As of 24 May, the Government of Indonesia announced 22,271 confirmed cases of COVID-19, 1,372 deaths and 5,402 recovered cases from 404 districts across all 34 provinces.

WHO is supporting the Ministry of Health (MoH) in provincial data analyses using publicly available data. Papua, the eastern most province of the country, is highlighted in this report.

WHO discussed the cross-border collaboration between Indonesia and Papua New Guinea in the context of COVID-19 response.

Five additional laboratories from the Indonesian Food and Drug Administration (BPOM) started to perform polymerase chain reaction (PCR) to boost COVID-19 testing capacity in the country.

Figure 1: Geographic distribution of confirmed COVID-19 cases in Indonesia, as of 24 May 2020. Source of data: [https://infeksiemerging.kemkes.go.id/](https://infeksiemerging.kemkes.go.id/)
• As reported on 16 May, President Joko Widodo announced that he will not yet ease the large-scale social restrictions (PSBB). The government aims to keep residents productive and safe at the same time in a 'new normal' with COVID-19. While the PSBB policy is still in place, the government will gradually allow more businesses to open with added health precautions to prevent further transmission. The President also said that almost all regions complained about their decreasing income, ranging from 30% to 50%, as the halt of economic activity affected revenue from regional levies\(^2\).

• As reported on 18 May, the Governor of Jakarta reiterated that mudik (returning to hometowns for Eid) will not be permitted. He urged residents to stay at home and socialize with friends and family through digital communication. Prior to that, on 15 May, the Governor issued a decree banning all residents from leaving Greater Jakarta (Bogor, Depok, Tangerang, South Tangerang and Bekasi), except for travel serving essential needs, to curb the transmission of COVID-19. The decree does not allow local mudik even within Greater Jakarta\(^3\).

• The COVID-19 Task Force revised the method of reporting the number of persons under observation (ODP) and patients under surveillance (PDP). Previously, the cumulative number of ODP and PDP also included those who had been subsequently tested\(^4\). Since 18 May, the cumulative number includes only those for whom testing is still pending (i.e. the figure is reduced by the number of those who have been tested for COVID-19 by PCR). Consequently, the reported number of ODP and PDP dropped dramatically from 270,876 to 45,047 and from 35,800 to 11,422, respectively, from 17 to 18 May. As per WHO guidance\(^5\), both ODP and PDP are considered as suspected cases (see WHO global case definitions on pages 15-16). It is important to continue to report the cumulative suspected cases (ODP and PDP) for epidemiological analyses as per standard practice.

The Indonesian Hospital Association (PERSI) has started to use the **WHO Essential Supplies Forecasting Tool** (ESFT) to forecast essential supplies for hospitals. On 18 May, WHO participated in a virtual meeting organized by PERSI to discuss dissemination of the ESFT to hospitals in Indonesia.

On 20 May, WHO and the United Nations Children’s Fund (UNICEF) jointly conducted a webinar to train field staff on the use of the WHO ESFT. A total of 34 participants from the MoH, the Ministry of National Development Planning (BAPPENAS), WHO and UNICEF field staff joined the training. The staff will provide support to estimate requirements for essential supplies needed for the development of the response plans at the provincial-level, in collaboration with the Province Health Officers.

From 15 to 16 May, WHO participated in meetings with the MoH and the COVID-19 Task Force to discuss the public health criteria and indicators for adjusting public health and social measures in the context of COVID-19. A cross-sectional survey was proposed to collect and analyze epidemiological, health system and public health surveillance information at subnational levels to inform risk levels that can be used to guide the adaptation of PSBB. On 20 May, WHO participated in a follow-up meeting. The COVID-19 Task Force has selected some of the proposed WHO indicators to be included in the new data reporting platform called “Bersatu Lawan Corona” (BLC), introduced by the BNPB.

On 19 May, WHO was invited to provide feedback on the draft criteria to relax PSBB, prepared by BAPPENAS, using the effective reproduction number \( (R_t) \) as the main criterion to make the final decision. At this meeting, the WHO Representative to Indonesia emphasized that the current surveillance data in Indonesia are insufficient to robustly assess \( R_t \) and make accurate \( R_t \) calculations. Therefore, as per WHO guidance “**Public health criteria to adjust public health and social measures in the context of COVID-19**”, WHO advised on the use of selected additional criteria to assess whether COVID-19 transmission is controlled in a particular geographical location (Table 1).
Table 1. Selected criteria to assess control of COVID-19 transmission in a geographical location

<table>
<thead>
<tr>
<th>Epidemiological criteria</th>
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<tbody>
<tr>
<td>• Decline of at least 50% over a 3-week period since the latest peak and continuous decline in the observed incidence of confirmed and probable cases</td>
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<tr>
<td>• Less than 5% of samples positive for COVID-19, at least for the last 2 weeks, assuming that surveillance for suspected cases is comprehensive</td>
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<tr>
<td>• Decline in the number of deaths among confirmed and probable cases at least for the last 3 weeks</td>
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<th>Health system criteria</th>
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<tr>
<td>• Continuous decline in the number of hospitalization and intensive care unit (ICU) admissions of confirmed and probable cases at least for the last 2 weeks</td>
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<tr>
<th>Public health surveillance criteria</th>
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<tbody>
<tr>
<td>• New cases can be identified, reported, and data included in epidemiological analysis within 24 hours</td>
</tr>
<tr>
<td>• At least 80% of new cases have their close contacts traced and in quarantine within 72 hours of case confirmation</td>
</tr>
<tr>
<td>• At least 80% of contacts of new cases are monitored for 14 days</td>
</tr>
</tbody>
</table>

Source: Public health criteria to adjust public health and social measures in the context of COVID-19

On 21 May, the WHO Representative joined a press conference organized by BAPPENAS, where the Honourable Minister for National Development Planning presented draft criteria to relax PSBB. The WHO Representative emphasized that the following interventions should continue: expanded testing of suspected cases; rapid isolation of suspected and confirmed cases; appropriate clinical care for those affected with COVID-19; quickly tracing and quarantining all contacts; and continuous implementation of proven public health measures, including frequent hand washing, wearing re-usable masks in public, and maintaining individual-level effective physical distancing. He reiterated that these are non-negotiable components of living with COVID-19 in 2020 and 2021 as the “new normal”.

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There were 526 new confirmed cases of COVID-19 reported on 24 May. The cumulative number of confirmed cases nationwide on the same date was 22,271 (Fig. 2).

As of 24 May, the majority of confirmed cases were in Java Island, followed by Sulawesi (in South Sulawesi) and Sumatra (in South Sumatera); the cumulative confirmed cases by province is shown below (Fig. 3).

As of 24 May, the proportion of confirmed cases was highest among 31-45-year-olds (29.2%), followed by 46-59-year-olds (27.8%), 18-30-year-olds (20.3%), over 60-year-olds (15.2%), 6-17-year-olds (5.4%) and 0-5-year-olds (2.0%) nationally; for 8.2% of the confirmed cases, there were no data on age. Age-disaggregated data on confirmed cases by province are shown below (Fig. 4).

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Footnote:

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[who.int/indonesia](http://who.int/indonesia)
Figure 3: Cumulative number of confirmed COVID-19 cases by province in Indonesia, as of 24 May 2020.

Source of data

who.int/indonesia
Figure 4: Age disaggregation among the confirmed cases of COVID-19 by province in Indonesia, as of 24 May 2020. Data on age were missing for 8.4% of cases. Source of data
On 19 May, WHO participated in a video conference with the WHO Papua New Guinea country office and the Regional Office for the Western Pacific to discuss cross-border collaboration between Indonesia and Papua New Guinea in the context of the COVID-19 response. Support and coordination will be extended between the countries, with a focus on epidemiology and surveillance. An official request from the Papua New Guinea MoH to the Indonesia MoH is pending.

SITUATION IN PAPUA

Papua is the eastern most province of the country and has a population of 3,435,430. On 31 January 2020, Papua New Guinea closed its borders to Indonesia, in Jayapura and Merauke districts. On 22 March, the first confirmed case was reported from Merauke district in Papua – 20 days after the first confirmed cases in the country were reported. By 26 March, Papua closed air and sea ports for passengers, however, there remains unofficial movement of people across the borders. As of 24 May, 556 people have tested positive for COVID-19, of which 90.3% are currently under care or in isolation, 8.6% have recovered, and 1.1% have died. The daily and cumulative number of cases reported are shown below (Fig. 5).

![Daily and cumulative number of confirmed COVID-19 cases in Papua](https://covid19.go.id/peta-sebaran)

Figure 5: Daily and cumulative number of confirmed COVID-19 cases in Papua, as of 24 May 2020. Source of data: [https://covid19.go.id/peta-sebaran](https://covid19.go.id/peta-sebaran)

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\(^7\) [https://covid19.go.id/peta-sebaran](https://covid19.go.id/peta-sebaran)
Of 44 hospitals in Papua, 16 have been assigned as referral hospitals for COVID-19. Of the 16 referral hospitals, half are in Jayapura City; the remaining eight are spread across the other districts, resulting in limited access to hospital care for citizens residing outside of Jayapura City. The distribution of medical supplies is a challenge due to Papua’s many hard-to-reach areas that are inaccessible by land transportation.

**LABORATORY**

![Graph showing daily and cumulative number of suspected COVID-19 cases tested with PCR in Indonesia, as of 24 May 2020.](source_of_data)

Figure 6: Daily and cumulative number of suspected COVID-19 cases tested with PCR in Indonesia, as of 24 May 2020. [Source of data](source_of_data)
• As reported by the government on 24 May, the number of persons tested for COVID-19 was 3,829 and the cumulative number of persons tested was 179,864 (Fig. 6).

• From 15 to 16 May, WHO facilitated a virtual coordination meeting in which the possibility of accelerating PCR testing for COVID-19 using HIV viral load machines was discussed. Participants included the Sub-directorate of HIV, MoH, provincial health laboratories and hospitals/laboratories that have HIV viral load machines.

• Five additional laboratories from the BPOM have joined the COVID-19 laboratory network. Four of the laboratories are in Papua, Ambon, Makassar and Gorontalo, which will boost testing capacity in the remote eastern part of Indonesia; and one is in Jakarta, which will enhance the province’s testing capacity. The WHO Representative, along with the Chairperson of the BPOM and the Head of the BNPB, attended the virtual inauguration event. As of 21 May, there are 103 laboratories in the laboratory network for COVID-19 testing.

• From 18 to 20 May, WHO, in collaboration with the NIHRD, facilitated the third batch of virtual training on COVID-19 PCR testing. The training was attended by 166 participants from 60 laboratories that have recently qualified or may qualify for PCR testing for COVID-19. On the first day of the training, a technical team presented the updated WHO laboratory guidance, including the latest guidance on biosafety.

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As of 24 May, the proportion of confirmed COVID-19 cases in relation to the number of persons tested with PCR was 12.4% (Fig. 7).

If the proportion of positive cases has continued to be less than 5% of samples tested for at least for two consecutive weeks, it is an indication that the transmission is coming under control, provided that the surveillance for suspected cases is comprehensive. In order to use this criterion, there should be an adequate number of PCR tests performed in the order of one test per 1,000 population per week in the particular geographical area or catchment population. Comprehensive surveillance includes surveillance at the community level, primary care level, in hospitals, and through sentinel surveillance sites for influenza and other respiratory diseases.  

Source of data

There has been an improvement in the proportion of people that recovered among the total confirmed cases from 6.0% in early April to 24.3% as of 24 May (Fig. 8). As of the same date, there were 15 497 confirmed COVID-19 cases under care or in isolation\textsuperscript{10}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{cumulative_number_recovered_cases.png}
\caption{Cumulative number of recovered cases and percentage recovery from COVID-19 in Indonesia, as of 24 May 2020. \textit{Source of data}}
\end{figure}

On 19 May, WHO participated in a water, sanitation and hygiene (WASH) coordination meeting with BAPPENAS. WHO presented on water safety in the community setting and highlighted the challenge of limited access to clean water for many communities. One of the important recommendations was to incorporate water safety as a component of field interventions.

\textsuperscript{10} https://covid19.go.id/
• On 19 May, WHO participated in an online training convened by the Southeast Asian Ministers of Education Organization (SEAMEO) and presented the WHO guidance on food safety amidst COVID-19. There were 648 participants, including Province Health Officers, District Health Officers and food safety practitioners from universities.

COMMUNICATIONS

• On 20 May, the COVID-19 Task Force published a COVID-19 cross-sector guidance describing the ‘new normal’. The guidance primarily aims to support the subnational COVID-19 Task Force coordinators, programme managers, and health service providers in various sectors from health to education to finance. The WHO website link has been shared in the guidance as one of the sources of reliable information that can be used by subnational stakeholders.

• WHO published additional COVID-19-related infographics on:
  - Keep cool – health advice in hot weather
  - Hand hygiene
  - Myth-busters:
    - Spraying or introducing bleach into the body will not protect against COVID-19 and can be dangerous
    - UV lamps should not be used to disinfect hands or other areas of the skin
    - Exposing oneself to sun or to temperatures higher than 25 degrees does not prevent nor cure COVID-19
    - There are currently no drugs licensed for the treatment or prevention of COVID-19
    - COVID-19 can be transmitted in areas with hot and humid climates
    - Adding pepper to soup or other meals does not prevent or cure COVID-19

RESEARCH

• WHO continues to support the NIHRD and participating hospitals in Indonesia in the global WHO Solidarity Trial, comparing four arms of treatment: chloroquine or hydroxychloroquine; lopinavir/rotinavir; lopinavir/rotinavir with interferon beta-1a; and remdesivir.
On 16 May, WHO convened the weekly meeting of key development partners to discuss and coordinate COVID-19 response activities. The Canadian Embassy and the Asian Development Bank (ADB) have joined the meeting. Other attendees were the Australian Department of Foreign Affairs and Trade (DFAT), the European Union (EU), UNICEF, the United States Agency for International Development (USAID), the US Centers for Disease Control and Prevention (CDC), the World Bank and the World Food Programme (WFP). The World Bank has finalized their disbursement-linked indicators (DLI) for the COVID-19 project in Indonesia; the list of indicators is available and partners will look into aligning their respective support to ensure consistency in partners’ technical assistance.

On 19 May, WHO participated in a meeting with ADB, DFAT, USAID, and the World Bank to discuss Indonesia’s need for ventilators. The need for invasive or non-invasive ventilators must be assessed before the procurement can be initiated.

Overall funding request for WHO operations and technical assistance is US$ 18 million, based on estimated needs as of May 2020 (Fig. 9).

Data presented in this situation report have been taken from publicly available data from the MoH (https://infeksiemerging.kemkes.go.id/) and BNPB (http://covid19.go.id) websites. There may be differences in national and provincial data depending on the source used. All data are provisional and subject to change.
WHO CASE DEFINITIONS

Suspect case

A. A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath), AND a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset;

OR
B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case (see case definition of contact) in the last 14 days prior to symptom onset;

OR
C. A patient with severe acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; AND requiring hospitalization) AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

A. A suspect case for whom testing for the COVID-19 virus is inconclusive.

OR
B. A suspect case for whom testing could not be performed for any reason.

Confirmed case

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Contact

A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:
A. Face-to-face contact with a probable or confirmed case within 1 meter and for more than 15 minutes;
B. Direct physical contact with a probable or confirmed case;
C. Direct care for a patient with probable or confirmed COVID-19 disease without using PPE;

OR
D. Other situations as indicated by local risk assessments.
Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken which led to confirmation.

**COVID-19 death**

Death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case, 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.

WHO periodically updates the [Global Surveillance for human infection with COVID-19](https://www.who.int/indonesia) document which includes surveillance definitions.
A LIST OF ONLINE WHO TRAINING AND INFORMATION MATERIAL

Online WHO COVID-19 courses:
- Operational planning guidelines and COVID-19
- Clinical management of severe acute respiratory infections
- Health and safety briefing for respiratory diseases – eProtect
- Infection prevention and control
- Emerging respiratory viruses, including COVID-19
- Design of severe acute respiratory infection treatment facility

WHO guidance:
- Considerations for public health and social measures in the workplace COVID-19 and food safety
- Guiding principles for immunization activities during the COVID-19 pandemic
- Safe Ramadan practices
- Advice on the use of masks
- Home quarantine
- Investigation of cases and clusters
- Clinical management of severe acute respiratory infections
- Rational use of PPE and considerations during severe shortage
- Maintaining a safe and adequate blood supply during the COVID-19 pandemic
- Advice for the use of immunodiagnostic tests (point-of-care) in health facilities

Infographics:
- Keep cool – health advice in hot weather
- Physical distancing is not social isolation
- Hand hygiene
- Safe grocery shopping and food safety
- Ramadan at home
- Medical workers: super heroes
- Healthy at home (Home ‘Dos’)
- Recognize and response
- Young adults and COVID-19
- The elderly and co-morbidity
- Protecting the vulnerable
- Communicating transmission
- Communicating severities
- Low risk is not no risk
- Noncommunicable diseases
- A selection of myth-busters

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