HIGHLIGHTS

- As of 17 March, the Government of Indonesia reported 1,437,283 (6825 new) confirmed cases of COVID-19, 38,915 (162 new) deaths and 1,266,673 recovered cases from 510 districts across all 34 provinces.¹

- To support improvements to COVID-19 testing capacity, WHO handed over 1,000,000 antigen-detecting rapid diagnostic tests (Ag-RDTs) to the Ministry of Health on 13 March (page 17).

- WHO is providing technical assistance to the Government for the continuity of essential health services. Highlights of vector surveillance activities are available on pages 21 to 23.

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 11 to 17 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.

¹ https://covid19.go.id/peta-sebaran-covid19
On 8 March, the National COVID-19 Task Force (Satuan Tugas (Satgas)) announced the extension of the implementation of micro-scale restrictions on community activities (pemberlakuan pembatasan kegiatan masyarakat (PPKM)) from 9 to 22 March, which is included in the Instruction of the Ministry of Home Affairs Number 5 of 2021. Under the ministerial instruction, the micro-scale PPKM has also been extended to three provinces outside Java and Bali, i.e. East Kalimantan, North Sumatra, and South Sulawesi.2

The Government kicked off the third stage of the national vaccination campaign with the provision of COVID-19 vaccines to persons with disabilities on 11 March. Persons with disabilities who hold the National Identity Card (Kartu Identitas Nasional (KTP)) from DKI Jakarta have since started to receive their COVID-19 vaccination at Istora Senayan Stadium, Jakarta. This stage targets around 63.9 million people from vulnerable populations.3 The Minister of Health said that the Ministry of Health (MoH) plans to administer around 1.5 million COVID-19 vaccine shots per day by the second half of 2021 to achieve the target of the national COVID-19 vaccination campaign.4

During a virtual conference on 12 March, MoH Director of Disease Prevention and Control said that MoH had signed an agreement with the Ministry of Research and Technology / National Research and Innovation Agency (Kementerian Riset dan Teknologi / Badan Riset dan Inovasi Nasional Republik Indonesia (Kemenristek / BRIN)) to improve detection of several variants of the SARS-CoV-2 virus (including the variant of the virus first identified in South Africa (B.1.351) and the United Kingdom (B.1.1.7)) through whole genome sequencing (WGS). She also mentioned that there are 17 laboratories with the capacity to conduct WGS in Indonesia, including laboratories of the Eijkman Institute for Molecular Biology, University of Indonesia, and the Indonesian Institute of Sciences (Lembaga Ilmu Pengetahuan Indonesia (LIPI)).5

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5 https://www.cnnindonesia.com/nasional/20210312225257-20-616933/pemerintah-fokus-telusuri-3-jenis-mutasi-corona
• On 17 March, 6825 new and 1 437 283 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 11 to 17 March was 5529 cases per day, compared to 6392 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 17 March 2021.

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 8 to 14 March, the provinces of Banten, Papua, North Maluku, Gorontalo and Bangka Belitung Islands experienced an increase in the number of weekly cases of more than 30% 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 the adjustment of public health and social measures.

Fig. 3. Percentage change of weekly number of confirmed cases by province during 8 to 14 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 8 to 14 March, the incidence\(^6\) of COVID-19 in Indonesia was 16.6 per 100 000 population, compared to 20.0 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 14 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. Other limitations include data incompleteness and data quality issues reported by MoH. 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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\(^6\) 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 8 to 14 March, the incidence of COVID-19 per 100 000 population ranged between 50 and 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.
The weekly incidence of COVID-19 decreased in all provinces in Java Island except Banten during the week of 8 to 14 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 14 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. 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 14 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. 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 14 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 14 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 14 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 14 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 17 March, the numbers of specimens and people tested (based on a 7-day moving average) were 59,401 and 47,027, respectively. On the same day, the daily number of suspected cases was 59,610 (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.

Fig. 12. The 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 17 March 2021. [Source of data](who.int/indonesia)

• Test positivity proportion nationwide increased sharply after 23 November and reached a peak of 30.5% in mid-February. Subsequently, the positivity proportion has declined and stands at 17.7% on 14 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).

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7 The numbers of specimens and people tested are calculated using a 7-day moving average, by averaging the last 7 days values.
Fig. 13. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 14 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: 22/02/21 to 28/02/21; Week 2: 01/03/21 to 07/03/21; Week 3: 08/03/21 to 14/03/21

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.

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who.int/indonesia
During the week of 8 to 14 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).

![Chart showing weekly number of confirmed COVID-19 deaths per 100,000 population by province in Indonesia during 8-14 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: 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.](chart.png)
During the week of 8 to 14 March, the number of confirmed COVID-19 deaths was 0.47 per 100 000 population\(^8\), compared to 0.53 per 100 000 in the previous week (Fig. 16).

Out of six provinces in Java, DI Yogyakarta and Banten 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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\(^8\) Weekly mortality of COVID-19 is calculated as the number of COVID-19 deaths per 100 000 population per week averaged over a two-week period. [Source of population data](https://who.int/indonesia)
Fig. 17. Deaths among confirmed COVID-19 cases and probable cases per week over three weeks between 22 February to 14 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 17 March, the daily number of people tested for COVID-19 was 58,752 and the cumulative number of people tested was 7,887,009 (Fig. 18).

Fig. 18. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 17 March 2021. Source of data

As of 17 March, the proportion of people recovered among the total confirmed COVID-19 cases was 88.1% and there were 131,695 active cases (Fig. 19).

Fig. 19. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 17 March 2021. Source of data
The reported number of confirmed COVID-19 cases hospitalized in DKI Jakarta reached a peak of 9888 hospitalized cases on 12 February. The number of hospitalized cases has since decreased to 3301 on 14 March (Fig. 20).

Fig. 20. Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 July 2020 to 14 March 2021. [Source of data]

Disclaimer: Data from Wisma Atlet are not included.

LABORATORY

WHO handed over 1 000 000 antigen-detecting rapid diagnostic tests (Ag-RDTs) to MoH on 13 March, with an estimated cost of US$ 4.9 million. The use of Ag-RDTs is expected to support improvements in COVID-19 testing capacity, especially in areas with limited access to polymerase chain reaction (PCR) testing and high turnaround time for test results.
WHO continues to translate important courses designed for key partners and frontline responders into Indonesian, also available on the OpenWHO platform. As of 15 March, 25,554 participants have enrolled in the seven OpenWHO courses available in Indonesian. Recently, WHO has added two more translated courses: ‘COVID-19 vaccination training for health workers’ and ‘Standard precautions: Environmental cleaning and disinfection’.

Table 1. Number of participants enrolled in the OpenWHO courses that have been translated into Indonesian, as of 15 March 2021.

<table>
<thead>
<tr>
<th>No.</th>
<th>OpenWHO courses</th>
<th>Number of participants enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Infection Prevention and Control (IPC) for COVID-19 Virus</td>
<td>8128</td>
</tr>
<tr>
<td>2.</td>
<td>ePROTECT Respiratory Infections</td>
<td>6643</td>
</tr>
<tr>
<td>4.</td>
<td>Introduction to COVID-19: methods for detection, prevention, response and control</td>
<td>3360</td>
</tr>
<tr>
<td>5.</td>
<td>WHO Clinical Care Severe Acute Respiratory Infection Training</td>
<td>1282</td>
</tr>
<tr>
<td>6.</td>
<td>Severe Acute Respiratory Infection (SARI) Treatment Facility Design</td>
<td>1256</td>
</tr>
<tr>
<td>7.</td>
<td>Long-term care facilities in the context of COVID-19</td>
<td>1095</td>
</tr>
</tbody>
</table>

On 8 March, WHO supported MoH to conduct a meeting on resource mapping for health security as the implementation of the Presidential Instruction Number 4 of 2019 on ‘Capacity enhancement in preventing, detecting, and responding to outbreaks of disease, global pandemic and nuclear, biological and chemical emergencies’. More than 100 participants attended the meeting, including representatives from MoH, Cabinet Secretariat, the National Board for Disaster Management (Badan Nasional Penanggulangan Bencana (BNPB)), Ministry of Home Affairs (MoHA), WHO and other multisectoral stakeholders. The meeting highlighted the importance of implementation and monitoring of the National Action...
Plan for Health Security (NAPHS) and resource mapping\(^9\) and prioritization to improve health security capacities to better prepare for and respond to public health emergencies.

- On 9 March, WHO supported MoH to conduct a meeting on the follow-up actions for Electronic State Parties Self-Assessment Annual Reporting (e-SPAR). This meeting was attended by more than 20 participants. During the meeting, WHO provided an update on several International Health Regulations (IHR) monitoring tools, including (i) **Joint External Evaluation tool (JEE tool)**, (ii) **e-SPAR Tool** and (iii) **COVID-19 Intra-Action Review (IAR)**, among others. MoH presented the assessment of the IHR core capacities reported for SPAR. The meeting highlighted the importance of embracing the lessons learned from COVID-19 IAR to improve IHR core capacities.

- On 9 and 10 March, representatives from the Government attended a virtual consultative meeting on the JEE and SPAR, organized by WHO. The meeting reported on the feedback from a survey that was conducted as part of the Member States e-SPAR 2021, aimed to capture lessons learned from the COVID-19 response.

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VACCINATION

- As of 15 March, 5 739 648 vaccine doses have been administered to health workers, essential public service workers and older people (above 60 years old) in the national COVID-19 vaccination campaign; 4 166 862 people have received the first dose and 1 572 786 people have received the second dose (Fig. 22).

![Cumulative number of vaccine doses administered in Indonesia, from 22 January to 15 March 2021. Source of data](source)

**Disclaimer:** COVID-19 vaccination started on 13 January. Published data from MoH is available starting from 22 January.

- As of 15 March, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1 183 715 (80.6% of the target population of 1 468 764). The number of essential public service workers who have received the first dose of the vaccine was 2 046 659 (11.8% of the targeted 17 327 169); and the number of older people who have received the first dose of the COVID-19 vaccine was 701 583 (3.3% of the targeted 21 553 118) (Fig. 23).
WHO continues to support the Government for programme analysis of various essential health services to ensure their continuity during the pandemic. Highlights from vector surveillance are presented below. Complementary updates on dengue and malaria programmes can be seen in WHO Situation Report 14 (pages 18-20), Situation Report 15 (pages 17-20), and Situation Report 25 (pages 20-22).

Impact of COVID-19 on mosquito-borne vector surveillance in Indonesia:

- Vector surveillance is regulated in the Minister of Health Regulation Number 50 of 2017 and part of the National Health Strategic Plan 2020-2024 under the MoH Sub-Directorate of Vector and Animal Reservoir Control. The target indicators for 2020 and 2021 are for 40 and 80 districts, respectively, to have 25% of community health centres (puskesmas) conduct vector surveillance of *Anopheles* (malaria vector) and *Aedes* (dengue vector) and report data through the SILANTOR application (MoH vector surveillance information system).
The implementation of large-scale social restrictions (PSBB) in Indonesia at the beginning of the pandemic contributed to the disruption of dengue and malaria vector surveillance activities in most areas of the country. The disruption was observed in Java Island, a low-endemic area with persistent local malaria transmission, and in Papua, the province with the highest malaria burden. However, several areas where malaria or dengue cases were reported were able to conduct vector surveillance activities as part of routine epidemiological investigation.

The disruption of vector surveillance and case-based malaria investigation contributed to a reduction and delay in reporting and a subsequent impact on the effectiveness of the outbreak warning system. In 2020, a prolonged malaria outbreak was reported in Rokan Hilir District, Riau and malaria resurgence was reported in Bintan District, Riau Islands.

To mitigate the impact of COVID-19 and maintain essential dengue and malaria vector surveillance services, interventions are being made in the following areas:

i. Guideline: A circular from the MoH Director General of Diseases Prevention and Control on the continuity of Dengue Control Programme (DCP) was disseminated to all provinces and districts on 6 April 2020 (WHO Situation Report 14 (page 19)). On 23 April 2020, MoH issued a protocol on the continuity of malaria programme activities (WHO Situation Report 15, page 18), which is in line with WHO guidance on tailoring malaria interventions during the COVID-19 pandemic response.
ii. Vector control: Activities to increase community participation and awareness for source reduction measures were conducted through the “1 Home 1 Jumantik (larvae inspector) Movement” (Gerakan 1 Rumah 1 Jumantik (G1R1J)) for dengue vector surveillance. Village malaria cadres and staff members of puskesmas conducted *Anopheles* habitat inspection, following strict health protocols, including use of personal protective equipment (PPE).

iii. Capacity building: WHO supported MoH to conduct trainings on SILANTOR for Banten, Central Java, East Java and West Java, between 24 September and 16 December 2020. A total of 1107 staff members of puskesmas and district health offices were trained on vector surveillance and SILANTOR. After the intensive training, vector surveillance activities recorded through SILANTOR showed an increase in the number of houses visited to monitor the risk of dengue outbreak. In 2020, a total of 19,571,173 houses from 6,011 villages in 72 districts were visited. Out of 301,175 breeding sites that were inspected for the malaria vector in 1553 villages, 9,201 breeding sites in 486 villages were positive for *Anopheles* larvae. Overall, 3,891 villages were at risk of a dengue outbreak and 486 villages had the potential for malaria transmission. This information was used by puskesmas to communicate and raise awareness with multisectoral stakeholders and communities on environmental management10 to prevent dengue and malaria outbreaks during the COVID-19 pandemic.

**PARTNER COORDINATION**

- On 9 March, WHO convened a meeting attended by key development partners to discuss essential health services in Indonesia. WHO provided a situation analysis of the impact of COVID-19 on the continuity of essential health services in the country, including HIV/AIDS, tuberculosis (TB), malaria, neglected tropical diseases (NTDs), and immunization services. In addition, WHO also provided information on their support to MoH related to the continuity of essential health services and several guidance documents that can be useful for countries to ensure the continuity of essential health services during the COVID-19 pandemic, including ‘Maintaining essential health services: operational guidance for the COVID-19 context’, ‘Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic’, ‘Immunization as essential health service: guiding principles for immunization activities during the COVID-19 pandemic and other times of severe disruption’, and ‘Continuity of essential health services: Facility assessment tool’.

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10 Messages on environmental management included cleaning/clearing breeding grounds (stagnant water) for *Aedes* inside and outside the home; and infrastructure work to lagoons and streams to reduce *Anopheles* risk.
• On 12 March, WHO and the European Union (EU) launched a new partnership to support the COVID-19 pandemic response and strengthen the health system in Indonesia to better prepare for future public health emergencies. The partnership was officially launched in a virtual event attended by the Minister of Health, the EU Ambassador to Indonesia and Brunei Darussalam, Ambassadors of EU Member States, and the WHO Representative to Indonesia. Through the partnership, the EU is providing €2.66 million to the WHO country office in Indonesia, as part of its €20 million commitment to the WHO-EU ‘South-East Asia Health Pandemic Response and Preparedness’ programme.

• 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. 25)

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

Table 2: Title and details of recent WHO resource materials

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to monitor and report COVID-19 vaccine side effects, 15 March 2021</td>
<td>This poster is designed to provide practical guidance on the steps that need to be taken by health workers on how to monitor and report COVID-19 vaccine side effects to ensure vaccine safety.</td>
</tr>
<tr>
<td>Monitoring COVID-19 vaccination: Considerations for the collection and use of vaccination data, 3 March 2021</td>
<td>This document provides guidance on: (i) minimum and optional data to collect as vaccines are being rolled out and delivered, (ii) key performance indicators and the anticipated use of these – to measure the performance of key components of the immunization system and to take corrective action when needed, and (iii) the use of information systems to collect, store, analyze and disseminate any relevant information.</td>
</tr>
</tbody>
</table>
Online WHO COVID-19 courses:

- COVID-19 vaccination training for health workers
- Standard precautions: Environmental cleaning and disinfection
- Management of COVID-19 in long-term care facilities
- Operational planning guidelines and COVID-19
- Clinical management of severe acute respiratory infections
- Health and safety briefing for respiratory diseases – eProtect

WHO guidance:

- Roadmap to improve and ensure good indoor ventilation in the context of COVID-19
- COVID-19 vaccine checklist
- Health worker communication for COVID-19 vaccination flow diagram
- Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern

Infographics:

- COVID-19 new variants
- COVID-19 vaccines and vaccination
- The truth about COVID-19 vaccines
- Quarantine and self-monitoring
- COVID-19 tests

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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