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As COVID-19 escalates in Indonesia, responses are fractured and fractious. (Terjemahan Bahasa Indonesia)

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Just over six months after the first COVID-19 case was officially confirmed in Indonesia, it is clear that it has failed to control the pandemic. As of early October 2020, infection numbers have yet to peak and continue to rise at more than 4,000 new cases per day. Testing rates, at 12,272 tests per million of population, are amongst the lowest in the world; and positivity rates, of more than 19 percent, are amongst the highest. The national government's pandemic response has been characterised by an overall rejection of coordinated large scale movement restrictions and apathy towards the responsive capacity of public health services.

Globally, assessments of pandemic responses have largely focused on bureaucratic capacity and competency, trust in government, and the quality of leadership. However, in Indonesia, the national government's inaction sits in stark contrast to sub-national governments—at the provincial, district, and municipal levels—who responded relatively quickly, initiating large-scale movement restrictions and social safety nets. Alongside this, the earliest frontline responses to the social, economic, and health crises caused by the pandemic, came from independent community

initiatives. At different levels of governance there has been considerable variance in responses (including conflicts) between the national and sub-national governments, and also between different sub-national governments. These observations expose tensions and rivalries at different levels of governance that mainstream pandemic analyses do not examine.

In our analysis, we adopt a scalar-politics approach to explaining pandemic governance outcomes in the country to date. We examine how competing social groups have harnessed different institutions, at different scales of governance, to forward or defend their respective agendas and interests. Institutions are important in explaining pandemic governance outcomes. Their form and capacity, however, are results of struggles and conflicts between social groups over the distribution of political power and resources through these institutions. Our analysis reveals that pandemic responses at different scales of governance—national, sub-national, and community—are products of different configurations of political coalitions and material conditions.

Variations and tensions between national, sub-national, and informal grassroots pandemic responses have been evident in other cases such as the United States, Australia, India, and Thailand. In Indonesia, these variations and tensions point towards deeper pre-existing tensions over the political project of decentralisation. Consequently, pandemic responses have been fractured and fractious to the point that it is highly problematic to speak of an "Indonesian response". Reformist district heads, city mayors and provincial governors riding on broad-based popular support have been more responsive to social and economic problems caused by the pandemic crisis, in stark contrast with crony-capitalist forces whose ascendancy rides solely on money politics or patronage networks and who are thus unresponsive to wider social interests. In contrast, the national government response reflects a far narrower oligarchic consensus in prioritising economic growth over public health. Predictably, this has led to considerable tensions between governance actors at different scales and presents significant impediments to a coordinated whole-of-government response. These findings imply that pandemic responses are best understood as

distributional conflicts over political and economic power at different scales of governance rather than as a global collective action problem.

Contested decentralisation: local government responses

As political decentralisation in Indonesia has rescaled the governance of key public services such as healthcare, education, and social welfare into the hands of district and municipal governments, these have become the critical focal point of on-the-ground pandemic crisis management. District and municipal governments have primary control and responsibility for staff management and budgets for regional and city schools, hospitals and community health centres, social welfare programs, and crisis response protocols. However, like the contested outcomes of political decentralisation more generally, the efficacy of these local responses has been uneven. While predatory elite interests from the authoritarian New Order era continue to dominate, the implementation of sub-national and village autonomy, together with the emergence of mid-level provincial capitalist classes, has presented unusual spaces for both elite and non-elite actors to test out different strategic and tactical approaches.

These configurations, in turn, influence the extent to which districts and municipalities were successful in mobilising resources for crisis management. In districts and municipalities with histories of popular political and social mobilisation including electoral campaigns for district heads and mayors driven by grassroots organisations, local officials demonstrated rapid responses in providing social assistance. These same district governments were able to swiftly secure Personal Protective Equipment (PPE) for health workers in hospitals and local health centres and initially did not experience high infection rates amongst health workers. Similarly, access to land, levels of social differentiation, and ensuing local power relations, are shown to have some impact on district and municipal government responses. Highly varied social relations of power across geographic regions have

presented different spaces and opportunities for multiple social actors and groups to contest the distribution of resources. Thus, political decentralisation in the post-New Order era has intensified contestations as local powerbrokers at district and village levels sit between, on the one hand, national elites or investors offering economic perks and on the other hand, the local electorates that powerbrokers rely on for votes.

For instance, in several districts of inland Central Java, where smallholder agriculture dominates alongside relatively low levels of social differentiation, district governments and village heads were able to deliver effective public health messages as well as mobilise resources to quarantine large groups of people who had arrived from the epicentre of the crisis in Jakarta and West Java. In the early months of the pandemic, these measures were reasonably successful in limiting the spread of the virus in these rural areas. Conversely, in coastal districts in Central and East Java, where industry, agribusiness and commercial forestry are more dominant, district governments have been generally less responsive both in preparing district health services and in the distribution of social assistance. Further, with limited access to land in these districts, local populations are more dependent on employment in industries with little concern for health and safety protocols and the informal sector which often involves travel between regions including cities with high levels of COVID transmission. It is, therefore, of little coincidence that it is these districts that have experienced more widespread transmission in the general population and higher levels of infection amongst health workers in the initial months of the pandemic.

At the provincial level, responses have been similarly uneven. Provincial governments elected on relatively broad-based popular support, such as those in West and Central Java, were able to produce or secure medical supplies, coordinate regional lockdowns and tracing regimes, and provide social assistance budgets. Yet, in provinces such as South Sulawesi, provincial and district governments actively misused social assistance funds to strengthen party cartels and attract voters before upcoming regional elections. However, the more proactive responses were in large

part stymied as the national government failed to secure global supplies of testing equipment and actively pushed back against provincial lockdowns. At the same time, public communications by provincial governments, particularly in Jakarta, were largely addressed to middle class electorates with little attention paid to the challenges faced by workers in the informal sector. Indeed, across provincial levels of governmentality, there are limited initiatives to develop effective public health responses for more than 60 percent of the population who work in this sector.

Community resilience at the grassroots

Some of the initial and most effective public health responses in Indonesia were strongly tied to community mobilisation and forms of social solidarity that included village- and neighbourhood-based lockdowns, including support for health workers and vulnerable members of the community. Local leadership, both formal and informal, backed by mobilised communities was critical in securing resources for COVID responses and in delivering social assistance for many vulnerable communities. These responses were common among geographically-bound communities with histories of social and political mobilisation. In the cramped and densely populated slums of Jakarta, urban poor communities that have historically been marginalised, ignored or threatened with eviction, were able to draw on informal organising capacities forged in long histories of self-advocacy. In North Jakarta, the Urban Poor People's Network (Jaringan Rakyat Miskin Kota) reported to us that they were able to mobilise networks and resources in urban poor communities that already had histories of facilitated social organising. Where these networks exist, they have histories of grass-roots campaigns organised through independent local initiatives or community programs supported by activist-based NGOs.

In smaller urban centres such as Yogyakarta and Salatiga in Central Java, community kitchens or meal packages were rapidly organised to provide support for vulnerable informal sector workers from online transport sector workers to

traditional market traders, *becak* drivers and sex-workers. Some of these initiatives sprang from local working-class communities, while other initiatives came from urban-dwelling social activists with social networks who have generously donated resources for people in need.

In rural villages, local mitigation measures have had a different character. In the early months of the pandemic crisis, tens of thousands of people living precariously in informal work or who had lost industry jobs, left urban cities to return to rural homes. At the village level, community activists in Central Java reported to us that communities responded quickly, establishing quarantine facilities and other logistics to support those who had returned. In the face of widespread economic hardship for many, self-initiated local farmers' groups set up mechanisms to distribute produce to urban and rural communities worst affected economically. To date, smallholder-dominated regions continue to demonstrate strong capacity to mitigate the spread of the virus through limited interactions outside of local villages, as well as providing basic social security guarantees such as adequate food supplies for village residents.

In our observations of early pandemic responses, local grassroots initiatives were critical in mitigating the potential for large scale social or economic crises for large sections of the population, despite significant losses in income for these same populations. Community support at the grassroots level, together with some (very uneven) delivery of financial assistance from various levels of government significantly cushioned these negative impacts. Here the pandemic highlighted the limited function of governmentality in responding to social, economic and health needs of large sections of both rural and urban society. The self-initiated organising capacity of sections of society across rural and urban spaces in a time of crisis demonstrates the significant spaces that operate beyond state governance structures or are neglected by the state.

Narrow elite consensus: the national government response

Any positive outcomes at sub-national level were undermined by the decision-making of the Joko Widodo government. The COVID-19 pandemic in Indonesia produced a national government response that was framed by elite-oligarchic consensus over the Widodo administration's national infrastructure drive and the prioritisation of GDP growth. Widodo's second term as President since re-election in 2019 has involved the building of a "grand coalition" of oligarchic interests tied to various national infrastructure projects. The centrepiece of this coalition is the distribution of project benefits to supporters and former political adversaries in return for elite political support, with the hope that GDP growth would secure more broad-based popular support. Correspondingly, the pandemic agenda at the national scale revolved around mitigating risks and threats posed by the pandemic to these broad economic objectives rather than public health per se.

The key prongs of the national government response focused on ameliorating economic contraction and economic hardship that might cause social unrest, in order to avoid major disruptions to national infrastructure and economic growth projections. This approach, in the early months of the crisis put the national government at odds with many provincial and local responses. Provincial and local governments needed action at a national level to restrict citizen movements, provide testing infrastructure and protective equipment for medical personnel on the front lines. In contrast, the central government initially provided only a single point of testing, based in Jakarta, whilst encouraging international and domestic tourism in the early months of 2020.

Consequently, open disputes arose between national and local governments in the early months of the pandemic over resources for mass testing capacity; the provision of protective equipment for medical staff that triggered a massive fallout between the Ministry of Health and the Indonesian Medical Association (IDI); and the national

government's refusal to impose movement restrictions. District governments soon fell in line behind the national imperative to protect the economy while testing and contact-tracing rates continue to remain abysmally low. Procurement of PPE remains a problem across many regions and the national government, through its failure to act, has effectively abdicated its responsibility. While the decision not to implement a national lockdown early in the pandemic appears to have cushioned some of the social and economic fallout for vulnerable groups, the reopening of the economy from July 2020 has seen an exponential growth in case numbers.

By early September, some national elites argued publicly that not solving the health crisis would only deepen the economic crisis facing Indonesia. However, attempts by the Jakarta provincial Governor to re-implement large-scale movement restrictions due to an escalating crisis in the Jakarta public health system, have been actively sabotaged by national ministers who argued that such restrictions were ineffective. This most recent conflict highlights how sub-national government responses can often be driven by a more diverse range of social interests, while the national government's response is driven by the narrow interests of oligarchic elites. It is this ongoing contestation that creates major problems in coordination and sometimes points of open conflict.

Further, the national government's inaction in resourcing public health services, has pushed many aspects of pandemic healthcare provision towards the market where state-owned pharmaceuticals and private healthcare providers stand to gain. Unlike other countries in Southeast Asia, voluntary testing is 'user-pays' with the most reliable swab test costing somewhere between Rp2-5 million. Further, in August and September 2020, data indicates that hospitals across many regions of Indonesia, in particular in the hotspots of Jakarta and East Java, are close to or have reached full capacity, in some cases turning away COVID-19 patients. While the national government promised that all COVID-19 treatments would be covered by government budgets, human rights activists in Central Java reported to us that hospitals are charging some inpatients as well as self-isolating positive patients for treatment and medication. These developments indicate the increasing adoption of a

user-pays system for COVID-19 detection and treatment which further undermines any potential for pursuing an effective 'trace, track and treat' public health approach.

Unresolved contention amid escalating COVID-19 cases

Economic contraction has been unavoidable during the pandemic, and in the second quarter of 2020 Indonesia suffered its sharpest economic downturn since the 1998 economic crisis. While the overall contraction to date has not been as significant as other countries, the first wave of the pandemic shows no signs of peaking. Financial reports show that the largest contractions in GDP have been in household spending and investment. With no strategy or even intent to effectively control the pandemic these sectors are unlikely to show any significant recovery and indeed may worsen as new daily cases continue to rise.

Some provincial governments continue to attempt to improve public health facilities in particular testing capacity in regional areas. However, the failure of the central government to act decisively in supporting the procurement of approved standard equipment and raw materials—instead leaving this to the market—has stymied many of these attempts and provinces received sub-standard equipment or chemical reagents that do not work. The efforts of many district governments have subsequently been pared back to providing public health education about wearing masks, washing hands and physical distancing, alongside punitive local enforcement of health protocols. This apparent compliance with the national political agenda of 'economy first' places a question mark over the capacity and willingness of district governments to engage further in open conflict with provincial and national governments over resourcing public health infrastructures. At the same time, some local governments face rising community dissent if they have no demonstrated plan of action in the face of rising case numbers and COVID-19 deaths.

The appointment of the army chief-of-staff as vice-chairperson of the national government's COVID-19 and economic recovery response team indicates that social and political stability is a key concern of the national government. The central government has also initiated punitive measures mobilising civilian paramilitary groups such as the Pemuda Pancasila to ensure orderly control of the public. The mobilisation of civilian militias has its roots in New Order dictatorship strategies to ensure order and compliance. Governance failures in managing the pandemic are blamed on the 'indiscipline' of individual citizens providing an argument for the use of repressive force.

As COVID-19 spreads more widely to poor workers in factories and the informal sector and to rural regions, the capacity for grassroots mobilisations to effectively mitigate the health and economic consequences is not yet known. We cannot yet measure the resilience of these networks in the face of longer term economic and social hardship, particularly if domestic demand for basic goods remains depressed. It is clear that the developing pandemic crisis will disproportionately affect workers in industries where support for health protocols are harder to guarantee and those with limited ability to demand safe working conditions. Furthermore, those in the informal sector, people dependent on mass transport, and regions where community organisations find it hard to mobilise adequate social resources will also be disproportionately affected. The other group being sacrificed because of economic priorities is frontline health workers which invariably weakens the capacity of the health system to respond. Coupled with a health system showing signs of reaching capacity and essential mitigation measures such as testing being available largely on a user-pays basis, this will mean that growing numbers of people infected will not be identified nor will they be able to access medical services if their condition becomes acute.

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