# Women at the frontlines: Women's unrecognised leadership role in Indonesia's COVID-19 response

## Policy Briefing – SEARBO

Australian National University

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## Acknowledgements

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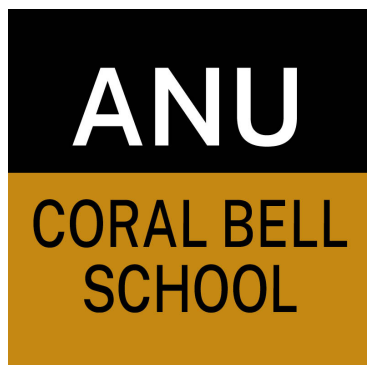
Front cover image: The Governor and Deputy Governor of Sumbar receive their second vaccine dose. Public domain..

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# Introduction

Globally, scholars and journalists have drawn attention to the role of women politicians leading COVIDCOVID-19 pandemic responses. Other scholars have examined pandemic impacts on women in terms of increased domestic violence, care duties, unemployment and poverty. This paper examines the role women have played leading mitigation and healthcare responses to COVID-19 in Indonesia, focusing both on women in leadership positions as well as the leading role women public servants play in frontline pandemic responses at local government level. With a focus on the city of Salatiga in Central Java, I show that leadership on the frontlines of pandemic mitigation and healthcare responses is highly feminised, even while the overwhelming majority of the city-wide COVID-19 taskforce members are men.[1] The taskforce is responsible for strategic pandemic mitigation policy and planning, cross-agency coordination, monitoring and enforcement of mitigation measures, budgeting and other resource allocations. Despite the leading role of this male-dominated body, I show that women lead mitigation and healthcare responses in ways that go beyond their formal responsibilities, often by default, especially when they step up to fill gaps in formal leadership of pandemic mitigation measures.

I examine this gap between women's minimal representation in official COVID-19 taskforce structures and their overwhelming majority representation in the frontlines of emergency and long-term pandemic responses. I show that women led not only by exercising their formal designated roles but through shaping local policy development, exercising everyday decision-making and initiating coordination among multiple government agency stakeholders when the citywide and subdistrict taskforces failed to do so. These women built significant knowledge through experience of managing this pandemic crisis. They know the shape of the COVID-19 pandemic and understand what practices work best – and what does not work – in mitigating the crisis. Yet their limited inclusion in formal structures with decision-making authority has restricted women's power to critique and shape political decision-making about priorities in COVID-19 pandemic responses.

The most immediate implication of this disjuncture was that decision makers did not effectively draw on this knowledge and experience in developing more effective local and national pandemic policies. The broader implication was that failure to make best use of this knowledge and experience meant the crisis remained ongoing with no vision of how to concretely improve mitigation strategies and their implementation. The most direct impact of these failures fell on frontline responders who, even through the first half of 2021, continued to face an ongoing crisis in an immediate everyday way, with no forum to have input or control over decisions that so directly impacted on their everyday working lives.

Scholars and advocates have argued for women's participation in the design,

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1        See table 1.

implementation and monitoring of COVID-19 related laws and policies at all levels of government decision-making.[2] My study shows that this participation is indeed necessary, not only to address the specific needs of women and girls in the pandemic, but, further, in order to draw upon the growing knowledge and experience of these women in developing timely pandemic strategies.

To examine the phenomenon of women's high representation in frontline COVID-19 responses in Indonesia, I draw on fieldwork conducted in the municipality of Salatiga in Central Java.[3] Fieldwork interviews were conducted with leaders of COVID-19 responses working in the city-level COVID taskforce, the municipal health department, the district hospital and one community health centre (*Pusat Kesehatan Masyarakat – PUSKESMAS*). There were significant constraints on fieldwork access beyond Salatiga,[4] due to high levels of COVID-19 transmission throughout Indonesia, especially in Java, at the time I was conducting the study. Additional data was provided by the Salatiga municipal government secretariat (*Sekretariat Daerah (Sekda) Kota Salatiga*) office and the department of Health in January and February 2021. Thirty-two questionnaires were completed by managers and frontline health workers across one community health centre and the district hospital.  Drawing on these sources, I present gender disaggregated data on women's representation in local government decision-making bodies and frontline leadership in local health services, comparing these with data on women's representation in national and provincial level COVID-19 response management teams. Together these diverse sources of data show that the significant knowledge and experience gained by women leading COVID-19 mitigation responses were not broadly represented in pandemic taskforces exercising structural authority over pandemic responses, nor were they drawn upon systematically to inform and improve mitigation strategies and practice.

2        CARE. (2020). "Where are the Women? The Conspicuous Absence of Women In COVID-19 Response Teams and Plans, and Why We Need Them". See https://www.care-international.org/files/files/CARE_COVID-19-womens-leadership-report_June-2020.pdf

3        Salatiga is a small urban municipality of 194,000 residents situated in the wider urban-rural vicinity of Semarang. It has one million residents. This small municipality has the seventh highest human development index in Indonesia with relatively better health infrastructures than other districts and municipalities. These services are normally accessed by residents of the surrounding district which has a human development index much closer to the national average. See https://semarangkab.bps.go.id/indicator/26/82/1/ipm-kabupaten-semarang.html

4        The writer and research assistant for this study both live in Salatiga and adhered to strict health protocols and official travel restrictions in the conduct of this fieldwork..

# Bearing the burdens of leadership in pandemic crisis

Women dominate the healthcare workforce globally.[5] Here, I build on previous studies that examine the critical role women play in healthcare generally and pandemic mitigation responses specifically.[6] I do so by focussing on an Indonesian case study and by drawing on a gendered political economy framework, taking inspiration from the work of social reproduction scholars.[7] Women's roles in everyday social reproduction,[8] in both paid and unpaid care work, prepares women to provide leadership in many aspects of pandemic responses.

Such a framework draws attention to how the uneven distribution of power to make decisions and allocate resources among people shapes power relations among individuals and groups, including along gender lines. This approach recognises the dependence of both polity and economy on the gendered division of labour in care work.[9] Using this approach I examine the disjuncture between men's high representation in formal leadership and decision-making and women's overwhelming domination of everyday pandemic leadership on the frontlines of both infectious disease mitigation strategies and healthcare responses.

In previous work, I have shown that Indonesia's national COVID-19 virus mitigation policies largely failed to halt the spread of the virus, making mitigation responses dependent upon the initiative and capacity of local governments and communities.[10]

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5       Women make up the largest majority of frontline pandemic responses historically and in this pandemic. See Davies, S. E., Sophie Harman, Rashida Manjoo, Maria Tanyag, and Clare Wenham. (2019). Why it must be a Feminist Global Health Agenda. *The Lancet*(393 ), 601-603. doi:http://dx.doi.org.libproxy.murdoch.edu.au/10.1016/S0140-6736(18)32472-3

6       Robinson, F. (2011). The Ethics of Care : A Feminist Approach to Human Security. Retrieved from https://ebookcentral.proquest.com/lib/murdoch/detail.action?docID=744005; and Harman, S. (2016). Ebola, Gender and Conspicuously Invisible Women in Global Health Governance. *Third World Quarterly*, 37(3), 524-541. doi:10.1080/01436597.2015.1108827

7       Bakker, I. (2007). Social Reproduction and the Constitution of a Gendered Political Economy. *New Political Economy*, 12(4), 541-556. doi:10.1080/13563460701661561; Laslett, B., & Brenner, J. (1989). Gender and Social Reproduction: Historical Perspectives. *Annual review of sociology,* 15(1), 381-404. doi:10.1146/annurev.so.15.080189.002121; Rai, S. M., Hoskyns, C., & Thomas, D. (2014). Depletion: The Cost of Social Reproduction. *International Feminist Journal of Politics*, 16(1), 86-105. doi:10.1080/14616742.2013.789641;

8       Social reproduction can be defined as the reproduction of social life, which includes biological reproduction, the unpaid production of goods and services in the home, the provision of social labour such as voluntary and other forms of work needed to maintain communities, including responding to social crises and disasters, as well as the reproduction of culture and ideology (Hoskyns & Rai, 2007). The labour of social reproduction consists of the variety of socially necessary work that provides the means to reproduce and keep the population alive and capable of producing (Bhattacharya, 2017; Laslett & Brenner, 1989).

9       Elias, J. and S. M. Rai. (2019). "Feminist Everyday Political Economy: Space, Time, and Violence." *Review of International Studies* 45(2): 201-220.

10      Meckelburg, R. and C. Bal. 2021. "Indonesia and COVID-19: Decentralization and Social

I have argued that conflicts between different levels of government over pandemic policy and management can be explained as distributional conflicts over political and economic power. This paper extends this analysis by applying a gender lens to examine why women healthcare workers and officials, who have limited roles and responsibilities on formal COVID-19 taskforces at the city-wide and subdistrict level, have played the critical roles in leading mitigation strategies at both levels. Further, I explain how the lack of representation of these women in formal decision-making bodies, whether by default or by design, effectively limits opportunities to reform and improve on government pandemic mitigation strategies at citywide and subdistrict level.

A gendered political economy approach also provides a counter to a culturally ascribed or biologically determinist view of explaining women's 'caring' leadership approaches. It is not women's feminine or biological characteristics that make them more capable and responsive leaders in a pandemic crisis — rather it is their role in social reproduction in everyday situations that prepares women to provide leadership in many aspects of pandemic responses. Women working in the 'care industries' are typically already experienced in responding to the day-to day crises that occur in societies where there are significant gaps in government funded social provisioning — that is where governments fail their citizens when they are most vulnerable. These vulnerabilities are heightened in the face of the multiple crises that arise from the COVID-19 virus pandemic. Women's leadership capacity in managing these crises comes even further to the fore during the COVID-19 pandemic.

Lastly, I examine the consequences for women working on the frontlines where the state has failed to provide a coordinated national response to the pandemic threat. I highlight how the costs of social crises are transferred to individuals or groups with limited access to power and resources. Social reproduction scholars refer to the concept of gendered harm or 'depletion',[11] which I define here as the compounding physical, emotional and psychological costs borne by women in their labour of social reproduction, or in the socially necessary work that they carry out to ameliorate and mitigate against the impacts of the pandemic. This depletion occurs when the outflows that occur in the labour of social reproduction are not balanced by inflows that sustain women's health and well-being.[12] This imbalance affects not only individuals but also the households and communities of these women. I show that the pandemic significantly increased the labour outflows produced by the women involved individually, both in the workplace and in the domestic sphere. These women leaders and frontline responders experienced ongoing depletion with limited power to make decisions to redirect responsibilities to other agencies or to increase staff numbers — whether men or women — to share their load.

Conflict". IN *COVID-19 and Governance: Crisis Reveals.* Edited by J.N. Pieterse, H Lim and H.H Khondker. New York: Routledge.

11      Rai, S. M., Hoskyns, C., & Thomas, D. (2014).

12      Shirin M. Rai, Catherine Hoskyns & Dania Thomas. (2014).

# City-wide COVID-19 taskforce structure and decision-making

Indonesia has had the worst track record on COVID disease mitigation of any country in Southeast Asia.[13] As of 14 May 2021, Indonesia had officially recorded 1,734,258 positive cases.[14] This reality is in stark contrast to daily news reports in Indonesia on aspects of the 'excellent handling' of the pandemic reported by members of the National COVID-19 Pandemic taskforce. In early March 2021 President Jokowi claimed that Indonesia's handling of the COVID-19 pandemic was significantly better than most other countries in the world, citing the low percentage active case rate.[15] However this data does not reveal the consistently very low testing rate in Indonesia, in particular outside of Jakarta and West Java, nor the high positivity rate nationally, with more than 30% positivity rates on February 28, 2021.[16]

A striking feature of national TV and online media coverage has been the almost exclusively male faces that front the interviews, press statements and reportage from the field. Indeed, when we look at the composition of national and provincial COVID-19 taskforces we find that these bodies are overwhelmingly male. National government regulations state that gender mainstreaming policies must be integrated into emergency and disaster response plans at the national and sub-national levels.[17] Even

13      Given low levels of testing and the consequently suspected high under-reporting of COVID-19 deaths, the high fatality rate of health workers in Indonesia is one indicator of this track record. As of late January 2021, 647 healthcare workers had died from the disease. See https://www.aa.com.tr/en/asia-pacific/coronavirus-kills-647-health-workers-in-indonesia/2125642

14      These numbers are well below the aggregate numbers of cases recorded at the district and municipal levels. On 9 May 2021 Salatiga municipal government data reported a total of 3,705 cases to date in Salatiga while the Central Java government COVID-19 website reported only 1,735 to date in Salatiga. Further many positive cases are never identified as only close contacts with symptoms are tested (See Meckelburg, R. (2021b). "Indonesia's COVID-19 Emergency: Where the Local is Central". *Journal of Contemporary Southeast Asia,* 43(1), 31-37. *Lapor* COVID-19 is a public website that collates COVID-19 patient data from district and municipality COVID-19 websites and reports on aggregate case numbers for each province based on this data. At 2 March, 2021 data from this website showed there are 193,134 confirmed cases in Central Java (See https://peta.laporCOVID19.org), meanwhile national data showed patient numbers at 153,029 (See https://COVID19.go.id/peta-sebaran-COVID19).

15      See https://www.cnnindonesia.com/nasional/20210304212958-20-613952/jokowi-pamer-penanganan-COVID-19-lebih-baik-dari-negara-lain

16      https://cdn.who.int/media/docs/default-source/searo/indonesia/COVID19/external-situation-report-45_3-march-2021.pdf?sfvrsn=c625ed82_5

17      The regulation made by the director of the National Board for Disaster Management (*Peraturan Kepala Badan Nasional Penanggulangan Bencana - BNPB*) No. 13 (2014) regulates gender mainstreaming in disaster responses. See Pernyataan Pers Kelompok Kerja *Pengarusutamaan Gender dalam Penanganan COVID-19* (Pokja PUG COVID-19). 2020. "*Urgensi Pengarusutamaan Gender dalam Penanganan Pandemi COVID-19*" Rabu, 29 June. Kalyanamitra. https://kalyanamitra.or.id/blog/news/pernyataan-pers-pokja-pug-COVID-19-urgensi-

so, women comprise only 7% of the national taskforce and 12% of the Central Java provincial taskforce. Further, since February 2020, COVID-19 pandemic policy making at the national level has not made specific provisions in relation to gender.

In the municipality of Salatiga, gender representation in government is higher than the national average and the city ranks comparatively well in national performance indicators in gender equality.[18] Women's representation in the municipal parliament in Salatiga is higher than national averages and women made up 20% of the representatives elected in the town in 2019.[19] In 2018, Salatiga was awarded the Parahita Ekapraya Award by the women's empowerment and child protection ministry, in recognition of the Mayor's commitment to fulfilling gender justice through gender mainstreaming efforts.[20] However, despite these achievements, women still occupy a minority of positions in the highest echelons of the local government public service. This disparity, in turn, had direct implications for the composition of Salatiga's COVID pandemic taskforce.

Salatiga's initial COVID-19 taskforce formed in April 2020 had 28% representation of women. However, in the revised taskforce appointed in October 2020, women's participation was reduced to 17% in a team of 12 members where there were two women appointed (See Table 1). The city-wide COVID-19 taskforce should have been critical to the COVID response in the city because it had the strategic role of developing COVID-19 pandemic mitigation policy and regulations, monitoring their implementation, and managing public communications. It was tasked with ensuring effective coordination across government departments and local levels of government, the security forces, businesses and community organisations to ensure that all government agencies, local businesses, schools, workplaces and places of worship had comprehensive policy and disease mitigation planning responses. Further, the taskforce was responsible for ensuring the monitoring and enforcement of regulations and health protocols for healthcare services, schools, public transport and public spaces, workplaces and social gatherings, hotels and restaurants and sporting activities, in order to prevent the further spread of the COVID-19 virus.[21]

The composition of the city-wide COVID-19 taskforce reflected deeper inequalities in the composition of the public service, as positions in it were allocated on the basis

pengarusutamaan-gender-dalam-penanganan-pandemi-COVID-19/

18      BPS. 2018. Gender Inequality Index Measurement 2018 (Second Advanced Study). BPS-Statistics Indonesia https://www.bps.go.id/publication/2019/11/07/4efb3f1db4e099743a35adbd/penghitungan-indeks-ketimpangan-gender-2018-kajian-lanjutan-2-.html

19      Taken from "*Statistik sektoral kota salatiga sem 1 2020". Dinas komunikasi dan informatika,* Salatiga.

20      https://salatiga.go.id/salatiga-raih-anugrah-parahita-ekapraya/

21      Specified in the Salatiga Mayor Regulation Number 17 of 2020 concerning the Implementation of Health Protocols, Prevention and Control of Corona Virus Disease 2019 (COVID-19) in Salatiga City.

of structural positions within government without specific reference to gender.[22] The heads of strategic government departments, such as the heads of the regional police (*Polres*), the local military command base (*Korem*), the municipal police (*Satpol PP*), the Regional Planning, Research and Development Agency (*Bappeda*) and the National Unity and Political Department amongst others (*Kesbangpol*), were automatically appointed to the taskforce. All of these positions were held by men. Heads of public service agencies within Salatiga local government are overwhelmingly male, even while women comprise 43% of public servants in the city. As elsewhere in Indonesia, women dominate the lower echelons, comprising a slim majority of the lowest levels of the public service. At every other level men dominate. In 2020 only three of thirty local government departments were headed by women: the health, social welfare and education departments highlight the highly gendered division of labour within local government. Despite violating gender mainstreaming principles, this local picture is typical of the situation across Indonesia both in elected government and amongst career public servants, with men holding a majority of higher echelon positions.[23]

Women are acutely aware of the challenges they face in leading in senior positions in the public service, in particular challenges caused by attitudes in broader society about women's capacity to lead. The woman head of the health department, explained:

> Society should understand that women are equal to men in their capacity to think, act, determine policy and in their tolerance of the challenges faced in leading this crisis…society should not label women with a negative stigma, women are clearly capable of leading.[24]

The health department head urged the community not to evaluate women's capacity to lead based on their gender, arguing that women were not only equal to men in their capacity to lead, but that this had been demonstrated during the pandemic.[25]

In contrast to the city-wide COVID-19 taskforce, the Salatiga health department has a far higher proportion of women in leadership roles, as well as comprising the majority of healthcare workers. This is not to say that women dominate the leadership of the department. While the head of the health department is a woman, the four most senior roles below her position are held by men. Overall women comprise 80% of the city's health department workforce.[26] The director of the city hospital is a man, while women comprise one third of the hospital leadership structure. While only 32% of hospital clinical specialists are women, leaders and workers in the COVID-19

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22      See table 1.

23      McLaren, H., et al. (2019). "Indonesian Women in Public Service Leadership: A Rapid Review." *Social sciences* (Basel) 8(11): 308.

24      Interview on 19 January 2021.

25      Interview on 25 January 2021.

26      Interview with health department officials on 19 and 25 January 2021.

inpatient care team are all women.[27] Emergency department services for suspected COVID cases have a smaller majority of women. The head of the health department's pharmaceutical services and the specialist lung disease unit are also headed by women.

At the community level, Salatiga's healthcare response to COVID-19 was even more female-dominated. The directors of the city's six community health centres (*Pusat Kesehatan Masyarakat - PUSKESMAS*) are all women, with women comprising up to 90% of the health centres' workforce.[28] The community health centres, located in subdistricts (kecamatan) across Indonesia, provide both curative and public health services, with a focus on six essential service areas: health promotion, communicable disease control, ambulatory care, maternal and child health, and family planning, community nutrition and environmental health including water and sanitation. These centres not only provide primary care for citizens; they are the gatekeepers for referrals to hospitals and specialist services through the Universal Health Coverage (*Jaminan Kesehatan Nasional*) program.[29] In one community health centre examined as part of this research, 90% of the 57 staff members were women. The head of the COVID-19 specific response team in the health centre was a male clinician, while the remaining members of the dedicated COVID team of approximately 25 persons were 90% women.

This highly feminised healthcare workforce can be compared to the health department workforces in Semarang and Surakarta, the two largest cities by population in Central Java, which have a similar workforce composition with 80% and 75% women respectively. This reflects the broader situation globally where women comprise 70% of health workers.[30] Yet despite women's overwhelming representation in the frontline of pandemic responses, Indonesia has failed to follow its own gender mainstreaming policies when determining the composition of disaster management teams from the national down to the local level.

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27    Interview with hospital COVID management team member 27 January 2021

28    Interview with head of the Community health centre in one district 2 February 2021.

29    Women make up 70 per cent of the paid global health-care workforce. Among this workforce, community health workers (CHWs) are a neglected group at the forefront of pandemic responses, particularly in developing countries. https://www.unwomen.org//media/headquarters/attachments/sections/library/publications/2020/policy-brief-COVID-19-and-the-care-economy-en.pdf?la=en&vs=407

30    See World Health Organization. Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. (Human Resources for Health Observer Series No. 24). Geneva: World Health Organization; 2019. Accessed on 1 June 2021.

# Failure of COVID-19 taskforce structures

In the formal structure of the COVID-19 taskforces formed in April and then again in October 2020, the health department was given a limited role, focussed on healthcare management of pandemic responses in healthcare-specific settings and providing timely data to support epidemiological study.[31] In practice, however, pandemic responses not only in healthcare, but also in the critical area of infectious disease mitigation, were largely led by women from the health department, women staff of community health centres, and some acute care staff in the district and other local hospitals. The Mayor, as the head of the city-wide taskforce, repeatedly referred public complaints and emerging management problems to the health department (led by a woman),[32] despite many of these referrals falling within the scope of duties of other members of the COVID-19 taskforce.[33]

While COVID-19 pandemic policy making should have been managed and supported by the city's secretariat office, government agencies typically made requests for policy directions as well as simple operational matters such as provision of logistics, directly to the head of the health department. One health department official explained:

> The burden of handling and preventing COVID rested on the health department even though in accordance with the actual duties and functions the health department is only authorized in the aspect of handling health… For example, regarding the implementation of the Mayor's regulations (perwali) Number 17 of 2020, the Assessment of Teaching and Learning Activities, public celebrations [weddings, circumcisions, funerals], and so on were assigned to the department of health. Even though each sector in the taskforce already has its own detailed tasks.[34]

The prominent role played by the health department and community health centres in pandemic leadership raises an obvious question about the place of the citywide COVID taskforce. Indeed, most members of this taskforce played minimal roles in pandemic mitigation.[35] A health department official said:

> Colleagues holding departmental head roles still assume that handling the pandemic is the responsibility of the health department, despite the division of tasks and responsibilities being clearly outlined in the regulation made by the mayor.[36]

The assumption that handling the pandemic was purely a health matter shifted

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31      These two positions were the heads of the health and social welfare departments.

32      Interview with health department official 25 January 2021.

33      See Table 1 outlining city-wide COVID-19 taskforce structure and responsibilities.

34      Interview on 19 January 2021.

35      Interviews with Community health centre staff on 1, 2 and 15 February 2021.

36      Interview with health department officials on 25 January 2021.

responsibility for pandemic disease mitigation to the health department without giving commensurate power and authority to it to manage the pandemic. The taskforce and local government relied on this very feminised healthcare workforce to carry the burden of pandemic healthcare and mitigation responses. Meanwhile, local government officials paid most attention to economic recovery which they prioritised over enforcing mitigation measures.[37] This prioritisation of the economic impacts of the pandemic over healthcare and disease mitigation followed the lead set by national government from early 2020.[38]

A concrete example of this prioritisation of the economy over mitigation efforts was given by healthcare workers. They stated they were upset with the Salatiga COVID-19 taskforce actions after the national government declared that regional pandemic restrictions should be implemented across Java and Bali in January 2021.[39] The Salatiga COVID taskforce did not prioritise implementing regulations that might disrupt the local economy and took no action to monitor and enforce restrictions on business activity. This was despite the fact that case numbers were rising rapidly across Java including in Salatiga. Only after the provincial government warned the Salatiga municipal government to implement and enforce movement restrictions including the closing of public facilities, limits on operating hours, 50% maximum capacity for retail, restaurant and other food businesses and requirements for 75% work from home, was the municipal policy amended. Despite these amendments, most public service offices did not allow work from home, and official monitoring and enforcement of these mitigation regulations and protocols was virtually non-existent. These failures to proactively prioritise and implement disease mitigation policy and procedures by taskforce members directly impacted on workers on the pandemic frontlines.

When a vacuum of leadership became obvious in the early months of the pandemic, the health department and community health centres took responsibility for monitoring and surveillance of positive patients who were self-isolating. Further, the health department was asked to develop disease mitigation regulations and protocols for workplaces, and to advise on school closures and design of school attendance protocols. Community health centre heads initiated the coordination of sub-district cross-sectoral pandemic management teams, formally the responsibility of sub-district heads.  The (female) heads of the community health centres played decisive roles in coordinating sub-district stakeholders from local neighbourhoods, including subdistrict heads (*camat*), police, military and municipal police – these latter

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37    Interview with public health officials and health workers 25 January, 1 February and 2 February.

38    See Meckelburg, R. and C. Bal. 2021. "Indonesia and COVID-19: Decentralization and Social Conflict". IN *COVID-19 and Governance: Crisis Reveals*. Edited by J.N. Pieterse, H Lim and H.H Khondker. New York: Routledge.

39    https://nasional.tempo.co/read/1420721/begini-teknis-pelaksanaan-psbb-jawa-bali-yang-mulai-diterapkan-11-januari

stakeholder groups all being headed by men. The preparedness of these women to step forward reflected their seriousness about developing mitigation strategies that they hoped would ultimately reduce their frontline health response workloads.

The main weakness in pandemic responses identified by all those interviewed was the failure of the city-wide taskforce to provide leadership and direction. A health department official said:

> There are government agencies with specific taskforce responsibilities... from opening schools or holding events to designing communications, but the role of each agency has not emerged... in practice for trifling things like the supply of vitamins to the more serious... they always run to the health department to get solutions.[40]

A community health centre manager elaborated,

> It is necessary to strengthen upper-level institutions, because so far the role of the taskforce has not been maximal. It is necessary to monitor and evaluate the implementation of policies in the field, so that the public communications and mitigation policies can be conveyed well to the public and the handling of the pandemic will improve... Likewise, if you look at health science related to COVID-19, which is very dynamic and developing fast, then the science of managing pandemic handling should also develop.[41]

A community health worker highlighted the burdens experienced by frontline workers:

> Cross-sectoral roles should be improved so that the workload is not centralised in the health centres, but is more evenly distributed across subdistrict agencies. Many of these responsibilities are divided formally across all sectors, because the duties of the health centres are only related to healthcare and providing data. A lot of work we do now can be redistributed. For example, monitoring of self-isolating patients, community closures, workplace protocols etc are cross-sectoral responsibilities.[42]

There are areas of implementation where male-dominated agencies should have played a significant role. One area which clearly falls outside the responsibility of the health agencies is supervision and monitoring of public health protocols and other strategic pandemic mitigation regulations. This monitoring was minimal, both at industry and office workplace level, as well as in public places where people gather. The responsibility for this monitoring within the taskforce lies with the district military commander, the Salatiga police chief and head of the district house of representatives. There are specific regulations that place strict controls on public

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40      Interview conducted on 2 February 2021.
41      Interview conducted on 2 February 2021.
42      Interview conducted on 15 February 2021.

gatherings, but when local wards (*kelurahan*) gave permission for a gathering with specific conditions to be followed, these were generally neither monitored nor enforced by the municipal police nor monitored and evaluated by the designated taskforce members. A community health centre staff member said of these stakeholders:

> They should have given support to community health centre workers by making regulations that are implemented and enforced by all taskforce parties, not only health department workers.[43]

In short, lack of leadership from sub-district heads, police, military and local ward officials made the work of community health centre staff more challenging while undermining their mitigation attempts in practice.

Health department staff also argued that a lack of male leaders as role models consistently implementing health protocols during the conduct of their public duties, such as failing to wear masks or ensure physical distancing, underpinned many negative attitudes on the part of many residents who underplayed the seriousness, or even existence, of the COVID-19 virus.[44] Such scepticism in turn made it difficult for health workers to carry out many essential mitigation tasks including tracing and testing. This point was made by male and female officials from the health department, the municipal secretariat (male), and female and male community health centre staff and managers.

To provide one example of the problems encountered: when a local resident in one neighbourhood tested positive for COVID-19, the whole neighbourhood rejected the swab testing of residents who were close contacts. Residents refused to participate in contact tracing as they were fearful that identification of more cases would negatively affect their small businesses and employment. Residents accused healthcare workers of intentionally falsely identifying positive COVID-19 cases and then blamed them for damaging their local businesses when they publicised data about case locations and when movement restrictions were placed on their neighbourhoods while contact tracing was conducted. In fact, data publication and movement restrictions were not the health department's responsibility, but there was no back-up from other government agencies such as municipal police or other taskforce officials to help health staff find a solution in this case. Instead, the health department head became directly involved in negotiating with community members.

The health department head emphasised that when leading pandemic responses, policy should not be implemented in a rigid way. Implementation of regulations needs

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43      Interview conducted on 15 February 2021.

44      Interviews with health department officials on 19 and 25 January 2021. "Volunteer" health workers are employed (thus paid) on a periodic contract basis and are not eligible to become public servants.

to consider the real conditions of communities and community members' ability to understand and comply with those regulations. She said that women are well suited to this leadership role as they are more able to empathise with the complexities of social groups and individuals.

I have argued previously that the relative success of some district and municipal governments in Indonesia in mobilising resources for pandemic response was in part contingent on the presence of mobilized social forces at the grass roots level:[45] regions with vigorous networks of social organisation tended to respond more effectively. In Salatiga, it should be stressed that women in the local health department and community health centres have led the most effective part of local government responses.

Health centres provided all pandemic related health activities, such as taking of swab samples, contact tracing and support for self-isolating patients within their existing pre-pandemic workforces. Women staff took on additional tasks, frequently without additional pay. As a consequence, it was women's unpaid labour in both their formal work as well as private citizen roles that plugged many of the gaps in social provision for pandemic responses including wide-ranging support for positive patients isolating at home. According to a health worker:

> At the beginning the subdistrict committee expected us to provide meals and shopping for self-isolating patients. We can't expect people to self-isolate with no food or essential goods… what happens to children whose parents are positive but children are negative… all of this fell on us to think about strategies and solutions. It is better now, neighbourhood groups do more of this work, but we still have to push others to do what they are assigned.[46]

Some health centre staff remain on call 24 hours a day responding to community calls for support and contact tracing. These women expressed a continuous state of being overwhelmed (*kewalahan*) although after 12 months this state has become their new normal.[47]

In practice health department and health centre managers led across this range of pandemic responses. However, they lacked the accompanying authority to instruct other government agencies, mobilise additional resources or push back on national and provincial government policy that limited the supply of resources for pandemic mitigation and healthcare services. This authority is held by the municipal secretariat and the Mayor.

Healthcare managers and frontline workers identified several areas that required

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45      Meckelburg, R. 2021. "Indonesia's COVID-19 Emergency: Where the Local is Central". *Journal of Contemporary Southeast Asia,* 43(1), 31-37.

46      Interview on 1 February 2021.

47      Interview with community health care staff 1, 2 and 15 February 2021.

serious and immediate action. First, there needs to be better coordination, leadership and implementation of official duties in the city-wide taskforce. Second, improved monitoring and enforcement of health protocols in workplaces, public spaces and approved events including weddings, public ceremonies and venues that facilitated public gatherings are required. Third, there must be monitoring and enforcement of movement restrictions and local regulations on work from home quotas, limits on numbers in restaurants, hotels and other venues and home isolation. Fourth, there needs to be more extensive trace and test capacity, achieved by expanding physical facilities to support expanded testing as the lynch pin of sound epidemiological monitoring of disease prevalence. This epidemiological monitoring would support the development of a road map to successful disease suppression.



Image credit: SiberianCat on Wikimedia Commons. (CC BY-SA 4.0)

## Women's leadership of disease mitigation and healthcare: the view from the frontline

In the context of the failures of national government to coordinate multi-level government responses to the pandemic, and given the de facto leadership role of women in many aspects of pandemic responses at the local level, how was infectious disease mitigation and healthcare actually managed on the ground in Salatiga? There were four institutions that were critical in frontline health care — the health department, community health centres, the district hospital and a special isolation facility; the first two of these institutions were also critical in mitigation responses. From the beginning of the pandemic, the department of health prioritised guaranteeing the safety of frontline healthcare workers under its authority.[48] Health department officials emphasised that they were actively supported by the mayor's office who agreed to all their requests for infrastructure and procurement of essential supplies for frontline mitigation and healthcare responses.

While the health department provided a guaranteed supply of high-quality PPE (Personal Protective Equipment) and other essential supplies, community health centre managers provided staff with routine training and education in mitigation protocols that were updated over time, maintained daily onsite cleaning protocols, implemented disease prevention monitoring practices and provided informal counselling for staff experiencing stress due to professional or domestic challenges. The health centre examined in this study had no cases of staff infection as of March 2021 despite having the highest total positive case numbers of the community health centres across Salatiga.

Managers and frontline workers interviewed for this report highlighted inclusive management and teamwork as being critical in health department and community healthcare responses. The community health centre team is divided into two — one team is responsible for standard health centre (non-COVID-19) tasks and a dedicated team is in charge of COVID-19 specific tasks. The community health centre COVID-19 team is organised into several local ward (*kelurahan*) response teams.[49] At the same time, when there are staff shortfalls in any team, members of other teams are prepared to add to their routine tasks to help each other out. While there were no increases in staffing levels in the health department or health care centres during the pandemic, managers organised flexible working arrangements where possible for women with children and other domestic or family circumstances that made significant demands on women healthcare workers' time and energy.  The health

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48      This does not include staff in the city hospital which has organisational and budgetary autonomy from the health department. Thus while provision of PPE for health department and community health centre staff has been consistent and very successful in minimising infection of healthcare workers, supplies and stocks of hospital PPE are an internal matter.

49      There are 4 sub-districts (*kecamatan*) and 23 local wards (*kelurahan*) in the Salatiga city municipality.

department head and the community health centre head emphasised that empathy and understanding in the supervision of team relationships and workloads, despite human resource shortages, had been a critical part of management strategy across health department services:

> Sometimes colleagues are emotional, short with each other at work... The pressure sometimes is heavy... There are team meetings to discuss workloads and policy changes... acknowledging the pressure is important, how it affects us.[50]

They also acknowledged the critical role played by health workers' families and work colleagues in providing support and empathy to help them cope with the additional burdens they carry as frontline leaders in pandemic responses.

In the district hospital, COVID-19 inpatients rose over time, to full capacity in November 2020 during a significant rise in cases.[51] Nursing staff provide full clinical and personal care to patients as no family members are permitted to stay with or visit COVID-19 positive patients.[52] The emergency department COVID-19 team provide emergency and transit care for patients awaiting COVID tests results prior to admission to the hospital. As of March 2021, thirty-one hospital health workers in one of the four district hospitals that accept COVID19 patients had been infected with the virus,[53] a significantly higher rate than the eleven community health workers infected across six community health centres city-wide. This relatively low rate of infection among members of community health centre COVID-19 teams has occurred despite the fact that they have been the first responders to a majority of positive patient cases in Salatiga.

The final component of the COVID-19 healthcare response in Salatiga is a supervised isolation facility for COVID-19 positive patients with mild or no symptoms who are not able to isolate at home. This facility, formerly a school for teacher education and more recently used for government employee training, was repurposed as a hostel during the pandemic. It is staffed by medical volunteers — one doctor and 11 nursing staff — recruited specifically by the health department to run this independent isolation facility for mild to moderate disease patients.[54] The majority of these staff are women. Their tasks include patient supervision, medical care and tracing of close contacts.

50    Interview 2 February 2021.

51    It was not possible to get precise data from the hospital or direct interviews despite requests for these being agreed to. However some healthcare workers and managers completed questionnaires that were approved by the hospital COVID-19 management team.

52    In Indonesian hospitals it is usual practice for one or more family members to stay 24 hours with a patient. It is usually these family members who provide personal care, not nurses. Shortages of clinical nursing staff are a normal phenomenon in hospitals sometimes making the presence of family members critical to patient care.

53    Data from department of health February 2021.

54    Interviews on 19 and 22 January 2021.

# Frontline roles of Community Health Centres in disease mitigation

Community health centres (*puskesmas*) have been the backbone of Salatiga's pandemic healthcare and disease mitigation strategy as the frontline for testing, tracing and supporting people infected with COVID-19. Their staff face high day-to-day risks in carrying out their primary healthcare roles. Ninety percent of health centre staff are women. Sixty-six percent of first-line managers in the health centre COVID-19 response team are women while 90% of the community health centre staff are women. The health department and centre managers have not applied special measures for women staff in the centres; rather they applied standard policies and procedures to all staff because all are affected by the restructuring of work teams, job roles and implementation of strict health protocols; health risks are also carried equally regardless of gender.

From the outset of the pandemic, pre-existing structures of the community health centre infectious disease management strategy made it possible to respond quickly to the pandemic threat by activating the health centres' model of rapid response teams (*Tim Gerak Cepat*).[55] Rapid response teams are purpose-specific teams in all health centres across Indonesia that respond in health emergency situations with the vision 'leave home safely, arrive home safely'.[56] On 16 March, 2020 the head of the Salatiga health department announced that a local state of emergency had been declared, and the rapid response teams were activated.

Beyond the formation of the rapid response team, the strategic response of the health centre examined here was innovative, as noted above, it rapidly reorganised health centre workers into two groups: dedicated teams that manage COVID-19 patient work directly and the remainder who continue to manage and provide general health services. At the community level, the community health centre head initiated cross-sectoral communication with sub-district stakeholders (subdistrict government, police, military and local ward officials)[57] and coordinated cooperation with community stakeholders, civil associations, religious groups and subdistrict government agencies.[58] The health centres assigned one doctor and several nursing staff to each local ward area to build community relations and support mitigation and clinical care of positive patients and close contacts isolating in the community. These

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55      According to the Indonesian health minister's regulation No 1501/2010 rapid response teams should be formed at national, provincial, district and municipal level in response to infectious diseases giving rise to pandemics,. Further, as part of the municipal /district rapid response team every community health centre at sub-district level should have a rapid response team.

56      Interview 2 February 2021.

57      These sub-district teams are headed structurally by the sub-district head (*Camat*). Interviews with Community health centre staff on 1, 5 and 15 February 2021.

58      Government offices were often a site of cluster transmission.

local ward level teams initiated coordination with local authorities, and training and education on COVID-19 virus transmissibility and mitigation measures at the local ward and neighbourhood level.[59] These intensive community engagements generated greater understanding of what COVID-19 is in local communities, provided better active support for positive patients, and reduced community stigmatisation.

Here we should note that the local ward teams provide the first frontline health care response for positive patients and that the large majority of COVID-19 positive cases will be cared for in their homes. The teams monitor medical issues for positive patients in the community, in the first instance by Whatsapp messaging and through visits to supply vitamins and medication and further assessment where required. The teams provide hospital referrals when needed, carry out contact tracing and PCR testing and provide psycho-social and medical support for patients isolating in their homes through daily monitoring contact.[60] It is the contact tracing work of these local COVID-19 teams that have identified a significant proportion of COVID-19 positive people in Salatiga. Simultaneously, these teams coordinate with other sub-district (*kecamatan*) government agencies and urban ward authorities to support surveillance of self-isolating positive patients and close contacts,[61] enforce community movement restrictions,[62] and to provide referrals for support from other agencies to provide welfare and other assistance.

The city health department and community health centres introduced a best-practice test, trace and treatment strategy, including a three-tier testing and tracing protocol from March 2020, though this was later changed, to the regret of health department officials and Community health centre staff:

> At the beginning [of the pandemic] colleagues in the community health centres were truly enthusiastic… they conducted contact tracing at level one, two and three [63]… Workers found so many cases, they were actively seeking them out. But the regulations from central government kept changing until now we only swab close contacts with symptoms… Even though at that time

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59      Local wards have a population of between 4000-15000 persons.

60      Contact tracing sometimes requires visits to close contacts' homes when phone numbers are not available. These visits can be in Salatiga or the surrounding district as there is high mobility between work and home across the city and surrounding district.

61      Close contacts who are not tested because they are asymptomatic but need to self-isolate are often not in the same local ward as a positive patient so cross-local ward/subdistrict coordination is essential.

62      In the case of virus clusters.

63      The first stage of a three tier system is contacting positive patients to ask for information of who might be a close contact. The second stage is contacting these close contacts to ask them to self-isolate for 14 days from their last point of close contact with a positive patient and ask them to inform the health centre if they develop symptoms. The third stage is tracing where cases are linked to workplaces, boarding houses (*pondok pesantren*) and other complex sites of contact where individual close contacts cannot be readily identified.

we were achieving 700%[64] of the minimum number of tests that should be conducted [according to WHO criteria]. The principle was the more cases we find the better… breaking the chain of infection could quickly be achieved. Then in the evaluation from provincial department of health we were scorned (*dicemooh*) for too much testing… After that… we do tracing until level 2. We did not attempt any further tracing for testing because we were afraid to be scorned again.[65]

In December 2020, the policy to restrict testing was formalised when the provincial government made a directive that only close contacts of positive patients with symptoms would now be tested in the province. Provincial-level health authorities had indeed previously criticised local authorities for carrying out so much testing. The Salatiga health department has no authority over any PCR testing facilities (which instead fall under provincial and national health department jurisdiction) and can only follow provincial health department directives. At this critical turning point, the Salatiga city government failed to advocate to the provincial government so that the health department could maintain its strong testing protocols, despite assigning the health department to:

Make efforts to increase the capacity of health infrastructure, including meeting the needs for medical material equipment to support massive testing, aggressive tracing, strict isolation and treatment according to the applicable procedures.[66]

The original test and trace effort had been effective in keeping case numbers low and deaths very low since the first case was recorded in late March 2020. It was also critical in bringing an outbreak in October 2020 rapidly under control. Health workers and managers were highly disappointed by the change in policy, as it undermined their infectious disease mitigation strategy.

Health officials cast light on the context for previously being 'scorned' for successfully tracing and testing so many contacts. Staff and other resources for facilitating contact tracing and obtaining swab samples are provided by community health centres. Meanwhile, all laboratory facilities for conducting PCR tests including

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64 The WHO set a target for each country to test one suspected case per 1,000 head of population per week –See https://www.thejakartapost.com/news/2020/12/10/indonesias-COVID-19-testing-capacity-approaching-whos-target-task-force.html. If Salatiga has 180,000 residents this would mean testing 180 people in one week. In November 2020 Salatiga had 500 active cases when it was testing more than 1300 cases per week or 700% of its WHO recommended target. This was less than three close contacts tested per active case.

65 Interview on 19 January 2021.

66 This is taken from the decision of the mayor of Salatiga No 443.1/598/2020 regarding the taskforce for handling the corona virus disease 2019 (COVID-19) Salatiga City. It should be noted that the reference for this wording is taken from National COVID-19 taskforce specification of tasks for health departments.

trained staff, raw materials such as reagents, and provision of PPE for lab staff, are the responsibility of the national health ministry and the provincial heath department. Districts and municipalities do not have their own testing facilities and the provincial government determines where lab samples will be tested within the province. Lab technology and the types of reagents that are used determine the daily testing capacity. The government-run Vector lab in Salatiga can test up to 600 samples a day if one particular reagent is available. However, according to health department officials this reagent is difficult to obtain. As a result, testing capacity of the vector lab is usually between 200 and 300 samples per day, while this lab services many districts in the province. The second lab at Satya Wacana Kristen University can only test 90 samples a day.[67] Responsibility for resourcing these labs in terms of technical staff and the necessary materials for conducting mass testing lies with the central and then the provincial government. Yet the Salatiga health department had on several occasions provided budgets for purchase of testing reagents, PPE and disposal of medical waste from the laboratories when higher levels of government failed to provide them. Without these resources being provided by the Salatiga health department periodically, testing would at times have been significantly impacted.[68]

Thus, the presence of laboratory facilities in Salatiga has not made government-funded lab testing more accessible in the town. Swab samples taken by community health centres are administered free of charge, but since December 2020, they are only provided under very narrow and specific criteria, that is, to close contacts of positive patients who are already demonstrating symptoms. Because these labs support a much wider geographical area in Central Java province, swab samples from Salatiga must queue with samples from many other districts. The result was that waiting times for results could be up to 7-8 days.

Beyond the lack of resourcing from national and provincial budgets for testing laboratories, national policies that restrict government supported COVID-19 testing have undermined a clinical best practice approach. Limited government testing facilities, and restrictions on community health service eligibility for testing criteria, have forced people to seek testing at private labs, or simply not get tested at all, as the cheapest price of a single PCR test at Rp900,000 can be the equivalent of a local monthly income. Since late 2020, people have been able to purchase significantly cheaper rapid antigen and antibody tests online and conduct tests themselves. The accuracy of these tests, even under best clinical conditions with trained practitioners, range between 50-85%.[69] Aside from poor accuracy, other problems associated with self-administered tests include the safe conduct and disposal of medical waste.[70] Furthermore, the pharmaceutical sector provides COVID-19 medications online for purchase if people who test themselves return a positive result; such individuals have

67    These data were provided in interview by a health department official on 19 January 2021.
68    Interview with health department officials 19 and 25 January 2021.
69    Interview with clinical staff at community health centre 1 February 2021.
70    This is important so as not to expose others to aerosol dispersion during testing.

no obligation to report their positive status or to seek medical care, with the result that no contact tracing is conducted for these persons. The larger point, therefore, is that testing based on ability to pay and not on rigorous epidemiological criteria seriously undermines local mitigation strategies.



A barrier to a neighbourhood in lockdown. Image credit: Rebecca Meckleburg

# Women's workloads

National pandemic policy failures in Indonesia and many other countries have increased women healthcare workers' paid and unpaid work burden. Much of the labour of women healthcare workers is not even visible let alone important in public policy — either in terms of the costs it imposes on a highly feminized workforce and society more generally, or the benefits it provides in terms of care work and social reproduction.[71] The result is that the pandemic produced more complex work practices with higher workloads for women working at the frontline of the response, without additional human resources, while these women also had to deal more intensively with everything related to the pandemic in their domestic roles.

In early 2021, eleven months after the first local COVID-19 case, community health workers in Salatiga's COVID-19 teams remained overloaded on a daily basis. Some remained on call 24 hours a day for contact tracing and rapid response to community calls for assistance. A community health centre hotline is the only contact number that can always be reached if residents require information, including if they are close contacts of positive people, have symptoms or their health condition worsens.

> The problem of contact tracing, is that many patients or others related to them call us at night, so health workers cannot respond only in office hours, but have to be ready 24 hours a day to respond for tracing information or health problems. This automatically impacts on family life. There are many protests from the family, housework is neglected and workers feel extreme fatigue.[72]

Tracing and on-call work has significantly impacted frontline workers' family relationships, causing conflict and tension over whether children or work get prioritised at home. Some health centre managers double up on job roles, going out to meet with suspected cases and patients and providing them with services, while also carrying out managerial roles. The community health centre head also provides a form of pastoral care for staff experiencing stress due to work and family pressures, while trying to manage flexible working arrangements, especially for women with children.

Additional daily workloads for healthcare workers include managing complex protocols for infectious disease control in interactions with positive and suspected cases, such as the daily donning and doffing of PPE and sterilisation of all work surfaces and equipment. Comprehensive patient-screening protocols contribute additional workloads across all aspects of healthcare provision. Healthcare workers have had to innovate in providing clinical assessment to reduce the need for close physical interaction between patients and workers where possible. Doctors sit behind consultation desks that have screens and signs are posted on clinic doors to

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71      Bakker, I. (2007).

72      Interview 15 February 2021.

explain that doctors will only conduct physical examinations in conditions of urgent need. Unlike medical services in countries like Australia, there are no telephone consultations.

Nurse workloads in hospital care have increased. They have to provide more personal patient care than previously, such as patient hygiene, feeding and bathing, (normally, personal care would be carried out by family members who stay with a patient; isolation requirements for positive patients mean no family members can accompany them). They must follow level-three protective equipment protocols due to high-risk contact with positive patients which adds to pre and post work preparation time. COVID-19 care nurses said there were shortages of nurses available for roster in COVID-19 patient care and nurse-patient ratios need to be increased, in particular when there is a rise in patient numbers.[73] Relatively high levels of infection of nursing staff have contributed further to staff shortages and lack of adequate staff training was identified as a problem by nurses surveyed for this research. Recruiting new staff to the team should require special training which is not always available. The physical challenges of patient care have proven difficult for many women because of their stature; there were no men on the dedicated COVID-19 nursing care team.

Hospital workers also reported a lack of adequate infrastructures in COVID acute care, exacerbated by shortages of or substandard PPE. Here, it should be recalled that district hospital management, including budgeting, is independent of the health department. Lack of infrastructure included a shortage of hepafilters for reducing airborne viral particulates in patient rooms.[74] Eight of 15 nurses in isolation and emergency wards referred to a shortage of clinical equipment. These shortages undermine workers' capacity to provide adequate patient care and put them at risk of infection. Additional work stresses at times included inadequate isolation beds in the emergency department and inadequate dedicated COVID-19 patient care wards. Further, the national government's financial incentive for COVID-19 health workers was not paid routinely.

The risks for women healthcare workers as frontline workers are high. These arise not only from the daily risks of infection, but also because they experience long-term exhaustion and unrelenting pressure affecting not only themselves, but also their partners and children. It is not only the heavy workload that causes exhaustion, but also the psychological impacts of living close to the virus on a daily basis. Most workers stated they felt fear on a routine basis — fear not that they would become infected but that they would transmit the virus to family members.

Health workers' domestic work has increased significantly as a result of the

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73      This data was collected in healthcare nurse questionnaires distributed and collected in mid-February 2021.

74      Hepafilters help to capture and remove virus particulates, contributing to reduction in patient-to-healthworker transmission.

pandemic. In particular, the burden of clothes washing has expanded, as workers change clothes multiple times a day in their transition from finishing a shift wearing PPE, bathing and changing at the workplace, and then bathing and changing clothes again before entering their family home. Washing protocols at home require special procedures to ensure clothes do not become a source of virus transmission.

Children have been schooled from home since the end of March 2020. As of May 2021, there were no definite plans for children to return to school in the foreseeable future. While the education ministry announced that schools would return in the new school year in July 2021, these plans were put on hold as Salatiga case numbers had risen consistently between March and May 2021. Hence, women with school-age children at home must divide their attention and energy on an ongoing basis. While many schools provide online classes, this time is limited to 1-2 hours per day, and in any case is a highly problematic media for delivering effective learning, leaving responsibility for education to individual families, which means mostly to women.

The consequences of shouldering pandemic responsibilities are far-reaching both in the physical and mental load being borne by women.[75] This load causes depletion as women shoulder the load of socially reproductive work (the work of survival) at home and at work. While the pandemic remains understood by many members of the pandemic taskforce as primarily a healthcare issue, this outlook undermines the potential for more integrated cross-sectoral mitigation responses. In the conditions of pandemic crisis, the subsidy provided by women's social reproductive labour is relied upon to fill gaps in the state provision of pandemic services. Ongoing depletion arises as a result of women filling gaps not only in the official COVID response through their formal work roles, but in shouldering additional burdens in the domestic sphere.

75      Roberts, N. J., McAloney-Kocaman, K., Lippiett, K., Ray, E., Welch, L., & Kelly, C. (2021). "Levels of resilience, anxiety and depression in nurses working in respiratory clinical areas during the COVID pandemic". *Respiratory medicine,* 176, 106219-106219. doi:10.1016/j.rmed.2020.106219

# Conclusion

The consequences of the global pandemic have been far-reaching for women, especially for women healthcare workers who make up the majority of frontline workers.[76] In the face of indications that women are not considered capable leaders in the wider Indonesian society,[77] I set out to investigate the leadership roles that women in government at the local level have played in facing one of the most significant challenges to the global order in the 21st century: the COVID-19 pandemic. I uncovered a disjuncture between men's high representation in formal leadership and decision-making bodies, and women's overwhelming domination of the daily work of pandemic leadership in both infectious disease mitigation and healthcare responses. While I focused on just one city in Central Java, we can assume that this division is mirrored in other parts of Indonesia and, indeed, in many parts of the world.

I have shown how local government pandemic responses have depended significantly on the gendered division of labour in healthcare and other forms of social reproductive work. While post-New Order Indonesia governments have increased healthcare spending from just under 2% of GDP in 2000, Indonesia currently spends less than 3% of its GDP on health,[78] a figure only slightly higher than Angola and Bangladesh. For those who can afford to pay, this weakness in state provision of healthcare tends to push unmet healthcare and other social provisions for a variety of crises, towards the market.[79] But for others with limited to no ability to pay, the result is major gaps in social provisioning for responding to the pandemic crisis, which has directly increased demands on women in both public and private spheres. From the view of social reproduction, this means that responsibility for systemic problems has been downloaded onto individuals, especially women.[80] Despite the leadership role demonstrated by these women — and indeed, the expectation that they would lead — the appointment of a male-dominated pandemic taskforce reinforced pre-existing gender inequalities in structural leadership.

Health department officials and community health centre managers and frontline workers in Salatiga should be commended for their role in providing essential health and wider disease mitigation responses since the start of the pandemic. Community health centres in Indonesia, run largely by women, have been a critical

76    See OECD policy responses to Coronavirus (COVID-19) at https://www.oecd.org/coronavirus/policy-responses/women-at-the-core-of-the-fight-against-COVID-19-crisis-553a8269/ AND Davies, S. E., Sophie Harman, Rashida Manjoo, Maria Tanyag, and Clare Wenham. (2019). "Why it must be a Feminist Global Health Agenda". *The Lancet* (393 ), 601-603. doi: https://doi.org/10.1016/S0140-6736(18)32472-3

77    White and Aspinall. (2019).

78    Taken from https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ID on 14 May 2021.

79    Meckelburg and Bal. (2021).

80    Bakker, I. (2007).

piece of infrastructure for Indonesia's pandemic response. Their workers' intensive community engagements have generated greater understanding of what COVID-19 is in local communities, driven coordination of cross-sectoral stakeholders where possible, provided active support for positive patients, and reduced community stigmatisation. Sadly, this critical role, as well as the knowledge and experience gained by these women, has not been acknowledged formally nor drawn upon as a critical resource in longer term pandemic planning and leadership.

Women's restricted inclusion in formal structures of power and decision-making limit the opportunities for those shouldering the burden of systemic problems, in this case the COVID-19 pandemic, to advocate and exercise power and to make changes that would make the state take greater responsibility for these social provisions. Ultimately, this failure undermines the capacity to provide well-coordinated holistic responses to the COVID-19 pandemic at the local level, resulting in ongoing high levels of virus transmission. Finally, the structural exclusion of women and the failure to acknowledge their experience, knowledge and leadership capacity in the formation of pandemic policy and resource allocations, effectively extends the timeframe of the multiple crises resulting from the pandemic.



Rapid Test facility at Pasar Senen Station. Image credit: Gaudi Renanda on <u>Wikimedia Commons</u> (CC BY-SA 4.0)

# Salatiga City-wide Covid-19 Taskforce as per October 2020

*(all functions described herein are related specifically to COVID-19 responses in Salatiga unless otherwise noted)

| No. | POSITION/FUNCTION | GENDER | JOB DESCRIPTION |
|---|---|---|---|
| 1. | **Chairperson (**Wali Kota) | **Male** | • Establish operational plan;<br>• Coordinate, supervise and control activities in Sub-districts;<br>• Determine the strategic steps to accelerate handling in Subdistricts and Kelurahan |
| 2. | **Vice-chair I** (Military District Commander Commander 0714 / Salatiga)<br><br>**Vice-chair II** (Salatiga Police Chief)<br><br>**Vice-chair III** (Chairperson of the District House of Representatives) | **Male**<br><br><br>**Male**<br>**Male** | • Coordinate law enforcement and health protocol discipline with TNI and POLRI units in collaboration with government, community, academia, business and media;<br>• Assist the Chairperson in their responsibilities;<br>• Supervise the implementation of Task Force work procedures; and<br>• Carry out tasks as requested by the Chairperson. |
| 3. | **Secretariat** (Regional Secretary) | **Male** | • Coordinate administration, supervise budgets, procure logistics and equipment, provide finance and financial administration, correspondence and other secretarial support;<br>• Process legal documents (cooperation agreements, circulars, protocols, permit documents); |
| 4. | **Coordinator of the Expert Team** (Head of the Regional Planning, Research and Development Agency) | **Male** | • Compile a strategic plan for based on an empirical framework;<br>• Formulate and provide strategic policy recommendations that must be taken by the Salatiga City Government.<br>• Identify and analyse problems and opportunities |
| 5. | **Section Coordinator 1** Data and Information (Head of Communication and Informatics Office) | **Male** | • Coordinate with the Sub-districts teams and other stakeholders;<br>• Conduct data collection, to determine pandemic priorities and compile an operational plan;<br>• Prepare accurate data and information for policy making;<br>• Strengthen communication and transportation networks to the sub-district and RT / RW levels |
| 6. | **Section Coordinator 2** Public Communication (Head of the Protocol and Communication Section of the Head of the Regional Secretariat) | **Male** | • Conduct Public Communication;<br>• Coordinate various partners to support Public Communication;<br>• Disseminate public information received from the Salatiga City COVID-19 Task Force; |
| 7. | **Section Coordinator 3** Behavior Change 3 (Head of the National Unity and Political Department) | **Male** | • Mobilise and coordinate resources from TNI and POLRI units in collaboration with government, community, academia, business and media towards education, socialization and mitigation efforts;<br>• Provide integrated support and mentoring for Sub-district, kelurahan, and neighbourhood Task Forces;<br>• Public communication, socialisation, education and mitigation efforts through Subdistrict, kelurahan, and neighbourhood Task Forces; |

| 8. | **Section Coordinator 4** Health Management (Head of Health Department) | **Female** | • Increase the capacity of health infrastructure facilities and support Subdistrict COVID-19 Task Forces to conduct massive testing, aggressive tracing, strict isolation and treatment according to the applicable procedures;<br>• Coordinate with the Subdistrict COVID-19 Handling Task Forces and get support from the City Task Force regarding health management;<br>• Surveillance in government and private hospitals, and health centers;<br>• Implement protocols to protect health workers to minimize the risk of infection;<br>• Cooperate with Subdistrict COVID-19 Task Forces to ensure the functioning of support systems for patients in recovery post;<br>• Formulate medical waste management plans with related parties;<br>• Monitor, control and regulate activities carried out by health services (Health Service, Hospital, Puskesmas, Laboratory);<br>• Coordinate and cooperate with health agencies at the provincial and city levels; and<br>• Periodically report on implementation, problems and achievements of the Health Management Sector. |
|---|---|---|---|
| 9. | **Section Coordinator 5** Law Enforcement and Discipline (Head of Civil Service Police Unit) | **Male** | • Conduct surveillance, coaching and community discipline to ensure compliance with health protocols, and isolation procedures;<br>• Enforce health protocol laws for violations;<br>• Compile the results of data collection carried out by the City Task Force regarding migrants/returned travelers, vulnerable residents, sick residents and visitors, residents and officers in quarantine or isolation; and report daily to the Covid-Handling Task Force Command Post;<br>• Periodic sterilisation of public facilities, temporarily close public areas that attract crowds;<br>• Supervise, guide and discipline managers of social, religious, celebratory, tourism, public service and social safety net program activities;<br>• Provide security in the City of Salatiga, including securing health facilities and work support facilities |
| 10. | **Section Coordinator 6** Volunteers (Head of Social Services department) | **Female** | • Recruit and mobilise volunteers;<br>• Assign, manage and monitor medical and non-medical volunteers;<br>• Provide volunteers for Task Force at the subdistrict, sub-district, RW / RT level if needed;<br>• Help people affected by the pandemic;<br>• Record and update volunteer database;<br>• Mobilise mass organisations to jointly handle COVID-19 |

# Australian National University

## Contact us

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