As of 14 July, the Government of Indonesia reported 2,670,046 (54,517 new) confirmed cases of COVID-19, 69,210 (991 new) deaths and 2,157,363 recovered cases from 510 districts across all 34 provinces.\(^1\)

During the week of 5 to 11 July, nationwide, 44% increase in cases and 69% increase in deaths were observed compared to the previous week. All provinces experienced an increase in the number of cases compared to the previous week; 15 provinces experienced an increase of 50% or more. More cases mean more hospitalizations, further stretching health workers and health systems, and increasing the risk of death. There is an urgent need to suppress COVID-19 transmission focusing on strict implementation of public health and social measures, including movement restrictions. The existing vaccination drive also needs to be strengthened, mainly focusing on improving the coverage among older and high-risk populations who are at an increased risk of severe disease and death.

\(^1\) [https://covid19.go.id/peta-sebaran-covid19](https://covid19.go.id/peta-sebaran-covid19)
Indonesia continues to face an increasing number of COVID-19 cases and deaths among health workers. The Head of District Health Office (DHO) Sampang, East Java reported that 100 health workers have contracted COVID-19 as of 3 July. In DKI Jakarta, 13 health workers have died due to COVID-19 in July alone (all were reported to have been vaccinated). The Governor of DKI Jakarta noted that the number was an alarming increase from a total of 18 deaths among health workers recorded in the province in 2020. During a virtual meeting with the House of Representative on 12 July, the Minister of Health acknowledged that Indonesia is in an urgent need of additional healthcare workers to manage COVID-19 patients. The Minister noted that the Ministry of Health (MoH) had identified a requirement of additional 16,000-20,000 nurses and 2200-2900 doctors to respond to the increase in COVID-19 cases in the country.

On 10 July, MoH reported that the preparation process for the inoculation of the third dose of COVID-19 vaccine (vaccine booster) to health workers had started. The third dose will use the COVID-19 vaccine manufactured by Moderna. On 11 July, Indonesia received over three million doses of Moderna COVID-19 vaccine, which came from the allocation donated by the U.S. Government through the COVAX Facility. During a press conference dedicated to the arrival of the vaccine, the Minister of Foreign Affairs stated that the Indonesian National Agency of Drug and Food Control (Badan Pengawas Obat dan Makanan (BPOM)) had issued emergency use authorization (EUA) for the vaccine on 2 July. The Minister stated that more doses of Moderna vaccine will be delivered to the country through the COVAX Facility.

The Indonesian health system continues to struggle amid the recent surge of cases. The Minister of Health reported that as of 2 July, the hospital bed occupancy rate (BOR) had reached 75% nationwide. Some COVID-19 referral hospitals in Java have reported over 90% capacity, including in DKI Jakarta. Shortages in medical oxygen were reported in many places, which the government attributed to bottlenecks in distribution and limited production capacity in the country. As an effort to reduce the pressure on the health system, MoH stated that the government will provide free telemedicine services to COVID-19 cases with mild symptoms, which will include free online consultations and medicine delivery.

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6 https://nasional.tempo.co/read/1482117/3-juta-vaksin-covid-19-moderna-tiba-di-indonesia

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who.int/indonesia
• On 14 July, 54 517 new and 2 670 046 cumulative cases were reported nationwide (Fig. 2). This is the highest number of new confirmed cases since COVID-19 was first reported in the country. The average for the last seven days from 8 to 14 July was 41 521 cases per day, compared to 28 732 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 14 July 2021. [Source of data](who.int/indonesia)

Disclaimer: Since 10 February, confirmed cases include those who tested positive using polymerase chain reaction (PCR), nucleic acid amplification test (NAAT) or antigen-detecting rapid diagnostic test (Ag-RDT). The number of cases reported daily is not the number of persons who contracted COVID-19 on that day and might be influenced by the number of people tested on that day (see Fig. 17); reporting of laboratory-confirmed results may take up to one week from the time of testing. Therefore, caution must be taken in interpreting this figure and the epidemiological curve for further analysis, either at the national or subnational level.
During the week of 5 to 11 July, all provinces experienced an increase in the number of cases compared to the previous week; 15 provinces experienced an increase of 50% or more, including five with an increase of more than 100%: West Nusa Tenggara (201%), Gorontalo (194%), Maluku (169%), North Sulawesi (139%) and North Kalimantan (107%) (Fig. 3). Stringent public health and social measures (PHSM), especially movement restrictions, should be considered to be urgently implemented throughout the country.

Fig. 3. Percentage change of weekly number of confirmed cases by province during 5 to 11 July 2021 compared to the previous week. Source of data

Disclaimer: The number of weekly confirmed cases is calculated taking into consideration the daily number of reported cases. It is important to conduct further investigation if there is a substantial change in new cases, especially in provinces with a change of 50% or more. Other factors, such as testing and contact tracing, may help elucidate the reasons behind substantial changes. Additional indicators, including case incidence and mortality, should be considered to guide adjustment of PHSM.
During the week of 5 to 11 July, the incidence\(^8\) of COVID-19 in Indonesia increased substantially to 67.1 per 100 000 population compared to 46.9 per 100 000 population in the previous week (Fig. 4). The incidence has been rapidly increasing in the country since mid-May and is more than two-fold greater than the previous high of 31.5 per 100 000 population reported in February.

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\(^8\) Weekly incidence of COVID-19 is calculated as the number of new cases per 100 000 population per week averaged over a two-week period. 

Source of data

Disclaimer: There are seven categories for transmission classification: (1) no (active) cases; (2) imported/sporadic cases; (3) cluster of cases; (4) community transmission 1 (CT1); (5) community transmission 2 (CT2); (6) community transmission 3 (CT3); and (7) community transmission 4 (CT4).

Caution should be exercised when interpreting this indicator due to limitations listed in the WHO interim guidance. Other epidemiological indicators also need to be evaluated to decide on the level of community transmission. This disclaimer applies to indicators at national (Fig. 4) and subnational levels (Figs. 5 to 11).
During the week of 5 to 11 July, the incidence of COVID-19 per 100 000 population was 605.5 in DKI Jakarta and 203.2 in DI Yogyakarta (corresponding to community transmission (CT) level 4 (the highest transmission scenario classification)); and 145.6 in Riau Islands, 144.4 in West Papua, 108.6 in East Kalimantan, 91.5 in North Kalimantan, 79.2 in Bangka Belitung Islands, 74.6 in West Java, 59.9 in Central Java, 59.1 in North Maluku, 55.4 in Maluku, 52.3 in Bali and 50.8 in Bengkulu (corresponding to CT level 3) (Fig. 5). Based on WHO interim guidance, this means there is a high to very high risk of COVID-19 infection for the general public and a high to very high number of locally acquired, widely dispersed cases detected in the past 14 days.

Fig. 5. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period by province in Indonesia during 5 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data
During the week of 5 to 11 July, the weekly incidence of COVID-19 increased in all provinces in Java and Bali, compared to the incidence in the previous week (Fig. 6). There has been a spike in incidence in June and July in Java, with record high incidence rates reported in this region.

**Fig. 6.** Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Java - Bali, from 13 April 2020 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

Source of data
In Sumatra, the weekly incidence of COVID-19 increased in North Sumatra, West Sumatra, Riau, South Sumatra, Bengkulu, Lampung, Bangka Belitung Islands and Riau Islands during the week of 5 to 11 July compared to the previous week. There has been an increasing trend in incidence since April in most provinces. Riau Islands has experienced a consistent and substantial increase in weekly incidence since March. There has also been a recent surge in weekly incidence in West Sumatra, South Sumatra, Bengkulu, Lampung and Bangka Belitung Islands (Fig. 7).

![Fig. 7. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in Sumatra, from 13 April 2020 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.](source_of_data)
During the week of 5 to 11 July, the weekly incidence of COVID-19 increased in all provinces in Kalimantan compared to the incidence in the previous week, with a rapid increase in cases since the end of June (Fig. 8).

Fig. 8. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in Kalimantan, from 13 April 2020 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

Source of data
In Sulawesi, the weekly incidence of COVID-19 increased in all provinces during the period of 5 to 11 July, compared to the previous week. The incidence has been consistently increasing in all provinces since the end of May (Fig. 9).

Fig. 9. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Sulawesi, from 13 April 2020 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data
During the week of 5 to 11 July, the weekly incidence of COVID-19 increased sharply in West Nusa Tenggara, East Nusa Tenggara, Maluku, North Maluku, Papua and West Papua compared to the previous week (Fig. 10).

Fig. 10. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in West Nusa Tenggara, East Nusa Tenggara, Maluku, North Maluku, Papua, and West Papua, from 13 April 2020 to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data

Nationwide test positivity proportion increased sharply after 23 November and reached a peak of 30.5% in mid-February. Subsequently, the positivity proportion declined and stood between 9% and less than 20% from 11 March, which is considered CT3 (high incidence), with a rapid increase in June. The positivity proportion increased to and has remained at CT4 since the end of June (very high incidence); it stood at 25.8% on 11 July (Fig. 11).
The percentage of positive samples can be interpreted reliably only with comprehensive surveillance and testing in the order of one person tested per 1000 population per week. This minimum case detection benchmark was achieved in DKI Jakarta, West Java, Central Java, DI Yogyakarta, West Sumatra, East Kalimantan, West Papua and Riau for the last three weeks. Nevertheless, these provinces still have a test positivity proportion of more than 5%, which means that transmission is still very high in the community (Fig. 12).

**Source of data**

**Disclaimer:** Caution should be exercised when interpreting this indicator due to limitations listed in the [WHO interim guidance](https://www.who.int/). Other epidemiological indicators also need to be evaluated to determine the level of community transmission.

- The percentage of positive samples can be interpreted reliably only with comprehensive surveillance and testing in the order of one person tested per 1000 population per week. This minimum case detection benchmark was achieved in DKI Jakarta, West Java, Central Java, DI Yogyakarta, West Sumatra, East Kalimantan, West Papua and Riau for the last three weeks. Nevertheless, these provinces still have a test positivity proportion of more than 5%, which means that transmission is still very high in the community (Fig. 12).
Fig. 12. Test positivity proportion and people tested per 1000 population per week at the national level and in select provinces.

Week 1: 21/06/21 to 27/06/21; Week 2: 28/06/21 to 04/07/21; Week 3: 05/07/21 to 11/07/21

Benchmark: one person tested per 1000 population per week
Threshold test positivity proportion: <5%

Source of data: Indonesia, DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Banten, West Sumatra, East Kalimantan, West Papua, Riau, Central Kalimantan, South Sumatra, Southeast Sulawesi

Note: Due to a limitation in data, other provinces could not be evaluated. For surveillance purposes, test positivity proportion is calculated as the number of confirmed cases divided by the number of people tested for diagnosis.
During the week of 5 to 11 July, DI Yogyakarta had the highest weekly number of confirmed COVID-19 deaths per 100 000 population, followed by DKI Jakarta, Riau Islands, Central Java and East Kalimantan (Fig. 13).

Fig. 13. Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period by province in Indonesia during 28 June to 11 July 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data

Disclaimer: Based on data availability, only confirmed COVID-19 deaths have been included. As per WHO definition, however, death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case is a COVID-19-related death, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma); there should be no period of complete recovery between the illness and death. Evaluation of excess mortality is also beneficial to complement information on COVID-19 death.
At the national level, during the week of 5 to 11 July, the number of confirmed COVID-19 deaths increased to 1.43 per 100 000 population\(^9\) compared to 0.96 deaths per 100 000 in the previous week. There was a steep increase in deaths throughout June, which has continued into July (Fig. 14).

Fig. 14. Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 11 July 2021. [Source of data](https://www.who.int/countries/idn)

**Disclaimer:** Based on data availability, only confirmed COVID-19 deaths have been included. As per WHO definition, however, death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case is a COVID-19-related death, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma); there should be no period of complete recovery between the illness and death. Evaluation of the level of community transmission could not be conducted due to data limitations.

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\(^9\) Weekly mortality of COVID-19 is calculated as the number of COVID-19 deaths per 100 000 population per week averaged over a two-week period. [Source of population data](https://www.who.int/countries/idn)
During the week of 5 to 11 July, the total number of weekly confirmed COVID-19 deaths in DKI Jakarta was 743, the highest weekly number of deaths reported in the province since the beginning of the pandemic, and almost double the number of deaths reported in the previous week (Fig. 15).

Fig. 15. Weekly number of confirmed COVID-19 deaths in DKI Jakarta, as of 11 July 2021. Source of data

Disclaimer: The data are provisional. There may be a discrepancy in the number of deaths in confirmed COVID-19 cases between national and provincial data sources.

**CONTACT TRACING**

- WHO continues to support MoH to accelerate contact tracing in Indonesia to respond to the recent surge of cases. In collaboration with partners, WHO supported MoH to conduct contact tracing trainings for volunteers from the Indonesian National Police (Kepolisian Negara Republik Indonesia (Polri)) and medical and public health students, from 29 June to 1 July. The trainings were attended by over 2100 participants from Banten, DKI Jakarta, West Java, Central Java and Bali. All volunteers were deployed to support the contact tracing activities in their respective areas immediately after the training.
HEALTH OPERATIONS

- As reported on 14 July, the daily number of people tested for COVID-19 was 172,859 and the cumulative number of people tested was 15,102,724 (Fig. 17).
As of 14 July, the proportion of people recovered among the total confirmed COVID-19 cases was 80.8% and there were 443 473 active cases (Fig. 18). The recovery percentage has been decreasing since the end of June.

Fig. 17. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 14 July 2021. Source of data

Fig. 18. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 14 July 2021. Source of data
• The reported number of confirmed COVID-19 cases hospitalized in DKI Jakarta increased sharply in June and the beginning of July to 30,418 hospitalizations on 7 July. It has since decreased slightly to 20,359 hospitalizations on 11 July. The previous high was 9,888 hospitalized cases reported on 12 February (Fig. 19).

![Graph showing number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 September 2020 to 11 July 2021.](source_of_data)

**RISK COMMUNICATION**

• WHO is regularly translating and sharing important health messages on its [website](https://who.int) and social media platforms - [Twitter](https://twitter.com) and [Instagram](https://www.instagram.com) – and has recently published:

  **Infographics:**
  - [COVID-19 vaccine and vaccination](https://who.int)
As of 12 July, 51 433 567 vaccine doses have been administered in the national COVID-19 vaccination campaign; 36 395 019 people have received the first dose and 15 038 548 people have received the second dose (Fig. 21).
As of 12 July, the number of older people who have received the first dose of the COVID-19 vaccine was 5 055 120 (23.4% of the targeted 21 553 118); only 3 023 237 (14% of the targeted population of older people) have received the second dose (fully vaccinated). The number of essential public service workers who have received the second dose of the vaccine was 8 781 959 (50.7% of the target population of 17 327 167). As part of the essential public service workers priority target group, 2 137 639 (37.8% of the targeted 5 659 560) teachers have received the first dose of the vaccine; 1 523 122 (26.9% of targeted population) have received the second dose. The number of health workers who have received the second dose of the vaccine was 1 428 202 (97.2% of the target population of 1 468 764) (Fig. 22).
As of 12 July, provinces with the highest number of unvaccinated (zero dose) health workers were Aceh, Papua and Maluku (Fig. 23).
As of 12 July, the number of people vaccinated with two doses of the vaccine (fully vaccinated) per 100 population was 5.5 nationwide. As of the same day, DKI Jakarta had the highest number of people fully vaccinated (18.3 per 100 population) amongst all provinces, followed by Bali (17.1), DI Yogyakarta (7.5), Central Kalimantan (7.0) and East Kalimantan (6.6) (Fig. 24).

Fig. 23. Number of unvaccinated health workers by province in Indonesia, as of 12 July 2021. Source of data

- As of 12 July, the number of people vaccinated with two doses of the vaccine (fully vaccinated) per 100 population was 5.5 nationwide. As of the same day, DKI Jakarta had the highest number of people fully vaccinated (18.3 per 100 population) amongst all provinces, followed by Bali (17.1), DI Yogyakarta (7.5), Central Kalimantan (7.0) and East Kalimantan (6.6) (Fig. 24).
As of 12 July, DI Yogyakarta had the highest coverage of first dose vaccination among older people, followed by Bali, DKI Jakarta and North Kalimantan. As of the same day, DKI Jakarta had the highest coverage of the second dose vaccination administered, followed by DI Yogyakarta, North Kalimantan and Bali (Fig. 25). As of the same day, provinces with the highest number of unvaccinated older people were West Java, Central Java and East Java (which are the provinces with the highest number of older people) (Fig. 26).

Fig. 24. Number of people vaccinated with two COVID-19 vaccine doses (fully vaccinated) per 100 population by province in Indonesia, as of 12 July 2021. Source of data

Fig. 25. COVID-19 vaccination coverage among older people by province in Indonesia, as of 12 July 2021. Source of data
Indonesia kicked off the third stage of the national COVID-19 vaccination campaign on 1 July. The third stage vaccination targets vulnerable and high-risk populations, the general population (above 18 years of age) and children (aged 12-17 years).

Fig. 26. Number of unvaccinated older people (over 60 years of age) by province in Indonesia, as of 12 July 2021. Source of data

- Indonesia kicked off the third stage of the national COVID-19 vaccination campaign on 1 July. The third stage vaccination targets vulnerable and high-risk populations, the general population (above 18 years of age) and children (aged 12-17 years).
On 9 July, WHO convened the 33rd meeting of key development partners to discuss and coordinate the COVID-19 response among partners in Indonesia. The meeting was attended by partners, including the Asian Development Bank (ADB), British Embassy, the Australian Government Department of Foreign Affairs and Trade (DFAT), the European Union (EU), Japan International Cooperation Agency (JICA), United Nations Children’s Fund (UNICEF), United States Agency for International Development (USAID), United States Centers for Disease Control and Prevention (US CDC), the World Bank and the World Food Programme (WFP). WHO presented COVID-19 updates, discussed the latest epidemiological situation at national and subnational levels, and explained the key WHO interventions to support the national pandemic response. Several key points of discussion among partners included the need for oxygen supplies for COVID-19 patient care, oxygen supply chain management, paediatric COVID-19 cases and deaths in Indonesia, and COVID-19 vaccination for children.

The overall funding request for WHO operations and technical assistance is US$ 46 million (US$ 27 million for response and US$ 19 million for recovery phase), based on estimated needs as of July 2021 (Fig. 27).

Data presented in this situation report have been taken from publicly available data from the MoH (https://infeksiemerging.kemkes.go.id/), COVID-19 Mitigation and National Economic Recovery Team (KPCPEN) (http://covid19.go.id) and provincial websites. There may be differences in national and provincial data depending on the source used. All data are provisional and subject to change.
COVID-19 AND MOBILITY ANALYSIS

- Mobility analysis can be used as a proxy to monitor population mobility during the implementation of movement restriction policies during the COVID-19 pandemic. Increased mobility may lead to increased interactions among people, which may affect COVID-19 transmission. Mobility of populations can be measured using several approaches. In addition to mobility trends, it is important to investigate other factors that may be associated with an increase or decrease in the number of cases such as testing strategies, laboratory capacity, compliance to public health and social measures (PHSM), presence of variants that may have increased transmissibility, and vaccination coverage, among others.

- Indonesia has implemented several movement restriction policies as a response to the COVID-19 pandemic.
  - The first large-scale social restriction (pembatasan sosial berskala besar (PSBB)) and the most stringent so far was implemented in April 2020. It covered restrictions of large-scale community activities, including school and office closures, restriction of public activities and transportation modes, among others.
  - PSBB was followed by transitional PSBB. During this transitional period, community activities in public places, workplaces, industrial areas and tourist attractions were allowed with a strict implementation of health protocols, including a mandatory mask use, physical distancing, and 50% capacity limit.
  - In early 2021, enforcement of restrictions on public activities (pemberlakuan pembatasan kegiatan masyarakat (PPKM)) was the main approach to the movement restriction used by the government. Micro PPKM has been used for implementation of restrictions at the village and sub-village level. Measures include closing of public places (excluding essential sectors) and implementation of curfew, among others.
  - More recently, in response to a sharp increase in cases, the government has implemented Emergency PPKM (PPKM Darurat) in parts of Java and Bali. During the implementation of emergency PPKM, work-from-office arrangement with 100% capacity with strict implementation of health measures.

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For purposes of current analysis in Indonesia, COVID-19 Community Mobility Reports (Google) have been used.
protocols is only allowed for critical sectors (including health, security, logistics and transportation) and construction sites.

- The implementation of movement restrictions and holiday periods may be associated with a change in mobility. In 2021, there was an increasing trend in relative mobility from February to May, reaching a high during Eid al-Fitr. This may be associated with a subsequent increase in daily confirmed cases. A similar pattern of an increase in new confirmed cases following an increase in population mobility was observed during previous holiday periods in 2020 such as during Christmas and the New Year holidays (Figs. 28-34).

- Close monitoring of relevant indicators during Emergency PPKM is essential. This includes monitoring of the trend in new cases and deaths, and rates of bed occupancy, hospitalization, testing, and test positivity proportion. During this period, mobility analysis can be conducted to monitor community mobility and its association with new cases.

![Fig. 28. Mobility analysis in DKI Jakarta, as of 10 July 2021](image-url)


**Note:** The baseline day is the median value from the 5-week period from 3 January to 6 February 2020 (prior to the first reported cases in Indonesia). Mobility is calculated for the report date (unless there are gaps) and reported as a positive or negative percentage change compared to the baseline day. **Source of data:** mobility; cases.

**Disclaimer:** Mobility analysis cannot demonstrate a cause and effect relationship between mobility and COVID-19 cases; interpretation should be based on the use of proxy measures for mobility to examine association with cases. This note and disclaimer apply to Figs. 28-34.
Fig. 29. Mobility analysis in West Java, as of 10 July 2021. Source of data: mobility; cases.

Fig. 30. Mobility analysis in Central Java, as of 10 July 2021. Source of data: mobility; cases.
Fig. 31. Mobility analysis in DI Yogyakarta, as of 10 July 2021. Source of data: mobility; cases.

Fig. 32. Mobility analysis in East Java, as of 10 July 2021. Source of data: mobility; cases.
Fig. 33. Mobility analysis in Banten, as of 10 July 2021. Source of data: mobility; cases.

Fig. 34. Mobility analysis in Bali, as of 10 July 2021. Source of data: mobility; cases.
## WEEKLY RISK ASSESSMENT

### Table 1. Weekly risk assessment by province in Indonesia, as of 11 July 2021.

<table>
<thead>
<tr>
<th>Province</th>
<th>Case incidence trend</th>
<th>New cases in last 7 days (%)</th>
<th>Change in new cases in last 7 days (%)</th>
<th>New deaths in last 7 days (%)</th>
<th>Change in new deaths in last 7 days (%)</th>
<th>Testing rate (per 1000 population per week)</th>
<th>Weekly test positivity proportion in last 7 days (%)</th>
<th>2nd dose vaccination among target population (%)</th>
<th>2nd dose vaccination among older population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aceh</td>
<td>Decrease</td>
<td>764</td>
<td>15%</td>
<td>46</td>
<td>-25%</td>
<td>0.4</td>
<td>38%</td>
<td>18.7%</td>
<td>1.1%</td>
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<td>North Sumatra</td>
<td>Increase</td>
<td>1757</td>
<td>57%</td>
<td>34</td>
<td>42%</td>
<td>1.4</td>
<td>8%</td>
<td>29.1%</td>
<td>9.4%</td>
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<tr>
<td>West Sumatra</td>
<td>Increase</td>
<td>3740</td>
<td>40%</td>
<td>66</td>
<td>25%</td>
<td>2.3</td>
<td>23%</td>
<td>19.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Riau</td>
<td>Increase</td>
<td>3941</td>
<td>45%</td>
<td>89</td>
<td>33%</td>
<td>0.8</td>
<td>66%</td>
<td>45.6%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Jambi</td>
<td>Decrease</td>
<td>896</td>
<td>18%</td>
<td>21</td>
<td>-35%</td>
<td>0.4</td>
<td>55%</td>
<td>29.6%</td>
<td>9.0%</td>
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<tr>
<td>South Sumatra</td>
<td>Increase</td>
<td>2233</td>
<td>44%</td>
<td>102</td>
<td>38%</td>
<td>0.7</td>
<td>37%</td>
<td>23.1%</td>
<td>7.5%</td>
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<tr>
<td>Bengkulu</td>
<td>Increase</td>
<td>1268</td>
<td>23%</td>
<td>14</td>
<td>-39%</td>
<td>0.6</td>
<td>75%</td>
<td>21.2%</td>
<td>8.0%</td>
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<tr>
<td>Lampung</td>
<td>Increase</td>
<td>2310</td>
<td>50%</td>
<td>43</td>
<td>34%</td>
<td>0.7</td>
<td>38%</td>
<td>20.5%</td>
<td>4.0%</td>
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<tr>
<td>Bangka Belitung</td>
<td>Increase</td>
<td>1797</td>
<td>59%</td>
<td>43</td>
<td>29%</td>
<td>2.4</td>
<td>49%</td>
<td>45.6%</td>
<td>23.0%</td>
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<td>Riau Islands</td>
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<td>3915</td>
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<td>75</td>
<td>-15%</td>
<td>2.0</td>
<td>28%</td>
<td>43.6%</td>
<td>13.0%</td>
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<td>811</td>
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<td>18.7</td>
<td>41%</td>
<td>64.9%</td>
<td>58.8%</td>
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<td>West Java</td>
<td>Increase</td>
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<td>45%</td>
<td>815</td>
<td>69%</td>
<td>2.2</td>
<td>44%</td>
<td>30.7%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Central Java</td>
<td>Increase</td>
<td>26273</td>
<td>40%</td>
<td>1366</td>
<td>72%</td>
<td>1.7</td>
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</tr>
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</tr>
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<td>Banten</td>
<td>Increase</td>
<td>3875</td>
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<td>48</td>
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<td>2.0</td>
<td>15%</td>
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<td>8.8%</td>
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<td>49</td>
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<td>3.2</td>
<td>7%</td>
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<td>59%</td>
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<td>1765</td>
<td>22%</td>
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<td>31%</td>
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<td>1582</td>
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<td>15%</td>
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<td>20</td>
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<td>1.6</td>
<td>25%</td>
<td>32.3%</td>
<td>8.0%</td>
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<td>43%</td>
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<td>48%</td>
<td>22.0%</td>
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<td>5.0%</td>
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<tr>
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<td>Maluku</td>
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<td>113%</td>
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<td>11</td>
<td>83%</td>
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<td>54%</td>
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<td>Increase</td>
<td>517</td>
<td>99%</td>
<td>0</td>
<td>0%</td>
<td>0.0</td>
<td>16%</td>
<td>23.2%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

**Source of data:** Cases, deaths and testing; vaccination

**Note:** Case incidence considers the trend of cases over the last three weeks. The change in new cases in the last seven days is marked as light red if there is an increase of 50% compared to the previous week. The change in new deaths is marked as light red if there is any increase in the percentage of deaths (and number of deaths ≥ 10) compared to the previous week. The testing rate is marked as yellow if it is less than 1/1000 population. Test positivity proportion is marked as light red if ≥ 20% and yellow if between 5% and 20%. The second dose vaccination is marked as light red if < 5% and yellow if between 5% and 10%. Target population for vaccination includes health workers, essential public service workers and older persons.
• Urgent action is needed throughout the country related to the continuing surge of cases, notably in provinces in light red, that is DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Banten, Bali, West Kalimantan, East Kalimantan and Southeast Sulawesi, and provinces in yellow. Bed occupancy rate has also been reported to be high in these provinces and is considered in the risk assessment.\textsuperscript{11,12,13,14}

• Strict implementation of PHSM throughout the country, even as vaccine coverage increases and expands to additional groups, is crucial. PHSM works even in the context of variants of concern (VOCs) as demonstrated in India (see Situation Report 60: Lessons Learned) and other countries that are facing a surge of cases. Considering that some VOCs have much higher transmissibility, timely adjustments of PHSM is very important during a surge, including the use of stringent measures (such as movement restrictions) as quickly as possible.\textsuperscript{15}

• Inadequate testing rate in some provinces continues to be a concern. Approximately 35\% of provinces report a testing rate below the recommended benchmark of 1 test per 1000 population per week. Testing services should be further strengthened across the provinces. Early diagnosis of cases is a backbone of public health response to COVID-19, as it enables timely isolation of cases, and tracing and quarantine of contacts.

• Strengthening genomic surveillance and investigating clusters when variant involvement is suspected/confirmed are also highly important.

• There is a need for hospitals to be equipped for the surge in cases, including ensuring the availability of isolation rooms, oxygen supplies, medical equipment, key therapeutics such as corticosteroids, low dose anticoagulants, antifungal medicines, and interleukin-6 receptor blockers, personal protective equipment (PPE), mobile field hospitals, body bags, additional human resources and capacity to convert hospital rooms to isolation or intensive care unit (ICU) rooms.\textsuperscript{16}

\textsuperscript{12} https://news.detik.com/berita/d-5641453/menkes-90-ribu-tempat-tidur-pasien-covid-di-rs-terisi-dalam-7-minggu
\textsuperscript{13} https://databoks.katadata.co.id/datapublish/2021/07/13/keterisian-rumah-sakit-covid-19-di-12-provinsi-masuk-zona-merah
\textsuperscript{15} https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance-publications
\textsuperscript{16} https://www.who.int/publications/i/item/critical-preparedness-readiness-and-response-actions-for-covid-19
Community engagement and support (strict implementation of personal protective measures) are essential to reduce the surge in cases, deaths and hospitalizations. It is important to provide accurate information and recommendations, adapted to community needs, and counter misinformation and hoaxes.

Vaccination needs to be expedited, especially for older populations who have had consistently low coverage. Actions to improve accessibility and awareness on benefits of COVID-19 vaccination for older and high-risk populations need to be strengthened. Vaccinated persons should continue to adhere to public health and social measures.

Health facilities should continue to adhere to key WHO recommended infection prevention and control (IPC measures), in particular, adhering to contact, droplet and airborne precautions, hand hygiene practices, adequate environmental cleaning and disinfection, and ensuring adequate ventilation in rooms.
### Table 2. Title and details of recent WHO resource materials

Source: [https://www.who.int](https://www.who.int)

<table>
<thead>
<tr>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO Weekly Epidemiological Update on COVID-19 (Edition 48), 13 July 2021</strong></td>
<td>This 48th edition includes data as of 11 July 2021. In this edition, two special focuses are provided: (i) synopsis of the latest WHO COVID-19 Rapid Risk Assessment, which aims to review the current status of global public health risks associated with the COVID-19 pandemic through an in-depth hazard, exposure and context assessment; (ii) short update on the geographical distribution of SARS-CoV-2 variants of concern (VOCs): Alpha, Beta, Gamma and Delta.</td>
</tr>
<tr>
<td><strong>Infection prevention and control during health care when coronavirus disease (COVID-19) is suspected or confirmed (Interim guidance), 12 July 2021</strong></td>
<td>This document provides interim guidance on infection prevention and control (IPC) strategies during health care when COVID-19 is suspected or confirmed. It is intended for health workers, including healthcare managers and IPC teams at facility level. However, it is also relevant for national and district/provincial levels. In this updated version, the scope and structure of the earlier guidance have been expanded with several new or revised sections, including implications of variants of concern (VOCs) and vaccination for IPC practices.</td>
</tr>
<tr>
<td><strong>COVID-19 Vaccines: safety surveillance manual. Module on safety surveillance of COVID-19 vaccines in pregnant and breastfeeding women, 12 July 2021</strong></td>
<td>This module provides an overview of factors to consider when monitoring the safety of COVID-19 vaccines administered to pregnant and breastfeeding women. It describes how national routine surveillance on adverse events following immunization (AEFI) should be adapted to cater for this specific group, using passive and active surveillance methods. Specific considerations and limitations of each method are provided as well as tools for implementation.</td>
</tr>
<tr>
<td><strong>Diagnostics, therapeutics, vaccine readiness, and other health products for COVID-19 (Interim guidance), 12 July 2021</strong></td>
<td>This tool was developed to assess present and surge capacities for the treatment of COVID-19 in health facilities. It allows health facilities to assess the availability and status of stockout of critical COVID-19 medicines, equipment and supplies on site and to identify areas that need further attention to enable the facility to respond effectively to the pandemic. This tool is designed for use from the early stages of the emergency to early recovery.</td>
</tr>
<tr>
<td>Title</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Modelling the health impacts of disruptions to essential health services during COVID-19, 9 July 2021</strong></td>
<td>This document provides an overview and description of models from a technical point of view. The focus is on what the various models do, how they work, and the underlying assumptions on which the models are based. The document includes modules on modelling the disruptions caused by COVID-19 on the essential health services of specific health areas or conditions. It is intended for people who need to understand what the models say, their construction and their underlying assumptions, or need to use models and their outcomes for planning and programme development, and to support policy decisions for a country or region.</td>
</tr>
<tr>
<td><strong>WHO Global Clinical Platform for the Clinical Characterization of COVID-19: Statistical Analysis Plan, 7 July 2021</strong></td>
<td>Concerted epidemiological surveillance strategies are needed to better characterize the clinical presentations of COVID-19 in different demographic groups and in the context of varying management approaches worldwide. At this juncture, it is also critical to gain a more comprehensive understanding of the risk factors portending severe COVID-19 so that appropriate preventive or mitigating strategies may be put into place. The purpose of this document is to present a succinct description of the proposed analytic plan to generate statistics at global, regional and national levels on the different clinical characteristics associated with COVID-19 and risk factors associated with poor clinical outcomes. The reports generated and published from these proposed analyses will help clinicians and national programmes prepare appropriate management and response strategies.</td>
</tr>
<tr>
<td><strong>Episode 45 of Science in 5, WHO’s series of conversation in science, 5 July 2021</strong></td>
<td>WHO Technical Lead for COVID-19 Dr Maria Van Kerkhove provides an update on the SARS-CoV-2 Delta variant and explains personal protective measures against the variant.</td>
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<tr>
<td><strong>Episode 44 of Science in 5, WHO’s series of conversation in science, 1 July 2021</strong></td>
<td>WHO Chief Scientist Dr Soumya Swaminathan explains COVID-19 vaccines and vaccine protection in the context of the SARS-CoV-2 Delta variant.</td>
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</table>
Online WHO COVID-19 courses:
- COVID-19 vaccination training for health workers
- Standard precautions: Environmental cleaning and disinfection
- Management of COVID-19 in long-term care facilities
- Operational planning guidelines and COVID-19
- Clinical management of severe acute respiratory infections
- Health and safety briefing for respiratory diseases – eProtect

WHO guidance:
- Technical considerations for implementing a risk-based approach to international travel in the context of COVID-19: Interim guidance
- Policy considerations for implementing a risk-based approach to international travel in the context of COVID-19
- Ethical Framework for WHO's work in the Access to COVID-19 Tools (ACT) Accelerator
- Protocol template to be used as template for observational study protocols for sentinel surveillance of adverse events of special interest (AESIs) after vaccination with COVID-19 vaccines
- Implementation guidance for assessments of frontline service readiness: strengthening real-time monitoring of health services in the context of the COVID-19 pandemic

Infographics:
- Vaccine prioritization
- Play your role
- Contact tracing: Confirmed contact & COVID-19 positive

Questions and answers:
- COVID-19: Vaccines
- COVID-19: Vaccine research and development
- COVID-19: Vaccine access and allocation

Videos:
- Science in 5: Evolution of the SARS-CoV-2 virus
- Time to abide (1-10)
- COVID-19 virus variants

For more information please feel free to contact: seinocomm@who.int
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