As of 10 March, the Government of Indonesia reported 1,398,578 (5633 new) confirmed cases of COVID-19, 37,932 (175 new) deaths and 1,216,433 recovered cases from 510 districts across all 34 provinces.¹

As a part of the more than 11 million doses of COVID-19 vaccines allocated to Indonesia by the COVAX Facility, Indonesia received the first shipment of 1,113,600 doses of the AstraZeneca vaccine on 8 March (page 21).

WHO is providing technical assistance to the Government of Indonesia for the continuity of essential health services. Highlights of Maternal and Newborn Health (MNH) services are on pages 22 and 23.

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 4 to 10 March 2021. Source of data

Disclaimer: The number of cases reported daily is not equivalent to the number of persons who contracted COVID-19 on that day; reporting of laboratory-confirmed results may take up to one week from the time of testing.
On 2 March, the Deputy Minister of Health announced that 80,000 to 100,000 staff from community health centres (puskesmas) and community police officers (Bhayangkara Pembina Keamanan dan Ketertiban Masyarakat (Bhabinkamtibmas)) will be mobilized to improve contact tracing efforts in Indonesia. He said that the staff and officers will be deployed to identify, monitor, and follow up individuals who have been in close contact with COVID-19 cases to interrupt the chain of transmission of SARS-CoV-2. The Deputy Minister underscored that stigma around COVID-19 in the community remains a challenge for contact tracing.²

On 2 March, the General Elections Commission (Komisi Pemilihan Umum (KPU)) signed a Memorandum of Understanding (MoU) with the Ministry of Health (MoH) to support the national COVID-19 vaccination campaign. Through the MoU, KPU is providing access to the voter database to MoH, which will be used in the COVID-19 vaccination plan in the country.³

On 3 March, MoH reported that the variant of the SARS-CoV-2 virus first identified in the United Kingdom (B.1.1.7) was found in two Indonesian migrant workers who returned to the country in late January 2021. The results of the whole genome sequencing were obtained on 1 March. During a virtual press conference on 8 March, the Minister of Health stated that four additional cases of the B.1.1.7 variant were reported from East Kalimantan, North Sumatra, South Kalimantan and South Sumatra.⁴ MoH highlighted the government’s efforts to improve the whole genome sequencing of specimens from COVID-19 cases as well as laboratory capacity to detect new virus variants across the country.⁵

On 8 March, the Head of Data and Information Technology of the National COVID-19 Task Force (Satuan Tugas (Satgas)) stated that there was a decrease in the number of specimens tested in early March 2021. She said that even after including the results of antigen-detecting rapid diagnostic tests (Ag-RDT) on 2 March, the number still decreased with a daily average number of specimens tested of around 52,000. It was also mentioned that there was an increase in the number of COVID-19 cases in several provinces during the last week, including Aceh, South Kalimantan, and Papua.⁶

⁴ https://nasional.kompas.com/read/2021/03/09/07120801/6-kasus-mutasi-virus-corona-b117-di-indonesia
⁵ https://jakartaglobe.id/special-updates/enhanced-3ts-helps-indonesia-detect-new-covid19-variant

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On 10 March, 5633 new and 1 398 578 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 4 to 10 March was 6392 cases per day, compared to 6813 cases per day reported in the previous week.

**Source of data**

Disclaimer: The number of cases reported daily is not the number of persons who contracted COVID-19 on that day and might be influenced by the number of people tested on that day (see Fig. 12); reporting of laboratory-confirmed results may take up to one week from the time of testing. Therefore, caution must be taken in interpreting this figure and the epidemiological curve for further analysis, either at the national or subnational level.
During the week of 1 to 7 March, the provinces of North Maluku, West Kalimantan, Central Kalimantan, and South Kalimantan experienced an increase in the number of weekly cases of more than 20% compared to the previous week (Fig. 3). It is critical to investigate reasons for the increase in new confirmed cases to guide decisions on response activities and inform adjustment of public health and social measures.

Fig. 3. Percentage change of weekly number of confirmed cases by province during 1 to 7 March 2021 compared to the previous week. Source of data

Disclaimer: The number of weekly confirmed cases is calculated taking into consideration the daily number of reported cases. Caution should be exercised when interpreting this figure due to data limitations reported by MoH.
During the week of 1 to 7 March, the incidence of COVID-19 in Indonesia was 20 per 100,000 population, compared to 22.4 per 100,000 in the previous week (Fig. 4).

Fig. 4. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period reported in Indonesia from 13 April 2020 (when Indonesia first reported community transmission in the country) to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. *Source of data*

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

Caution should be exercised when interpreting this indicator due to limitations listed in the [WHO interim guidance](https://www.who.int). Other limitations include data incompleteness and data quality issues reported by [MoH](https://mo.h). Other epidemiological indicators also need to be evaluated to decide on the level of community transmission. This disclaimer applies to indicators at national (Fig. 4) and subnational levels (Figs. 5 to 11).

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7 Weekly incidence of COVID-19 is calculated as the number of new cases per 100,000 population per week averaged over a two-week period. *Source of population data*
During the week of 1 to 7 March, the case incidence per 100 000 population was between 50 to 150 in DKI Jakarta, East Kalimantan and North Kalimantan, which corresponds to community transmission level 3 (Fig. 5). Based on WHO interim guidance, community transmission level 3 means that there is a high risk of COVID-19 infection for the general population and that a high incidence of locally acquired, widely dispersed cases was detected in the past 14 days.

Fig. 5. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period by province in Indonesia during 1 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data
The weekly incidence of COVID-19 decreased in all provinces in Java Island during the week of 1 to 7 March compared to the previous week (Fig. 6 to 11).

Fig. 6. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in DKI Jakarta, from 13 April 2020 to 28 February 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. [Source of data]

Fig. 7. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in West Java, from 13 April 2020 to 28 February 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. [Source of data]
Fig. 8. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in Central Java, from 13 April 2020 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. 

Source of data

Fig. 9. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in DI Yogyakarta, from 13 April 2020 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. 

Source of data
Fig. 10. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in East Java, from 13 April 2020 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data

Fig. 11. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in Banten, from 13 April 2020 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data
• On 10 March, the numbers of specimens and people tested (based on a 7-day moving average) were 61,848 and 38,279, respectively\(^8\). On the same day, the daily number of suspected cases was 63,128 (Fig. 12). There is still a wide gap between the number of suspects and people tested. This indicates that improving testing capacity, especially among suspected cases, is integral to narrow the gap.

![Graph showing daily number of specimens and people tested using a 7-day moving average (7DMA) and number of suspected COVID-19 cases in Indonesia, from 1 November 2020 to 10 March 2021. Source of data](source)

• Test positivity proportion increased sharply after 23 November and was 21.1% at the national level on 7 March (Fig. 13). However, the percentage of positive samples can be interpreted reliably only with comprehensive surveillance and testing in the order of one person tested per 1000 population per week. This minimum case detection benchmark was achieved in DKI Jakarta, DI Yogyakarta, and East Kalimantan for the last three weeks, but none of these provinces had a test positivity proportion of less than 5% (Fig. 14).

\(^8\) The daily numbers of specimens and people tested are calculated using a 7-day moving average, by averaging the last 7 days value.
Fig. 13. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. Source of data

Disclaimer: Caution should be exercised when interpreting this indicator due to limitations listed in the WHO interim guidance. Other epidemiological indicators also need to be evaluated to determine the level of community transmission.
Fig. 14. Test positivity proportion and people tested per 1000 population per week at the national level and in select provinces.

Week 1: 15/02/21 to 21/02/21; Week 2: 22/02/21 to 28/02/21; Week 3: 01/03/21 to 07/03/21

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

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

Note: Due to a limitation in data, other provinces could not be evaluated. For surveillance purposes, test positivity proportion is calculated as the number of confirmed cases divided by the number of people tested for diagnosis.
During the week of 1 to 7 March, DKI Jakarta had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by East Kalimantan, Bali, North Kalimantan, and DI Yogyakarta (Fig. 15).

**Fig. 15.** Number of confirmed COVID-19 deaths per 100,000 population per week averaged over a two-week period by province in Indonesia during 1 to 7 March 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.  

**Disclaimer:** Based on data availability, only confirmed COVID-19 deaths have been included. As per the WHO definition, however, death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case is a COVID-19-related death, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma); there should be no period of complete recovery between the illness and death.
During the week of 1 to 7 March, the number of confirmed COVID-19 deaths was 0.53 per 100 000 population\(^9\), compared to 0.56 per 100 000 in the previous week (Fig. 16).

Out of six provinces in Java, Central Java, DI Yogyakarta and East Java showed a consecutive decline over the last three weeks in the number of deaths in confirmed and probable cases (Fig. 17).

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\(^9\) Weekly mortality of COVID-19 is calculated as the number of COVID-19 deaths per 100 000 population per week averaged over a two-week period. [Source of population data](who.int/indonesia)
Fig. 17. Deaths among confirmed COVID-19 cases and probable cases per week over three weeks between 15 February to 7 March 2021 in Java. Source of data: DKI Jakarta, West Java, Central Java, DI Yogyakarta, East Java, Banten

Disclaimer: The data are provisional. There may be a discrepancy in the number of deaths in confirmed COVID-19 cases between national and provincial data sources.
As reported on 10 March, the daily number of people tested for COVID-19 was 61,625 and the cumulative number of people tested was 7,566,800 (Fig. 18).

As of 10 March, the proportion of people recovered among the total confirmed COVID-19 cases was 87.0% and there were 144,213 active cases (Fig. 19).
• After an increase in the reported number of confirmed COVID-19 cases hospitalized in DKI Jakarta in December 2020, there was a decline since 23 January 2021. However, the number has been increasing since 31 January and reached a peak of 9888 hospitalized cases on 12 February. The number of hospitalized cases has since decreased to 3015 on 7 March (Fig. 20).

![Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 June 2020 to 7 March 2021.](source_of_data)

**Disclaimer:** Data from Wisma Atlet are not included.

**RISK COMMUNICATION**

• WHO is regularly translating and sharing important health messages on its website and social media platforms -- Twitter and Instagram – and has recently published:

  Infographics:
  - COVID-19 new variants
International Women’s Day 2021 took place on 8 March with the theme of “Women in leadership: Achieving an equal future in a COVID-19 world.” WHO commemorated this day by elevating stories of women leaders in health across the country. These women work hard to lead important health research, fight for the rights of the vulnerable, and educate their communities for better health. During the COVID-19 pandemic, their roles have become even more important for society, the workplace, and their families.

Fig. 22. Stories from the WHO campaign to commemorate #InternationalWomensDay, March 2021
As of 8 March, 4 256 457 vaccine doses have been administered to health workers, essential public service workers and older people (above 60 years old) in the national COVID-19 campaign: 3 098 025 people have received the first dose and 1 158 432 people have received the second dose (Fig. 23).

As of 8 March, the number of health workers who have received the second dose of COVID-19 vaccine (fully vaccinated) was 1 149 547 (78.3% of the target population of 1 468 764). For the second stage of vaccination: the number of essential public service workers who have received the first dose of the vaccine was 715 767 (4.1% of the target of 17 327 169); and the number of older people who have received the first dose of the vaccine was 267 603 (1.2% of the target of 21 553 118) (Fig. 24).
WHO continues to support MoH with technical assistance for COVID-19 vaccination to ensure a safe and efficient rollout of the vaccination campaign. At the subnational level, WHO provides technical assistance to the Provincial and District/City Health Offices. WHO field staff continue to disseminate the latest technical guidance, facilitate training for vaccinators and assist in implementing the vaccination information system. WHO field staff in Papua supported the Province and District Health Offices to conduct five COVID-19 vaccination and vaccine safety trainings (online and offline) between January to February 2021. More than 490 health workers from Boven Digoel, Mimika, Timika, Mappi, Asmat, Puncak, and Supiori districts attended the trainings.

Fig. 24. Cumulative number of people who have received COVID-19 vaccine in Indonesia as of 8 March 2021. Source of data

Disclaimer: COVID-19 vaccination started with health workers on 13 January. The second stage of COVID-19 vaccination started on 17 February, targeting essential public service workers and older people (above 60 years old). Published data from MoH is available starting from 22 January.
On 8 March, Indonesia received 1 113 600 doses of the AstraZeneca vaccine from the COVAX Facility\textsuperscript{10}. The vaccines were produced in South Korea and shipped via AstraZeneca’s hub in Amsterdam, Netherlands. As part of the Advance Market Commitment (AMC) to finance low and middle-income countries, the COVAX Facility will initially provide 11 704 800 vaccine doses to Indonesia during the first half of 2021 at no cost. This quantity will contribute to the target of vaccinating 181 million people in the country, prioritizing health workers, frontline workers, older people, and vulnerable populations.

\textsuperscript{10} https://www.who.int/indonesia/news/detail/09-03-2021-indonesia-receives-first-shipment-of-1.1-million-covid-19-vaccines-doses-through-covax
WHO continues to support the government for programme analysis of various essential health services to ensure their continuity during the pandemic. Highlights from maternal and newborn health (MNH) services are included below:

Impact of COVID-19 on MNH services in Indonesia:

- The percentage of pregnant women who attended four antenatal care (ANC) visits\(^{11}\) decreased by 7.5% in 2020 compared to 2019. A similar trend was observed for coverage of institutional deliveries and postnatal care visits in newborns (Fig. 27).

![Percentage of pregnant women attending four ANC visits, institutional deliveries, and newborn postnatal care visits in 2019 compared to 2020. Source of data: MoH Directorate of Family Health.](https://www.who.int/publications/i/item/9789241549912)

**Fig. 27.** Percentage of pregnant women who attended four antenatal care (ANC) visits, percentage of institutional deliveries, and postnatal care attendance in 2019 compared to 2020. Source of data: MoH Directorate of Family Health.

**Disclaimer:** Due to a change in the reporting form in 2020 to focus on monitoring of the National Medium-Term Development Plan (RPJMN) indicators, data are available for the first postnatal care visit in 2019 but for three postnatal care visits in 2020.

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\(^{11}\) WHO recommends a minimum of eight contacts of antenatal care to reduce perinatal mortality and improve women’s experience of care (https://www.who.int/publications/i/item/9789241549912). As MoH is updating the guidelines and the recommended number of antenatal care contacts, currently routine data are being collected for four antenatal care visits.
To mitigate the impact of COVID-19 and maintain essential MNH services, interventions are being made in the following areas:

i. Guidelines: MoH issued the ‘National Guideline on Antenatal Care, Delivery, Postnatal and Newborn Care Services in the New Normal’ in September 2020. This document is an update to the guideline that was issued in May 2020. The updated guideline focuses on infection prevention, health facility readiness and health services for maternal and newborn programmes in the new normal, both at the primary health care and hospital levels. A series of webinars has been conducted to disseminate this updated guidance to the subnational level. On 14 January 2021, WHO published interim guidance on ‘Analysing and using routine data to monitor the effects of COVID-19 on essential health services: practical guide for national and subnational decision-makers’ which provides guidelines on how to use routine data to monitor the impact of COVID-19 on essential health services, including MNH programmes.

ii. In 2020, MoH conducted electronic-based monitoring and evaluation for the continuity of maternal and child health (MCH) services in 120 prioritized districts with the highest burden of maternal deaths. This activity was conducted in collaboration with 12 universities across Indonesia and aimed to: (i) monitor the impact of COVID-19 on the health services; and (ii) conduct advocacy at provincial and district levels to support the continuity of the services and to ensure that it is in line with the national policy.

iii. WHO continues to support MoH to strengthen the Maternal and Perinatal Death Surveillance and Response (MPDSR) in the country. Selected participants from MoH, professional organizations and UN partners were enrolled in a series of virtual regional trainings on MPDSR, organized from 29 September to 2 October 2020 (followed by facilitators’ training on 22 and 23 October) and 8 to 11 December 2020 (the facilitators’ training is planned to be conducted on 17 and 18 March 2021). WHO provided further technical assistance in 2021 to finalize the national guideline for MPDSR.

**PARTNER COORDINATION**

- On 5 March, WHO convened the fourth meeting of key development partners in 2021 to discuss and coordinate COVID-19 response activities in Indonesia. The meeting was attended by partners, including the Asian Development Bank (ADB), Australian Government Department of Foreign Affairs and Trade (DFAT), United Nations Children’s Fund (UNICEF), United States Agency for International Development (USAID), and United States Centers for Disease Control and
WHO presented COVID-19 updates, discussed the latest epidemiological situation analysis at national and subnational levels, and explained the key WHO interventions to support the national pandemic response. Several key points of discussion among partners included the use of Ag-RDTs and information system for recording and reporting of the results, SARS-CoV-2 variants of concern and whole-genome sequencing activities, updates on the allocation of vaccines from the COVAX Facility, and updates on the external quality assessment process for laboratory testing. In addition, WHO provided updates on the progress of the oxygen survey and seroepidemiological study in Indonesia.

- The overall funding request for WHO operations and technical assistance is US$ 46 million (US$ 27 million for response and US$ 19 million for recovery phase), based on estimated needs as of March 2021 (Fig. 28)

![WHO funding situation for COVID-19 response, March 2021](image)

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

Table 1: Title and details of recent WHO resource materials

Source: https://www.who.int/

<table>
<thead>
<tr>
<th>Title</th>
<th>Details</th>
</tr>
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<tbody>
<tr>
<td><strong>Episode 28 of Science in 5</strong>, WHO’s series of conversations in science, 5 March 2021</td>
<td>The WHO Technical Lead for COVID-19, Dr. Maria Van Kerkhove answers questions on the SARS-CoV-2 virus variants and provides information on how WHO is tracking these virus mutations globally.</td>
</tr>
<tr>
<td><strong>Roadmap to improve and ensure good indoor ventilation in the context of COVID-19</strong>, 1 March 2021</td>
<td>This roadmap aims to define the key questions users should consider to assess indoor ventilation and the major steps needed to reach recommended ventilation levels and improve indoor air quality (IAQ) to reduce the risk of COVID-19 transmission.</td>
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<tr>
<td><strong>COVID-19 vaccine checklist</strong>, 1 March 2021</td>
<td>The COVID-19 vaccine checklist is for frontline health workers planning a COVID-19 vaccination session. This checklist can help them to prepare and complete a COVID-19 vaccination session at a fixed post or outreach session.</td>
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<tr>
<td><strong>Health worker communication for COVID-19 vaccination flow diagram</strong>, 1 March 2021</td>
<td>The ‘Health Worker Communication for COVID-19 Vaccination Flow Diagram' supports health workers by outlining key steps and messages to communicate during a COVID-19 vaccination session.</td>
</tr>
<tr>
<td><strong>Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern</strong>, 25 February 2021</td>
<td>This special edition of COVID-19 weekly epidemiological update provides working definitions for SARS-CoV-2 variants of interest and variants of concern and the associated actions WHO will take to support Member States, their national public health institutes and reference laboratories, along with the recommended actions Member States should take. It includes general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the context of wider SARS-CoV-2 transmission, and established response mechanisms and public health and social measures.</td>
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</tbody>
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Online WHO COVID-19 courses:
- Standard precautions: Environmental cleaning and disinfection
- Management of COVID-19 in long-term care facilities
- Operational planning guidelines and COVID-19
- Clinical management of severe acute respiratory infections
- Health and safety briefing for respiratory diseases – eProtect
- Infection prevention and control

WHO guidance:
- WHO living guideline: Drugs to prevent COVID-19
- COVID-19 Strategic Preparedness and Response Plan (SPRP 2021)
- COVID-19 vaccine introduction and deployment costing tool (CVIC tool)
- Anti-interleukin-6 therapies for hospitalized patients with COVID-19: a protocol for a prospective meta-analysis of randomized trials

Infographics:
- COVID-19 vaccines and vaccination
- The truth about COVID-19 vaccines
- Quarantine and self-monitoring
- COVID-19 tests
- Mental health

Questions and answers:
- COVID-19: Vaccines
- COVID-19: Vaccine research and development
- COVID-19: Vaccine access and allocation
- How are vaccines developed?

Videos:
- Time to abide (1-10)
- Hand sanitizer routine
- COVID-19 virus variants
- Science in 5: “I am vaccinated, what next?”

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

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