As of 31 March, the Government of Indonesia reported 1 511 712 (5937 new) confirmed cases of COVID-19, 40 858 (104 new) deaths and 1 348 330 recovered cases from 510 districts across all 34 provinces.¹

WHO continues to support the National Institute of Health Research and Development to strengthen quality assurance systems in COVID-19 testing laboratories (page 16).

WHO supported the Ministry of Health to review the implementation of the Indonesian Electronic Health Alert Card (eHAC) and conduct a refresher training on eHAC application in East Java (page 17).

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HIGHLIGHTS

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 25 to 31 March 2021. [Source of data](https://covid19.go.id/peta-sebaran-covid19)

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.

State-owned pharmaceutical company, Bio Farma, announced that it had distributed 5000 vials of AstraZeneca COVID-19 vaccine to each province, namely DKI Jakarta, North Sulawesi and Riau Islands on 29 March. Previously, the company distributed 45 000 vials of the vaccine to East Java. Each vial consists of 10 doses. The spokesperson of Bio Farma said that the Ministry of Health (MoH) had instructed the company to distribute AstraZeneca COVID-19 vaccines to several provinces including Bali, DKI Jakarta, East Nusa Tenggara, North Sulawesi and Riau Islands. The company is awaiting further instructions from MoH on the distribution of the remaining vials.²

On 27 March, the Minister of Health stated that Indonesia will ration its vaccine use in response to expected delays in the shipments of AstraZeneca COVID-19 vaccine from the COVAX Facility and a slowdown in the production of Sinovac vaccine manufactured by Bio Farma. Initially, Indonesia was expected to receive a shipment of 10 million doses of AstraZeneca vaccine in March and April. In addition, the Minister said that the country would only have around 7.6 million ready-to-use Sinovac vaccines manufactured by Bio Farma available in April 2021.³

During a virtual press conference on 27 March, the Minister of Health said that COVID-19 vaccination for those aged 60 years and above has been rolled out slower than expected. He mentioned that the low vaccination rate in this priority group is due to several reasons, including vaccine hesitancy and limited mobility. To address this issue, MoH is considering several options to ensure easier access for older populations to receive their vaccination and boost national vaccination coverage.⁴

On 26 March, the Coordinating Minister for Human Development and Cultural Affairs announced that the Government will ban the Eid al-Fitr tradition of mudik (returning to hometowns for Eid) in 2021. The ban is intended to prevent a spike in COVID-19 transmission and deaths after the holiday. Furthermore, he explained that the ban is effective for civil servants, military personnel, police and the general public. In addition, regulations specifying the mobility restrictions during the ban will be issued by related authorities after coordinating with the National COVID-19 Task Force.⁵

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⁵ https://www.thejakartapost.com/paper/2021/03/28/govt-to-ban-idul-fitri-exodus-again-this-year.html
• On 31 March, 5937 new and 1,511,712 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 25 to 31 March was 5037 per day, compared to 5596 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. 17); reporting of laboratory-confirmed results may take up to one week from the time of testing. Therefore, caution must be taken in interpreting this figure and the epidemiological curve for further analysis, either at the national or subnational level.
During the week of 22 to 28 March, the provinces of Maluku, Riau Islands, Aceh, North Sulawesi and South Sumatra experienced an increase in the number of weekly cases of more than 50% 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 (PHSM).\(^6\)

![Fig. 3. Percentage change of weekly number of confirmed cases by province during 22 to 28 March 2021 compared to the previous week. Source of data](image-url)

**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.

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\(^6\) It is also important to conduct further investigation if there is a substantial decrease in new cases, especially in provinces with 50% or more decline. Other indicators, such as testing and contact tracing, may help elucidate the reasons behind a drop in new cases.
• During the week of 22 to 28 March, the incidence\(^7\) of COVID-19 in Indonesia was 14.4 per 100,000 population, compared to 15.2 per 100,000 in the previous week (Fig. 4).

![Graph showing incidence of COVID-19 per 100,000 population per week over a two-week period]

**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 28 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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\(^7\) 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 22 to 28 March, the incidence of COVID-19 per 100 000 population was 92.1 in DKI Jakarta, 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.

![Incidence of COVID-19 per 100 000 population per week averaged over a two-week period by province in Indonesia during 22 to 28 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](who.int/indonesia)
The weekly incidence of COVID-19 decreased in all provinces in Java Island except DI Yogyakarta and Banten during the week of 22 to 28 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 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 28 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**

who.int/indonesia
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 28 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 28 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 28 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 28 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
- Test positivity proportion nationwide increased sharply after 23 November and reached a peak of 30.5% in mid-February. Subsequently, the positivity proportion declined and stood at 12.8% on 28 March (Fig. 12). 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 Banten for the last three weeks, but none of these provinces had a test positivity proportion of less than 5% (Fig. 13).

Fig. 12. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 28 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. 13. Test positivity proportion and people tested per 1000 population per week at the national level and in select provinces.

Week 1: 08/03/21 to 14/03/21; Week 2: 15/03/21 to 21/03/21; Week 3: 22/03/21 to 28/03/21

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, Southeast Sulawesi

Note: Due to a limitation in data, other provinces could not be evaluated. For surveillance purposes, test positivity proportion is calculated as the number of confirmed cases divided by the number of people tested for diagnosis.
• During the week of 22 to 28 March, DKI Jakarta had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by Bali, East Kalimantan, North Kalimantan, and Bangka Belitung Islands (Fig. 14).

Fig. 14. Number of confirmed COVID-19 deaths per 100,000 population per week averaged over a two-week period by province in Indonesia during 22 to 28 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:** Based on data availability, only confirmed COVID-19 deaths have been included. As per WHO definition, however, death resulting from a clinically compatible illness in a probable or confirmed COVID-19 case is a COVID-19-related death, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma); there should be no period of complete recovery between the illness and death.
• During the week of 22 to 28 March, the number of confirmed COVID-19 deaths was 0.38 per 100 000 population\(^8\), compared to 0.42 per 100 000 in the previous week (Fig. 15).

![Deaths per 100 000 population](image)

Fig. 15. Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 28 March 2021. [Source of data]

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

• Out of six provinces in Java, only DKI Jakarta showed a consecutive decline over the last three weeks in the number of deaths in confirmed and probable cases (Fig. 16).

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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]
Fig. 16. Deaths among confirmed COVID-19 cases and probable cases per week over three weeks between 8 to 28 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 31 March, the daily number of people tested for COVID-19 was 45 714 and the cumulative number of people tested was 8 490 864 (Fig. 17).

![Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 31 March 2021.](source)

- As of 31 March, the proportion of people recovered among the total confirmed COVID-19 cases was 89.2% and there were 122 524 active cases (Fig. 18).

![Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 31 March 2021.](source)
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 3830 on 28 March (Fig. 19).

![Fig. 19. Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 July 2020 to 28 March 2021.](source of data)

Disclaimer: Data from Wisma Atlet are not included.

**LABORATORY**

- WHO continues to support the National Institute of Health Research and Development (NIHRD) to strengthen quality assurance systems in COVID-19 testing laboratories (more information can be found in WHO Situation Report 34 (pages 14 to 16) and Situation Report 37 (page 16)). A total of 177 COVID-19 polymerase chain reaction (PCR) testing laboratories participated in the first phase of the External Quality Assessment (EQA), which was supported by the Royal College of Pathologists of Australasia Quality Assurance Programs (RCPAQP), United States Agency for International Development (USAID) and WHO. The submission of EQA results was finalized on 15 March. From 24 to 26 March, WHO supported NIHRD to conduct supportive supervision visits to several laboratories identified based on the preliminary analysis of the EQA results. The visit was conducted to identify possible causes of problems in laboratory practices and to provide recommendations for corrective actions. Continuous supervision and technical assistance will be provided to underperforming laboratories to improve their quality management systems to reach the national standards.
WHO is regularly translating and sharing important health messages on its website and social media platforms – Twitter and Instagram – and has recently published:

Videos:
- Science in 5: Evolution of the SARS-CoV-2 virus

RISK AND NEEDS ASSESSMENT, AND PLANNING

On 29 March, WHO supported MoH to conduct a training on contact tracing and use of selected indicators to guide the adjustment of PHSM for East Kalimantan. A total of 38 participants from the provincial health office (PHO) and district health offices (DHOs) participated in the training.

On 27 March, WHO participated in a meeting organized by MoH to discuss a strategy and action plan to respond to the surge of COVID-19 cases in communities living around ground crossings between Papua province of Indonesia and Papua New Guinea. Several actions to improve and strengthen the response in Papua were recommended, including: (i) mobilizing resources to improve testing (including provision of PCR reagents and antigen-detecting rapid diagnostic tests (Ag-RDTs) and increasing human resources for laboratory testing); (ii) strengthening contact tracing activities by involving multiple stakeholders (including armed forces, Indonesian Red Cross Society, universities, and professional organizations); and (iii) accelerating vaccination to improve vaccine coverage. In addition, the meeting concluded that there is a need to increase hospital bed capacity in the province to be prepared for the surge of cases.

On 25 March, WHO supported MoH to conduct a virtual session to review the implementation of the Electronic Health Alert Card (eHAC) in East Java and provide a refresher training on the eHAC application. The review found that not all districts in the province have access to the application to keep track of travellers. In addition, the number of travellers who have completed the eHAC remains relatively low. MoH will continue to improve the implementation of eHAC to support screening of travellers and contact tracing efforts.
As of 29 March, 10 766 490 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; 7 435 851 people have received the first dose and 3 330 639 people have received the second dose (Fig. 21).

**Disclaimer:** COVID-19 vaccination started on 13 January. Published data from MoH is available starting from 22 January.
As of 29 March, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1,275,981 (86.9% 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 4,549,721 (26.3% of the targeted 17,327,169); and the number of older people who have received the first dose of the vaccine was 1,453,977 (6.8% of the targeted 21,553,118) (Fig. 22).

Fig. 22. Cumulative number of people who have received COVID-19 vaccine in Indonesia, as of 29 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.

CONTINUITY OF ESSENTIAL HEALTH SERVICES

To commemorate World Tuberculosis (TB) Day on 24 March, MoH organized a virtual event in collaboration with the Office of the Vice President and the Coordinating Ministry for Human Development and Cultural Affairs. Adapted from the global theme of World TB Day 2021 “The Clock is Ticking”, the theme of the national commemoration was “Every Second is Precious, Save the Nation from Tuberculosis”. The theme was intended to remind relevant stakeholders and the public that focusing on TB elimination efforts despite the COVID-19 pandemic still remains critical. During the event, the Vice President highlighted the importance of strengthening the national commitment and collective efforts in the fight against TB. The Director of the WHO Global TB Programme Dr Tereza Kasaeva attended the session and showed her appreciation for Indonesia’s efforts against TB during the pandemic.
During a virtual event to commemorate World TB Day organized by WHO on 24 March, the Minister of Health delivered a speech reiterating Indonesia’s commitment towards TB elimination by 2030. Indonesia’s three main strategies to improve TB notification and treatment include: (i) advancing TB screening, diagnosis and treatment; (ii) ensuring the availability and continuity of essential TB services for all Indonesian citizens; and (iii) ameliorating a multisectoral collaboration in the fight against TB. In line with the joint movement to end TB which was declared by President Joko Widodo in 2020, Indonesia is aiming to reduce TB incidence to 219 per 100,000 population and TB mortality to 27 per 100,000 population by 2024.

On 24 March, the National TB Programme launched a new application called “Dashboard TB Indonesia”. The application intends to provide a platform for health officers and stakeholders to easily and swiftly monitor the programmatic achievements based on relevant indicators that are aligned with the National TB Programme and Global TB Report indicators. The application is also accessible to the public and it serves to raise public awareness on TB in the country.
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. 24).

Fig. 24. WHO funding situation for COVID-19 response, March 2021

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 1: 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>
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<tbody>
<tr>
<td>WHO-convened global study of origins of SARS-CoV-2: China Part (joint report), 30 March 2021</td>
<td>In May 2020, the World Health Assembly in resolution WHA73.1 requested the Director-General of WHO to continue to work closely with the World Organization for Animal Health (OIE), the Food and Agricultural Organization of the United Nations (FAO) and countries to identify the zoonotic source of SARS-CoV-2 and the route of introduction to the human population, including the possible role of intermediate hosts.</td>
</tr>
<tr>
<td>Operational considerations to expedite genomic sequencing component of GISRS surveillance of SARS-CoV-2, 30 March 2021</td>
<td>This document provides practical guidance to Global Influenza Surveillance and Response System (GISRS) laboratories and other national laboratories to move beyond virus detection to genomic sequencing of SARS-CoV-2 PCR positive materials obtained from sentinel surveillance of influenza-like illness (ILI), acute respiratory infection (ARI) and severe acute respiratory infection (SARI).</td>
</tr>
<tr>
<td>Episode 31 of Science in 5, WHO’s series of conversations in science, 26 March 2021</td>
<td>WHO Director of Immunization, Vaccines and Biologicals Dr Katherine O’ Brien answers questions related to COVID-19 vaccines, variants and vaccine doses.</td>
</tr>
<tr>
<td>COVID-19 new variants: Knowledge gaps and research (draft meeting report), 25 March 2021</td>
<td>This draft report is a summary of presentations and panel discussions of the WHO ad hoc consultation to discuss the development of a research and development agenda in response to the existing and emerging SARS-CoV-2 variants, organized on 12 January 2021.</td>
</tr>
<tr>
<td>Evaluation of COVID-19 vaccine effectiveness, 17 March 2021</td>
<td>This document provides interim best practice guidance on how to assess COVID-19 vaccine effectiveness (VE) using observational study designs. It discusses critical considerations in the design, analysis and interpretation of COVID-19 VE evaluations. This interim guidance is targeted mainly to evaluations undertaken in low- and middle-income countries but most of the concepts also apply to VE evaluations in high-income settings.</td>
</tr>
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A SNAPSHOT OF WHO COURSES AND INFORMATION MATERIAL

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:
- Interim guidance for developing a Smart Vaccination Certificate
- A guide to contracting for health services during the COVID-19 pandemic (conference copy)
- Interim recommendations for the use of the Janssen Ad26.COV2.S (COVID-19) vaccine
- Background document on the Janssen Ad26.COV2.S (COVID-19) vaccine

Infographics:
- Contact tracing
- 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
WHO Indonesia Reports