

Intra-action Review of Indonesia's Response to COVID-19

SUMMARY REPORT FOR PARTNERS
JANUARY 2021

Intra-action Review of Indonesia's Response to COVID-19: Summary Report

© World Health Organization 2021

Some rights reserved. This work is available under the Creative Commons Attribution-Non-Commercial-Share Alike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules/>).

Suggested citation. Intra-action Review of Indonesia's Response to COVID-19: Summary Report for partners, August 2020. Jakarta: World Health Organization; 2021.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use. This publication contains the collective views of those participating in Indonesia's First Intra-Action Review on COVID-19 and does not necessarily represent the decisions or the policies of WHO.

Contents

Executive Summary.....	2
Intra-Action Review Findings	5
Coordination, planning, and monitoring	5
Risk communication and community engagement.....	6
Surveillance, rapid response team, and case investigation	8
Points of entry, international travel and transport.....	11
Large-scale social restrictions.....	12
Laboratories	14
Infection prevention and control.....	16
Case management.....	18
Operational support and logistics.....	21
Maintaining essential health services and systems	22
Comparison of IAR findings with other measures of capacity.....	25
Progress Against Recommendations and Next Steps	26

Executive Summary

In early 2020 COVID-19 rapidly developed into a global health emergency, with WHO declaring it a Public Health Emergency of International Concern (PHEIC) on 30 January 2020, and a pandemic on 11 March. The Government of Indonesia, with support from the World Health Organization and partners, has been responding to the threat of COVID-19, since its emergence was first recognized, to when the first cases were identified in Indonesia in March 2020, through to the present.

As of the 31 December 2020, Indonesia has recorded 735,124 cases of COVID-19 as well as 21,944 deaths. Case numbers are continuing to grow, with around 50,000 new cases recorded per week at the end of 2020.

The protracted nature of the COVID-19 pandemic requires Governments and responding agencies to continually work to strengthen their response. The Intra-Action review is a tool to facilitate this process. The IAR is a country-led facilitated process conducted during the COVID-19 outbreak. The IAR enables us to identify areas within the public health response which require remediation or strengthening to improve the ongoing COVID-19 response in real time.

Indonesia conducted its first IAR from 11 to 14 August 2020. During the review representatives of various units within the Indonesia Ministry of Health and a range of other Government Departments and Units as well as key response partners, the World Health Organization (WHO) and other United Nations agencies met virtually to review and critically reflect on progress in the response to COVID-19. The review was arranged to assess Indonesia's response across the nine pillars of the COVID-19 strategic preparedness and response plan:

1. Coordination, planning, and monitoring;
2. Risk communication and community engagement;
3. Surveillance, rapid response team, and case investigation;
4. Points of entry, international travel and transport, and large-scale social restrictions;
5. National laboratories;
6. Infection prevention and control;
7. Case management;
8. Operational support and logistics; and
9. Maintaining essential health services and systems.

The findings of this IAR will assist the Government of Indonesia and its partners to continue the fight against COVID-19 and strengthen our collective response to this ongoing challenge. The response to COVID-19 in Indonesia requires a coordinated effort with support from all partners and stakeholders. The purpose of this report is to provide a summary of IAR key findings and recommendations in a format which enables partners and response stakeholders to identify opportunities to contribute to strengthening our response.

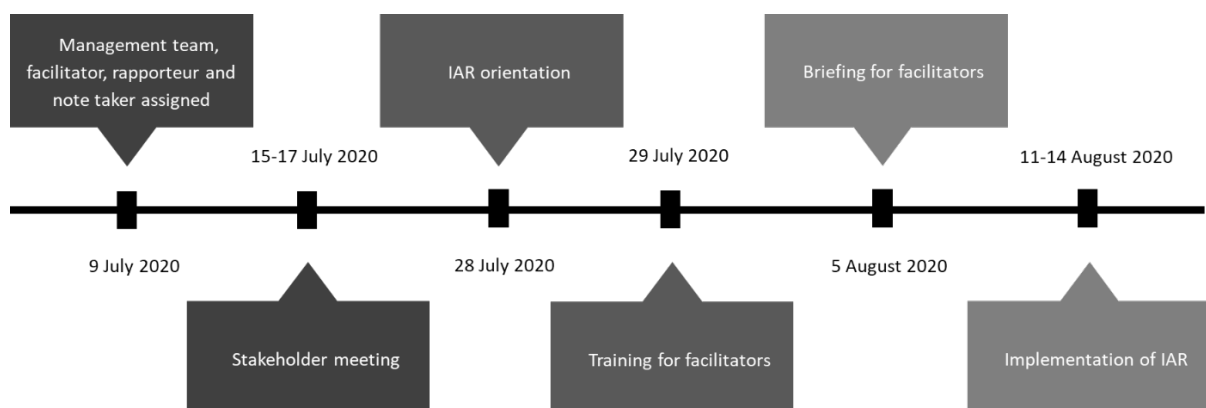
Select priority recommendations from the IAR are provided below. Whilst this document is designed to provide a more high-level overview of the IAR findings and recommendations, a more detailed summary of key gaps and lessons learned under each pillar of the response plan. Full background, methods and in-depth findings are available in the full IAR report.

Overarching IAR Recommendations

1. Enhance command and coordination among multisectoral stakeholders in the national and subnational levels, review response plan and routine monitoring of response plan indicators, activation of health clusters, and enhance the use of COVID-19 Partners Platform to monitor COVID-19 response.
2. Use the Essential Supply Forecasting Tool (ESFT) to harmonize the logistic reporting system for the purposes of mapping and logistic needs fulfilment.
3. Enhance surveillance for contact detection, tracing and monitoring by activation of rapid response teams, multisector collaboration and community engagement.
4. Increase accuracy and completeness of case reporting on New All Record from healthcare facilities and laboratories to allow for data analysis that will be used for response strategies. Enhance interoperability and information sharing between Public Health Emergency Operation Centre (PHEOC), online hospital information system) and Data and Information Centre (Pusdatin) to cross sectors and partners including the Bersatu Lawan COVID system (BLC) of the COVID-19 Task Force. In line with the Global Influenza Surveillance Response System (GIRS) COVID-19 platform, enhance surveillance of influenza-like illness (ILI)/severe acute respiratory infection (SARI) to monitor COVID-19.
5. Enhance strategies and laboratories testing capacity with COVID-19 laboratory network using PCR, viral load, rapid molecular test and mobile PCR.
6. Strengthen the integrated hospital referral system (SISRUTE) and COVID-19 referral hospitals network in prioritized provinces. Triage and case management is to be conducted based on the severity level of the cases. Continue participation in solidarity trial for COVID-19 medicine.
7. Better triage in healthcare facilities to avoid exposure of patients and healthcare workers to COVID-19, enhance infection prevention and control (IPC) in healthcare facilities through trainings, healthcare workers monitoring, and medical audit for COVID-19 infection in healthcare workers; enhance surveillance of healthcare associated infections (HAI) COVID-19 and insurance scheme of healthcare workers.

8. Appoint health and safety officers in offices to monitor the implementation of COVID-19 protocols in workplaces. Implement and monitor the infection control in the communities and public places.
9. Enhance compliance of using electronic Health Alert Card (HAC) for international travellers and optimize the use of HAC for contact tracing.
10. Enhance risk communications, rumour monitoring, counter hoax, hotline and information, education and communication such as the wear mask campaign. There is a need to reassess the zoning indicators that was conveyed by the COVID-19 Task Force to the media. Zoning status is to be used for planning purposes to avoid misunderstanding by the public in interpreting it. Communications strategies for the general public should be based on main messages on prevention of transmission risk such as physical distancing, mask use, hand washing and reduced mobility regardless the zoning status.

Figure 1: Intra-Action Review Process Timeline



Intra-Action Review Findings

Coordination, planning, and monitoring

The President of Indonesia declared COVID-19 a national emergency in February 2020 and in March 2020 formed the COVID-19 task force to support high-level coordination of the national response. The Ministry of Health provides leadership for health system response and has adopted its influenza pandemic contingency plan for the COVID-19 response plan.

Gaps and challenges

- A siloed approach to response operations was noted, with limited coordination and communication, between sectors at the national level, and between national and sub-national levels of the coordination structures.
- Individuals involved in the response have at times had multiple and competing priorities, including operational responsibilities. This has at times impacted on strategic and planning related tasks.
- There is a need to improve monitoring of COVID-19 response plan indicators. This is in part due to issues in data and information management, including delayed reporting and mismatched data.
- Utilisation of health clusters for COVID-19 response has been sub-optimal. Not all clusters have been activated and regular coordination meetings have not been held.

Best Practices and Lessons Learned

- Conducting regular coordination meetings across sectors at the national level and between national and provincial levels, with a clear systematic agenda is improving coordination, accountability and monitoring of response plan indicators.
- Use of online collaborative technology such as video conferencing is improving communication for developing regional response plans and other coordination functions.
- The WHO Partner's Platform is assisting in information dissemination to COVID-19 response operations partners.
- IHR Core capacity monitoring, State Party Annual Reporting, National Action Plan for Health Security

Recommendations for coordination, planning, and monitoring

Short Term:

1. Conduct a review of the command and coordination structure of the health sector response plan and ensure focal point and COVID-19 response team duties and operational and strategic functions are clearly defined
2. Ensure periodic coordination meetings and increased utilization of the COVID-19 Partner's Platform to monitor response plan indicators are held for multiple sectors at the national level and between the national and sub-national levels
3. Activate health clusters at the national and regional levels for COVID-19 response

Medium to longer term:

4. Develop tiered training modules for pandemic readiness, preparedness, and response, based on lessons from the COVID-19 pandemic
5. Conduct a COVID-19 After Action Review
6. Develop a dashboard to facilitate decision-making in pandemic response command and coordination

Risk communication and community engagement

A range of guidance documents and tools have been developed to support community engagement and risk communication. Key messages have been developed, both for the broader community and targeted messaging for specific high-risk groups. This messaging has been informed by various surveys of the public to assess knowledge and understanding of relevant aspects of COVID-19. The Ministry of Health has assigned several teams to conduct important core tasks of daily media monitoring, counter-hoax activities and provision of a COVID-19 hotline. The Ministry of Health has provided daily press briefings and regular press releases. Media networks and journalists have been engaged by the Ministry of Health to ensure provision of accurate information to the public and assist in countering false information.

Gaps and challenges

- Communicating with the public about transmission zone-based precautions has been challenging, resulting in misinterpretation of precaution requirements. For example, there has been public perception that green zones are free of risk.
- Communities have not always implemented key messages optimally as the Information, Education and Communication (IEC) materials that have been disseminated are not followed-up with relevant social support and or regulation.
- There is an ongoing need for further simplification and tailoring of communication language for better understanding by communities.
- There has been a lack of monitoring and evaluation of risk communication and community engagement (RCCE) implementation.
- There is a need to better train and equip all cadres and volunteers to deliver risk communication messages. This activity has been constrained by infrastructure and funding issues. There is a need for better involvement of existing volunteers such as Disaster-Resilient Youths (Tagana), village volunteers, and coordination between the volunteer coordinator and BNPB/BPBD/Task Force.
- Not all Government agencies, companies and other organisations have adhered to COVID-19 protocols, demonstrating that further efforts are needed to ensure that messaging is getting through to these groups and sectors.

Best Practices and Lessons Learned

- The Ministry of Health has engaged with other Government departments, such as the Ministry of Women and Children Empowerment to develop targeted information, education and communication (IEC) content for different age-groups and other population groups.
- A range of tools and guidance documents have been developed, such as risk communication strategies, community empowerment guidelines in COVID-19 prevention in RTs/RWs/villages, communication guidelines, behaviour change in COVID-19 prevention and control. Tools and risk communication strategies have been informed by surveys of the public, health care workers and other groups to ensure that gaps in knowledge are identified and addressed.
- A range of measures were implemented to improve access to accurate, timely, consistent and trusted Government messaging around COVID-19, including: a designated media spokesperson, a media centre, COVID-19 hotline, the official www.covid19.go.id website, and communication channel (call centre).
- Media monitoring and periodic public opinion surveys are undertaken, along with significant efforts to identify and counter hoaxes and other false and misleading information sources by the risk communication team with the help of “cyber troops”.

- Spokesperson training was delivered in nine provinces to support improved media and public communication at the provincial level.
- Communication strategy for COVID-19 prevention behaviour change.
- A national ‘wear a mask campaign’ was undertaken to boost uptake and compliance with mask wearing, in-line with relevant guidelines.

Recommendations for risk communication and community engagement

Short Term:

7. Enhance cooperation with telecommunication service providers to relay key messages on COVID-19 prevention through mobile messaging
8. Conduct risk communication and community engagement training for relevant Government and community organisations
9. Improve cross-sectoral coordination for risk communication and community engagement through regular meetings
10. Develop tools to improve monitoring of hoaxes and evaluation of risk communication

Medium to longer term:

11. Develop risk communication and community engagement strategies and information-filtering platforms

Surveillance, rapid response team, and case investigation

The Ministry of Health rapidly implemented and regularly updated COVID-19 surveillance guidelines, adopting WHO operational definitions. COVID-19 case reporting takes place through the All Record application which is managed by the Ministry of Health. This system interfaces with the hospital information system (SIRS). The Public Health Emergency Operation Centre (PHEOC) conducts data verification and analysis and shares data with Centre of Data and Information of the Ministry of Health. As part of the one-gate data policy, the Centre of Data and Information shares data with relevant stakeholders including the National Disaster Management Agency. The Ministry of Health conducts sentinel surveillance at 27 Influenza-Like Illness (ILI) sites and six Severe Acute Respiratory Infection (SARI) sites. A seroprevalence study is being planned.

Gaps and challenges

- Due to changing case definitions, testing guidelines and other operational aspects of COVID-19 surveillance, dissemination and implementation of updates at sub-national levels has been challenging. Not all revisions have been fully implemented in all areas, and a lack of clarity around operational definitions has been reported by some officials.
- There are a range of data management platforms in use across the different levels of the clinical and public health systems. Issues of poor interoperability and duplication of data entry tasks and case records has added to surveillance workload.
- Issues have arisen as a result of data transparency, limiting understanding of the on-the-ground epidemiological situation in some areas. The transmission zone categorisation system has incentivised regions to reach green zone status, which they have sometimes done by refraining from detecting, concealing data or not reporting cases.
- A recommendation on prioritising laboratory testing for suspect cases has not been implemented. As a result, laboratory confirmation or exclusion is not available for many persons who have died, potentially resulting in under-enumeration of COVID-19 deaths.
- There remain many opportunities to improve the completeness and timeliness of epidemiological investigation, contact tracing and reporting. Issues related to use of paper-based forms, incomplete reports, inadequate training and late and incomplete reporting need to be addressed.

Best Practices and Lessons Learned

- The Ministry of Health has ensured that surveillance guidelines are regularly updated in line with the latest WHO guidance.
- Use of the All Record application has helped to streamline COVID-19 case reporting from health facilities, laboratories, and district health offices to improve the timelines and completeness of case notification.
- Several partners have supported the Ministry of Health with development of applications for epidemiological investigation, contact tracing and monitoring. Open source applications such as ODK, Kobo toolbox have been effectively used to improve data collection, reporting and analysis.
- The Indonesian Epidemiology Association has supported the Government through the development of applications to facilitate situational awareness and forecasting.

Recommendations for surveillance, rapid response team, & case investigation

Short Term:

12. Establish comprehensive surveillance criteria, indicators and targets, such as case finding and laboratory testing targets, to encourage regions to strengthen their surveillance systems
13. Work with NIHRD to strengthen laboratory capacity to support surveillance activities
14. Conduct training and regular refreshers on contact tracing and quarantine
15. Improve guideline dissemination and consultation implementation at sub-national levels
16. Review zoning indicators and appropriate use of the zoning strategy to avoid misinterpretation
17. Increase volunteer support for contact tracing
18. Produce regular situation reports and analyses of health and surveillance indicators
19. Develop brief technical guidelines for contact tracing and training materials
20. Train rapid response teams on data analysis in collaboration with Field Epidemiologist Training Program (FETP) or Indonesian Epidemiology Association
21. Review data entry procedures in All Record to reduce delays in the reporting of laboratory testing results
22. Implement seroprevalence testing into national COVID-19 surveillance
23. Conduct an audit of deaths
24. Review and update All Record data entry system to allow entry by health facility and health office staff to support data completeness and timeliness and reduce the burden on laboratory staff

Medium to longer term:

25. Prepare additional workforce to undertake community-based surveillance, case-finding and contact tracing

26. Mortality Audit and death data or specific review in hospitals
27. Develop a grand design for use of mobile technology for contact tracing
28. Ensure rapid response team personnel are identified at district level in all areas
29. Develop short online training modules on COVID-19 surveillance and case-finding
30. Undertake an analysis of death data using available tools in collaboration with relevant parties

Points of entry, international travel and transport

COVID-19 screening is conducted at points of entry, including seaports, airports and ground-crossing points across Indonesia. The Ministry of Health has collaborated with the Ministry of Transportation, the immigration office and airlines and shipping companies to implement measures to reduce risk at points of entry. Such measures have included the use of e-Health Alert Cards, provision of risk communication messaging to travellers and implementing a referral system to quarantine facilities and hospitals for new arrivals.

Gaps and challenges

- Capacity to implement public health response measures has been variable between points of entry. Ensuring adequate communication and coordination with all points of entry, and implementation of risk communication messages for travellers has been challenging. The Port Health Authority has had limited resources.
- Overall, there has been limited infrastructure, supplies and operational personnel to implement quarantine procedures for travellers.
- Despite implementation of the e-Health Alert Card system, use of Health Alert Card data has been suboptimal.
- There is limited capacity to undertake any form of validation of negative COVID-19 PCR test results carried by passengers.

Best Practices and Lessons Learned

- Cross-sectoral communication and coordination with other Government departments and private airlines and shipping companies has assisted in efforts to mitigate the risk of COVID-19 importation and transmission at points of entry.

- Efforts have focused on early identification of suspect cases through risk communication messaging, health screening, medical evaluation, and referral to quarantine and isolation facilities.
- The electronic health alert card (e-HAC) has helped to facilitate contact tracing efforts.

Recommendations for points of entry, international travel and transport

Short Term:

31. Undertake a rapid assessment of capacity at all points of entry
32. Ensure that Port Health Authority resource needs are met
33. Ensure point of entry policies are effective, efficient and in-line with at-risk group characteristics
34. Coordinate with relevant partners to improve implementation of the electronic Health Alert Card
35. Implement mobile PCR testing at points of entry
36. Develop Memorandums of Understanding with relevant bodies to ensure availability of suitable quarantine facilities

Medium to longer term:

37. Ensure longer term resource needs at points of entry are guaranteed
38. Support the designation of additional points of entry for disembarkation of repatriated persons
39. Continue to implement preventive measures at points of entry

Large-scale social restrictions

The President released a government regulation on large-scale social restrictions on 31 March 2020. The implementation included closure of schools, restrictions on mass gatherings including religious gatherings, public facilities, socio-cultural activities, and transportation mobility, with exception for security and defence, public facilities for essential services such as health facilities, and markets for essential needs. Local governments proposed large-scale social restrictions implementation in their respective areas. A committee assigned by the

Ministry of Health reviewed and made recommendations to approve the large-scale social restrictions implementation considering the given epidemiological situation. Other considerations included availability of basic essential supplies, capacity to support implementation of large-scale social restriction, social safety net, health facilities, and security. DKI Jakarta, West Sumatera, and Riau applied province-level large-scale social restrictions, while others applied district level large-scale social restrictions.

Gaps and challenges

- Implementation of the Test, Trace and Treat strategy for COVID-19 could be improved.
- There has been limited cross-sectoral coordination in implementation of large-scale social restriction management. Additional regulation and guidance are needed at all levels, particularly around criteria for terminating, relaxing or extending restrictions.
- Better reporting and recording at all levels are needed.
- There is a lack of capacity to adequately monitor workers before arriving to and after leaving their workplaces.
- Implementation of social restrictions is not supported with enforcement and incentivisation or penalties.
- Large-scale social restriction can result in economic issues, both to individuals and society. Adequate social and financial supports are required.

Best Practices and Lessons Learned

- Involvement of all sectors, including the military in social restriction implementation and extension in some provinces and districts has proved effective.
- Implementation at lower government levels is making monitoring of restrictions easier.
- Guidelines on health protocol implementation at workplaces
- Aid money throughout the period of restriction has been provided by local governments.

Recommendations for large-scale social restrictions

Short Term:

40. Develop monitoring and evaluation tools together with other sectors
41. Disseminate monitoring and evaluation tools for large-scale social restriction
42. Evaluate large-scale social restriction implementation

43. Revise the large-scale social restriction guidelines to include declaration, implementation, recording and reporting, and guidance and supervision
44. Conduct coordination meetings on epidemiological assessment between national and subnational governments to determine which areas should implement restrictions

Medium to longer term:

45. Revise Ministry of Health Regulation no.9 of 2020 on large-scale social restriction guidelines to include monitoring and evaluation to determine the success of implementation
46. Develop guidelines on quarantine at the subnational level
47. Disseminate the guidelines on quarantine to the subnational level

Laboratories

Initially, COVID-19 test samples were sent to National Institute for Health Research and Development (NIHRD) for testing. In mid-March 2020, the Ministry of Health expanded its laboratory network for COVID-19 testing. As of August 2020, a total of 205 laboratories have been designated for COVID-19 testing nationwide. These included PCR testing, rapid molecular testing, and viral load testing. In addition to human health laboratories, animal health laboratories, food and drug laboratories, and mobile PCR testing facilities have helped bolster access to COVID-19 testing.

Virtual training has been conducted for 430 laboratory technicians. The NIHRD has been conducting external quality control checks for the COVID-19 laboratory network. The expansion of the laboratory network and provision of virus transport media and swabs for laboratory testing has reduced turnaround time for laboratory results.

Gaps and challenges

- There has been suboptimal coordination between central and local governments on availability and distribution of laboratory supplies and consumables, impacting on testing capacity in some areas, especially at lower levels of the health system.
- Quality issues need to be addressed. Not all laboratory equipment has been calibrated, available reagents are varied and not all are appropriately validated, and not all laboratories are participating in external quality control activities.
- Not all laboratories are reporting results in real time using the All Record application.

- A biosafety incident resulted in one laboratory not being able to continue COVID-19 testing.

Best Practices and Lessons Learned

- The laboratory network has been effectively expanded to all provinces of Indonesia. Use of mobile PCR testing has assisted in expanding access to testing.
- Use of the new All Record application for laboratory reporting has assisting in improving the timeliness of case reporting for epidemiological investigation and analysis.
- Virtual and on-the-job training has been delivered to volunteers to boost testing capacity.

Recommendations for laboratories

Short Term:

48. Conduct periodic laboratory coordination meetings at the national level, and between national and subnational levels (provincial/district health offices and referral laboratories)
49. Boost laboratory capacity through recruitment of additional human resources, and provision of relevant training through standardised modules
50. Integrate logistics and supply chain systems to help ensure availability and timely distribution of supplies to laboratories
51. Develop a Standard Operating Procedure for RT-PCR testing and regulations for mobile PCR testing
52. Improve the laboratory reporting system to ensure real time data utilisation
53. Ensure relevant regulations are enacted for both commercial and non-commercial laboratories providing COVID-19 testing
54. Ensure monitoring of laboratory biosafety and biosecurity is maintained
55. Disseminate and promote access to the on the NIHRD COVID-19 dashboard

Medium to longer term:

56. Develop an emerging infectious disease laboratory roadmap in preparation for future emerging disease and pandemic responses
57. Ensure ongoing availability and distribution of laboratory supplies

58. Maintain continuous quality improvement of laboratory reporting
59. Ensure all laboratories and laboratory staff are participating in the accreditation and biosafety level 2 certification
60. Organise external quality control for all COVID-19 PCR tests

Infection prevention and control

Infection prevention and control (IPC) has been a component of health facilities accreditation, which has helped to ensure baseline capacity prior to the COVID-19 response. The Ministry of Health has delivered IPC training to facilities via video-conference throughout the pandemic response.

Gaps and challenges

- An exposure risk analysis among healthcare workers revealed that 40% of healthcare workers were exposed to COVID-19 while providing healthcare, 45.7% were exposed whilst performing aerosol generating procedures, and only 17.3% healthcare workers were exposed to COVID-19 in their communities.
- Protocols for IPC and use of personal protective equipment have not been fully disseminated and further work is needed to monitor their implementation in some hospitals and health facilities.
- A sustainable supply of personal protective equipment has not been secured. Fabric masks which are used in some areas are not up to standard for use in a healthcare setting.
- COVID-19 Healthcare Associated Infection surveillance for health workers is not carried out.
- Waste management in healthcare facilities has been challenging and better management of waste is needed.

Best Practices and Lessons Learned

- Local and religious leaders are engaged in implementing dead body management in hospitals and promoting community understanding of protocols around the safe management of dead bodies.
- Hospital emerging and re-emerging infectious diseases (PINERE) team have been carrying out infection prevention and control management during outbreak response.

- Establishment of an Infection Prevention and Control team is one of the accreditation criteria for health facilities. Safe waste management is included in the accreditation criteria. Infection prevention and control guidance for health facilities has been in place since 2017.

Recommendations for infection prevention and control

Short Term:

61. Develop simple and applicable workplace health protocols and short educational videos about infection prevention and control in the workplace. Establish occupational health and safety teams with supervision from primary health centres to help implement protocols in workplaces
62. Develop guidance on manufacturing and care of fabric masks
63. Conduct a medical audit of COVID-19 outbreak incidents among health workers at health facilities, involving professional organisations
64. Engage the Ministry of Home Affairs and COVID-19 Task Force in the implementation of health protocols in the community and disseminate health protocols in the media that are accessible to the public
65. Engage with the Ministry of Religious Affairs to develop user-friendly guidance on dead body management
66. Update the administrative Standard Operating Procedure for obtaining death insurance claims
67. Strengthen the roles of infection prevention and control doctors (IPCDs) and infection prevention and control nurses (IPCNs) at health facilities
68. Strengthen monitoring of water, sanitation, hygiene, waste management, and environmental health programmes at health facilities

Medium to longer term:

69. Develop infection prevention and control training modules, guidance documents and tutorial videos
70. Ensure routine infection prevention and control refresher training for healthcare workers

71. Conduct regular monitoring and evaluation of infection prevention and control practices in health facilities
72. Conduct an evaluation of water, sanitation, and hygiene programmes implemented at healthcare facilities
73. Develop guidance documents and a road map on strengthening water, sanitation, hygiene, waste management, and environmental health at healthcare facilities

Case management

As of August 2020, 132 COVID-19 referral hospitals have been officially designated by Ministry of Health decree and 707 referral hospitals designated by Governor's decree. Designated public facilities and buildings have been converted into emergency hospitals for mild cases and quarantine facilities to help reduce the burden in referral hospitals. The integrated referral hospital referral system (SISRUTE) has optimised the hospital referral system. Telemedicine practice has been used to help reduce the risk of COVID-19 exposure to healthcare workers.

Gaps and challenges

- Limited human resources and high rates of morbidity and mortality among health workers due to COVID-19, as well as physical resource limitations, including supplies of personal protective equipment, medications, oxygen, ventilators and negative pressure isolation rooms, as well as logistical and hospital infrastructure limitations have affected patient care.
- Ensuring equitable distribution of human and other health system resources has been challenging. In addition, the integrated referral information systems application for inpatient distribution has not been optimally used, leading to excessive burden in some facilities.
- Some vulnerable patients such as pregnant women and the elderly have had difficulties in accessing routine health services as non-COVID-19 patient services have not been separated.
- Suboptimal absorption of the budget for the increase of hospital capacity
- Implementation and adherence to case management guidelines has been sub-optimal in some areas.
- Reports of non-evidence-based interventions being used, such as herbal or traditional medicines as COVID-19 drugs circulating in the public.

Best Practices and Lessons Learned

- In Surabaya, a network has been established in collaboration with armed forces to monitor the availability of hospital beds and ventilators for patients.
- An online hospital dashboard (Sistem Informasi Rumah Sakit or SIRS) has been established to improve data use.
- Telemedicine has been utilised to reduce COVID-19 infection risk for both patients and staff in health facilities.
- Multidisciplinary management of COVID-19 patients is being used to ensure comprehensive care.
- Cross-ministry assistance has been obtained from the Ministry of Tourism and Ministry of Communication and Informatics to assist in disseminating information and providing quarantine locations for health workers.
- Efforts have been made to improve mobilisation of health workers and volunteers to improve human resource distribution and overcome staff shortages in referral hospitals.
- Triage and patient flow management has been applied in accordance with the latest recovery criteria to reduce overcapacity in hospitals.

Recommendations for case management

Short Term:

74. Monitor COVID-19 case trends and hospital bed and isolation room capacity
75. Ensure adequate financing is available for COVID-19 patient claims
76. Disseminate the 5th revision of the case management guidelines to districts
77. Provide a circular letter to sub-national leaders and governments on the latest criteria for patient recovery and discharge from COVID-19 treatment
78. Conduct coordination and monitoring of patients who are undertaking self-isolation after fulfilling the requirements of the treatment period or clinical improvement in the hospital
79. Establish a COVID-19 hub where military members report the availability of beds and ventilators in COVID-19 referral hospitals and public safety centres (PSC)

80. Hold cross-sectoral meetings to discuss medical management of COVID-19. These meetings would aim to avoid a legal action against healthcare workers resulting from substandard treatment, such as use of herbal and traditional medicine
81. Monitor and address any false information about COVID-19 treatment circulating in the community
82. Establish a monitoring system for drug administration and treatment in hospitals
83. Conduct medical audits of health workers who have died
84. Conduct medical audits of children who have died, including analysis of risk factors, comorbidities and severity of disease in comparison with recovered cases
85. Improve triage processes to avoid transmission of COVID-19 in the triage room, resulting from suspect cases having to wait a long time before being transferred
86. Improve use of space within health facilities, to ensure adequate separation of COVID-19 and non-COVID-19 sections and patient management areas
87. Designate dedicated hospitals for COVID-19, especially in areas with high disease burden, so that other hospitals can provide services for non COVID-19 patients
88. Conduct clinician meetings and virtual consultations with the use of video-conferencing and online or mobile-based connection, to discuss COVID-19 management and perform virtual consultations for hospitals in remote areas with their respective regional referral centre
89. Develop information, education and communication and advocacy materials on case management that are easily accessible to the public so that there is standardised information in the community
90. Establish a team to manage COVID-19 patient claim disputes

Medium to longer term:

91. Socialize and disseminate guidance on new normal in hospitals
92. Support research and development around COVID-19 treatment and case management

Operational support and logistics

Use of the Essential Supply Forecasting Tool (ESFT) has been implemented and training has been conducted at the provincial level. The National Disaster Management Agency has developed a logistics reporting system to facilitate information sharing and supply management between sub-national and national levels. However, further synchronization of logistic reporting systems between the National Disaster Management Agency and the Ministry of Health on essential commodities will strengthen the response.

Gaps and challenges

- Gaps in training on use of the Essential Supply Forecasting Tool have led to instances of incorrect provincial needs forecasting, deviating significantly from national estimations. Follow-up support and mentoring to improve use of the system is needed.
- Not all regions have good internet connection to enable stable access to the online system. As a result, issues of suboptimal data completeness and accuracy have occurred.
- Inequitable distribution of supplies to the field has resulted from variations to the logistics distribution plan through suboptimal coordination.
- Insufficient availability of polymerase chain reaction (PCR) and viral load reagents, molecular rapid test cartridges, and personal protective equipment has occurred due to delays in manufacturing licence issuance.

Best Practices and Lessons Learned

- Use of video-conference training, mentoring and WhatsApp messaging groups have been effective in supporting good needs forecasting using the Essential Supply Forecasting Tool (ESFT).
- Amid health policy relaxation, there has been an increase in manufacturers and licensure of medical devices and textile industry innovation to manufacture personal protective equipment.
- Use of a logistics receipt and mobilisation dashboard which displays stock levels in real-time has helped streamline reporting and use of this data.
- Contributions from a range of parties, including civilian-military collaboration and non-government organisations have boosted logistics capacity.
- Coordination among Ministries, agencies and donor countries and efforts to cut red tape have led to faster importation and licencing processes.

Recommendations for operational support and logistics

Short Term:

93. Coordinate and review needs assessments, distribution plans, and monitoring and evaluation with provinces, BNPB and the military. Ensure there is a system for regular monitoring through use of apps
94. Ensure certification and calibration of supplies that will be distributed, including vendor after-sale services

Medium to longer term:

95. Update pandemic contingency and logistics procurement and distribution plans considering lessons learned
96. Build capacity at provincial level for management of chemical, biological, radiological and nuclear (CBRN) disaster (including pandemic) through trainings and exercises

Maintaining essential health services and systems

Maintaining routine essential health services is a critical task within the pandemic response to minimise excess non-COVID-19 related morbidity and mortality. Efforts have been made to support health facilities to maintain routine essential service provision. Measures have included promoting the use of telemedicine to reduce COVID-19 exposure risk during routine care and implementation of triage and referral systems to allow non-COVID-19 designated facilities to maintain essential service provision.

Gaps and challenges

- Ineffective dissemination of technical guidance and training delivery due to issues of poor internet connection have hampered the ability of some facilities to implement best practice.
- COVID-19 clusters among healthcare workers have impacted health facility capacity to deliver routine care at times.
- There has been a lack of cooperation and regulation between public and private sectors at times, such as for provision of cancer care.
- There is concern among the public about visiting health facilities to receive routine care, for fear of being infected with COVID-19.

- System capacity for delivery of telemedicine is lacking, particularly in some primary health centres.

Best Practices and Lessons Learned

- National guidelines and circular letters on provision of essential services during the pandemic, including the role of primary healthcare centres in COVID-19 prevention and control have been provided. Health cluster guidelines including rapid health assessments in disaster conditions have been disseminated.
- Awareness raising and risk communication activities have been used to encourage re-utilisation of primary health centres and hospitals for receipt of essential health services.
- Data from the Healthy Indonesia Programme with Family Approach (PISPK) has been utilised for mapping of risk factors, comorbidities and non-communicable diseases (NCDs) in several areas
- Telemedicine has been utilised where available for management of non-communicable diseases.
- Modifications to routine health service delivery have been made to improve service efficiency, such as use of less frequent drug dispensing for routine disease management.
- Mobilisation of healthcare workers and human resource support between primary health centres has helped to minimise the impact of COVID-19 related staff shortages. In addition, there has been collaboration with the military in human resource support from military hospitals.

Recommendations for operational support and logistics

Short Term:

97. Provide technical assistance on essential health service delivery at national and subnational levels
98. Conduct regular and tiered cross-programme coordination meetings on essential health services
99. Undertake public awareness-raising on safe health services through improved cross-sectoral cooperation
100. Promote telemedicine utilisation, e.g. TEMENIN

101. Conduct socialization with the House of Representatives regarding guidelines on health clusters and community empowerment in several areas as well as disaster anticipation preparedness during the pandemic
102. Improve regional preparedness to face other disasters during the COVID-19 pandemic
103. Conduct periodic monitoring and rapid assessment of programme indicators and feedback provision
104. Utilise monitoring and evaluation feedback for improved coordination of essential services
105. Collaborate with professional organisations as a form of social responsibility to overcome human resources constraints
106. Conduct an evaluation of infection prevention and control (including triage and anteroom) in health facilities
107. Document essential services strategy innovation at subnational levels
108. Develop acute respiratory infection prevention and control guidelines in regions affected by forest and land fire smog during the COVID-19 pandemic

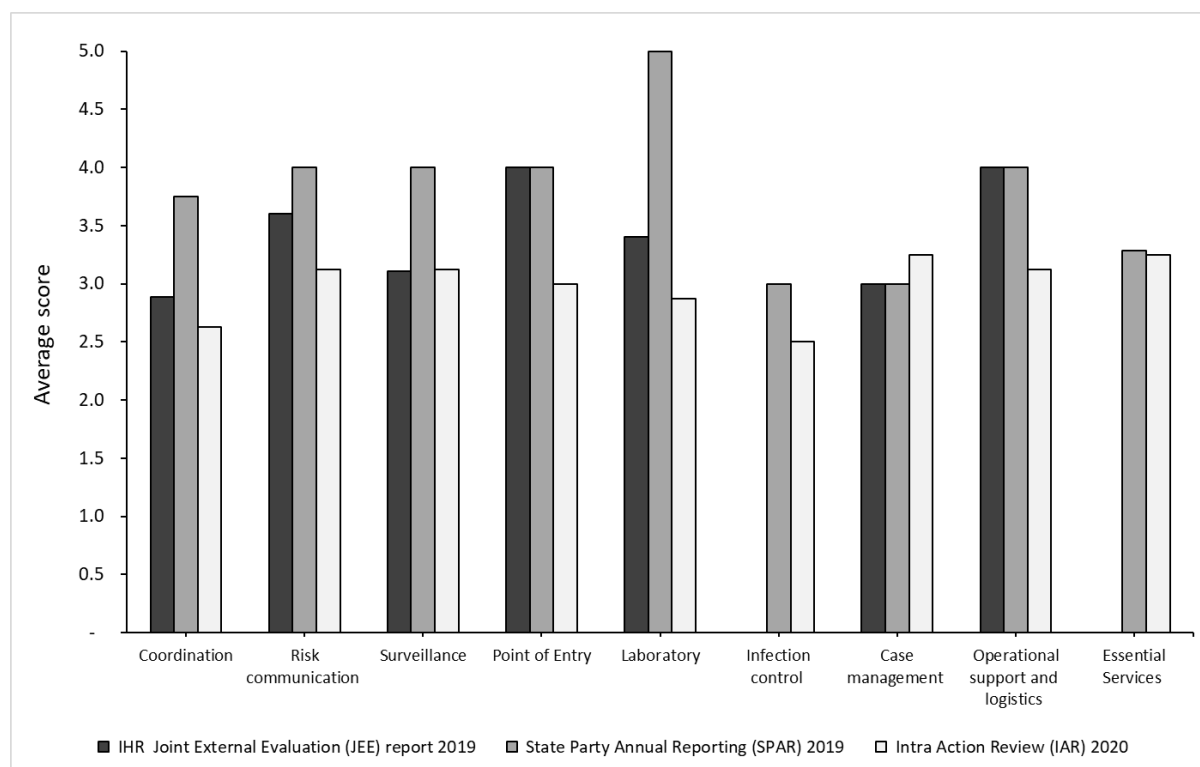
Medium to longer term:

109. Update subnational health disaster contingency plans
110. Evaluate each essential health service guidelines
111. Improve capacity for pneumonia detection and management at primary health facilities and influenza-like illness sentinel surveillance sites

Comparison of IAR findings with other measures of capacity

The figure below provides a visual summary of Indonesia's preparedness and response capacity as measured by the Intra-Action Review, the IHR Joint External Evaluation and State Party Annual Reporting.

Average IHR core capacity score, by COVID-19 strategic response plan pillar, based on IHR Joint External Evaluation, State Party Annual Reporting and pandemic response capacity perception during Intra-Action Review*



*Score:

1. Capacity is not in place
2. Capacity in development stage (some are achieved, and some are undergoing)
3. Capacity in place, however there is the issue of sustainability and measured by lack of inclusion in the national health sector planning and / or secured funding. Capacity need improvement.
4. Capacity is in place, sustainable for few more years and can be measured by the inclusion of IHR capacity in health sector plan
5. Capacity functional, sustainable and the country is supporting other countries in its implementation

Progress Against Recommendations and Next Steps

Pillar	Term	#	Recommendation	Progress (as of February 2021)
Coordination, planning, and monitoring	Short	1	Conduct a review of the command and coordination structure of the health sector response plan and ensure focal point and COVID-19 response team duties and operational and strategic functions are clearly defined	A virtual meeting was conducted to develop the second revision of the Health Operation Response Plan of the COVID-19 Pandemic on 10 – 11 September and on 23 – 30 September, involving all focal points in the 9 pillars of response strategy and relevant parties. The revised health sector response plan has been signed as of February 2021.
		2	Ensure periodic coordination meetings and increased utilization of the COVID-19 Partner’s Platform to monitor response plan indicators are held for multiple sectors at the national level and between the national and sub-national levels	A multisectoral coordination meeting in the national level was conducted on 26 November and 27 November to monitor the fulfilment of indicators of the operational response plan
		3	Activate health clusters at the national and regional levels for COVID-19 response	Coordination meetings of the health clusters have been conducted on 28 August and 21 September (both virtually), involving coordinators and sub-cluster members (non-governmental organizations and professional organizations) and international partners (WHO, UNFPA, UNICEF, UN-OCHA). The meeting aimed to discuss the coordination of health support in case of disaster situation during the COVID-19 pandemic. Despite incomplete health cluster activation, cluster stakeholders will continue to support COVID-19 response.
	Medium to long	4	Develop tiered training modules for pandemic readiness, preparedness, and response, based on lessons from the COVID-19 pandemic	
		5	Conduct a COVID-19 After Action Review	
		6	Develop a dashboard to facilitate decision-making in pandemic response command and coordination	An information flow has been developed for indicators monitoring of the operational response plan for focal points of each of the pillars and subnational levels for Partners Platform.

Risk communication and community engagement	Short	7	Enhance cooperation with telecommunication service providers to relay key messages on COVID-19 prevention through mobile messaging	Task Force/KPCPEN/Ministry of Communications and Information have collaborated with telecommunications company (for WhatsApp/SMS blast) for information sharing. There remains a need to improve engagement with community and religious leaders.
		8	Conduct risk communication and community engagement training for relevant Government and community organisations	Media coaching will be done for Vice Minister of Health and other officials in the Ministry of Health.
		9	Improve cross-sectoral coordination for risk communication and community engagement through regular meetings	Multiprogram and multisector coordination has been enhanced, even though regular coordination has not been conducted in national and subnational levels. Risk communication guidelines for the health sector have been developed and coordination of different COVID-19 hotlines has been improved, including analysis of hotline data.
		10	Develop tools to improve monitoring of hoaxes and evaluation of risk communication	Counter hoax has been prepared when hoax is identified, however, analysis has not been conducted. Risk communications monitoring and evaluation has not been conducted regularly in national and subnational levels. Counter hoax materials have been disseminated in official WhatsApp groups of various agencies and WhatsApp groups of various regions.
	Medium to long	11	Develop risk communication and community engagement strategies and information-filtering platforms	
Surveillance, rapid response team, and case investigation	Short	12	Establish comprehensive surveillance criteria, indicators and targets, such as case finding and laboratory testing targets, to encourage regions to strengthen their surveillance systems	
		13	Work with NIHRD to strengthen laboratory capacity to support surveillance activities	
		14	Conduct training and regular refreshers on contact tracing and quarantine	There is an ongoing need to strengthen commitment to contact tracing and implementation of isolation and quarantine procedures.
		15	Improve guideline dissemination and consultation implementation at sub-national levels	

		16	Review zoning indicators and appropriate use of the zoning strategy to avoid misinterpretation	
		17	Increase volunteer support for contact tracing	
		18	Produce regular situation reports and analyses of health and surveillance indicators	
		19	Develop brief technical guidelines for contact tracing and training materials	
		20	Train rapid response teams on data analysis in collaboration with Field Epidemiologist Training Program (FETP) or Indonesian Epidemiology Association	
		21	Review data entry procedures in All Record to reduce delays in the reporting of laboratory testing results	Duplicated process for data entry in multiple platforms remains an ongoing issue.
		22	Implement seroprevalence testing into national COVID-19 surveillance	A seroepidemiological survey has been conducted in 17 provinces in collaboration with WHO and CDC/FETP
		23	Conduct an audit of deaths	
		24	Review and update All Record data entry system to allow entry by health facility and health office staff to support data completeness and timeliness and reduce the burden on laboratory staff	Refreshing of the use of ALL RECORD application for PIC for COVID-19 in provincial and district health offices
	Medium to long	25	Prepare additional workforce to undertake community-based surveillance, case-finding and contact tracing	
		26	Mortality Audit and death data or specific review in hospitals	
		27	Develop a grand design for use of mobile technology for contact tracing	Contact tracing application use and daily monitoring of direct contact (SILACAK) has been conducted in 44 districts and will be developed in 98 districts.
		28	Ensure rapid response team personnel are identified at district level in all areas	
		29	Develop short online training modules on COVID-19 surveillance and case-finding	
		30	Undertake an analysis of death data using available tools in collaboration with relevant parties	
		31	Undertake a rapid assessment of capacity at all points of entry	Additional resources have been mobilized to support points of entry
Points of entry, international	Short			

travel and transport		32	Ensure that Port Health Authority resource needs are met	Additional resources have been mobilized to support points of entry
		33	Ensure point of entry policies are effective, efficient and in-line with at-risk group characteristics	
		34	Coordinate with relevant partners to improve implementation of the electronic Health Alert Card	The provincial health officers have been given access to e-Health Alert Card data to enhance contact tracing and monitoring.
		35	Implement mobile PCR testing at points of entry	
		36	Develop Memorandums of Understanding with relevant bodies to ensure availability of suitable quarantine facilities	
	Medium to long	37	Ensure longer term resource needs at points of entry are guaranteed	Health quarantine facility is available, including human resources, detection and response equipment and support systems. However, ongoing work is needed to ensure sustainability.
		38	Support the designation of additional points of entry for disembarkation of repatriated persons	Quarantine facilities are available at Jakarta and Surabaya for international travellers
		39	Continue to implement preventive measures at points of entry	Screening at points of entry is ongoing. Guidance documents and protocols are in place to support management of travellers at points of entry
	Large-scale social restrictions	Short	40	Develop monitoring and evaluation tools together with other sectors
41			Disseminate monitoring and evaluation tools for large-scale social restriction	A monitoring and evaluation tool for PSBB has been developed and tested
42			Evaluate large-scale social restriction implementation	
43			Revise the large-scale social restriction guidelines to include declaration, implementation, recording and reporting, and guidance and supervision	Minister of Health Regulation No. 245/2020 on Assessment Team is being revised.
44			Conduct coordination meetings on epidemiological assessment between national and subnational governments to determine which areas should implement restrictions	Lack of coordination between national and subnational levels in case recording.

	Medium to long	45	Revise Ministry of Health Regulation no.9 of 2020 on large-scale social restriction guidelines to include monitoring and evaluation to determine the success of implementation	
		46	Develop guidelines on quarantine at the subnational level	Drafting guidelines / regional quarantine protocols (PSBB, regional quarantine, hospital quarantine, home quarantine / quarantine facilities)
		47	Disseminate the guidelines on quarantine to the subnational level	Training of health quarantine officers has been conducted back in 2019.
Laboratories	Short	48	Conduct periodic laboratory coordination meetings at the national level, and between national and subnational levels (provincial/district health offices and referral laboratories)	
		49	Boost laboratory capacity through recruitment of additional human resources, and provision of relevant training through standardised modules	A workshop has been conducted to build capacity in respiratory swab specimen collection for COVID-19 PCR testing, as well as development of video, flyers and other resources. Training in PCR procedure has been conducted for laboratory technicians. The Ministry of Health is collaborating with PPSDM for provision of human resources. 30 lab technicians trained in PCR testing using accredited curricula.
		50	Integrate logistics and supply chain systems to help ensure availability and timely distribution of supplies to laboratories	
		51	Develop a Standard Operating Procedure for RT-PCR testing and regulations for mobile PCR testing	A standard operating procedure validated by the National Reference Laboratory is being used to standardise laboratory testing for COVID-19. Validation of PCR reagents has been implemented
		52	Improve the laboratory reporting system to ensure real time data utilisation	Test results are being entered into the New All Record System. Training has been provided in nine provinces to improve data entry into the All Record System and onsite technical support is available.
		53	Ensure relevant regulations are enacted for both commercial and non-commercial laboratories providing COVID-19 testing	New policies on laboratories, including on Use of Rapid Diagnostic Test Antigen (RDT) in COVID-19 testing have been issued
		54	Ensure monitoring of laboratory biosafety and biosecurity is maintained	Monitoring of occupational accidents in COVID-19 testing laboratories is now being undertaken

		55	Disseminate and promote access to the on the NIHRD COVID-19 dashboard	
	Medium to long	56	Develop an emerging infectious disease laboratory roadmap in preparation for future emerging disease and pandemic responses	
		57	Ensure ongoing availability and distribution of laboratory supplies	
		58	Maintain continuous quality improvement of laboratory reporting	
		59	Ensure all laboratories and laboratory staff are participating in the accreditation and biosafety level 2 certification	
		60	Organise external quality control for all COVID-19 PCR tests	External quality assurance validation is being undertaken. A dashboard for external quality assurance is being developed. External quality assurance for 177 labs has been conducted. An EQA dashboard has been developed.
Infection prevention and control	Short	61	Develop simple and applicable workplace health protocols and short educational videos about infection prevention and control in the workplace. Establish occupational health and safety teams with supervision from primary health centres to help implement protocols in workplaces	Workshop on infection control in workplaces has been held.
		62	Develop guidance on manufacturing and care of fabric masks	
		63	Conduct a medical audit of COVID-19 outbreak incidents among health workers at health facilities, involving professional organisations	A morbidity and mortality audit for health workers infected by COVID-19 has been initiated.
		64	Engage the Ministry of Home Affairs and COVID-19 Task Force in the implementation of health protocols in the community and disseminate health protocols in the media that are accessible to the public	
		65	Engage with the Ministry of Religious Affairs to develop user-friendly guidance on dead body management	Finalization of IPC guidelines on corpse handling in health facilities is complete.
		66	Update the administrative Standard Operating Procedure for obtaining death insurance claims	

	Medium to long	67	Strengthen the roles of infection prevention and control doctors (IPCDs) and infection prevention and control nurses (IPCNs) at health facilities	
		68	Strengthen monitoring of water, sanitation, hygiene, waste management, and environmental health programmes at health facilities	
		69	Develop infection prevention and control training modules, guidance documents and tutorial videos	A series of webinars to increase capacity of health workers on infection prevention and control has been developed for Western, Central and Eastern regions
		70	Ensure routine infection prevention and control refresher training for healthcare workers	
		71	Conduct regular monitoring and evaluation of infection prevention and control practices in health facilities	A series of monitoring and technical guidance visits on infection prevention and control have been undertaken in Bandung and Yogyakarta with the national infection prevention and control committee.
		72	Conduct an evaluation of water, sanitation, and hygiene programmes implemented at healthcare facilities	
		73	Develop guidance documents and a road map on strengthening water, sanitation, hygiene, waste management, and environmental health at healthcare facilities	
Case management	Short	74	Monitor COVID-19 case trends and hospital bed and isolation room capacity	Daily monitoring of the increase in cases and bed capacity in hospitals is being undertaken through RS Online.
		75	Ensure adequate financing is available for COVID-19 patient claims	
		76	Disseminate the 5 th revision of the case management guidelines to districts	A coordination meeting was conducted to discuss the implementation of the 5th revision of the COVID-19 case management guidelines with 5 professional organizations.
		77	Provide a circular letter to sub-national leaders and governments on the latest criteria for patient recovery and discharge from COVID-19 treatment	Issued a circular letter from acting Director General of Health Services to Head of DHO and Hospital Directors regarding the improvement of COVID-19 services by increasing 30% isolation room and ICU from total bed capacity. Several circulating letters have been disseminated to improve COVID-19 patient care in referral hospitals, to ensure

			availability of hospital beds and implementation of COVID-19 polyclinics at referral hospitals.
78	Conduct coordination and monitoring of patients who are undertaking self-isolation after fulfilling the requirements of the treatment period or clinical improvement in the hospital		
79	Establish a COVID-19 hub where military members report the availability of beds and ventilators in COVID-19 referral hospitals and public safety centres (PSC)		
80	Hold cross-sectoral meetings to discuss medical management of COVID-19. These meetings would aim to avoid a legal action against healthcare workers resulting from substandard treatment, such as use of herbal and traditional medicine	Conducted Workshop on clinical management of COVID-19 patients with serious and critical condition for 24 Provinces. Training webinars have been held with 5 professional organisations on COVID-19 patient management.	
81	Monitor and address any false information about COVID-19 treatment circulating in the community		
82	Establish a monitoring system for drug administration and treatment in hospitals		
83	Conduct medical audits of health workers who have died		
84	Conduct medical audits of children who have died, including analysis of risk factors, comorbidities and severity of disease in comparison with recovered cases		
85	Improve triage processes to avoid transmission of COVID-19 in the triage room, resulting from suspect cases having to wait a long time before being transferred		
86	Improve use of space within health facilities, to ensure adequate separation of COVID-19 and non-COVID-19 sections and patient management areas		
87	Designate dedicated hospitals for COVID-19, especially in areas with high disease burden, so that other hospitals can provide services for non COVID-19 patients		

	Medium to long	88	Conduct clinician meetings and virtual consultations with the use of video-conferencing and online or mobile-based connection, to discuss COVID-19 management and perform virtual consultations for hospitals in remote areas with their respective regional referral centre	
		89	Develop information, education and communication and advocacy materials on case management that are easily accessible to the public so that there is standardised information in the community	
		90	Establish a team to manage COVID-19 patient claim disputes	
		91	Socialize and disseminate guidance on new normal in hospitals	Conducted a national seminar on hospital services in pandemic transition period with professional organizations, PHOs and Hospitals in 34 provinces. Discussed development of COVID-19 field and emergency hospitals and hospital guidelines in new normal with local government and hospital directors and Local Government.
		92	Support research and development around COVID-19 treatment and case management	
Operational support and logistics	Short	93	Coordinate and review needs assessments, distribution plans, and monitoring and evaluation with provinces, BNPB and the military. Ensure there is a system for regular monitoring through use of apps	A digital logistic information system for COVID-19 has been developed. The needs assessment for needs forecasting has been updated and sent to 34 provinces. The distribution plan and monitoring and evaluation framework have been reviewed and updated in October 2020. Logistic needs assessment has been done using the ESFT
		94	Ensure certification and calibration of supplies that will be distributed, including vendor after-sale services	
	Medium to long	95	Update pandemic contingency and logistics procurement and distribution plans considering lessons learned	
		96	Build capacity at provincial level for management of chemical, biological, radiological and nuclear (CBRN) disaster (including pandemic) through trainings and exercises	

Maintaining essential health services and systems	Short	97	Provide technical assistance on essential health service delivery at national and subnational levels	Developed technical guidelines for implementation by Puskesmas. Meeting to strengthen Puskesmas for delivering optimal basic health services in new normal conducted. Webinar series developed to increase COVID-19 care capacity of health workers in primary care.
		98	Conduct regular and tiered cross-programme coordination meetings on essential health services	A training workshop has been held.
		99	Undertake public awareness-raising on safe health services through improved cross-sectoral cooperation	
		100	Promote telemedicine utilisation, e.g. TEMENIN	Socialization of Telehealth was conducted in October 2020
		101	Conduct socialization with the House of Representatives regarding guidelines on health clusters and community empowerment in several areas as well as disaster anticipation preparedness during the pandemic	
		102	Improve regional preparedness to face other disasters during the COVID-19 pandemic	
		103	Conduct periodic monitoring and rapid assessment of programme indicators and feedback provision	Routine data analysis for the achievement of the PISPK indicators
		104	Utilise monitoring and evaluation feedback for improved coordination of essential services	
		105	Collaborate with professional organisations as a form of social responsibility to overcome human resources constraints	
		106	Conduct an evaluation of infection prevention and control (including triage and anteroom) in health facilities	
		107	Document essential services strategy innovation at subnational levels	
	108	Develop acute respiratory infection prevention and control guidelines in regions affected by forest and land fire smog during the COVID-19 pandemic		
Medium to long	109	Update subnational health disaster contingency plans		
	110	Evaluate each essential health service guidelines	Development of technical guidance for dental care during the new normal has been completed.	

		111	Improve capacity for pneumonia detection and management at primary health facilities and influenza-like illness sentinel surveillance sites	
--	--	-----	---------------------------------------------------------------------------------------------------------------------------------------------	--

