



INDONESIA MULTI-SECTORAL RESPONSE PLAN TO COVID-19

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Last updated: 6 June 2020

Front cover

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

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LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AHA Centre	ASEAN Coordinating Centre For Humanitarian Assistance
AMCF	Asia Muslim Charity Foundation
ARV	antiretroviral (treatment)
BASARNAS	Badan SAR Nasional (National Search and Rescue Agency)
BNPB	Badan Nasional Penanggulangan Bencana (National Agency Disaster Management)
CCCM	Camp Coordination and Camp Management Cluster
CSO	civil society organization
FAO	Food and Agriculture Organization of the United Nations
GBV	gender-based Violence
HCT	Humanitarian Country Team
HFI	Humanitarian Forum Indonesia
HI	Human Initiative
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
ICU	intensive care unit
IFRC	International Federation of Red Cross and Red Crescent Societies
ILI	Influenza-like illness
ILO	International Labour Organization
IMF	International Monetary Fund
INGO	international non-governmental organization
IOM	International Organization for Migration
IPC	Infection Prevention and Control
Kemenko PMK	Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan (Coordinating Ministry for Human Development and Culture)
Keppres	Keputusan Presiden (Presidential Decree)
LGBTI	lesbian, gay, bisexual, transgender, and intersex
LPBI NU	Lembaga Penanggulangan Bencana dan Perubahan Iklim, Nahdlatul Ulama
MHPSS	mental health and psychosocial support services
MoEC	Ministry of Education and Culture
MoH	Ministry of Health
MOSA	Ministry of Social Affairs
MOWE-CP	Ministry of Women's Empowerment and Child Protection

MPBI	Masyarakat Penanggulangan Bencana Indonesia (Indonesian Society for Disaster Management)
MSF	Médecins Sans Frontières (Doctors Without Borders)
MSMEs	micro, small and medium enterprises
NGO	non-governmental organization
NLC	National Logistics Cluster
OCHA	UN Office for the Coordination of Humanitarian Affairs
PHEIC	public health emergencies of international concern
PLHIV	people living with HIV
PMI	Palang Merah Indonesia (Indonesian Red Cross)
PPEs	personal protective equipment
Pusdokkes POLRI	Pusat Kedokteran dan Kesehatan Polisi Republik Indonesia (Indonesia Police's Centre for Medicine and Health)
PUPR	Ministry of Public Works and People Housing
RC	Resident Coordinator of the United Nations
RCCE	Risk Communications and Community Engagement
SARI	severe acute respiratory infection
SDGs	Sustainable Development Goals
SOP	standard operating procedures
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCT	United Nations Country Team
UNCTAD	United Nations Conference on Trade and Development
UNDSS	United Nations Department of Safety and Security
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNIDO	United Nations Industrial Development Organization
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USD	United States dollar
WASH	water, sanitation and hygiene
WHO	World Health Organization
WVI	Wahana Visi Indonesia
YKMI	Yayasan Kemanusiaan Muslim Indonesia

AT GLANCE

TOTAL NGOs/CSOs, UN AND UNIVERSITIES ACTIVITIES PER PROVINCE (as of 6 June 2020)



Requirements (US\$)

\$ 113.4 million

The following financial requirements are estimated for the implementation of the plan. At the time of writing, many agencies are working on their revised plans for the COVID-19 response.

STRATEGIC PRIORITIES



Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality.

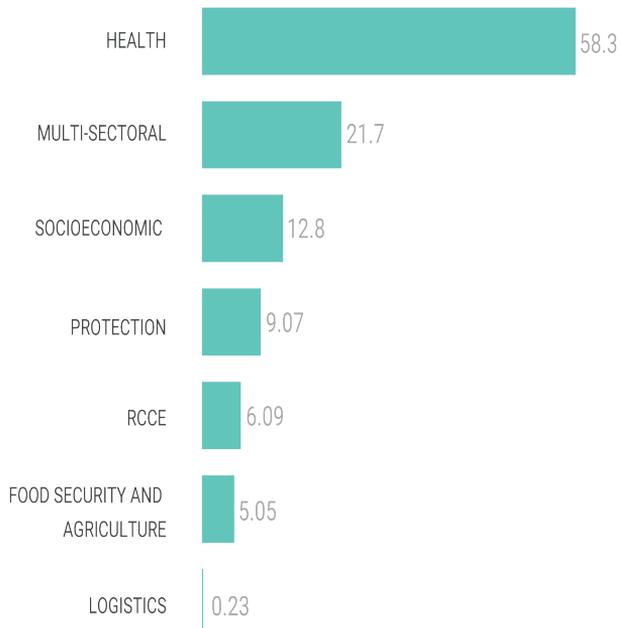


Decrease the deterioration of human assets and rights, social cohesion and livelihoods.



Protect, assist and advocate for refugees, internally displaced people, migrants and host communities particularly vulnerable to the pandemic

FUNDING REQUIRMENTS BY SECTOR (million \$)



INTRODUCTION

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

As of 6 June, more than 6,6 million confirmed cases of COVID-19 worldwide, including more than 392,802 associated deaths have been reported.

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

As of 6 June, the Government of Indonesia has confirmed a total of 30,514 cases of COVID-19 throughout all 34 provinces with a total of 1,801 deaths reported. On 13 April 2020, the Government of Indonesia declared COVID-19 as national non-natural disaster. Large scale social restrictions were implemented in major cities, affecting socio-economic activities.

Indonesia’s emergence as one of the world’s leading economies with ensuing strong economic growth, a rapid decrease in poverty rates, improvements in education and access to better health services, food, water, sanitation and electricity is challenged. The COVID-19 pandemic may adversely affect important

gains accrued over the past years across a range of SDGs are at risk; including progress in the fight against poverty (SDG1), food security and nutrition (SDG2) and is likely to exacerbate inequalities (SDG10), particularly gender inequality (SDG5). This pandemic has also seen an interruption in routine health services (SDG3).

The economic impact of COVID-19 in Indonesia is fundamentally affecting macro-economic stability and employment. The World Bank and the Ministry of Finance have reassessed 2020 economic growth from 5% to around 2%, and although it is too early to assess with certainty, a worst-case scenario may even foresee minus growth in 2020¹. It is estimated that an additional 5.9 million to 8.5 million people will become poor due to COVID-19⁵. As of 13 April 2020, 2.8 million workers have been reportedly laid off from their jobs as a result of this crisis, and more layoffs are expected to happen². The ADB estimates that the unemployment loss due to COVID-19 could reach 7.2 million people³.

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

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

1 Ministry of Finance, 2020

2 Jakarta Post, 13 April 2020

3 ADB, 2020

I. NEEDS ANALYSIS

1.1. PUBLIC HEALTH IMPACT OF THE COVID-19 EPIDEMIC IN INDONESIA

1.1.1. HEALTH EFFECTS ON PEOPLE

As of 6 June, the Government of Indonesia has confirmed a total of 30,514 cases of COVID-19 throughout all 34 provinces. A total of 1,801 deaths have been reported.

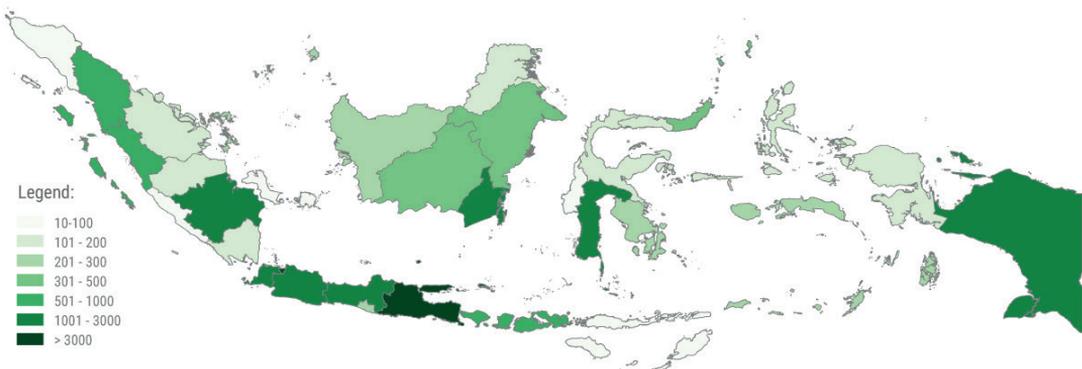


Figure 1: Geographic distribution of COVID-19 cases in Indonesia as per 6 June 2020. All provinces in the country have confirmed cases.

According to data from countries affected early in the pandemic, about 40% of cases of COVID-19 will experience mild disease, 40% will experience moderate disease including pneumonia, 15% of cases will suffer severe disease, and 5% of cases will have critical disease. The most common symptoms of COVID-19 are fever, dry cough and shortness of breath. Some patients may have aches and pains, nasal congestion, runny nose, sore throat or diarrhea. Some people become infected but do not develop any symptoms and do not feel unwell. Most people (about 80%) recover from the disease without needing special treatment.

The crude mortality rate varies from country to country, depending on where the country is on the epidemiological curve, the population affected, and the number of tests carried out per 1,000,000 people. Globally, the crude clinical case fatality is currently over 3%, increasing with age and rising to approximately 15% or higher in patients over 80 years of age. Other high-risk groups include those with certain pre-existing health conditions such as cardiovascular disease, diabetes, chronic respiratory disease and immuno-compromised persons. Health care workers constitute an additional high-risk group due to their elevated and prolonged exposure, increasingly paired with a lack of personal protective equipment (PPE).

Indonesia is at different stages in different provinces. Initially, the country carried out a risk assessment, considering the following vulnerabilities, risks and capacities: percentage of the population older than 65 years, percentage of the population with hypertension, number of flight and ship arrivals, the incidence of pneumonia and influenza-like illness, as well as hospital capacity and that of other health care facilities. As a result, 8 provinces are being considered at high or very high risk, and 7 provinces at moderate risk. As a matter of fact, given that COVID19 is a pandemic, the entire country is considered to be at high risk, as are all other countries. Nevertheless, due to the size and geographical conditions of Indonesia, a risk-ranking of provinces will enable the government to focus where risk and vulnerabilities are highest.

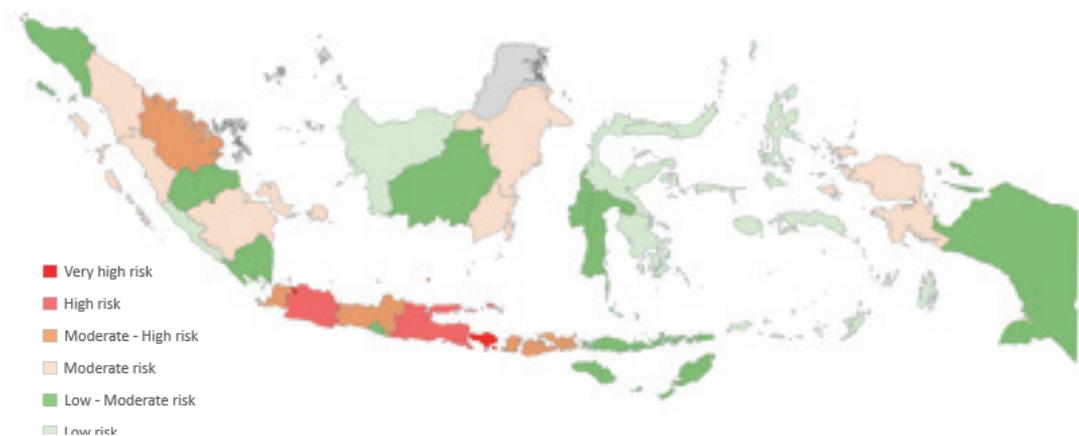


Figure 2: Level of Risk among regions in Indonesia

1.2.2. EFFECTS ON HEALTH SYSTEMS

Globally, the most important goals of the COVID-19 response are to slow down transmission and protect the health system. To do so, it is essential to diagnose, isolate and care for all cases of COVID-19, including those with mild or moderate disease. In Indonesia, as in many other countries, the focus lies on the rapid identification, testing and treatment of patients with serious and severe COVID-19.

As in many other countries, Indonesia is in the phase where the containment of the disease spread is the major focus. While containment will unlikely prevent the virus from spreading, it will, if done appropriately, flatten the epidemiological curve, with the aim to prevent an overload of patients in hospitals. Forecasting tools have been used to estimate caseloads in hospitals and ICUs and predict needs for equipment and consumables. Based on existing capacity and estimated caseload by province, demand for PPEs, hospital beds, ICUs and ventilators will be extremely high, in addition to trained health care and support staff.

1.2. INDIRECT IMPACT OF THE COVID-19 EPIDEMIC

1.2.1. MACRO-ECONOMIC EFFECTS

Services, consumption and trade

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

COVID-19 is severely impacting manufacturing production in developing countries because: 1) demand from high-income countries for manufacturing goods and raw materials is decreasing; 2) value chains are being disrupted

due to delays in the delivery of necessary components and supplies from more technologically advanced countries; and 3) other factors, including policies (e.g. restriction of movement of goods and people), inability of employees to reach the workplace or financial constraints, which affect the normal production process. UN economists⁴ have estimated a USD 50 billion decrease in manufacturing production in February 2020, and the IMF warns that the negative economic effects will be felt “very intensively” in developing countries that sell raw materials. All these negative channels will inevitably have an impact on exports from developing countries. The losses in export volume will be further intensified by the decline in energy and commodity prices. In recent estimations, UNCTAD⁵ projects that developing countries as a whole (excluding China) will lose nearly USD 800 billion in terms of export revenue in 2020.

Due to Indonesia’s trade exposure, the effects of the pandemic are already being felt. China, including Hong Kong, is one of Indonesia’s top export destinations (accounting for around 18% of its total exports, particularly lignite and coal). Indonesia is also a buyer of China’s industrial machinery as intermediate inputs (with China’s import share representing 30% of total import particularly on electronics and mobile telephone components). China production of machinery is currently operating below its capacity, thus disturbing the machinery supply lines. This situation heavily jeopardizes the macro-stability and trade balance that Indonesia had achieved.

As economic growth has slowed, government revenue is predicted to decrease by around 10%. Both tax and non-tax revenue is decreasing due to tax revenue reduction, tax incentives increase and the falling price of commodities⁶. In addition, there is also an increase in government spending to pay for the three stimulus packages put in place to ameliorate the impact of COVID-19; this has led to an increased in the national budget deficit from 3% to 5.07% of GDP. Apart from cuts to unnecessary spending and the rearrangement of budget allocation in different line ministries to fund the deficit, the Government of Indonesia issued global bonds for USD 4.3 Billion on 7 April 2020 and has been discussing with multiple development banks the possibility to get loans⁷.

The impact of the COVID-19 pandemic is likely to also influence inflation. Overall, inflation slightly decreased during March 2020 compared to the previous month,

4 <https://ns.un.org/en/story/2020/03/1058601>

5 https://unctad.org/en/PublicationsLibrary/gds_tdr2019_covid2_en.pdf?user=1653

6 *Ibid*

7 *Reuters*, 7 April 2020

and it still is within the Central Bank's target range of 2% to 4%. However, the volatility of food inflation has increased due to the push and pull effect of the pandemic⁸. The push effect is due to the disruption of supply chains, as well as rush buying to secure supplies during the quarantine period. On the other hand, the drop of global oil prices since the beginning of 2020, that has lowered the cost of transportation has prevented a large inflation hike for now. The inflation could worsen as the overall population purchasing power continues to decline, and more and more people lose their jobs during the crisis.

Impact on food systems

Up to Mid-April, food supplies have remained stable and no shortages were reported in Indonesia despite the volatility of prices. However, food security remains an area of high risk, and at the end of April some provinces have reported shortages of some basic food supplies, including cooking oil, eggs and chicken. Some households have adapted to the crises for now by eating less than they should.⁹ However, when crises prolong over time, this strategy is likely to backfire, and in the context of a pandemic it may increase people's vulnerability to the virus.

Under-employment and unemployment

The COVID-19 pandemic has created unprecedented economic challenges globally because large segments of economic activity have come to a sudden stop due to health measures. Economic sectors such as tourism, that account for a large share of the national revenue and employment are highly vulnerable, and likely to create a wave of massive redundancies. The emergency is also likely to have a heavy impact of start-ups and MSMEs, which account for more than 90% of the economic tissue of the country¹⁰. This, in turn, is having a big impact on the livelihoods of millions of Indonesians, particularly as a large segment of the Indonesian labor force includes the informal sector and daily-wage workers. These groups are a disadvantage to weather the crisis, and they are being hit the hardest by the pandemic, the loss of jobs, the economic slowdown and public health measures imposed by the government.

According to data from the Ministry of Manpower and BPJS Ketenagakerjaan (Social Security Agency), as of the second week of April 2020, about 2.8

8 LPEM, 2020

9

10 The Ministry of Cooperatives and SMEs records over 64 million MSMEs in Indonesia

million workers have been reportedly laid off from their jobs as a result of this crisis¹¹. The Center of Economic Reform of Indonesia has estimated the surge in unemployment due to COVID-19 ranges between 4.25 and 9.35 million.¹² In addition to that, many other workers have been forced to take unpaid leave. The numbers of unemployed are expected to continue to rise due to the pandemic – according to estimations by the Ministry of Finance, this number could reach up to 5.2 million people. The rise in unemployment means the loss of valuable productive resources for the economy, and a certain increase of poverty and inequality. Unemployment also creates other problems, such as the increase of mental health issues, crime and conflict. Finally, unemployment affects not just the unemployed, but it has an impact on all family members, which may have a cost to the health and education prospects of the next generation. The current crisis threatens to push back the limited gains made on women's equal participation in the labour force¹³.

1.2.2. INDIRECT EFFECTS ON PEOPLE AND SYSTEMS

Poverty

COVID-19 will impact past progress in poverty reduction in Indonesia. A recent study by SMERU Research Institute estimates that an additional 5.9 million to 8.5 million people will become poor if Indonesia's economic growth drops from 5% to 2.1% and further to 1% in 2020, as currently forecasted¹⁴. A spike in poverty rate means that greater social protection programmes are needed not only to address the existing poor but also the newly poor. The resources required to expand the social protection would also need to be increased significantly.

11 Jakarta Post, 13 April 2020

12 <https://www.coreindonesia.org/view/467/waspada-lonjakan-pengangguran-dampak-pandemi-covid19>

13 United Nations, "Shared Responsibility, Global Solidarity: Responding to the Socio-Economic Impact of COVID-19", New York, March 2020. < <https://unsdg.un.org/sites/default/files/2020-03/SG-Report-Socio-Economic-Impact-of-Covid19.pdf> >

14 Suryahadi, A. et al., "The Impact of COVID-19 Outbreak on Poverty: An Estimation for Indonesia", SMERU Research Institute, Indonesia, April 2020 < http://smeru.or.id/sites/default/files/publication/wp_covid19impact_draft.pdf >

Health

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

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

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

The impact on Posyandus (integrated health post), as primary care centers for many Indonesians, is likely to lead to a severe disruption of key routine preventive services such as immunization. It is also expected that communicable diseases such as malaria, dengue, HIV and TB will rise, as essential services are decreased. This may result in the long-term discontinuity

of essential services, and the risk of population losing trust in the health system, leading to a decrease in service utilization. Finally, there is a possible adverse psychological impact of a sustained epidemic on vulnerable groups such as children.

A considerable number of Indonesians live in areas affected by environmental degradation and air pollution, whether major urban centres or areas with annual burning of vegetation for agricultural purposes. Air pollution is one of the top ten health risk factors in Indonesia; post neo-natal and under-5 mortality rates per 100,000 due to lower respiratory infection are 212 and 13, respectively, and children, older people and people with medical conditions are more likely to be affected. Many of the poorer urban settlements within Indonesia's large urban centers are extremely dense, with inadequate WASH facilities, increasing the risk of disease spread. The impact of COVID-19 is likely to be greater in these areas.

Sexual and Reproductive Health

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

As health systems become overstretched during an epidemic, the availability and access to reproductive and maternal health care also decreases. Movement restrictions due to quarantines mean that woman and young people may not be able to access sexual and reproductive health services such as contraceptives, and pregnant woman may forego antenatal care and even give birth unattended. This can increase the number of unwanted pregnancies and increases the potential risks of sexual and reproductive health related morbidity and mortality. The provision of family planning and other sexual and reproductive health commodities, including menstrual health supplies, are central to women's health, empowerment and sustainable development, and may be impacted as supply chains are disrupted by the pandemic.

ARV and HIV prevention and counselling services

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

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

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

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

Nutrition

The short-term impact of COVID-19 on family incomes and higher food prices results in adverse nutritional outcome and can potentially translate into the long-term loss of human capital¹⁵, especially for the most marginalized population, limiting the accessibility, availability affordability and sustainability of healthy food items. The pandemic may cause the disruption of essential nutrition services targeting adolescents, women of reproductive age, pregnant and lactating mothers and children under-five years of age, as well as programmes for growth monitoring and promotion, micronutrient supplementation, dietary counselling, infant and young child feeding counselling, and distribution of high-energy biscuits.

The disruption of essential nutrition services and household food insecurity is expected to contribute to an increased burden of malnutrition (such as undernutrition and micronutrient deficiencies). It is also likely to significantly increase severe wasting among children under-five and pregnant and lactating mothers; importantly, with people avoiding mass gatherings, it is expected that the Posyandus (Integrated Health Post) may temporarily close, causing serious challenges to the screening of children for severe wasting, which will likely contribute to the increased number of cases of child wasting.

Shelter

The spread of COVID-19 has resulted in increasing levels of tenure insecurity across Indonesia. This is particularly the case for both formal and informal private sector workers in Indonesia's dense urban centres, many of whom rent on a month by month basis, with rent making up a considerable portion of their monthly income. Loss of employment amongst these workers is leading to increasing urban homelessness as well as increased migration back to rural villages, bringing increased spread of disease and adding pressure to communities with already limited health and economic infrastructure.

The medical impact of COVID-19 also brings a range of direct shelter impacts with families travelling from urban centres to seek medical assistance for family members and then in need of shelter assistance. In many circumstances, shelter solutions are also needed for those in need of self-isolation or quarantine. The mandatory closure of hotels and guest houses, while villages and suburbs

15 World Bank Group, "East Asia and Pacific in the time of COVID-19", Washington, D.C., April 2020

refuse to accept foreigners is compounding shelter needs across the country.

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

Education

In response to the COVID-19 spread, as of 6 May, a large number of provinces (23) in Indonesia have decided to sustain complete school closures. This measure is affecting around 40 million students from early childhood education to upper secondary schools. In the remaining 11 provinces, although the governors haven't decided on school closures yet, some districts have taken the initiative to do so.

The Ministry of Education and Culture (MoEC) has been encouraging innovative approaches to provide distance education. However, despite the MoEC's encouragement for online and distance learning, the lack of or inadequate infrastructure in many provinces and districts is affecting the capacity to continue the provision of education.

Many poor parents do not have access to internet and computers to allow their children to access home learning. According to the World Bank, two-third of extreme poor people in Indonesia do not have internet subscriptions in the household¹⁶. Therefore, online learning benefits predominantly advantaged students. Women also bear the additional responsibility of supervising children for home-learning. Families in which both parents work may not be able to supervise their children's education at home. Moreover, the impact of lost income is expected to have a reflection in the rate of schools drop outs or school enrolment, as some families will no longer be able to keep their children in school.

Gender-based violence

The impact of the COVID-19 pandemic on gender equity will also be significant. Crises compound deep-rooted forms of existing discrimination and inequalities, including gender inequalities, increasing harm and risks for women, girls and

16 World Bank Group, "East Asia and Pacific in the time of COVID-19", Washington, D.C., April 2020

gender diverse people both in the home and in the community. Epidemics such as the Ebola outbreak in 2015 saw an increase in violence, sexual exploitation and abuse of women and girls due to increased financial stress on families, increased demands of household chores in caring for the sick, decreased access to livelihoods, more frequent and longer journeys to obtain food or water which increases exposure to sexual assault, and disintegration of social protection structures as resources are diverted towards responding to the outbreak. With restrictions to freedom of movement, combined with fear, tension and stress related to COVID-19, and the negative impacts on household incomes, risks of violence will continue to grow.

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

1.2.3. EFFECTS ON LIVELIHOODS

Decreased income and increased vulnerabilities

Indonesia has made significant progress in reducing poverty and increasing human development during the last decade. For the first time in Indonesia's history, the poverty rate is below 10%, and Indonesia's standing in the human development index continues to grow. Despite this progress, 40% of Indonesia's population, although above the poverty line, remains vulnerable to socio-economic shocks and dependent on their daily wages and small incomes, with very little or no savings. While the immediate effects of the pandemic on livelihoods are quite clear, it is important to also prepare for secondary and

tertiary effects, where many MSMEs (Micro, Small, and Medium Enterprises) may have to be closed, employees laid off in massive numbers, creating the conditions for people to slide back into poverty.

A large number of Indonesians rely on daily wages or tourism to make a living. The loss of income resulting from the current travel restrictions and restrictions of movement will likely have a more compounded effect for these population segments, along with people leaving below or close to the poverty line.

Indonesia is a major migrant-sending country, with overseas workers remitting some 1% of total GDP each year. More than 120,000 migrant workers have already officially returned to Indonesia after losing their employment overseas due to the COVID-19 outbreak in destination countries. In response to the crisis, the government has cancelled formal placement services for returning or aspiring overseas workers, a decision aimed at reducing exposure to COVID-19 overseas and limited access to health services. However, this decision will negatively impact livelihood options for many Indonesians and, for those who are being encouraged to return to Indonesia amidst the pandemic, it means a loss of income as well as remittance incomes sent to family and community members. Without formal means of recruitment and placement, prospective workers are increasingly vulnerable to economic pressures and will seek alternative means of travel and employment, significantly raising the prospect of human trafficking, and reducing protection measures for some of the most vulnerable segments of Indonesian society.

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

Increased food insecurity

Restrictions of movement, as well as basic aversion behaviour by workers, may possibly impede the food production, leading to increased food insecurity. The latest WFP's food price monitoring shows that until mid-March, there has been no significant impact of the COVID-19 outbreak on the prices of listed strategic food commodities in Indonesia, except for garlic and sugar¹⁷. The price of rice has been monitored stable. Panic buying was noticed in big cities.

1.2.4. MOST AFFECTED AND AT-RISK POPULATION GROUPS

Certain population groups face increased vulnerabilities in face of the COVID-19 pandemic.

The poorer segments of the population are more likely to live in crowded conditions, consequently having little change to practice effective social distancing or, in case of symptoms or exposure to the disease, self-isolation. As a rapidly urbanizing country, it is estimated that just under 22 per cent of Indonesia's urban population live in sub-standard housing with deteriorated or incomplete infrastructure. Inhabitants of these areas, including children, are more likely to be excluded from basic services. Within these, single-headed households may feel the effects of the COVID-19 outbreak more severely, especially if a member of the household falls sick, resulting in loss of income.

In times of the COVID-19 pandemic, ***women and girls*** may be at higher risk of intimate partner violence and other forms of domestic violence due to increased tensions in households. As systems that typically protect women and girls, including community structures, may weaken or break down, specific measures are needed to protect women and girls, such as updated referral pathways to reflect changes in available facilities. Similarly, this may also impact the transgender people, as they may experience an increased risk of intimate partner violence and other forms of economic violence during the COVID-19 pandemic.

Older Persons, people with medical conditions and people with disabilities are also more vulnerable, given that the case fatality rate for COVID-19 increases with age and pre-existing medical conditions. Persons 60 years or older are

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

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

Refugees and IDPs are also at increased risk. As of March 2020, Indonesia hosts 13,550 refugees¹⁸ from 46 different countries, 3,761 of which are children¹⁹; as of January 2020, there are 104,000 IDPs due to natural disasters and 40,000 IDPs due to conflict and violence in Indonesia.²⁰ Refugees live in different parts of the country, with concentration points in larger cities, particularly the capital Jakarta, where around 7,700 reside. While refugees have access to basic primary health attention in the local health centres (Puskesmas), both IOM and UNHCR run complementary health programmes to ensure, to the extent possible, that refugees receive the health care needed. During the COVID-19 outbreak in Indonesia, official statements of the Indonesian authorities and the established health protocols have highlighted

18

19 UNHCR Monthly Statistical Report, March 2020

20 Data from the Internal Displacement Monitoring Center, 28 April 2020.

the principle of non-discrimination, thus refugees can in principle access health facilities, albeit the payment will most likely have to borne with external funding. However, the resilience of the extremely vulnerable refugees to deal with the increasing prices of basic commodities and services has critically weakened and increased their exposure to negative coping mechanisms, and therefore their vulnerability has increased.

Health-care workers constitute another high-risk group due to their elevated and prolonged exposure to the COVID-19 virus, increasingly paired with a lack of personal protective equipment and specific psychosocial needs. Women represent 70% of the health and social sector workforce globally, and special attention should be given to how their work environment may expose them to discrimination.

Returned Indonesian migrant workers – Since the start of the outbreak and as of 20 April, more than 120,000 Indonesian migrant workers have already returned to Indonesia from destination countries through official channels, according to the National Board for the Protection of Indonesian Migrant Workers (BP2MI). The actual number of returnees is higher due to an unknown number of migrant workers who have returned through irregular means. Indonesian migrant workers have been significantly impacted economically, with many reporting to have been forced to return without their full salaries being paid by their employers, according to case records taken at government transit shelters. Returning migrant workers are not included in estimated statistics of newly unemployed Indonesians affected by the pandemic and encounter increased barriers in accessing government's social benefit schemes. The situation faced by returned migrant workers is compounded with the stigma they face upon return to their home communities. If not mitigated, the deterioration in the economy may potentially drive more Indonesians into desperate attempts to migrate abroad for employment by irregular means, especially as international mobility becomes restricted due to measures put in place by destination countries.

Religious or ethnic minorities, who may not fall into one of the six official religions are at a greater risk of harassment and discrimination, including the lack of access to appropriate health and social and economic support services.

Children, particularly children in remote communities and in the Eastern parts of

Indonesia, are exposed to poverty in several dimensions. In addition, children with disabilities, children living in institutions, including within child protection facilities, juvenile detention facilities and residential schools face an increased risk of violence and abuse. Studies have shown that the prevalence of violence against children within institutions ranges from 40-60%.

Detainees and prison population are another group with increased vulnerabilities to COVID19, due to crowded conditions and limited access to health facilities. **Institutional residents** of old people's homes, nursing homes, boarding houses. Homes for the mentally or physically ill, dense work place accommodation for factory or migrant workers, are all areas of concern for increased risk of disease spread.

1.2.5. CAPACITIES TO COPE WITH THE ADDITIONAL PRESSURE FROM THE EPIDEMIC_

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



Going to work
after the
tsunami.

Credit:
UNOCHA Indonesia

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

With regard to health, the projection up to December largely depends on the evolution of the epidemiological curve over the next few weeks. While a flatter curve is beneficial in terms of coping capacity of the healthcare systems, it also most likely means a prolongation of the outbreak. Estimates even speak of a duration until 2021.

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

The socio-economic impact of the pandemic in Indonesia will be heavy, multi-sectorial and long lasting. Economic sectors -such as tourism-, that account for large share of national revenue and employment, are highly vulnerable, and massive lay-off expected in April and beyond. There will also be a heavy impact on start-ups and SMEs, which account for more than 90% of the economy and on the large informal sector. High levels of unemployment will bring increasing levels of homelessness, particularly in urban centres, along with increasing migration to rural villages to seek shelter, placing additional burden on poorer rural communities.

Remittances received by Indonesian migrant households, which represented more than 1% of GDP before the pandemic, are due to drop as massive numbers

of Indonesian migrant workers are pushed to return home due to economic downturns in destination countries. Furthermore, temporary restrictions on the official placement of migrant workers will limit critical access to livelihoods for hundreds of thousands of migrant workers lacking gainful employment in Indonesia. Anticipation of an increase in irregular recruitment of workers and potential trafficking and exploitation of Indonesian migrant workers is essential.

In a country with a population of over 260 million, large groups are at risk, particularly the 9.6% of the population or about 25 million people who live below the national poverty line and the 40% of Indonesia's population (~180 million people) living just above that line and being vulnerable to external shocks. It is estimated that between 1.3 to 8.5 million of people may be pushed into poverty²¹.

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

III. THE GOVERNMENT RESPONSE

Declaration of National Disaster

On 13 April, through Presidential Decree number 12 of 2020, the President of Indonesia declared the COVID-19 pandemic as a national disaster.

21 Suryahadi, A., et al (2020). The Impact of COVID-19 Outbreak on Poverty: An Estimation for Indonesia.

National Response and Mitigation Plan for COVID-19

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

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

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

1. Implementation of command and coordination;
2. Surveillance;
3. Medical and laboratory responses;
4. Pharmaceutical intervention;
5. Non-pharmaceutical interventions;
6. Risk communication and community engagement.

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

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

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

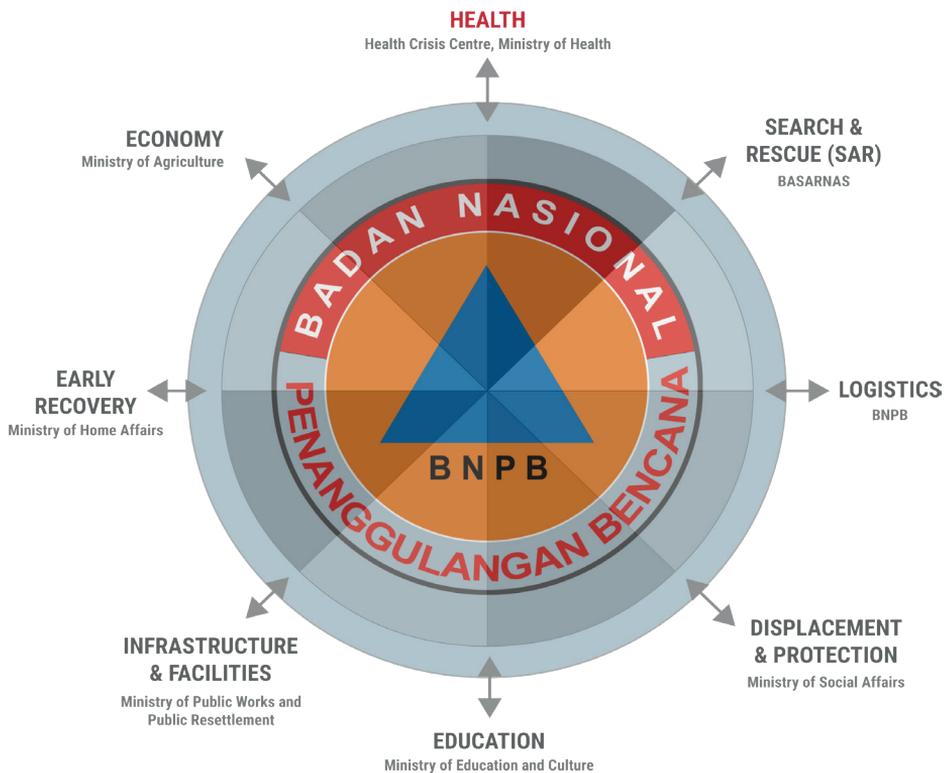


Figure 3: Structure of the Indonesian National Cluster system

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

IV. COORDINATION MECHANISMS

The Resident Coordinator in Indonesia provides leadership and strategic direction to the United Nations Country Team, consisting of 24 different UN agencies, funds and programmes. The RC also leads the work of the Indonesian Humanitarian Country Team, which brings together UN agencies supporting humanitarian emergencies, as well as the IFRC, the Indonesian Red Cross (PMI), and a

representation of national and international NGOs. ICRC, MSF, the AHA Centre and UNDSS participate in the HCT with observer status.

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

In 2014, BNPB and a number of government ministries/institutions agreed to adopt the cluster approach as the mechanism for multi-stakeholder coordination on humanitarian issues in Indonesia; the agreement was formalized through decree number 173/2014 from the Head of BNPB. As a follow up, the Ministry of Social Affairs enacted the Regulation of the Ministry of Social Affairs (Permensos) Number 26, Year 2015, on the National Cluster for Displacement and Protection Guidelines. The Ministry of Health also issued the Regulation of the Ministry of Health (Permenkes) Number 75 Year 2019 on Health Crisis Management. The national cluster system in Indonesia is envisioned to work before, during and after a disaster. A total of eight national clusters were established, as follows:

NO	National Cluster	Coordinator	Co-Coordinator
1	Health, with six sub-cluster and three support teams: <ul style="list-style-type: none"> • Health Service • Disease control, environmental sanitation and clean water supply • Reproductive Health • Mental Health • Disaster Victim Identification (DVI) • Nutrition Three support teams: <ul style="list-style-type: none"> • Health Logistic Team, • Data and Information Team, and • Health Promotion Team 	Health Crisis Centre, Ministry of Health	Pusdokkes POLRI
2	Search and Rescue (SAR)	BASARNAS	TNI

NO	National Cluster	Coordinator	Co-Coordinator
3	Logistics	BNPB	Ministry of Social Affairs
4	Displacement and Protection with eight sub-clusters and two working groups: <ul style="list-style-type: none"> • Shelter • Water, Sanitation and Hygiene • CCCM • Child Protection • Protection of Elderly, Disability, and other Vulnerable Groups • Prevention and Response to Gender-based Violence and Women Empowerment • Psychosocial Support • Security Two working groups: <ul style="list-style-type: none"> • Cash and Voucher Assistance, and Community Engagement 	Ministry of Social Affairs	POLRI
5	Education	Ministry of Education and Culture	Ministry of Religious Affairs
6	Infrastructure and Facilities	Ministry of Public Works and Public Resettlement	
7	Economy, with one sub-cluster: Food Security	Ministry of Agriculture	Ministry of Cooperatives and SMEs
8	Early Recovery	Ministry of Home Affairs	BNPB

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

However, as the impact of COVID-19 goes beyond health, the Coordinating Ministry of Human Development and Culture, as the Chair of the Steering Committee to the Task Force for the Acceleration of the COVID-19 Response, has taken

the responsibility to coordinate the national cluster system. With that position, the Coordinating Ministry is linking the work of the national clusters with the Government's National Task Force for the COVID-19 Response. Currently, the national clusters and the working groups on Community Engagement, Information Management and Cash and Voucher Assistance are in the process to be embedded into the Task Force coordination efforts.

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

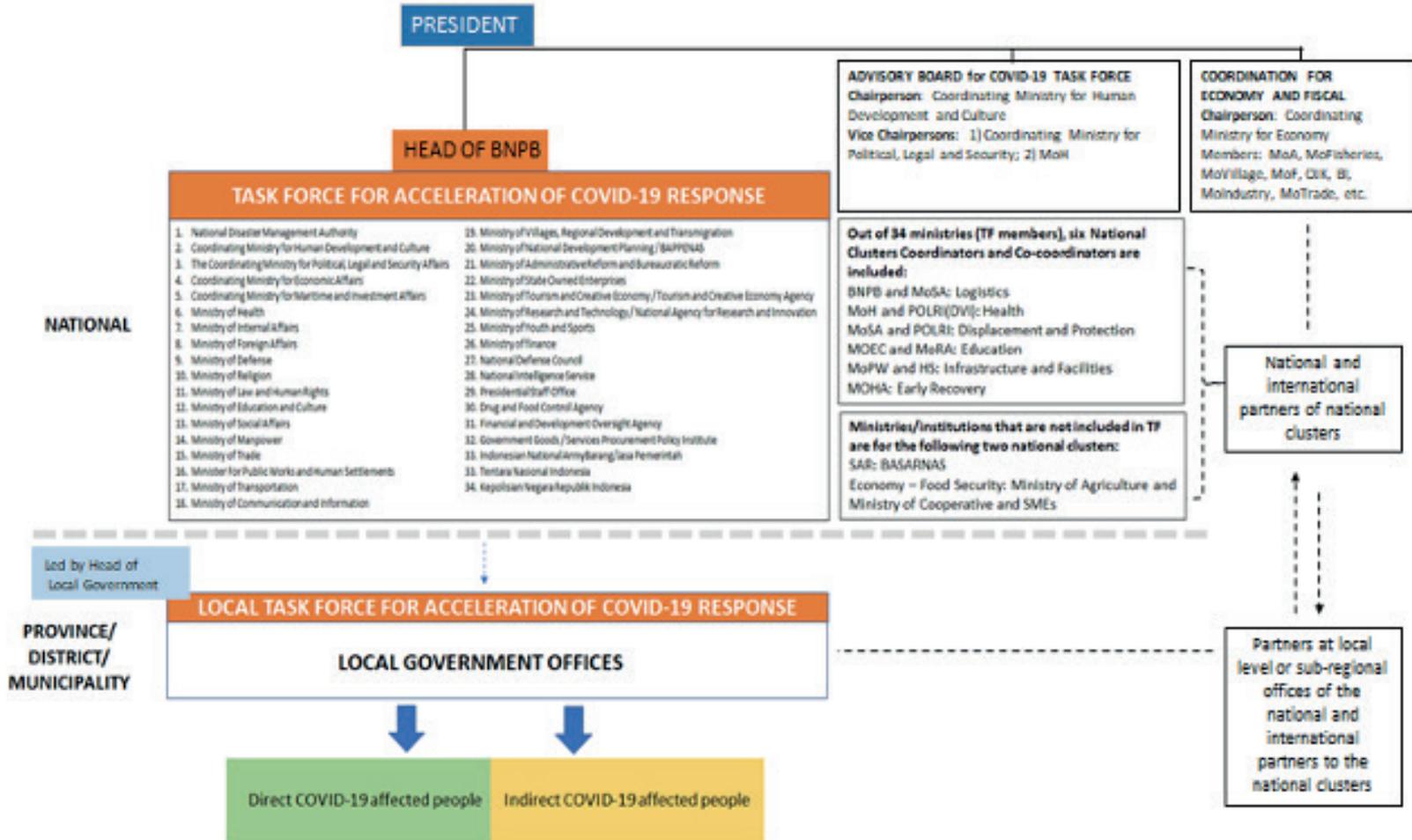
The Regional Task Forces for COVID-19 are being created on the basis of the Presidential Decree that requested the governors and head districts/municipalities to form a local task force for acceleration of the COVID-19 response. The local Task Force is led by the Head of local government, and administratively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

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

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

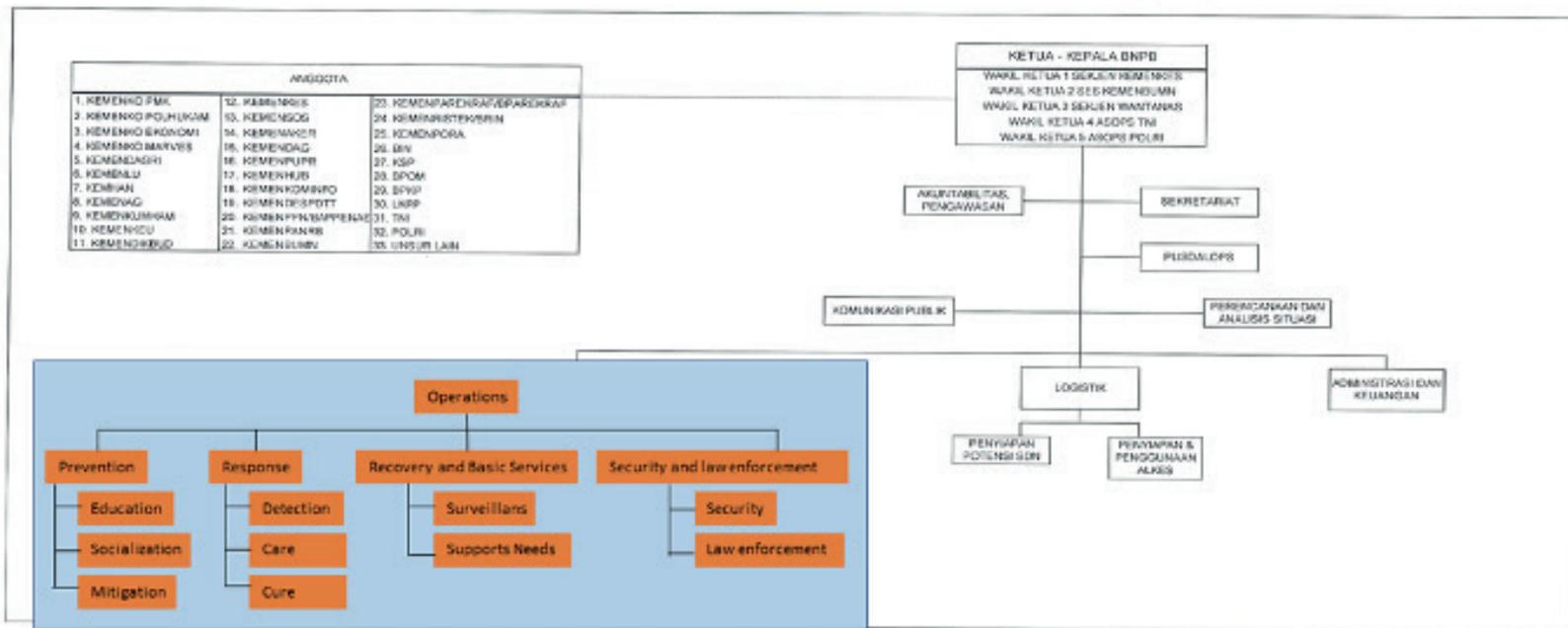
The structure of national coordination for COVID-19 is as follows:

Figure 4: Structure of national coordination for COVID-19



LAMPIRAN B
KEPUTUSAN KETUA PELAKSANA GUGUS TUGAS
PERCEPATAN PENANGANAN CORONA
VIRUS DISEASE 2019 (COVID-19)
NOMOR 16 TAHUN 2020

STRUKTUR ORGANISASI PELAKSANA GUGUS TUGAS PERCEPATAN PENANGANAN CORONA VIRUS DISEASE 2019 (COVID-19)



KETUA PELAKSANA GUGUS TUGAS
PERCEPATAN PENANGANAN CORONA
VIRUS DISEASE 2019 (COVID-19)
[Signature]
DONI MORAIDO

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

- Medical treatment operations
- Security operations
- Support operations

In these operations, TNI carries out medical assistance, logistics, deployment, and infrastructure building services, dengan pembagian tugas berdasarkan kewilayahan: the western, central and eastern parts of the country, under each Joint Regional Defense Command (Kogabwilhan – Komando Gabungan Wilayah Pertahanan).

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

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

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

1. The developed Regional Task Forces for the Acceleration of COVID-19 response. Although it is not known how many task forces that TNI is engaged, it is not surprising that all of them have local TNI involvement.

2. The standing Regional Leadership Communication Forum (Forkopimda) at each local government, which consists of the head of local government, local chiefs of police, TNI and court.

V. HCT AND UN COUNTRY TEAM RESPONSE STRATEGY

5.1. OBJECTIVES

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

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

5.2. DURATION AND FOCUS

The initial plan, with a focus on life-saving and early recovery activities is envisioned for an initial duration of six months, from April to September 2020, however HCT and UNCT members fully recognize the need for adaptation to the particular challenges of responding to COVID-19, as well as to adjust the plan as needs may evolve or arise. Regular reviews of the plan based on the evolving situation are envisaged as a minimum after 4 and 6 months whereupon the plan may be extended or otherwise adapted to prevailing needs.

5.3. PRIORITY AREAS

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

- Health
- Risk Communications and Community Engagement (RCCE)
- Logistics
- Food security
- Mitigate the socioeconomic impact of the crisis
- Critical multi-sectoral services
- Protection of vulnerable groups

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

5.4. RESPONSE PRINCIPLES

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

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

groups get information about how to prevent and respond to the epidemic in ways they can understand.

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

5.5. MONITORING

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

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

5.6. FINANCIAL REQUIREMENTS

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

PRIORITY AREA	RESOURCE REQUIREMENTS (IN USD)
HEALTH	58,344,470
RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT (RCCE)	6,094,720
LOGISTICS	236,954
FOOD SECURITY AND AGRICULTURE	5,055,000
MITIGATE THE SOCIOECONOMIC IMPACT OF THE CRISIS	12,887,000
CRITICAL MULTI-SECTORAL SERVICES	21,797,379
PROTECTION OF VULNERABLE GROUPS	9,078,504
TOTAL	113,494,027

VI – RESPONSE OPERATIONAL DELIVERY PLANS

PRIORITY AREA 1: HEALTH (INCLUDING REPRODUCTIVE HEALTH, MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT)

Government lead: **MoH**

Support lead: **WHO**

Partners: **UNICEF; PMI; IFRC; UNDP; UNFPA; MSF; HFI; ICRC; UNAIDS, IOM, UNHCR, Save the Children, Nahdlatul Ulama, Muhammadiyah, ITU, Dompot Dhuafa, YAKKUM, WVI, Caritas Indonesia, Human Initiative, Rebana Indonesia, PGI, Rumah Zakat, BAZNAS, ADRA Indonesia**

Objectives:

To support the Government of Indonesia to:

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

Priority Actions: **To support the Government and national counterparts:**

1. To suppress the human-to-human transmission of COVID-19

1. **Ensure adequate laboratory capacity**, incl. provision of reagents, supplies, laboratory protocols and SOPs, and supporting the implementation of quality assurance mechanisms and biosafety procedures
2. **Enhance active case finding, contact tracing and monitoring**, quarantine of contacts and isolation of all cases

3. **Improve the case-based and aggregate reporting systems and intensify COVID-19 surveillance** using existing respiratory disease surveillance systems, hospital-based SARI and primary care-based ILI surveillance, and community-based surveillance.
4. **Prevent transmission of COVID-19 to staff, patients and visitors by supporting implementation of appropriate Infection Prevention and control (IPC) practices in health care facilities** including proper segregation of suspected, possible and confirmed cases from ANC, neonatal and maternal health units.
5. **Ensure adequate laboratory capacity**, incl. provision of reagents, supplies, laboratory protocols and SOPs, and supporting the implementation of quality assurance mechanisms and biosafety procedures
6. **Enhance active case finding, contact tracing and monitoring**, quarantine of contacts and isolation of all cases
7. **Improve the case-based and aggregate reporting systems and intensify COVID-19 surveillance** using existing respiratory disease surveillance systems, hospital-based SARI and primary care-based ILI surveillance, and community-based surveillance.
8. **Prevent transmission of COVID-19 to staff, patients and visitors by supporting implementation of appropriate Infection Prevention and control (IPC) practices in health care facilities** including proper segregation of suspected, possible and confirmed cases

2. To provide care and support for patients affected by COVID-19 and their families

1. Support the **mapping of public and private health facilities and the assessment of their capacities**, as well as the establishment of referral mechanisms from Puskesmas [community health care] to higher level of health facilities.
2. **Improve capacities** of ICUs, primary and secondary level hospitals, alternative community health facilities, and the referral system, including the **provision of medicines, PPE and health equipment**.
3. Collaboration with **tele-health service providers for triage and monitoring of health status** of patients with mild symptoms; and facilitation of telemedicine online platforms.
4. Build the **capacity of health workers** in health facilities, laboratories, pharmacies and transportation)

5. Integrate **mental health and psychosocial support services (MHPSS)**
6. Supporting the delivery of **incentives schemes for the health workers**
7. Support the provision of **health waste management technical assistance** - upgrading, provision, and instalment of autoclaves and incinerators-, to reduce exposure to biological hazards and contaminants.
8. Support national counterparts in the field of **management of dead bodies**

3. Ensure the continuity of other essential health services during and after the pandemic

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

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

4. Strengthen the resilience of health systems at provincial and district level

1. Development of provincial recovery plans
2. **Strengthening of the surveillance and case detection system**
3. Training and SOPs for outbreak investigation and appropriate lab referrals
4. Strengthening of IPC at health facilities
5. Improvement of patient flow and quality at infectious disease hospitals and wards

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

Total funding requirements: **58,344,470 USD**

WHO: 17,000,000; UNAIDS: with existing resources; Save the Children: 600,000; UNDP: 2,400,000; UNFPA: 200,000; UNICEF: 10,156,200; IOM: 4,900,000 USD; UNHCR: 405,270; UNOPS: 12,000,000; Muhammadiyah: 7,800,000; Nahdlatul Ulama: 1,300,000; Human Initiative: 600,000; Wahana Visi: 586,000; Dompot Dhuafa: 170,000; Yakkum: 212,000; Caritas Indonesia: 15,000

PRIORITY AREA 2: RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT

Government lead: **BNPB, KOMINFO**

Support lead: **UNICEF, IFRC**

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

Priority objectives:

1. Build public **trust** in national authorities on public health information and instructions related to COVID-19.
2. Provide a RCCE **guiding framework** and **coordinated** approach to enable an effective country response.
3. Ensure all RCCE **approaches, messages, and materials** shared at all levels and in all phases of the response are based on technically accurate medical and public health science.
4. Promote and facilitate participatory **community engagement** to improve people's knowledge, motivate action, reduce stigma and create an enabling environment for change to contain the spread of virus.
5. Scale up RCCE approaches at national and sub-national levels to promote and sustain critical behaviors during the **various phases** of the response: RESPOND – RECOVER – RESTORE.

Priority Actions:

1. Support to national and sub-national authorities

1. Support the development and implementation of national and sub-national risk-communication and community engagement strategy.
2. Build the capacity of national and subnational authorities, including government officials, programme managers and providers, and community-based organizations on prevention and response in order to support RCCE plans at national and sub-national levels.

2. Coordination of partners

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

3. Communication and community engagement

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

Linkages with clusters and sectors: **Health, Multisectoral services, Protection of vulnerable groups**

Total funding requirements: 6,104,720 USD

UNICEF: 1,663,200; WHO: 1,000,000; OXFAM: 200,000; UNAIDS: 50,000; Save the Children: 250,000; UNFPA: 150,000; IOM: 400,000; MPBI: 34,000; CARE: 150,000; UNHCR: 113,520; UNDP: 250,000; Muhammadiyah: 750,000; Nahdlatul Ulama: 430,000; Wahana Visi: 292,000; Human Initiative: 200,000; Dompet Dhuafa: 100,000; Caritas Indonesia: 8,000; Yakum: 20,000; Planas: 34,000; HFI Secretariat: 10,000;

PRIORITY AREA 3: LOGISTICS

Government lead: BNPB, Kemenko PMK

Support lead: WFP

Partners: Indonesian Red Cross (PMI), Save the Children, MPBI

Priority objectives:

1. Support the Government-led National Logistics Cluster's coordination aiming to minimize duplication of efforts, provide a platform to identify and address common challenges, ensure effective engagement with key inter-agency and/or cross-sector forums, promote sharing of technical expertise, and engage in advocacy to highlight operational challenges;
2. Develop a Logistics Concept of Operations based on existing logistics gaps and capacities, aimed to improve efficiency and effectiveness of emergency logistics operations, and ensure alignment with the Government's Operational Plan;
3. Support the Government and humanitarian community in facilitating the private sector's engagement to ensure the necessary logistics services can be made available and are accessible to all stakeholders.

Priority Actions:**1. Provide coordination support to the Government-led National Logistics Cluster**

The following coordination activities are intended to minimize duplication of efforts, provide a platform to identify and address common challenges, ensure effective engagement with key inter-agency and/or cross-sector forums, promote sharing of technical expertise, and engage in advocacy to highlight operational challenges.

1. Establish a dedicated **coordination cell under the NLC**, aiming to strengthen cooperation, synchronize response efforts, and identify shared supply chain challenges;
2. **Coordinate mobilization of technical expertise** within the NLC and the humanitarian logistics community to evaluate the context and identify emerging issues and concerns;
3. **Provide appropriate venues** to discuss sector-specific logistics operations;
4. **Support the ongoing logistics coordination's efforts** undertaken by local government institutions, mainly focusing on provinces with pre-established logistics clusters.

2. Provide a logistics related information management and sharing mechanism to the wider humanitarian community

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

3. Facilitate the engagement of private sector in the provision of logistics services

The services facilitated by the NLC are not intended to replace the logistics capacities of any agencies or organizations, but rather to complement through access to the pre-committed logistics services as part of NLC strategy established during the preparedness phase.

1. **Coordinate the provision of necessary logistics services from NLC members** based on their existing capacities and resources.
2. **Facilitate the provision of specific services required from the NLC members** and/or wide range supply chain actors in the country, such as cold chain operations, inventory management, commodity tracking, etc.
3. **Advocate formal activation of alternative international entry points and hubs** in several major cities in the country to facilitate the distribution of critical supplies throughout the country, as stipulated in the Ministry of Health Operational Plan, to which WFP contributed during the development process.

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

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

WFP: 236,954

PRIORITY AREA 4: FOOD SECURITY

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

Support lead: **WFP and FAO**

Partners: **Dompot Dhuafa, Caritas Indonesia (KARINA), Nahdlatul Ulama, Muhammadiyah, Rumah Zakat, BAZNAS, YKMI, AMCF, Human Initiative, PGI**

Support objectives:

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

Priority Actions:

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

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

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

Short-term measures:

1. Support the Government of Indonesia in the area of policy through:

- a. Development of **policies for the removal of impediments to the food production and distribution in supply chain** that has been inadvertently introduced through aspects of the large-scale-social-restriction arrangements;
 - b. Development of **policies to ensure the health/safety of agricultural labour force** while having adequate freedom of movement.
2. **Strengthen access to inputs by supporting the following activities:**
- a. Map actual and potential **food needs** across the country;
 - b. Target procurement and distribution of essential **agricultural inputs**;
 - c. Ensure **agricultural inputs remain available for sale** during the large-scale-social-restriction and transport and logistics of these items remains unhindered;
 - d. Establish mobile units to **support livestock production** (including veterinary services) in poorest areas.
3. Support controlled movements of agricultural labour to fill gaps in labour availability, under clear social distancing guidelines.
4. Contribute to effective **logistic arrangements**:
- a. Ensuring current transportation capacity is maintained and in place, with inter-provincial transport routes fully open to movement of foodstuffs, together with the availability of refrigeration and storage points in main markets, to enable food access and minimize food losses along the supply chain and at selling points;
 - b. Consideration is given to **integrating capacities with the private sector**, including the capillary online selling/distribution platforms.
5. **Financial Support:** Consider stimulus packages for more affected groups, such as interest-free agricultural loans or grants.

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

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

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

Total funding requirements: **5,055,000 USD**

No funding required for WFP; this will be covered through existing resources. Immediate funding allocation from FAO on Covid-19 response: 250,000 USD to be allocated to develop a Roadmap and provide targeted technical assistance to the Government. Further funding requirements will be defined as needs become apparent.

Muhammadiyah: 1,550,000; Nahdlatul Ulama: 1,700,000; Human Initiative: 1,200,000; Dompot Dhuafa: 340,000; Caritas Indonesia: 15,000

PRIORITY AREA 5: MITIGATE THE SOCIOECONOMIC IMPACT OF THE CRISIS

Government lead: **Kemenko PMK/KemenkoEk/Bappenas/BNPB**

Support lead: **UNDP**

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

Support objectives:

1. To provide effective and timely **support to the Government at the national and sub-national levels in addressing socio-economic impact of COVID19**, with particular emphasis of vulnerable groups and households;
2. Provide **advice** to the Government of Indonesia on effective policies and **adjustment of existing as well as new social protection measures** to ensure that vulnerable people are able to better withstand the immediate and secondary effects of the COVID-19 crisis;
3. Provide **support to key stakeholders, especially the business community and small-medium scale enterprises**, particularly those led by women, to implement adequate **measures for immediate response and recovery**, to mitigate the immediate impact and secondary impact of the COVID-19 crisis, and sustain their business and the jobs they create.
4. Provide direct support to **Indonesia's most vulnerable population**, particularly women, children, people with disabilities and marginalized groups to **safeguard them from the socio-economic impact of the COVID-19 crisis**.

Priority Actions:

1. Mezzo-level assessment of the impact of COVID-19 crisis on **selected economic sectors with significant impact on employment and incomes**, and development of recommendations for overcoming the crisis while adhering to the principle of building back better and enhancing resilience;
2. **Assessment** of the impact of COVID-19 crisis on **micro, small and medium enterprises**;

3. **Socio-economic impact assessment** of the COVID-19 pandemic on **households in hardest hit areas**, including potential secondary and tertiary impact - with particular focus on vulnerable groups, including women, self-employed, daily workers, migrant households, and people living with disabilities – covering areas of livelihoods, employment, remittances, labour exploitation/human trafficking and access to social services and strengthening their resilience to shocks. The assessment will be followed by recommendations on policy and programmatic measures and actions for implementation to mitigate the impact of the crisis on the most vulnerable and prevent them from sliding back to poverty. Assessment of impacts COVID-19 on international migration from Indonesia, wider impact of decline of remittances, consequences on human trafficking and labour exploitation, and internal migration patterns during pandemic.
4. Support designing of policies and **leveraging existing as well as innovative instruments for social protection** for mitigating impact of the COVID-19 pandemics on the most vulnerable.
5. Implement support programme to SMEs, with a focus on women entrepreneurs
6. Support to the national and sub-national counterparts in **coordination of cash transfers and voucher assistance**, ensuring adequate linkages between crisis interventions and existing social protection mechanisms to target the most vulnerable and most affected population in a coordinated and timely manner.
7. Initiate implementation of **initiatives with quick impact** to ease socio-economic challenges of the most vulnerable and disadvantaged groups.

Linkages with clusters and sectors: **Protection, Economy, Food Security, Logistic, Health and others as relevant.**

Total funding requirements: **12,887,000 USD**

OXFAM: 550,000; UNAIDS: 210,000; Save the Children: 300,000; UNICEF: 1,188,000; IOM: 1,000,000; UNFPA: 150,000; MPBI: 34,000; UNIDO 50,000; UNDP 3,350,000; CARE 300,000; UN Women: 320,000 USD; Muhammadiyah: 1,550,000; Nahdlatul Ulama: 1,700,000; Human Initiative: 1,200,000; Dompet Dhuafa: 350,000; Caritas Indonesia: 15,000; Wahana Visi: 586,000; Platform Nasional: 34,000;

PRIORITY AREA 6: CRITICAL MULTI-SECTORAL SERVICES

Government lead: **Coordinating Ministry for Human Development and Culture, MoSA**

Support lead: **IOM for CCCM; IFRC for SHELTER; UNICEF for WASH and NUTRITION**

Partners: **UNICEF, IFRC, WVI, UNDP, ILO, WHO, UNHCR, UNFPA, IOM, ITU, HFI, PMI, MPBI, Planas PRB, Pulse Lab Jakarta**

Support objectives:

1. Support to ensure **infection-free, continuity, and safety of critical services, including health, water and sanitation, nutrition, food and non-food items, shelter, protection, and education for at-risks population and groups most exposed and vulnerable to the pandemic.**
2. Support the **coordination of government and non- government actors sectoral response** at national and sub-national level in the context of COVID19, including through the provision of **Information Management (IM)** materials and tools to enable evidence-based humanitarian decision making based on the evolving scale of the pandemic in the country, needs, and support required in ensuring the delivery of critical multi-sectoral services.
3. Support the **delivery of multi-sectoral COVID-19 assistance to vulnerable population** whose conditions are exacerbated due to COVID-19, including internally displaced persons (IDPs), refugees and asylum seekers, migrants, survivors of gender-based violence, children, people with disabilities, older persons, people of concern and host population groups who are particularly vulnerable.
4. **Advocate** for measures to be in place to **address COVID-19 pandemic in camps and camp-like settings and the surrounding host communities.**
5. Support the provision of **information management platforms** and training available for responders to identify and coordinate the multi-sectoral responses.

A. Camp Management

Government lead: **Ministry of Social Affairs and PUPR**

Support lead: **IOM**

Partners: **UNICEF, IFRC, WVI, UNDP, ILO, WHO, UNHCR, UNFPA, Save the Children**

Priority Actions:

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

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

B. Shelter
Government lead: Ministry of Social Affairs and PUPR
Support lead: IFRC
Partners: UNICEF, IFRC, WVI, UNDP, ILO, WHO, UNHCR, UNFPA, PMI, HFI, Habitat for Humanity Indonesia, WVI, Human Initiative, PGI
<p>Priority Actions:</p> <ol style="list-style-type: none"> 1. Shelter Opportunity Surveys in deeply affected areas. Assisting local governments to coordinate with both private and public sector landlords for temporary use of existing facilities for: <ol style="list-style-type: none"> a. Emergency Shelter assistance for migrating and displaced families stuck between provinces b. Self-isolation and self-quarantine facilities c. Housing for families of those seeking medical assistance 2. Decongestion support programs for heavily congested camps, barracks and urban slums 3. Advocacy with government and private sector for rental support and moratoriums on evictions
Linkages with clusters and sectors: Protection of vulnerable groups; Risk Communication and Community Engagement, Mitigating the socioeconomic impact of the Crisis; Camp Management; WASH

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

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

Priority Actions:

1. Provide technical support to the Ministry of Education and Culture (MoEC) and the Ministry of Religious Affairs to enhance education system-level response to the pandemic
2. Support to MoEC crisis management team including, technical assistance, coordination and communication of activities, including the development and dissemination of school guidance on Preparedness and Response to COVID-19 as well as for safe school reopening including clean-up for schools
3. Strengthening coordination capacity of sub-national governments in their role in responding to the crisis
4. Provide support for continued learning during school closure for the most vulnerable population
5. Support the planning and implementation of safe school operations and risk communications
6. Support the planning and implementation of safe school operations and risk communications
7. Enhanced knowledge sharing and capacity building both for the current response and future pandemics
8. Development of Education Cluster COVID-19 response plan

Linkages with clusters and sectors: Protection of vulnerable groups, MHPSS, RCCE, WASH, Nutrition

D. WASH

Government lead: BNPB, Ministry of Health, Ministry of Education, Ministry of Public Works, MoSA

Support lead: UNICEF

Partners: Save The Children, Oxfam, PMI, Dompot Dhuafa, WVI, Human Initiative, PGI, Rumah Zakat, Muhammadiyah, Nahdlatul Ulama, BAZNAS

Priority Actions:

1. Provide **technical support and assistance** to BNPB, Ministry of Health, Ministry of Education, Ministry of Public Works, MoSA and other WASH sector leaders to accelerate behaviour change interventions through development and dissemination of **guidance for hygiene promotion, IPC, disinfection and waste management** to ensure sustainability in WASH services and reduce the risk of COVID-19 recurrence.
2. **Facilitation of WASH Cluster** to coordinate WASH sector response plan and COVID-19 related training to WASH Cluster partners.
3. **Procurement of critical WASH supplies** and prioritization of settings and institutions for immediate support.
4. **Engage the private sector to mobilise support** for COVID response in hygiene promotion behaviour change in public places, their workplaces, surrounding communities and as an innovations partner to the Government.

Linkages with clusters and sectors: **Protection of vulnerable groups, MHPSS, RCCE, Shelter**

E. Nutrition

Government lead: **BNPB, Ministry of Health, Ministry of Education, Ministry of Public Works, MoSA, Presidential Staff Office (KSP)**

Support lead: **UNICEF**

Partners: **Save The Children, Caritas Indonesia, Rumah Zakat, BAZNAS**

Priority Actions:

1. Provide technical support to the Ministry of Health and Bappenas in **strengthening their nutrition preparedness and response capacity**, especially in the context of COVID-19 pandemic

2. Support the **procurement of essential nutrition supplies** to ensure continuity of services
3. Support the social behavior change **communication on nutrition** in the context of COVID-19 pandemic to raise the awareness on various nutrition issues and generate demand for essential nutrition services
4. Provide support to strengthen **government coordination on nutrition** in the context of COVID-19 pandemic
5. Lead inter-agency coordination of COVID-19 response efforts being made by UN agencies in the areas of nutrition and food security

Linkages with clusters and sectors: **Child protection, MHPSS, RCCE**

Total funding requirements for Critical multi-sectoral services: **21,797,379 USD**

Save the Children: 600,000; UNICEF: 7,275,668; IOM: 5,000,000; Oxfam: 400,000; CARE: 200,000; UNHCR 600,711; Muhammadiyah: 3,200,000; Nahdlatul Ulama: 2,560,000; Human Initiative: 800,000; Wahana Visi: 878,000; Dompot Dhuafa: 260,000; Caritas Indonesia: 23,000

PRIORITY AREA 7: PROTECTION OF VULNERABLE GROUPS

Government lead: **MOSA, BNPB, Refugee Task Force, MOWECP, Komnas HAM, Directorate General of Prisons**

Support lead: **UNHCR, UNFPA**

Partners: **Humanity & Inclusion, UNAIDS, UNODC, UNAIDS, UNICEF, IOM, UNDP, UN Women, Save the Children, WVI, HFI, OXFAM, CARE, ICRC, PMI, Nahdlatul Ulama, Muhammadiyah, Caritas Indonesia, YAKKUM, Dompot Dhuafa, Rumah Zakat, ADRA Indonesia**

Support objectives:

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

Priority Actions:

1. Backgrounds and initial rapid assessments
2. **Protection mechanism and Referral pathway** (access to health, legal services, safe place, advocacy, case management)
3. Access to primary COVID19 **prevention and hygiene supplies** (masks, hand sanitizer, clean water and soap) and other logistics for survival

4. Access to **social and financial assistance** (exploring cash for protection modalities and associated risks)
5. **Risk communication and community engagement** materials (lifesaving information)
6. **Capacity building and awareness creation**, and support to accountable feedback mechanisms
7. **Online legal counseling** for PLHIV and Key Affected Populations
8. Supports community and civil society organisations to **conduct rapid assessments on the situation of vulnerable groups** during the pandemic.

Linkages with clusters and sectors: **Health, Logistics, Risk Communication and Community Engagement, Multisectoral Services**

Total funding requirements for Critical multi-sectoral services: **9,078,504 USD**

UNFPA: 500,000; UNHCR: USD 2,333,704; UNDP: 240,000; Oxfam: 150,000; UNAIDS: 50,000; Save the Children: 300,000; IOM: 1,700,000; ITU: 50,000; UNICEF: 902,800; UN Women: 330,000; CARE: 150,000; Muhammadiyah: 750,000; Nahdlatul Ulama: 860,000; Wahana Visi: 586,000; Dompet Dhuafa: 150,000; Yakkum: 26,000 USD

Indonesia Multi-Sectoral Response Plan to COVID-19
May - October 2020