disabilities who wish to work rely on skills training to enter an occupation. Such training is available in limited options, usually linked to the type of disability. In many areas, massage training is targeted to people with vision impairment, while those with mobility limitation are often offered training in making snacks or handicraft. Other common types of training include sewing and barbering/hairdressing (often offered to people with hearing impairment and certain physical impairment). Very little training is offered to people with mental or intellectual disability, so casual physical labour becomes the most common work available to them.

Unfortunately, many of the occupations where skills training is available happen to be severely impacted by the COVID-19 crisis, as massage parlours, hair salons, and food stalls were ordered to close. With such a limited scope of skills, these workers are left with no alternative livelihood when their businesses close. The least income effect was observed among respondents working in agriculture, particularly subsistence farmers, given their lack of reliance on the market. Farmers who do sell their products tended to experience little or short-lived market disruptions at the beginning of the pandemic, if at all.

Box 3-1: Poorly Skilled Workers are Vulnerable to Loss of Work

Respondent with vision impairment, also a disability activist and teacher in a school for people with vision impairments, Banda Aceh:

“Most of the people with disabilities here are daily workers. Blind people who work as masseuses, they have had no work since March. They do not have much to eat. The same happened to our friends with physical disabilities, who normally make cakes and other snacks. The coffee shops are closed, they cannot sell their products.... These job specialisations for people with disabilities, it does not have to be that way. They should be able to do other things. Blind people do not have to become masseuses, they can be teachers, computer operators etc., but they have low education. They have no other skills. So, when they get the skill to be masseuses, or ... get the opportunity to learn to produce cakes, that is what they do. They don't have other options.”

Although more protected, formal workers were not spared from the economic impacts of COVID-19. Many private sector workers experienced wage cuts, working hour reductions, and layoffs with little to no severance pay. Even respondents working for the government reported reduced income, as they no longer receive travel allowances or speakers' fees with the reduction in travel and conferences.

In both the formal and informal sector, a higher level of education means less exposure to shocks and better capacity to cope. Not only are those with higher education occupying jobs with a higher income and more job security, but they are also more equipped to diversify or create new livelihoods to cope with shocks, as illustrated by a respondent with vision impairment in East Jakarta (Box 3.2).

This respondent has a diploma in English and has taken up several skills training opportunities in sport massage, computer operations, and, more recently, online business management. He worked as a masseuse and started an online business selling mobile phone accessories. The technical skills he gained from the training played a crucial role in his ability and motivation to run the business. As he described it:

“I was already interested in running an online business, but after I took the training, I had the technical skill, and I was confident to do it. It helps that I understand English since my business involves ordering products from overseas.”

When the pandemic started, his work as a masseuse declined by more than 90 per cent. He then focused more on the online business, which provided sufficient income to cover his expenditures.

“The online business is doing well in the pandemic. People do not go to stores as much anymore. There were some hiccoughs in the supply chain of some products, but the demand is still strong. Overall, my income is still good.”

He acknowledged that living in Jakarta gave him better opportunities to obtain an education and access to national-level training programs which his peers in other areas may not be able to enjoy.

3.1.2 Increased expenditure heightens the economic shock experienced by people with disabilities

People with disabilities are also experiencing higher expenses due to the pandemic. These increases were felt with general household expenses as well as on items related to disability. Respondents reported having to pay higher prices for some foodstuffs like sugar⁸, electricity, phone credit, and data credit that comes with schooling and working from home and additional expenses for masks and cleaning products. In addition, transport costs have always been more expensive for many people with disabilities but have now become even more costly (and, in some circumstances, very difficult to obtain). The use of public transport has been limited to avoid exposure to COVID-19 and some means of transport such as motorcycle taxi may not be available due to restrictions.

3.1.3 Common coping strategies have long-term negative impacts

The most common coping strategies among respondents include reducing food consumption (both in quality and quantity), reducing disability-specific expenditure such as therapy or food supplements, borrowing money/food, and selling/consuming productive assets. A small proportion of respondents rely on savings and assistance from family and friends, but these strategies are limited by the availability of such resources. Most of the coping strategies have negative long-term consequences for the entire household but can be especially detrimental for more vulnerable household members such as children and people with disabilities.

Cutting down on food or switching to less nutritious food may have serious consequences for people with disabilities, especially those who have underlying health issues. This is particularly concerning as budget cuts in respondents' households often include reduction/suspension of special food or supplements. These include prescribed vitamins, formula milk, or other processed food needed by those with oral–motor feeding problems such as cerebral palsy, cleft palate, and Down Syndrome, among others. Individuals with these disabilities are at higher risk of nutritional deficiency to begin with, meaning that, in the long term, the situation creates a perpetuating cycle of sub-optimal nutrition, disability, and worsening health status (Turunen and Hiilamo 2014).

Another potentially damaging coping strategy is the reduction/suspension of therapy which is occurring due to income constraints, limited movement given lockdown policies, or a combination thereof. For instance, a rehabilitation centre in NTB province had to close due to the pandemic and, although they tried to replace on-site services with remote guidance to caregivers to conduct activities at home, this has been challenging since most clients do not own smart phones and struggle to afford internet data. In addition, in situations where clients require medical attention, some have reduced or postponed visits to doctors/clinics.

⁸ The sugar price increased by around 50 per cent at the start of the pandemic. The price increase is particularly high outside Java, with Papua and Kalimantan experiencing an increase of approximately 100 per cent (Kompas 2020a; National Food Price Information—PIHPS Nasional 2020).

While many of the caregivers cited fear of COVID-19 exposure as the main reason for not seeking medical attention (see Subsection 2.2), some also mentioned transport cost as a reason. As the head of the rehabilitation centre explained: *“Many of the parents lost their income. Cost is one of the reasons for not taking their children to the clinics.”* A caregiver of a child with multiple disabilities mentioned that her income has dropped from IDR 45,000 per day to IDR 10,000-15,000 per day. Taking her child with disability on a motorcycle taxi for therapy costs at least IDR 10,000, a significant proportion of her income. She can still afford food for her child, but she finds it difficult to pay for the transport and she no longer buys the vitamins recommended by the doctor.

After reducing consumption, borrowing money/food has been the most common strategy. Borrowing from friends and relatives appears to be respondents’ preferred option, as it is interest-free and usually comes with flexible terms of payment. Social networks that include those who have the means and willingness to lend money is rare, however, particularly among the poor and in the current context. Other respondents purchase on credit from local grocery shops and local cooperatives, where available.

The long-term impacts of borrowing will depend on how long the crisis lasts or how soon households are able to recover their income. Evidence suggests, however, that prolonged indebtedness can increase stress levels, further exacerbating mental and physical health problems. Unpaid debts, in turn, will push households to take other debts or resort to other coping mechanisms, deepening the severity of the problem. For many households, social assistance or employment programs may be the only mechanism to break such indebtedness and have been a lifeline for many households (as discussed in the following chapter).

4. DISRUPTION IN HEALTH AND EDUCATION SERVICES WITH POTENTIAL LONG-TERM IMPACTS ON PEOPLE WITH DISABILITIES

4.1. COVID-19 secondary health impacts: access to health services for people with disabilities

Aside from the direct epidemiological effects of the COVID-19 disease, the pandemic has dire consequences on people's health through indirect secondary effects resulting from disruption to essential health services, limited social and care networks, and heightened stress level. People with disabilities are particularly susceptible to negative health outcomes in this situation, as many of them have underlying health conditions and have higher needs for health care. Although the primary health effects of contracting the virus are important and significant for people with disabilities, they are not included in this analysis (see UNICEF 2020a and SDD 2020 for an examination of the primary health impacts on people with disabilities). This study focuses on the secondary impacts—that is, the indirect consequences of the measures taken to contain and control the disease.

As is the case with 90 per cent of the world's countries, Indonesia is experiencing health service disruptions due to the COVID-19 pandemic (WHO 2020a). This includes suspension of rehabilitation services, outpatient services, inpatient services, community-based care, and even emergency services—with potentially harmful health impacts in the short, medium, and long term. Disruptions were caused by factors on the supply and demand side. On the supply side, these include closure of services or health facilities, reduced availability of medical staff (because they have been redeployed to provide COVID-19 relief or have limited patient contact to reduce COVID-19 exposure), or interruptions in the supply of medical equipment and health products. On the demand side, patients needing health care or therapy may reduce or suspend seeking services due to fear of exposure to the virus, movement restrictions, and financial difficulties.

Such disruptions are particularly detrimental to people with disabilities, many of whom require regular rehabilitation service. The WHO global survey (2020a) showed that, in most countries, rehabilitation services have been among the most disrupted essential health services during the pandemic. The following section elaborates on the obstacles faced by people with disabilities in Indonesia in obtaining health services during the pandemic, from both the demand and supply perspectives.

4.1.1 Closure of rehabilitation centres and suspension of rehabilitation services

In our study areas, all rehabilitation services had to close or significantly reduce their on-site services due to the pandemic. Given the types of therapies provided (many require physical contact between clients and therapists) and the typical living arrangement for clients who live in the centres (dormitories with many people occupying small spaces in proximity), these institutions were at high risk of experiencing an outbreak and, therefore, had to take drastic measures to limit risk. The institutions were faced with the difficult choice of eliminating/reducing services or risking their clients/staff to COVID-19 exposure. Even when precautions were taken, some institutions still experienced an outbreak (see Box 4.1).

Box 4-1: Exposed to COVID-19 while living with disability: the challenges of dealing with an outbreak

A foundation in Jakarta has been providing education, rehabilitation, and care services for children with vision impairment who also have other disabilities. Many of the children have a combination of vision and hearing impairment, or visual impairment and intellectual disability, resulting in significant communication barriers. In April 2020, several students and staff were infected with the COVID-19 virus and had to be isolated. Some of them needed to quarantine in the hospital or the government's quarantine facility (*Wisma Atlet*), as they were showing symptoms and needed to be monitored, however, the facility was not conducive and accessible for these children. The staff were not familiar with the children's condition and were not able to communicate with them or support their needs.

Seeing these difficulties, the foundation then collaborated with *Wisma Atlet* and the local community health centre (*Puskesmas*) to set up a quarantine location in its own dormitory, where the children are accompanied by some of their regular carers. *Wisma Atlet* then sent a team of physicians to train these carers in health and safety aspects, and provided the foundation with protective gear, food supplies, and vitamins. The quarantine process then continued under the supervision of the local *Puskesmas*. This alternative quarantine set-up for people with disabilities was more conducive to their needs. A respondent from the foundation stated that, "in the process, we saw that children who were isolated in our own dormitory recovered faster than those isolated in the hospital."

Both government and non-profit institutions provide rehabilitation services to clients who live in the institution, at home, or a combination of the two. As a result of the pandemic, clients who live at home had to stop going to the centres, those who normally stay at the centre were sometimes sent home to families, and those who have no families stay at the centre with reduced services (as contact with visiting therapists, teachers, and health workers have become limited). For all clients, this means the therapy that they normally receive has either stopped completely or been limited in availability (Box 4.2). These findings are in line with a survey conducted by Litbang Kompas (September 2020) that showed that one-quarter of children with special needs faced difficulties in accessing therapy or medical care during the pandemic (Kompas 2020d).

Box 4-2: Rehabilitation centres have adjusted their service model, usually with negative outcomes

One rehabilitation centre for people with psychosocial disabilities in Sukoharjo, which has all their clients living full time in the institution, managed to continue their operation by limiting contact with the outside world and forgoing sessions from visiting therapists and family members. The biggest change was that the institution had to put a moratorium for new clients to sign up. At least 10 new clients had to be rejected between March and June 2020 and have been deprived of the treatments they needed. As the director of the rehabilitation centre explained: *“We have many people living side by side here. If one is exposed to the virus, we have a big problem. We had to be strict, we put a moratorium. It is the first time we rejected people. We cannot help them.”*

Some institutions attempted to replace the therapy sessions with some form of distant therapy by providing guides to parents or caregivers to conduct therapy at home. This has proven to be very challenging due to:

- (i) difficulties for parents/caregivers to replicate what professional teachers and therapists do; and
- (ii) communication barriers caused by lack of technology and high cost of phone credit, data, or internet connection. Furthermore, depending on the type and severity of the condition, some therapies require specific skills or training which parents/caregivers are not equipped with.

After implementing this approach for three months, a director of a rehabilitation institution in West Nusa Tenggara (NTB) observed that: *“The situation is very difficult for those with high needs of physiotherapy. The treatments require special skills, which parents are too afraid to do even after we tried to train them.”*

He added that the success of such therapy at home also depends on parents' familiarity and involvement before the pandemic. Furthermore, not all parents/caregivers own telephones, smart phones, or computers, and those who do may not be able to afford the high phone/data credit needed to conduct video calls or download video tutorials. In all institutions interviewed, most of the clients come from low-income families. According to this director: *“Less than one-third of our clients have internet at home to download the videos we created. With others we try to communicate by phone once a week. But there are many who do not have any communication technology. For this group, now we try to visit them maybe once a month.”*

During the home visits, staff of the institution observed that the lack of therapy has resulted in serious health impacts and, in some cases, reversed the progress made over years. Most of their clients' conditions have worsened—especially those with severe disabilities and high therapy needs.

4.1.2 Service disruptions in health facilities

With the discontinuation or interruption of regular rehabilitation services, people with disabilities may face deteriorating health conditions that, in turn, require more serious medical attention. The medical services that they need may, however, be less available as the health system is overburdened by COVID-19 cases. Health care workers are struggling to keep up with the demand of COVID-19 patients while facing the risk of infection themselves.

Several local health providers stopped operating when their health workers were infected with the virus. A respondent in South Sulawesi experienced limited access to health care as the *Puskesmas* in her area was closed for nearly one month due to an outbreak in the facility. This was not a rare occurrence, as many *Puskesmas* and even hospitals across Indonesia were temporarily closed (completely or partially) due to health workers infections (BBC News 2020a).

Furthermore, many health care facilities must operate with reduced human resources to protect their workers. This has resulted in facilities limiting patient contact or reducing working hours for doctors and nurses who are older or have preexisting health conditions. With limited capacity and a high focus on COVID-19 cases, other health care needs may receive less attention.

4.1.3 Fear of COVID-19 exposure, movement restrictions, and lack of transportation deter people from seeking health care

Across Indonesia, hospitals and clinics have seen a drop in non-COVID patient numbers—both for inpatient and outpatient visits (Berita Satu 2020; Katadata 2020b; Kompas 2020b). Health workers and social workers interviewed in this study confirmed that many people, including people with disabilities who regularly need medical attention, are reducing their visits to clinics due to fear of exposure to COVID-19, as well as difficulties reaching health facilities due to movement restrictions. The director of a rehabilitation centre in NTB stated that their clients are also hesitant to seek medical treatment from the hospitals:

“During the pandemic they rarely go to the hospital. Clients who have congenital illnesses normally get their medications regularly from the hospital because we do not provide the drugs. But many of them are now afraid to go.”

He added that, aside from fear of contracting COVID-19, people with disabilities are afraid of the additional stigma they will have to face:

“If they are exposed to the virus, they will be stigmatised. They are already stigmatised for being disabled, then they get more stigma for getting COVID-19 disease. That will be more difficult for them.”

Access to treatment was also deterred by movement restrictions due to strict lock down policies in some areas. For instance, a social worker in East Java mentioned that some patients with psychosocial disabilities could not go to the psychiatric hospital (located around 200 kilometres from the area) to get treatment when lock down was in place, as roads were closed, and transportation became very difficult to obtain (see Box 4.3). A psychiatrist mentioned that she saw some of her patients' conditions getting worse because they missed their regular hospital visit:

“Some of our mental health patients relapsed. Those who usually come every two weeks or every month, but then stopped coming for their check-ups.”

It should be noted that these COVID-19-related difficulties do not imply that the support available pre-pandemic was enough to meet the need as there is a dearth in community support services and few alternatives to institution-based care. The pandemic simply put more stress on the already limited support available. There are, however, examples of successful community-based rehabilitation models across Indonesia where further research is warranted as they are outside of the study research areas.

Box 4-3: Higher need but lower access to mental health services in the COVID-19 pandemic

Due to the COVID-19 pandemic, mental health services experienced serious disruptions in nearly every country (WHO 2020a). Mental health prevention and treatment has been more difficult to obtain at a time when many people are facing adverse mental health impacts of COVID-19 (WHO 2020b). Indonesia's Ministry of Health has recorded a significant increase in mental health diagnoses since the COVID-19 pandemic started (277,000 cases reported up to June 2020, compared to only 197,000 cases in 2019). This can be attributed to social isolation, fear, and economic hardships resulting from the pandemic (Media Indonesia 2020; BBC News 2020b). Our interviews with social workers confirmed this situation which is exacerbated by a drop in mental health services, leaving many cases unattended. Given that psychiatric hospitals and rehabilitation centres have high rates of COVID-19 transmission, they have formed clusters of COVID-19 (BBC News 2021c). The situation is partly attributed to the set-up of psychiatric wards, with high numbers of patients in a room and small spaces between patients (Bisnis.com 2020; interview with physicians).

An official of the Ministry of Health stated that, in response to the high infection rate, the policy was to reduce the number of patients to allow physical distancing, however, this resulted in several patients not getting the treatment they need (BBC News 2021c). Outpatient consultations also pose high risks of COVID-19 transmission as “psychiatric consultations require relatively longer sessions, requiring longer face-to-face contacts between doctors and patients” explained a psychiatrist. Psychiatry specialists are among doctors with high COVID-19 deaths, further limiting patient contact, especially among high-risk doctors. Along with the supply-side shortage, many more patients are not getting treatment as they are hesitant to seek health care due to fear of COVID-19 infection in health facilities. One of the respondents with psychosocial disability mentioned that he now needs more time to get his regular consultations in the hospital given the long queues. It has also taken more time to get the referral that he needs from his local health centre as they are under capacity.

4.2. COVID-19 impacts on education: how students with disabilities are disproportionately affected

The COVID-19 pandemic is disproportionately impacting students with disabilities who were already experiencing significant social and educational disadvantages pre-pandemic (UNESCO 2020a). In a survey taken since the outbreak of COVID-19 (Susenas 2020), we see that 31 per cent of children with disabilities between the ages of 13 to 15 dropped out of school—compared to only 7 per cent of children without a disability in the same age group (Table 4.1).

Table 4-1: Children Out of School (Based on Age and Disability)

Student Cohort	7-12 years old (%)	13-15 years old (%)	16-18 years old (%)
Children without disabilities	0.57	7.16	22.00
Children with disabilities	10.16	31.27	62.92

Source: BPS 2020b (from Susenas March 2020).

With COVID-19 related school closures, many schools in Indonesia turned to other methods to attempt continuity of learning. They include online learning, phone and radio communication, home visits or sending learning materials to parents. In April 2020, the majority of respondents who were studying remotely were doing so via the internet (72.4 per cent)—either by using learning applications (35.2 per cent) or through online communications such as WhatsApp groups (37.5 per cent). Sixteen and a half per cent of students learned independently or with parents—mainly due to lack of internet access—while 4.7 per cent used other methods and 3.1 per cent did not engage in learning activities during the pandemic⁹.

¹⁰. The new ways of learning are not easy for students to adopt, and they are especially detrimental for the educational attainment of students with disabilities, as elaborated in the following section.

4.2.1 Distance learning may leave many learners with disability left behind

As observed by UNESCO (2020b), school closure has exacerbated the already-widespread educational inequalities for disadvantaged students. Among the most disadvantaged are students with disabilities who face multiple barriers to distance learning. Given the limited learning support according to their needs, children and adolescents with disabilities faced three times higher a risk of dropping out as compared to their counterparts with no disability (UNICEF et al, 2021). In April 2020, most student respondents (68 per cent) reported having difficulties following online learning, and only 20.3 per cent stated that they could easily access and participate in online learning. Some of the barriers include a disruptive home environment (with potential violence and abuse), lack of assistance/guidance at home, inaccessible programs, lack of internet connectivity, and the high costs of the internet¹¹. As Table 4.2 illustrates, students with disabilities have much more limited access to information and communication technology compared to students without disability—posing a clear disadvantage in the adoption of online learning.

Table 4-2: Students Accessing Information and Communication Technology (by Age and Disability Status)

Student Cohort	Using cellular phone (%)	Using computer (%)	Using internet (%)
Children without disability	77.25	24.18	59.46
Children with disabilities	50.32	11.30	33.44

Source: BPS 2020b (from Susenas March 2020).

⁹ It should be noted that the high percentage of respondents participating in online learning may be biased because respondents participated via online surveys.

¹⁰ <https://www.ksi-indonesia.org/id/wawasan/detail/2007-can-the-covid-19-pandemic-boost-inclusive-education>

¹¹ Drawn from Save the Children Indonesia (2020). Our research did not specifically ask about violence or abuse experienced within home environments.

The following section further elaborates on how the current pandemic is particularly harmful for people with disabilities from a remote learning perspective.

Students with disabilities are less likely to benefit from online learning as the methods were not designed with accessibility in mind.

Many websites and programs are simply not accessible for blind or deaf students. While more accessible programs have been invented, they are not widely used by schools (GEM 2020). Children with disabilities are at risk of exclusion from education if distance learning programs are not accessible or they do not have assistive devices that they need to allow participation (UNESCO 2020c). The barriers are even stronger in less developed areas where access to technology is generally limited.

One student with hearing and speech impairment in Papua mentioned that from the beginning of the pandemic (in March 2020) to when the interview was conducted (June 2020), he had not been to school and the school had not organised online learning. He stated:

“The teacher will come to drop some textbooks. I have not received them so far, but maybe soon. Maybe we will do online learning too, through YouTube or other medium, but I don’t know how it’s going to work.” John, as translated by his mother.

Many students with disabilities come from low-income families but require additional resources to actively participate in distance learning.

Many students with disabilities need additional devices such as talking calculators, text magnifiers, alternative keyboards, and audio books—all of which make learning more costly (UNICEF 2020b). These requirements are in addition to the general equipment needed for online learning such as computers, smart phones, and internet access. All the education institutions interviewed in this study mentioned that cost is a big hurdle for students to participate in online learning, since most of them come from low-income families. According to the director of a disability institution in Jakarta:

“We face challenges from the technological side. Not all parents have laptops or phones that facilitate video calls or video downloads, plus they have difficulties affording internet and phone credits.”

Some students with disabilities require an individualized curriculum which is difficult to accommodate in distance learning.

Due to their specific needs, learners with disabilities often learn with specially designed materials and one-on-one support (UNICEF 2020b). When learning is taken out of the classrooms, such support may no longer be available. This challenge is faced, among others, by an institution in Jakarta that provides education and care for children with multiple disabilities. The director explained:

“When they were in our school, we developed custom curriculum for each of them... For those with multi-sensory impairment, they cannot see, they cannot hear, communication is done through touching, with hand under hand method.”

Continuation of learning has been difficult when students must learn at home with their parents. This institution created video guides and tutorials to help parents assist home learning, however, as previously mentioned, the method comes with various limitations.

A special education institution in Papua implemented online learning (via the WhatsApp application) but decided that it was too difficult for students and parents to participate. The school then switched to the home visit method, whereby the teachers created an adjusted syllabus that they delivered to parents and guided parents on their use during the home visit. This method was considered a better alternative, despite the time and distance challenges. As one of the teachers explained:

“All the teachers create the modules and deliver them to the parents all the way to the districts of Wanimbo and Keerom [more than 100km distance from Jayapura district] ... because the teachers have to explain the modules directly to the parents.”

School closures also lead to disruptions in daily routines and loss of social interaction, which is particularly difficult for children with developmental disabilities.

Schools perform many functions outside of education, such as providing a safe haven, a social arena, and a support system (GEM 2020). School activities also come with daily routines and losing this adds a significant layer of difficulty for learners with disabilities who are sensitive to change (for example, those with autism spectrum disorder). Staff of education institutions that we interviewed mentioned that switching from school to home learning increases stress levels—both for the students and their parents. Their home environments are often not conducive for learning and they lose the important interaction with friends and teachers.

4.2.2 Vocational training opportunities have significantly reduced during the pandemic

As elaborated in section 2.1.2, many people with disabilities in Indonesia must rely on skills training to be able to enter an occupation given their limited education attainment. Skills training tends to be technical and generally does not require education pre-qualifications.

The availability of training has been largely impacted by the COVID-19 pandemic and, for the most part, had to stop with no option to transition to distance learning. Institutions that provide vocational training had completely stopped providing training for the second half of 2020. Some training courses have been eliminated as the need for on-site training equipment (for example, machines for sewing and carpentry) and direct contact (such as masseuse trainers) could not be substituted by distance learning.

This was the case with training institutions interviewed in Jakarta, South Sulawesi, and East Java. An institution in South Sulawesi redirected some of their training funds to provide social assistance to people with disabilities outside of the institutions. In Central Java, an institution that has all its clients living in its dormitory, managed to continue their regular training but had to reduce some components. As the director of this institution stated:

“Usually, we send them to work outside, such as in construction sites, as part of their training. But now there are no more activities outside.”

People with disabilities were faced with limited access to education and health care, even before the pandemic, however, the COVID-19 crisis has accentuated the barriers and widened the health and education gap between people with disabilities and people without disabilities. People with disabilities face disproportionate long-term impacts of the pandemic and will endure further challenges to recover from the crisis. Recovery policies need to pay attention to the disproportionate impacts endured by people with disabilities and help reduce the gaps.

5. PRE-COVID 19: CHALLENGES EXPERIENCED BY PEOPLE WITH DISABILITIES IN ACCESSING INDONESIA'S SOCIAL PROTECTION SYSTEM

5.1. Most people with disabilities are not covered by Indonesia's national social protection system

Despite their high vulnerability, people with disabilities in Indonesia have historically received little social protection from the national government. Prior to the pandemic, social protection programs targeted to people with disabilities covered only 5 per cent of people with severe disabilities¹², leaving the vast majority without protection. Regular social assistance for people with disabilities mainly consists of two cash transfer programs—Social Assistance for People with Disabilities (*Asistensi Sosial Penyandang Disabilitas*: ASPD), Family Hope Program (*Program Keluarga Harapan*: PKH), and social insurance schemes for workers under the Social Security Agency for Employment (*Badan Penyelenggara Jaminan Sosial-Ketenagakerjaan*: BPJS-TK) Program.

Indonesia started implementing a cash transfer program for people with severe disabilities in 2006 under the Social Insurance for People with Severe Disability (*Jaminan Sosial Penyandang Cacat Berat*: JSPACA) Program. JSPACA was subsequently renamed Social Assistance for People with Severe Disabilities (*Asistensi Sosial Penyandang Disabilitas Berat*: ASPDB) and later again as ASPD. ASPD is implemented under the management of MoSA's Directorate General of Social Rehabilitation (Rehsos). In 2019 the program provided a cash transfer of IDR 3,600,000 (approx. USD 250.00) per year to people with severe disabilities. The benefit level declined to IDR 2,000,000 (approx. USD 140.00) per year in 2020 as MoSA announced a small increase in the number of beneficiaries from 22,000 to 23,700 but without increasing the overall budget for the program.

PKH is a cash transfer program for families, conditional on utilisation of health and education services. Families are eligible for the benefit if they have children or a pregnant woman and are ranked as being in 'the very poor' category in the national poverty-targeted social registry (*Data Terpadu Kesejahteraan Sosial*: DTKS) (Box 5.1). The program added a disability component and an elderly component in 2016. While children and pregnant women are the program's primary target group, households that contained a person with severe disability could only be eligible if they had other family members as existing beneficiaries¹³. Eligible families received a benefit top-up of IDR 2.4 million (approx. USD 167,000) per year, paid to the PKH beneficiary. Box 5.2 shows that this top-up has helped some PKH families cope with household expenses.

Box 5-1: Integrated Social Welfare Database (*Data Terpadu Kesejahteraan Sosial*: DTKS)

DTKS (previously known as the Integrated Database: *Basis Data Terpadu*) is an electronic system containing social, economic, and demographic information of around 27 million poor and near poor households, or around 38 per cent of the population (TNP2K 2020b). The database was first developed in 2011, and subsequently updated a few times since to determine eligibility of potential beneficiaries for social protection programs (UNICEF, et al 2021). Social assistance programs such as PKH and *Program Sembako* are aimed at the poorest 40 per cent of households.

Poverty levels in the DTKS are assessed with the proxy means test (PMT) method, where information on household characteristics correlated with welfare levels are used to proxy household income or welfare status. Households are then ranked based on their PMT score to determine their relative welfare level. This 'ranking,' however, is done infrequently, meaning that sudden drops in household income, as experienced in the current pandemic, are not adequately reflected.

The DTKS registration form includes only two questions pertaining to disability: (i) whether there is a household member with a disability, and: (ii) if so, the type of disability (with a list of four options for the household to choose from: physical, sensory, mental, or intellectual disability). Not all households know which type of disability their family member has, or may not disclose the information out of fear of stigma.

¹² Some 1.8 per cent of the population is estimated to have severe disabilities based on the *Sakernas* survey 2016 (in ILO and LPEM FEB UI 2017).

¹³ Although the rules seem to shift from one year to the next, PKH's limitation to people with disabilities living in family units was stated in 2019 through a MoSA Technical Instruction about PKH (2019b). In our interviews, the limitation appeared to be taken as the norm by program implementers.

In addition to the limited coverage, the benefits received for people with disabilities are relatively low, particularly when given the extra costs related to disability and the high poverty rate among people with disabilities. For instance, the PKH benefit for people with disabilities is set at IDR 2,400,000 (approx. USD 167.00) per year, lower than the benefits received by pregnant women or children under 5 years of age who receive IDR 3 million per year respectively. Moreover, the ASPD benefit was reduced from IDR 3,600,000 (approx. USD 250.00) per year in 2019 to IDR 2,000,000 (approx. USD 140.00) per year in 2020. Given the higher cost of living and the high poverty rate experienced, people with disabilities should be prioritised to receive a relatively higher benefit level.

Box 5-2: Experience of a PKH Beneficiary with a Disability

Anto, a respondent in Central Java, is a father of three. He has a psychosocial disability which began emerging five years ago. He used to work in an accounting unit of a company but had to stop working due to his disability. Now he stays at home taking care of the children and his wife works 12-hour shifts in a factory, making a minimum wage (around IDR 2 million per month). Since then, the family's income does not cover their monthly needs. "Our spending is usually more than our income. We need to buy milk for the small one, and daily expenses can add up to nearly three million per month." Anto is very happy that his family has been receiving PKH since 2019 and it has helped them cover food expenditure. "Thankfully we don't have debts. The most important thing is that we can eat and we have rice. Now we receive an additional IDR 400,000 (approx. USD 28.00) per month from PKH, we also get rice and eggs."

By 2019, ASPDB covered 22,500 beneficiaries (a mere 0.42 per cent of Indonesia's population with severe disabilities)¹⁴, while PKH covered 108,863 people with disabilities (2.03 per cent) (PKAKN 2020). In addition, 112,490 people with disabilities were receiving disability or work injury benefits and old age benefits from the workers' social insurance scheme under BPJS-TK in 2017—constituting nearly three per cent of people with severe disabilities (TNP2K 2018) (Table 5.1).

Table 5-1: Social Protection Coverage for People with Severe Disabilities in Indonesia (pre-pandemic)

Non-contributory Scheme (Social Assistance)

Social Protection Scheme	Program Description	Number of Beneficiaries	% of People with Severe Disabilities
ASPDB	An unconditional cash transfer program for people with disabilities since 2006. In 2019, beneficiaries received IDR 3,600,000 per person per year, but the amount declined to IDR 2,000,000 per year in 2020. Implemented by the Ministry of Social Affairs (MoSA) Directorate General of Social Rehabilitation (Rehsos).	22,500 (2019)	0.42
PKH	A conditional cash transfer program, traditionally targeting very poor families with children and pregnant women. PKH added a disability component in 2016 applying soft conditionalities. In 2019 and 2020, the benefit level for people with disabilities was IDR 2,400,000 per year. Implemented by MoSA's PKH Directorate.	108,863 (2019)	2.03
Total			2.45

¹⁴ The number of people with severe disabilities is estimated based on the proportion of people with disabilities in *Supas* 2015, applied to the number of people in the population in 2019 (TNP2K 2020a).

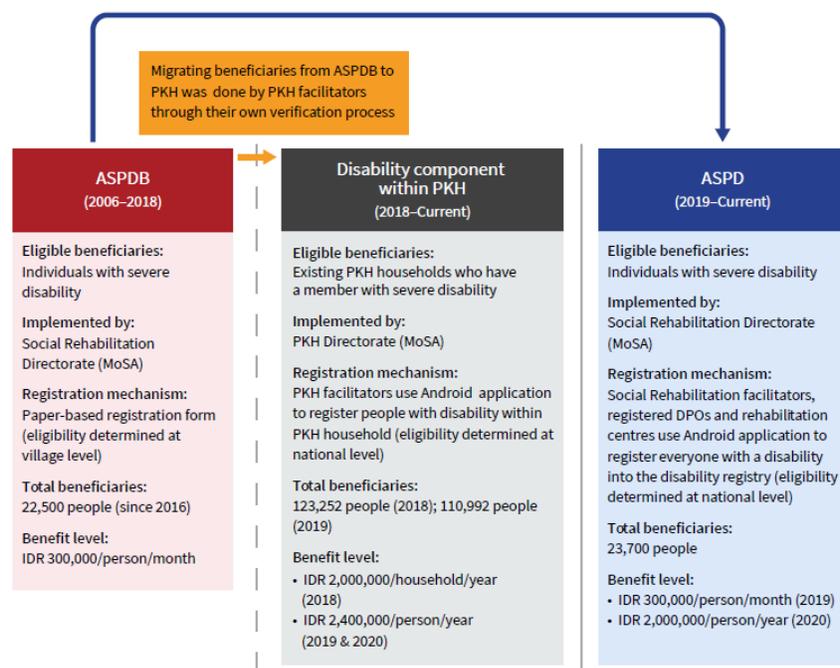
Contributory Scheme (Social Insurance)

Social Protection Scheme	Program Description	Number of Beneficiaries	% of People with Severe Disabilities
Social insurance benefits in BPJS-TK	BPJS-TK provides disability benefits under the work injury insurance (<i>Jaminan Kecelakaan Kerja</i> : JKK), and old age provident fund (JHT) schemes. The benefit amount is based on previous income and severity of the disability. In 2017 112,490 people with disabilities benefited from BPJS-TK (TNP2K 2018).	112,490 (2017)	2.95

Total % of People with Severe Disabilities 5.40%

Aside from these disability-specific programs, people with disabilities may also receive benefits from general social protection programs targeted to poor households. There is, however, no reliable data showing the proportion of households with members with disability in these programs. Moreover, when these households do receive household-based benefits, the household member with disability may not enjoy the full benefits as they tend to have lower bargaining power and receive lower priority within their households (Meeme and Gakuu 2017).

Despite some progress, the social protection system has been expanding at a snail's pace for people with disabilities. Indonesia's disability benefit, ASPD, has not expanded its membership since 2012 given limited political support for the program (TNP2K 2020a). Coverage of the PKH disability component doubled from 45,635 beneficiaries 2017 to 108,863 beneficiaries in 2019, leaving nearly 95 per cent of people with severe disabilities in Indonesia without regular social protection support. PKH's 2020 target for its disability component has shrunk to 106,599 beneficiaries since a new program policy put a limit of only one beneficiary with disability per household (PKAKN 2020). While the initial expectation was for PKH to take over all ASPDB's beneficiaries in 2018, issues with data consolidation and differing program structures did not allow for this transition (elaborated further in the section below). Figure 5.1 summarises the evolution of Indonesia's cash transfer for people with disabilities.



Source: TNP2K, 2020 – Presentation on Social Assistance Implementation for People with Disabilities (unpublished)

5.1.1 ASPDB-PKH transition issues led to a discontinuation of benefits for many

With the inclusion of the disability component in the PKH cash transfer program in 2016, ASPDB (as it was called at the time) was expected to phase out and transition all its beneficiaries to PKH by 2018.

This proved to be challenging, however, and problems in the transition process led to several beneficiaries losing their benefits due to a combination of the following factors:

PKH and ASPDB draw on different target groups and data management systems.

The difficult transition between programs is best explained by a DinSos staff member in one of the districts:

“People with severe disabilities are only included within PKH if their family has pregnant women, children under 6 years old or school-age children. Also, PKH can only be given to people registered in DTKS, so not all people with disabilities can benefit.”

ASPDB targeted its beneficiaries at an individual level regardless of family composition, while PKH beneficiaries are drawn from the DTKS social registry. The transition of beneficiaries from ASPDB to PKH, therefore, needed to go through a complex verification process to determine continued eligibility. PKH facilitators (from the PKH Directorate within MoSA) physically visited PKH households to register individuals within those families who have a disability, and this data was sent to MoSA to determine program inclusion¹⁵. The process took place, however, without the involvement of disability facilitators (from the *Rehsos* Directorate).

As a result, there was a breakdown in communication between the *Rehsos* and PKH units and a lack of information on which ASPDB beneficiaries were subsequently enrolled into the PKH scheme. Furthermore, the additional data on disability that PKH facilitators collected (and the process by which it was verified) is unclear. The DTKS, like many social registries, asks disability-related questions in the registration form, but this information is limited and insufficient to determine program eligibility (Barca et al. 2021).

The lack of clarity has caused particular confusion at subnational level, as many staff in district *DinSos* were unaware of the transition process and its results. Staff of the *Rehsos* unit of the *DinSos* in one district explained:

“In the district we [staff of social rehabilitation unit] find it difficult to get data on people with disabilities who are in the PKH program. There should be a connection between PKH and social rehabilitation data, so we know who are receiving PKH benefits. There should be connectivity between the two directorates within the same ministry.”

Entry to PKH was further constrained by the program’s limitation to include only one person with disability per beneficiary household (MoSA 2020a; PKAKN 2020). Additionally, some ASPDB beneficiaries were not included within PKH for various reasons—for example, because the person was not at home or could not provide certain documents during the data verification process.

Transition issues resulted in a national decision to revert PKH beneficiaries with a severe disability back to a disability benefit—which resulted in even more people slipping through the cracks.

Issues in the ASPDB-PKH transition led to a decision by MoSA to reinstate the ASPDB program in 2019, under a slightly different name (ASPD), however, ASPD utilised a different targeting mechanism from its predecessor ASPDB. Under ASPDB, targeting was done at district level with a quota system and data was managed manually. Each district was allocated a quota of beneficiaries and they were responsible for identifying eligible beneficiaries and then submitting this list to MoSA. With the introduction of ASPD, a decision was made to no longer use manual processes, but rather draw on the Information Management System for People with Disabilities (*Sistem Informasi Manajemen Penyandang Disabilitas: SIMPD*), a new database which began collecting data on people with disabilities nationwide in 2018 (refer to Box 5.3 for a description).

¹⁵ The questions that the Directorate used to determine severity level of disability are not known.

To create a comprehensive database on people with disabilities, as mandated by Law No. 8/2016 on Disabilities, the MoSA Directorate General of Social Rehabilitation developed the SIMPD in 2018. The registration form captures name and address (with GPS coordinates) on the person with disability; household information (if applicable); type/s of disability they are experiencing; and relevant photographs. It does not collect information on functional limitations and, therefore, does not calculate the severity of disability.

SIMPD data collection is conducted by social workers for people with disabilities (TKSPD/PPD/TPD), working under the social rehabilitation unit in the district *Din*Sos offices. Additionally, data can be submitted directly by rehabilitation centres, OPDs, and other institutions that have been verified and received SIMPD technical training from MoSA. At village level, data collection can also involve other actors such as village officials, midwives, and community-based rehabilitation staff—extending the reach beyond the limited capacity of the social workers.

SIMPD offers a more comprehensive database on people with disabilities. Some of its main features that set it apart from DTKS include:

- Data is captured at individual level, not limited to household units;
- Registers people with disabilities regardless of their poverty status;
- More detailed information on the type of disability;
- Updates, data entry, and changes can be done on a real-time basis; and
- Rehabilitation centres and disabled people’s organisations are empowered to register people with disabilities and are trained to use the system, significantly increasing its reach as compared to DTKS.

SIMPD only contains information on approximately 100,000 individuals, however, and is currently being phased out as MoSA develops a new data registry on all vulnerable populations (including people with disabilities).

Note TKSPD: *Tenaga Kesejahteraan Sosial Penyandang Disabilitas* (Social Welfare Workers for People with Disabilities); PPD: *Pendamping Penyandang Disabilitas* (Companion for People with Disabilities); TPD: *Tenaga Pendamping Disabilitas* (Support Worker for People with Disabilities).

The development of a national disability database that collects information on ALL people with disabilities (regardless of their poverty status) was a critical step forward and aligns with best practice globally (Barca et al. 2021). The registry was also linked to the issuance of national disability cards that provided people with disabilities official status. Approximately 30,000 cards have been distributed by MoSA based on SIMPD data, although the cards are not yet linked with access to programs or benefits as they are in other countries¹⁶. SIMPD did not, however, carry over all the information from the previous ASPDB beneficiary list, meaning not all previous beneficiaries received this legal disability status.

Furthermore, ASPD applied a new targeting mechanism where the list of beneficiaries is determined at national level and any new beneficiary candidate must go through a waiting list to replace old beneficiaries who passed away. This is different from the district quota system used in the previous version of the program, where districts had the autonomy to directly register eligible individuals and/or replace beneficiaries who passed away with others eligible from the same district.

As a result, several former ASPDB beneficiaries were neither taken up by PKH nor ASPD and had their benefits discontinued. Even when social workers or district officials find these cases and try to put them back into the system, there is no way to influence their inclusion. Given that ASPD has not expanded beyond 23,700 beneficiaries, there is little scope to re-enroll these beneficiaries even if eligible. This situation caused confusion and disappointment, not only among former beneficiaries, but also *Din*Sos staff in the study districts as one explained:

“Until 2017 our district had 316 people with disabilities receiving ASPDB. In 2018 we submitted the data of all 316 people to PKH. We do not understand how many of these ASPDB beneficiaries became PKH beneficiaries, as there was no report provided to us on this process. When the program transitioned back to ASPD in 2019, I was expecting to see data of all 316 people transferred to ASPD. But I saw only 14 of the 316 become recipients of ASPD, the rest were taken from new SIMPD data. We received many complaints from communities at that time. I asked TKSPD [social workers for people with disabilities] to find out what happened to these 316 people. Then we found out that some of them received PKH, and some did not receive anything at all.”

¹⁶ The Ministry of Social Affairs’ recently passed Disability Regulation 2/2021 on the Disability Card stipulates that everyone with a disability card will be entitled to concessions moving forward.

As Box 5.4 illustrates, these individuals are left extremely vulnerable with no social protection support and are susceptible to falling deeper into poverty in the current pandemic environment.

Box 5-4: Beneficiary Experience Through ASPDB-PKH Transition

Discontinued benefits, a lack of information and no grievance mechanism

Sam lives with his elderly mother who is the main caregiver and breadwinner of the family. He was a beneficiary of ASPDB until 2018, but in 2019 he stopped receiving benefits without any explanation. When asked about the issue, the office of social affairs said that the program has stopped, they do not know why or whether there will be another program. Since the discontinuation of his ASPDB benefit, Sam's family has not received other cash transfer programs including any of the COVID-19 cash assistance.

“Especially these days because of COVID-19, food becomes more difficult to buy. I hear Mama complain that rice and sugar become very expensive now. We are also getting less help from the family. They used to come and give us food or some money, but they don't come anymore. One time we received food assistance from the village, that's it. We don't get any of the cash assistance from the government.”

5.1.2 A new and improved disability registry will hopefully improve coverage of people with disabilities

Issues with disparate data systems has been acknowledged by the government, and changes to the current system are being discussed (for example, MoSA 2020b). The Government of Indonesia is aware of the need to move to more integrated systems, as evidenced in Presidential Decree No. 39/2019 on the One Data policy. This stipulates the development and utilisation of comprehensive and interconnected data involving different ministries and different levels of government, but considerable effort is, however, needed to make this a reality. The Ministry of Social Affairs is currently drafting a regulation stipulating the collection, management and use of disability data, which is a positive step in the right direction.

At the time of writing this report, MoSA is developing a new database for vulnerable individuals, including children, the elderly, and people with disabilities—in effect, those who may not be a part of a household and, therefore, left out of the DTKS but are in need of social assistance and other services (MoSA 2020d; MoSA 2020e). This new data management system seeks to eventually replace the SIMPD. The system aims to house more comprehensive information on people with disabilities (including functional limitations and severity of disability) and be interoperable with the DTKS. Nevertheless, it remains to be seen if this will be realised and if all SIMPD beneficiaries will be successfully transitioned into this new system.

6. SOCIAL PROTECTION FOR PEOPLE WITH DISABILITIES IN THE COVID-19 CRISIS: AN OPPORTUNITY TO BUILD BACK BETTER

The COVID-19 crisis provides a rare and valuable opportunity to learn about the adequacy of countries' social protection systems and, to what extent systems can be expanded when the need arises. In Indonesia, the government introduced a substantial stimulus package estimated at IDR 695 trillion (USD 50 billion) or 4.3 per cent of GDP¹⁷. The biggest share of the package goes to expanding social protection (34.5 per cent) and providing support to small and medium enterprises (18.4 per cent). Another 17.4 per cent is allocated to providing tax incentives for firms and 12.7 per cent goes to strengthening the country's access to health care services (World Bank 2020a; Almenfi et al. 2020).

Evidence is emerging that the Indonesian Government's robust response to the crisis has already begun to mitigate the pandemic's devastating impact on poverty, particularly for children (IMF 2020; Gentilini et al. 2020). There is, however, little knowledge so far on how such responses have impacted people with disabilities who, pre-pandemic, had been receiving a very small share of social protection despite the apparent need. This chapter attempts to fill this information gap.

6.1. COVID-19 responses significantly improved social protection coverage for people with disabilities

Faced with the urgency of protecting the incomes of millions of vulnerable citizens, the Government of Indonesia responded decisively by expanding existing schemes and rolling out new programs at an unprecedented scale. As of February 2021, the total allocated budget for social protection measures in 2021 amounted to IDR 157.41 trillion (USD 10.9 billion), equivalent to 1.02% of GDP in 2020 (MoF, 2021a). Table 6.1 presents the social assistance and employment programs that Indonesia has rolled out in response to the COVID-19 crisis. These have been implemented since April 2020, with plans to continue benefits until April 2021 (except for temporary cash top-ups to PKH and *Program Sembako* beneficiaries)¹⁸. As the following section argues, the size, delivery mechanisms, and targeting methods for these COVID-19 response programs may well have a lasting impact on Indonesia's social protection system.

Table 6-1: Indonesia's Social Assistance and Employment COVID-19 Response Programs

Program Name	Program Overview	Coverage	Benefits in 2020
Cash Transfer (Bantuan Sosial Tunai: BST)	A new unconditional cash transfer program introduced for eligible residents outside the Greater Jakarta region who have already registered in the social registry but are not recipients of PKH or Program Sembako.	9 million households (HH)	IDR 600,000/month for 3 months, then IDR 300,000/month
Food transfer for Greater Jakarta residents (Bantuan Sosial Sembako: BSS)	A new in-kind food assistance for Greater Jakarta (Jabodetabek) residents, providing food assistance worth IDR 600,000 in April-June 2020, then Rp 300,000 since July 2020. In 2021 the program was converted to cash transfer.	1.9 million HH	IDR 600,000/month for 3 months, then IDR 300,000/month
Electricity subsidy for households	Newly launched electricity fee waiver for all households subscribing to 450VA (24 million HH) and partial discounts for households subscribing to 900VA (7.2 million HH), starting in April 2020.	31.2 million HH	Fee waiver and discounts on electricity use
Cash transfer funded from Village Funds (Bantuan Langsung Tunai Dana Desa: BLT-DD)	A new unconditional cash transfer funded from the village funds, for village residents affected by the crisis but are not registered in the social registry and are not recipients of other programs. Identification of beneficiaries is done through the community consultation forum.	8 million HH	IDR 600,000/month for 3 months, then Rp 300,000/month

¹⁷ The level of spending is comparable to China and Philippines but lower than Thailand and Malaysia. For the 10 East Asia and the Pacific (EAP) countries where comparable data are available, the average of their fiscal response package is 4.9 per cent of GDP (World Bank 2020a).

¹⁸ Cash top-ups provided to PKH beneficiaries (three months in 2020) and non-cash food assistance (*Bantuan Pangan Non Tunai*: BPNT) beneficiaries (one-off in September 2020) were temporary, although the horizontal expansion is permanent.

Program Name	Program Overview	Coverage	Benefits in 2020
Program Sembako (previously BPNT) Vertical and horizontal expansion	Program Sembako food assistance program (previously called BPNT), expanded from 15.2 to 20 million low-income households and the benefit level increased from IDR 150,000 to IDR 200,000 (33%) starting April 2020.	20 million HH	IDR 200,000 per month
PKH Vertical and horizontal extension	PKH conditional cash transfer expanded from 9.2 to 10 million beneficiary families and double the benefit level for 3 months (April-June 2020).	10 million HH (800,000 new HH)	Increased benefits by 100% for 3 months
One-off cash top-up for Program Sembako recipients	A one-time unconditional cash transfer of IDR 500,000 was given in September 2020 to Program Sembako beneficiaries who are not receiving PKH.	9 million HH	IDR 500,000 per HH
Rice for PKH beneficiaries	Additional benefit of 15kg rice/month provided to recipients of PKH program for three months.	10 million HH	15 kg of rice Aug-Oct 2020
Electricity subsidy for micro and small enterprises	Newly launched electricity fee waiver for micro/ultra-micro-enterprises subscribing to 450VA (501,000 enterprises) and partial discounts for certain businesses and industries subscribing to 900VA and 1,300VA (1.3 million enterprises).	501,000 + 1.3 million enterprises	Fee waiver and discounts on electricity use
Cash for work (CFW) programs	The government allocates a total of Rp 16.9 trillion for CFW programs through various ministries and Village Fund projects.	More than 589,000 workers	Local daily wage
Kartu PraKerja Job training and cash transfer for job seekers	A new program targeting jobseekers who are not receiving PKH or Program Sembako, providing a IDR 1 million voucher for online training of choice, plus cash transfer of IDR 600,000 per month for 4 months to be paid after completing at least one course. Subsequently, an incentive of IDR 50,000 for 3 months is provided for completing three employability surveys.	5.6 million (progressive rollout)	Online training + IDR 2,550,000 cash
Banpres Produktif Cash grant for micro enterprises	A grant of IDR 2,400,000 for micro enterprises affected by Covid-19 and not receiving credit programs.	12 million micro enterprises	IDR 2,400,000 (one time)
Wage subsidy for low-income workers in the formal sector (Bantuan Subsidi Upah: BSU)	Cash transfer for workers with salary less than IDR 5,000,000 and registered on the national social security program (BPJS TK).	15.7 million workers	IDR 600,000 per month

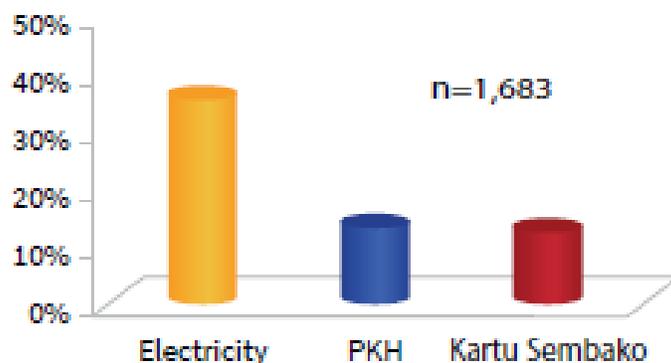
6.1.1 As social protection programs expanded, so did the coverage for people with disabilities

We have seen a significant increase in social protection coverage among people with disabilities with the implementation of COVID-19 response programs. In April 2020, our analysis was limited to PKH and *Program Sembako* expansion and the new electricity subsidy which were among the first COVID-19 social protection programs to reach full implementation across the country¹⁹. By then, the introduction of these new programs had significantly improved coverage among people with disabilities compared to pre-pandemic. At 35 per cent coverage among respondents, the electricity subsidy reached the highest number of people with disabilities while PKH and *Program Sembako* have 13 per cent and 12 per cent coverage respectively (Figure 6.1). Our analysis suggests that these programs are generally pro-poor as the coverage and intensity

¹⁹ Other programs have been launched as part of the COVID-19 response, including unconditional cash transfers, food transfers, and modified CFW programs. They had not, however, had significant rollouts by the time the survey was conducted in April. These other programs were explored in the follow-up qualitative research.

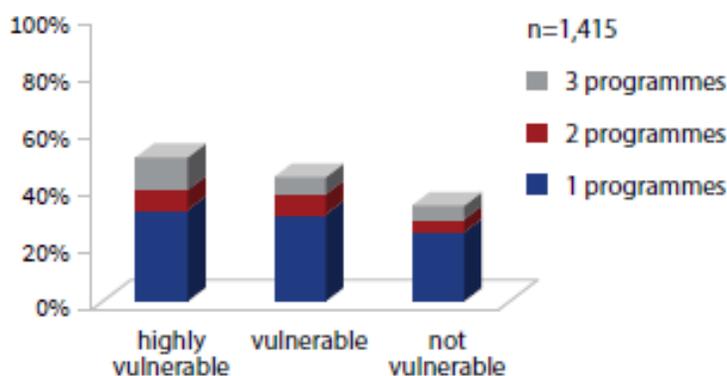
are greater among highly vulnerable respondents compared to less vulnerable ones (Figure 6.2)²⁰. Another survey also highlighted that the electricity subsidy was found to be extremely useful by the general population as it offset costs of studying and working from home (UNICEF et al, 2021).

Figure 6-1: Proportion of Respondents who are Program Beneficiaries (April 2020)



Source: Quantitative data survey (MAHKOTA, April 2020).

Figure 6-2: Proportion of Respondents Benefiting from Main COVID-19 Social Protection Programs (April 2020)



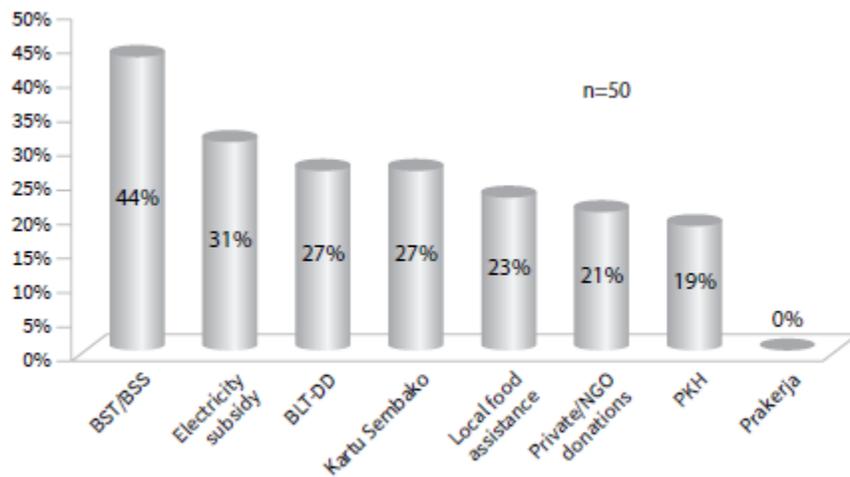
Source: Quantitative data survey (MAHKOTA, April 2020).

By July 2020 we found that most respondents received some form of social assistance, although in varying amounts and frequency, ranging from one-off food donations to the more substantial periodic cash transfers (Figure 6.3)²¹. This is in-line with the general population, as most households across Indonesia (85.3%) received at least one form of social assistance, and half of them (50.8%) received transfers in the form of cash (UNICEF et al 2021). BST, BLT *Dana Desa*, Electricity Subsidy, and *Program Sembako* the greatest coverage among respondents, while PKH constituted more limited coverage. The coverage of social assistance programs among respondents are in line with the overall size of the program, with Electricity Subsidy and BST/BSS among the biggest. Employment-related programs such as *Prakerja*, *Banpres Produktif*, and the wage subsidy were not seen as being widely accessed by people with disabilities. This is attributed to the fact that the wage subsidy targets formal workers, while mechanisms for enrolling in *Prakerja* and *Banpres Produktif* were not well communicated to people with disabilities.

²⁰ We grouped respondents based on their baseline income and income reduction during the pandemic. The “highly vulnerable” are those who have low baseline income and large income reduction and almost certainly end up under the poverty line. “Vulnerable” respondents end up under or just slightly above the poverty line.

²¹ Note: the qualitative survey sampled only 50 respondents and, therefore, has limited representativeness. The percentages in Figure 6.3 are presented for indicative purposes only and should not be compared with those in Figure 6.1 that are statistically representative.

Figure 6-3: Coverage of COVID-19 Social Protection Programs Among Respondents of Qualitative Survey (July 2020)



Source: Qualitative research respondents (July 2020).

The Ministry of Social Affairs has also made significant developments in ensuring that every person registered in the disability registry would be entitled to a disability card. According to a recently passed regulation, the *Kartu Penyandang Disabilitas* (KPD) entitles registered individuals to receiving official disability status, and eventually access to concessions. Concessions provision at a national level, however, has not yet been established in Indonesia. A total of 30,000 disability cards have been issued thus far, with plans to distribute 13,000 more in 2021.

In addition, MoSA has recently adopted a comprehensive care and social services system referred to as ATENSI, or *Asistensi Rehabilitasi Sosial* (Social Rehabilitation Assistance). People with disabilities are one of their five clusters of focus. Such a system is vital to ensure that people are provided with an array of support services (including rehabilitation services, therapy, vocational training, etc.), based on the assessment of individual case managers. A technical review on ATENSI is ongoing, with an objective to provide evidence to relevant ministries on how to enhance program implementation as the program moves from pilot to scale-up²².

6.1.2 Social protection expansion was made possible through a combination of national, local, and village-level programs, and the adoption of new targeting methods

To sufficiently respond to the crisis, countries that had not developed comprehensive social protection systems prior to the pandemic had to adopt a variety of new measures under duress. Sometimes this involved a fair degree of improvisation and missteps during development (ILO 2021a). This was certainly the case for Indonesia as the country adopted a new set of schemes and targeting mechanisms within a short period of time.

Unlike PKH and *Program Sembako* that used DTKS data to expand beneficiary lists, the village fund cash transfer program (BLT *Dana Desa*) used a community-based targeting mechanism²³. The new unconditional cash transfer program (BST) used a combination of DTKS and new data submitted by local governments (SMERU 2020a). BST also has a specific allocation for people with disabilities that uses the disability registry (SIMPDP) as a source of beneficiary data (as discussed further in section 6.1.3 below). These innovations were critical in improving social protection access among people with disabilities and provide valuable lessons for ensuring that Indonesia's social protection system is more inclusive in the future.

6.1.3 The use of the SIMPD disability registry was essential in expanding social protection coverage among people with disabilities

²² The study is commissioned by MAHKOTA and will be completed in August 2021.

²³ Program beneficiaries are proposed by communities and selected through deliberations (*musyawarah*) in the village.

It has become apparent through the COVID-19 pandemic that a poverty-based social registry system has many weaknesses in accommodating a crisis response (Barca and O'Brien 2017; Rodolfo 2020). DTKS has limited ability to register those who have become poor because of the crisis and lacks mechanisms to update data quickly in response to a crisis (World Bank 2020b; DPR RI 2021). Moreover, as discussed in Chapter 2, poverty measurements in the DTKS do not accurately reflect the vulnerabilities and real poverty of people with disabilities in Indonesia.

Globally, social registries may miss many people who experience disability but might not necessarily self-identify as having a disability (such as older persons). Others may feel too ashamed to admit their disability status (Barca et al. 2021). The focus on household units also potentially excludes people with disabilities who are living in institutions or other settings outside of the family, a problem that has also been observed by MoSA (2020b). In the case of the DTKS, questions pertaining to disability are extremely limited. Households may not know what 'type' of disability their family members have, or those with multiple boxes may be unable to simply tick one box.

Following the launch of the BST Program at the start of the crisis, MoSA specifically allocated a portion of the program for people with disabilities and decided to use SIMPD for targeting these beneficiaries. The decision led to significant inclusion of people with disabilities within BST in a relatively quick timeframe, something that could not have been achieved without a readily available disability registry.

Notwithstanding its significant contribution, this process was undertaken in a hasty manner and lacked coordination and communication with local-level implementers. Officials at district and village levels were generally unaware of the policies and selection process behind the BST component for people with disabilities. Nevertheless, respondents from social welfare offices were delighted at the high number of people receiving the benefits, but also criticised the process.

As one of the districts' social welfare staff recalled:

"In this district 844 people with disabilities receive BST, out of the 1,626 registered in SIMPD. We are very happy to see such a high number of beneficiaries included but were also baffled with the process. First, we were told to submit the data of 100 people with disabilities in our district - we were not clear what it was for. We were then asked to submit data of people with disabilities who were not getting any assistance. After this, we were asked to filter this data only for those who are registered in DTKS. After all the checks, we submitted the information of 198 people. Then we received from the ministry a list of 844 BST beneficiaries. We later found out that they were selected from SIMPD. MoSA should have used SIMPD from the outset - it belongs to MoSA, and the data is all verified."

6.2. COVID-19 responses demonstrate the important role that the village can play in the implementation of social protection programs and policies for people with disabilities

6.2.1 A complete overview of social protection beneficiaries is only available at village level, giving the village administration a unique position to fill the gaps

The smorgasbord of social protection programs on offer can be overwhelming to manage and monitor. Implementers in one ministry (or one directorate within a ministry) may not be aware of the scope of programs implemented by another, regardless of their complementarity. Likewise, programs initiated by provincial governments are independent of those coming from the central government or district governments, making it very difficult to synchronise benefits and coverage.

When asked about programs implemented by the national, provincial, and village governments, one DinSos staff member explained:

"From the province I do not know the number of beneficiaries, and for the village programs, we do not have the data unless the villages send them to us. I also don't know the details of program beneficiaries that come from DTKS. It is likely that many of these programs overlap."

Nevertheless, and despite the complexity, the program benefits and beneficiary registries all come together at the village level-this respondent described how, when these different levels of government select beneficiaries, they decide separately and:

“The names are locked. The benefits are there, the names are there, and we don’t know if person A or person B are also getting assistance from other sources. When the data arrives at the village, then they can find out if they also receive other assistance.”

Another respondent confirmed by stating:

“The one who knows all the program beneficiaries is the village government.”

This gives the village a very important role as a gatekeeper to identify errors, overlaps and gaps in program coverage.

6.2.2 BLT Dana Desa allows communities to cover people who are missing out on programs, providing much-needed assistance to people with disabilities

The villages’ oversight complements their new role as the implementers of BLT *Dana Desa*—allowing them to fill the gaps and cover residents who are otherwise missed by other programs. A village head in East Java explained that “before determining the beneficiaries of BLT *Dana Desa*, we check with social workers for PKH, BPNT, and staff at the district *DinSos*. If we see beneficiaries of these other programs, we reallocate BLT *Dana Desa* to other people. The elderly and people with disabilities who do not get any benefits, we can prioritise them for BLT *Dana Desa*.”

This has helped to make strides with the inclusion of people with disabilities and other vulnerable groups who are often missed by central government programs. Our interviews found that many villages (although not all) prioritise people with disabilities as they acknowledge their vulnerabilities during the crisis and their possible exclusion from other schemes.

A village in South Sulawesi made sure that all people with disabilities in the village can be covered:

“We have 43 people with disabilities who we have identified in our village documents. We make sure they all benefit from a program—some have PKH, BPNT, BST, and the rest gets BLT Dana Desa. The ones who are not covered by MoSA programs, we make sure they are covered in BLT Dana Desa. We synchronise the data manually, so out of 43 people with disabilities in this village, seven people are receiving BLT Dana Desa.”

It is noteworthy that people with disabilities who are not a part of ‘poor’ households are still prioritised—as one village head explained:

“More than 90 per cent of people with disabilities here are poor. Only three out of these 43 people are from middle-class families. For them, we give the same treatment because in their families they are not getting the necessary attention. The government assistance is also needed for them.”

The recognition that these individuals have less bargaining power within their families and may, therefore, not be benefitting equally from household resources is a critical reflection. While people with disabilities may be members of families who are receiving social protection benefits, stigma and other barriers can contribute to their marginalisation within their households²⁴.

6.2.3 Villages have limited ability to influence inclusion into national social protection schemes

Despite their important position in overseeing all existing programs, villages have very limited authority to influence program targeting. Beneficiary selections are decided at the national level and the results are only informed to the village once the beneficiary lists are final, leaving little room for rectifying errors.

A report by PEKKA (2020) found that, in their research areas, 71 per cent of village officials reported finding inclusion and exclusion errors within the DTKS data. The most common problems reported were the inclusion of beneficiaries who passed away and beneficiaries who have migrated from the village, followed by program overlaps and exclusion of poor residents. This is confirmed by one of our respondents from a village in East Java who stated that:

²⁴ For example, Kelly (2018) found that cash transfers targeted to people with disabilities in South Africa often made them a ‘breadwinner’ and created opportunities for them to have decisional autonomy, exercise agency within households, and be seen as valuable household members, despite requiring assistance from others.

“While they are grateful that the village receives cash assistance and food assistance from the government, unfortunately, there are overlaps where a beneficiary is listed in two programs. In this case one of the benefits cannot be used because they are not allowed to get double benefits in one household.”

When data problems are identified at the village level, there are limited options to address them and no clear guidelines on what the villages are permitted to do. The respondent added:

“When we identify data errors, like beneficiaries in multiple programs, people who died or moved, what should the village do? Can we reallocate these funds to other eligible residents, or should it just go unused? For now, the benefits are just returned to the national level.”

This is a difficult situation for the local governments because they feel the benefit is wasted rather than redirected to those who need it.

Most villages in our research areas decided to return the unused benefits to be on the safe side. Nevertheless, one village decided that, for beneficiaries who have passed away, they will provide a letter allowing family members to receive the benefits. Village officials interviewed said this was the right thing to do because the families still need the assistance. Some villages proposed new names to replace the wrong data, but there is no mechanism to change the list immediately and they do not know whether the suggestions are considered for the next round of disbursements.

6.2.4 The use of the Village Information System (Sistem Informasi Desa: SID) could significantly improve social protection coverage but could benefit from more guidance from the central government in collecting standardised data

The massive expansion of social protection programs, including those for people with disabilities, relied heavily on new data provided by village governments. Village-level data, whether originating from existing village databases or recently collected for the COVID-19 programs, has proven crucial in reaching people in need of assistance. This important contribution needs to be sustained beyond the crisis in developing a more comprehensive social protection system. Existing mechanisms at the village level lack consistency, however, and are devoid of clear guidelines from the national government. While this study focuses on data on people with disabilities, the notion holds for other vulnerable groups as well.

Most of the villages interviewed in this study held data on people with disabilities prior to COVID-19 which then proved very useful during the crisis. The scope and depth of the data varies, however, as there is no standardised data collection mechanism. Some villages collect information based on requests from district *DinSos*—for instance to verify information in the DTKS database—while others take a more proactive approach. The former tend to limit data collection within the poverty category, while the latter are more likely to collect information of all people with disabilities regardless of family income level²⁵.

Reflecting on the experience in delivering COVID-19 pandemic response, village officials expressed not only the importance of having a disability registry, but also the need for a guideline or standard mechanism to collect such data. As one village official in South Sulawesi explained:

“There doesn’t seem to be [a regulation or guideline from the central government in collecting data on people with disabilities]. But it is the responsibility of the government to make sure no one is marginalised. Everyone has the same rights. The government has to be present.”

At the same time, the last few years have seen advancements in the village data system through the development of the digital village information system (SID). Law No. 6/2014 mandated the development of the village information system as a data management system to be hosted by the village government and accessible to village stakeholders. While the system is not yet in place in all villages in the country, it promises a comprehensive and interoperable data system for social protection (as well as other purposes).

SID generally includes data on people with disabilities which may cover those beyond the poor category. Three villages in our study had developed and activated the SID, and these villages found that the data on people with disabilities facilitated the targeting of COVID-19 social protection programs. The integration of SID in the social protection system as part of the One Data policy may potentially facilitate timely and reliable updating of social protection data if measures are taken to ensure the data quality standard.

²⁵ This finding is consistent with the findings in Pattiro (2018).

As Box 6.1 shows, local governments have adopted innovative mechanisms to collect data on people with disabilities. Nevertheless, greater effort is required to standardise such practices so they can be nationally scaled.

Box 6-1: Innovatively Capturing Data on People with Disabilities at The Village Level

Participatory and innovative data collection using SID in Sukoharjo, Banjarmasin, and West Sumba

With the support of DFAT's *Peduli Program*, *DinSos*, and local OPD partners designed and implemented a disability assessment that aligned closely with the Washington Group Short Survey Questions. The survey was then administered in 165 villages through *Posyandu* (local health cadres), community rehabilitation teams, self-group cadres and subdistrict staff. Once the data was collected and cleaned, *DinSos* staff were responsible for entering the information into SID. This strategy kept costs low as external data collection agencies were not required and helped to identify people with disabilities who typically remain hidden.

A similar strategy was undertaken in Banjarmasin and West Sumba, where a simple disability assessment was administered by a local OPD in partnership with *DinSos* and *Bappeda* (local budgeting and planning agency). Over three months in Banjarmasin, 368 people with disabilities who were missed from MoSA's national databases were then identified and registered into the local SID. In the district of West Sumba, an additional 498 people were identified and registered.

In West Sumba, the village level data was further integrated into the district's database, and individuals were then supported to receive national identification, birth certificates and other support services, such as wheelchairs and assistive devices.

Participatory practices of involving people with disabilities in the data collection process has proved to be essential in improving the quality of data and building the capacity of local government staff.

Source: Pattiro, 2018

6.3. Social assistance, particularly cash transfer programs, had a significant impact on people with disabilities in dealing with the crisis

The frequency and continuity of the COVID-19 social protection programs play an important role in helping beneficiaries mitigate negative impacts of the crisis. World Bank simulations show that Indonesia's COVID-19 package may have prevented millions of individuals from falling into poverty (World Bank 2020a). While more detailed analysis is needed to fully assess the impacts, the Ministry of Finance (MOF 2021b) announced that the stimulus package has saved more than 5 million people from poverty²⁶. At a micro level, experiences of our respondents, as described below, show the difference social protection benefits make in their ability to cope with the crisis.

6.3.1 Cash transfer programs are felt to have the most significant impact, providing a lifeline to many beneficiaries who lost their income

While most respondents expressed that any assistance would help in coping with the crisis, significant impacts were particularly reported by those receiving the COVID-19 cash transfers programs (BST and BLT-DD). While one-off food transfers were appreciated, respondents receiving them felt that the impacts were short lived and did not necessarily respond to their needs. Our interviews found, for instance, rice farmers who received rice assistance and a chicken farmer who received chicken meat which the beneficiaries did not find particularly helpful. They felt that cash assistance, on the other hand, would have helped them cover the extra transportation cost or special food supplements that have been more difficult to afford during the crisis. Beneficiary preference for cash assistance is consistent with other studies on COVID-19 social protection programs, including one by UNICEF et.al. (2021) which stated that 72.6 per cent of beneficiaries preferred cash over in-kind assistance.

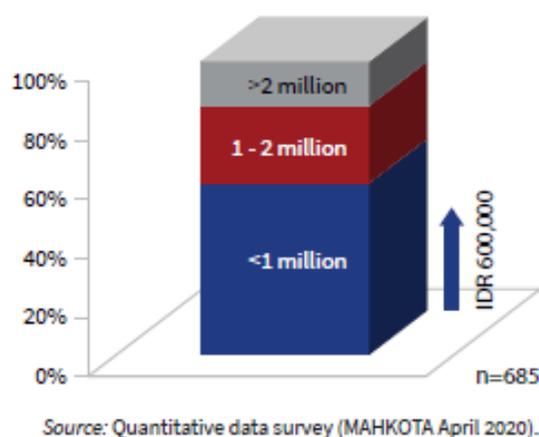
²⁶ Poverty figures in 2020 have shown to be lower than initially anticipated without the government interventions. In September 2020, the poverty rate was 10.19 per cent (an increase of 0.97 percentage points from September 2019) (BPS 2020c)—smaller than the initially projected poverty rate of between 11.5 to 12.4 per cent (World Bank 2020a; SMERU 2020b).

Our research highlights the ways in which cash can accommodate a much wider range of needs, particularly those related to disability. Cash assistance provided through BST and BLT-DD (IDR 600,000 per month for three months in the first round of disbursement) also tended to be higher in value compared to existing in-kind assistance²⁷. One OPD representative commented on the positive effects of cash transfers for people with disabilities and how more programs are now providing cash than food:

“I have traditionally seen that assistance has focused on basic food needs, and they are viewed to be the same for people with disabilities or other groups. Now, MoSA seems to be more aware of the different needs of people with disabilities, their basic need for therapy, for instance, and a greater provision of cash.”

We know that the majority of workers with disabilities earn less than IDR 1 million per month and are losing more than 50 per cent of their income in the crisis. For these individuals, the IDR 600,000 per month that they receive in assistance is a significant income boost that can save their families from being hungry or indebted (Figure 6.4). A respondent in Lombok recalled his experience being laid off from his job in Bali with no severance pay. He had no savings and had a monthly obligation to pay child support. He stopped sending money to his child and had to borrow money from friends to cover daily expenses. He then received BST cash transfers and the IDR 600,000 per month has helped him pay for basic daily expenses and send some money to his child again.

Figure 6-4: Government Assistance and Monthly Income Level of Workers with Disabilities (IDR/month)



6.3.2 Cash transfer benefit levels for people with disabilities are inadequate as it does not compensate their higher costs of living. Recent changes to PKH and ASPD benefit levels further undermine their adequacy.

While this study did not explore in detail the adequacy of existing social assistance benefits, it is worth noting that the benefit value for households with disability tends to be relatively low—particularly given the higher cost of living that they must bear. While the amount of benefit may be the same for households with disability and those without disability, its ability to compensate for their needs is different since extra cost of living is not considered. This applies to COVID-19 social assistance programs as well as regular social assistance programs.

Recent policy changes in the disability benefits under ASPD and PKH are an additional setback in terms of benefit adequacy and fairness. In 2020, ASPD reduced its benefit amount from IDR 3,600,000 per person per year to IDR 2,000,000 per person per year, while PKH applied a cap of one person with disability receiving PKH benefits per household. This reduces the total amount of benefits received by households with more than one member beneficiary, while these households are likely among the most economically vulnerable. The change in policy led to a fall in the number of people with disabilities receiving PKH from 108,863 in 2019 to 102,222, a drop of 6,641 people with disabilities (PKAKN 2020).

²⁷ For international standards, the benefit of IDR 600,000/month is still relatively low as it constitutes 12 per cent of Indonesia’s GDP per capita (Gentili et al. 2020).

6.3.3 Continuation and adjustments in program approaches indicate potential for more sustainable impacts

The effectiveness of the COVID-19 social protection programs cannot be judged only by their immediate impacts, but also by the sustainability of these impacts. The crisis will have a long-term impact on the economy, indicating the need for long-term policy responses. Indonesia's decision to extend most of its COVID-19 stimulus package through 2021 is positive, even though some programs have lowered their benefit levels. In the second year of the COVID-19 response, the 2021 budget allocation includes a stimulus package of IDR 619 trillion (USD 44 billion), of which IDR 151 trillion (24 per cent) goes to social protection-related interventions (MoF 2021a)²⁸.

One noteworthy sustainability feature is the government's ability to shift from in-kind to cash transfers. In the current context, the benefits of cash over in-kind include minimising human contact as cash can be distributed safely through bank accounts or post services. Cash transfers are also cheaper and more efficient to administer (quicker, limited leakages, and wastage). While food may benefit the beneficiaries, cash strengthens local economies through 'multiplier effects' and helps keep businesses afloat (see Stuckler and Basu 2013; Davies and Davey 2007).

These considerations and recent implementation experiences have prompted changes in Indonesia's social protection delivery systems and mechanisms. MoSA announced that in 2021 the government will be replacing food assistance with cash assistance and money will be transferred directly to all beneficiaries— either through their bank accounts or via the post office to the beneficiary's address. These innovations will no longer require payment points—where beneficiaries queue and create crowding—and will likely change the face of social protection delivery for the long-term (Kompas 2020c; Liputan6 2020).

Without universal social protection for people with severe disability, however, there are still people with severe disability who are falling through the cracks—even with the significant increase in social protection coverage during the pandemic. Box 6.1 depicts the situation of a household that, despite needing urgent assistance, was bypassed by both the national and local social protection system.

Box 6-2: Experience of a Respondent Without Social Protection

Without access to cash transfers, people with severe disabilities fall through the cracks during difficult times

Mina is a 65-year-old single mother, supporting a child with multiple (physical and cognitive) disabilities. She works as a cook in a small restaurant owned by a relative. She works in the restaurant 12 hours a day while caring for her daughter who she brings to work every day. In normal times Mina is paid IDR 30,000 (USD 2.00) per day plus meals. Since the pandemic, the restaurant gets a significantly lower number of customers and Mina's wage is down to IDR 10,000-15,000 per day.

With an income of less than IDR 15,000 (USD 1.00) a day, Mina is struggling to meet her daughter's needs. To bring her daughter for therapy, the transportation cost of IDR 10,000 becomes very difficult to afford. She also had to stop buying food supplements that the doctor recommended for her daughter. This has led to a deterioration in her daughter's physical condition.

Despite their condition, Mina and her daughter have not received any social assistance. She is aware of the COVID-19 cash transfer programs distributed in her village but has never received the benefits and never been informed of who is eligible for the program. She has complained to village officials, but the answer was that beneficiaries of the program are determined at a higher level.

²⁸ The 2021 stimulus package nearly matches the 2020 stimulus of IDR 695 trillion, of which the biggest allocation (34 per cent) was on social protection measures. Social protection remains a major share of the package, but smaller compared to the 2020 budget proportion due to lower benefit levels for some programs.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1. Conclusions

Expansion of social protection programs can be achieved, quickly and inclusively.

Through the COVID-19 crisis, one clear and valuable lesson to take forward is that massive expansion of social protection programs, including to previously hard-to-reach groups such as people with disabilities, is possible and can be done quickly. When the urgent need occurred, Indonesia made a decisive response to mitigate the economic impacts of COVID-19. The policy reached an unprecedented number of people and helped them reduce their economic hardship. While nearly 95 per cent of people with disabilities remained untouched by regular social protection prior to the pandemic, most respondents of our qualitative study reported being reached by the COVID-19 response programs.

Social protection has proven to stimulate the economy and protect the vulnerable in the face of crisis.

Social protection interventions in the COVID-19 pandemic have been acknowledged by the Government of Indonesia and academic institutions as an effective strategy in preventing a much worse outcome of the crisis. As announced by the Ministry of Finance, the COVID-19 stimulus package—a significant proportion of which consists of social protection schemes—have kept poverty increase at a much lower level than initially anticipated. While the poverty rate in September 2020 increased by 0.97 percentage points to 10.19 per cent, the projected poverty increase, without COVID-19 economic interventions, was anticipated to be much higher at 11.5 to 12.4 per cent (MOF 2021b). This implies that more than 5 million people have been spared from poverty, and this level of investment in social protection should be retained as Indonesia moves from recovery to rebuilding.

Poverty-based social registries are not accurately capturing poverty and vulnerability in the face of a crisis.

The COVID-19 crisis has confirmed the highly dynamic nature of poverty—particularly for groups with higher vulnerability such as people with disabilities, where economic uncertainties are more prominent and impacts of shocks tend to be deeper and long lasting. Indonesia's social registry (DTKS) captures household poverty levels at a single point in time and lacks mechanisms for 'real-time' data updating, meaning it is unable to urgently expand social protection schemes to the 'new poor and vulnerable' when the need occurs. Poverty-targeted social registries also fail to accurately reflect the poverty that people with disabilities experience given their higher costs of living.

A disability registry that covers all people with disabilities is critical.

The SIMPD disability registry was developed in 2018 by MoSA, had limited coverage (compared to the overall population with disabilities) and was not widely used for social protection targeting prior to the COVID-19 pandemic. SIMPD was, however, used to target people with disabilities for unconditional cash transfer schemes rolled out during the crisis. Although not perfect, the SIMPD proved to be a more comprehensive database on people with disabilities compared to the DTKS. Some distinguishing features include: (i) data is captured at the individual level; (ii) the system covers all people with disabilities regardless of family income level; (iii) contains more detailed information on the type of disability that the individual is experiencing; (iv) the ability to update the system on an 'on-demand basis'; and (v) local OPDs were registered and empowered to update the system to ensure greater coverage.

Community targeting and self-registration mechanisms have filled targeting gaps.

Given the limitations of existing data within the DTKS, additional mechanisms were needed to expand social protection programs to those who had become poor and vulnerable due to the crisis. The Government of Indonesia, therefore, decided to employ a combination of new and innovative targeting mechanisms, including community-based targeting (for example, in BLT *Dana Desa*). This proved crucial in identifying those who needed assistance in the crisis, but also those who have been excluded from social protection programs in the past despite being chronically poor. Community targeting has been particularly helpful in identifying beneficiaries with disabilities who have a higher tendency to be excluded from the DTKS due to limited participation, lower access to documentation, stigma, and other barriers.

Cash transfers have proven to be useful, convenient, and safe for beneficiaries with disabilities.

In the COVID-19 crisis, cash transfers have once again shown to be more beneficial and more practical than in-kind transfers. Some of the well-known advantages of cash over in-kind assistance include: (i) the flexibility to cover different needs; (ii) cost-efficient distribution mechanisms and easier oversight; (iii) economic “multiplier effects” where impacts go beyond the direct beneficiaries (noteworthy during the crisis when local economies came to a halt); and (iv) no crowding at distribution points—a serious concern for COVID-19 transmission. Given the various challenges of in-kind transfers, the government has made the welcome decision to eliminate food transfers and only distribute cash moving forward. Cash will be distributed either through bank accounts or through the post office. This mechanism creates an opportunity to increase financial inclusion among beneficiaries and would help increase accessibility to the social protection programs for people with disabilities.

7.2. Recommendations

7.2.1 Policy Area One: Access to Social Protection for People with Disabilities

Short term recommendations:

Recommendation One: Reinstate adequate benefit levels for national social protection programs for people with disabilities (PKH and ASPD).

Recent benefit reductions in both ASPD (from IDR 3,600,000 per year/ person in 2019 to IDR 2,000,000 per year/ person) and PKH (limiting the number of people with disabilities to only one person per family) should be reversed. This would assist in recognising the extra cost of living endured by families that have a person with disabilities. Families with multiple people with disabilities should once again be entitled to a benefit per person (with no caps in place) to compensate them for the significant additional expenses they must incur.

Recommendation Two: Improve outreach and communications campaigns for social protection schemes.

Ensure social protection programs have an inclusive outreach strategy to inform people with disabilities: (i) of programs that are available to them; (ii) how to register; and (iii) how to demand participation in case they have been bypassed. Local OPDs and grassroots organisations, in partnership with local governments, can play an effective role in ensuring that people with disabilities receive information through accessible modalities (for example, SMS messages, automated voice messages for those with vision impairment, and use of video and easy-to-read formats for people with intellectual disability) (Sammon et al. 2021).

Medium term recommendations:

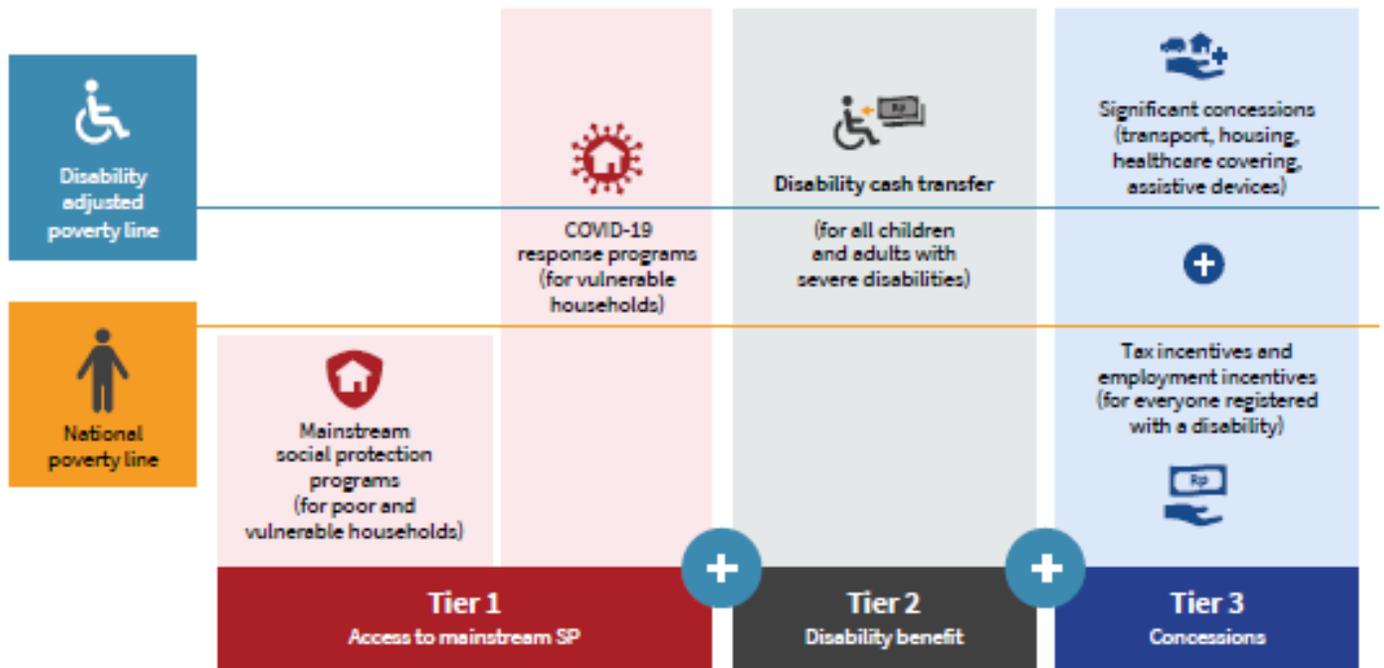
Recommendation Three: Introduce a multi-tiered social protection system for people with disabilities.

To ensure that people with disabilities can fully participate in society and maintain their economic security during difficult times, it is important to put in place a three-tiered non-contributory social protection system for people with disabilities (see Figure 7.1)²⁹:

- mainstream social protection programs and COVID-19 response programs for households with a person with disabilities;
- cash transfers for people with severe disabilities; and
- concessions for everyone registered with a disability.

²⁹ For this report we are focusing on non-contributory social protection, but incentivising contribution into BPJS Employment is also a critical component of a comprehensive social protection system.

Figure 7-1: Multi-tiered Social Protection System for People with Disabilities



Source: Larasati et al. 2019.

Tier 1: Improved access to mainstream social protection and COVID-19 response programs for households with a person with disability:

Recognising that the eligibility for national social protection schemes comes from the DTKS, a simple way to achieve improved coverage of people with disabilities within social protection programs would be to improve the disability-related questions within the DTKS. Following internationally agreed disability requirements for census and household surveys, such as the Washington Group Short Questions on Disability, should be a minimum requirement implemented during the upcoming social protection reform (Barca et al. 2021).

Tier 2: Cash transfers for people with severe disabilities:

A specific cash transfer for people with severe disabilities should be prioritised. Many individuals with disabilities may not reside within households that are eligible for mainstream social protection, and therefore may not benefit from PKH and other national programs. A disability cash transfer for everyone recognised as having a severe disability would go a long way towards ensuring that the support needs of the most vulnerable individuals are met (Sammon 2021).

Tier 3: Concessions for all people with disabilities in Indonesia

Implement concessions as per Articles 114-116 of the Disability Law (Law No. 8/2016) and Regulation 2/2021 on the Disability Card to greatly benefit everyone with a disability. Concessions enable people with disabilities to have greater participation in society, and when coupled with cash transfers, can help meet a diverse set of needs (Prospera 2020). Gol has already recognised the importance of concessions in legal documents, although this commitment is yet to be realised.

For concessions to be meaningful, they must be offered in significant areas of spending. Concessions should include: (i) affordable health care (including rehabilitation services and assistive devices); (ii) free or heavily subsidised access to public transport, housing, and utilities; (iii) tax incentives; and (iv) prioritised inclusion within economic empowerment programs (vocational training, return-to-work programs, and self-employment schemes).

Recommendation Four: Establish a specific database and needs assessment for all people with disabilities (also known as a disability registry).

To implement a disability benefit and concessions as per the previous recommendation, it is critical for Indonesia to establish a comprehensive database on ALL people with disabilities, regardless of their income level. The disability registry, which is already in progress in Indonesia, should capture: (i) personal identification information; (ii) level of difficulty they experience in completing daily activities; and (iii) any costs of disability that they incur. To capture this information, a simple but comprehensive needs assessment should be integrated with the registration form. OPDs and local governments can play an important role in the registration process.

Recommendation Five: Establish livelihood interventions complementary to social protection.

With the phasing out of *Kartu Prakerja*, a continued vocational training scheme (with a cash benefit to offset individuals for their time investment in gaining a new skill) is urgently needed to help people re-enter into a post-COVID 19 economy. These schemes should be proactively communicated to people with disabilities through outreach campaigns and people with disabilities should be prioritised for enrolment. Moving forward, it is also important for vocational training schemes to offer training mediums that are accessible to those with impairments.

7.2.2 Policy Area Two: Enhance access to health care and rehabilitation for all people with disabilities.

Short term recommendations:

Recommendation Six: Expand coverage of the national health insurance programme (JKN) and ensure better access to assistive devices.

A minimum standard health insurance program should be provided to all people with disabilities to reduce their barriers to health care. JKN-PBI, the section of the national insurance program where contributions are paid by the government, should be made available to all people with disabilities identified through the disability registry. As JKN-PBI is currently targeted to poor and near poor households registered in DTKS, many people with disabilities are not covered by the program despite being in high need. Social health insurance should be available for people with disabilities regardless of the status of their household according to the poverty database.

Access to therapy and assistive devices should be made more accessible in the JKN package, including by reducing cost-sharing requirements. For those already covered by JKN, provision of assistive devices is still limited and often with significant cost-sharing requirement. For many people with disabilities, therapy and assistive devices are a necessity that determines their quality of life, participation in, and contribution to the society.

Medium term recommendations:

Recommendation Seven: Improve community-based rehabilitation (CBR) to reduce reliance on institutions-based services.

Institution-based rehabilitation services need to be complemented with community-based rehabilitation (CBR). COVID-19 showed the negative impact of over-reliance on institution-based services as social care institutions experienced high infection rates and services breakdown due to closures. It is critical to learn from CBR models to progressively develop a range of community support services and rehabilitation that provides support in the community in a more flexible and responsive manner. With a functioning CBR, institutions can become more of a resource centre than primary provider.

7.2.3 Policy Area Three: Improve accessibility in remote learning, prioritise children with disabilities in the transition back to school and make mainstream education more inclusive.

Short term recommendations:

Recommendation Eight: Improve remote learning accessibility for students with disabilities.

Schools and teachers require clear guidelines, appropriate technology, and the knowledge to provide remote learning to students with learning disabilities. In line with the Ministry of Education's policies, all teachers should receive training on how to support children with disabilities in remote learning environments. The ministry should also ensure, at the minimum, the availability of internet data, accessible technology (for example, learning applications that are accessible for different types of disability), as well as psychosocial support in remote learning contexts.

Recommendation Nine: Prioritise students with disabilities in transitioning back to school.

As soon as the situation permits, children with a disability should be prioritised for enrolment in school re-openings as well as remedial classes. Teachers should be trained in identifying learning loss and offering remedial classes that are accessible to children with a disability to help with their smooth transition back to the education system.

Medium term recommendations:

Recommendation Ten: Make schools more inclusive.

Make schools more inclusive overall, with less reliance on special schools. A more inclusive education system with better integration of support services for children with disabilities would help educators to be more aware of the needs of children with disabilities. Such an approach would also allow for better adaptation to remote learning environments for children with disabilities, should the need arise.

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**DIREKTORAT PENANGGULANGAN KEMISKINAN DAN
PEMBERDAYAAN MASYARAKAT
KEMENTERIAN PPN/BAPPENAS**

**JL. HR. RASUNA SAID
WISMA BAKRI 2, LANTAI 7
JAKARTA SELATAN
TELP: (021)3915227
EMAIL: DITPK@BAPPENAS.GO.ID**

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