HIGHLIGHTS

- As of 7 April, the Government of Indonesia reported 1,547,376 (4,860 new) confirmed cases of COVID-19, 42,064 (87 new) deaths and 1,391,742 recovered cases from 510 districts across all 34 provinces.¹

- To strengthen Indonesia’s capacity for health security, WHO continues to support the Ministry of Health in the development of the national influenza pandemic contingency plan. Consultation meetings with multiple sectors were conducted on 31 March and 1 April (page 16).


[Map showing geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 1 to 7 April 2021. Source of data]

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 1 to 7 April 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

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On 4 April, the Ministry of Health (MoH) reported that the E484K strain of the SARS-CoV-2 virus had been detected in Indonesia. The Eijkman Institute for Molecular Biology traced the strain of the virus to an individual in Jakarta in February. The Government will intensify its whole genome sequencing efforts to strengthen the COVID-19 response in the country. In addition, MoH urged the public to remain vigilant and strictly comply to the health protocols to curb transmission of the E484K and other strains of the virus.2

On 1 April, the MoH Director of Disease Prevention and Control stated that the start of the third phase of the national COVID-19 vaccination campaign has been postponed from April to June due to the limited vaccine stock and delays in the shipment of AstraZeneca vaccines from the COVAX Facility.3 On 5 April, the Minister of Health stated that the current roll-out of COVID-19 vaccination will be prioritized to older people (above 60 years old) due to the limited vaccine stock in country4.

During a press conference on 30 March, the Coordinating Minister for Human Development and Cultural Affairs reported that he had signed a joint ministerial decree together with the Minister of Education, Minister of Religious Affairs, Minister of Home Affairs and Minister of Health to allow limited face-to-face learning for the 2021-2022 school year. On the same occasion, the Minister of Education advised provincial governments to take the necessary preparatory steps to ensure safety precautions and measures are in place before the start of the new academic year in July.5

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2 https://go.kompas.com/read/2021/04/06/014528974/e484k-covid-19-strain-detected-in-indonesia?page=all#page2
4 https://nasional.kompas.com/read/2021/04/05/18530121/stok-vaksin-terbatas-vaksinasi-bulan-april-diprioritaskan-untuk-lansia
5 https://go.kompas.com/read/2021/03/31/032834474/indonesia-allows-limited-face-to-face-classes-for-2021-2022-academic-year
On 7 April, 4860 new and 1 547 376 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 1 to 7 April was 5095 cases per day, compared to 5037 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 7 April 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. 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 29 March to 4 April, the provinces of Banten and Bengkulu 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 the new confirmed cases to guide decisions on response activities and inform the adjustment of public health and social measures (PHSM).²

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.

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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² 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 29 March to 4 April, the incidence\(^7\) of COVID-19 in Indonesia was 13.7 per 100 000 population, compared to 14.4 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 4 April 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).

\(^7\) 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 29 March to 4 April, the incidence of COVID-19 per 100,000 population was 83.5 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.

Fig. 5. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period by province in Indonesia during 29 March to 4 April 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 except DI Yogyakarta and Banten during the week of 29 March to 4 April compared to the previous week (Fig. 6 to 11).

**West Java**

![Graph](image1)

**Source of data**

**DKI Jakarta**

![Graph](image2)

**Source of data**

[who.int/indonesia](http://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 4 April 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 4 April 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 4 April 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 4 April 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 12.3% on 4 April (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 4 April 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: 15/03/21 to 21/03/21; Week 2: 22/03/21 to 28/03/21; Week 3: 29/03/21 to 04/04/21

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 29 March to 4 April, Bali had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by East Kalimantan, DKI Jakarta, DI Yogyakarta, 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 29 March to 4 April 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 29 March to 4 April, the number of confirmed COVID-19 deaths was 0.36 per 100 000 population\(^8\), compared to 0.38 per 100 000 in the previous week (Fig. 15).

![Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 4 April 2021.](Fig. 15)

**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 and Banten 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 data](#)
Fig. 16. Deaths among confirmed COVID-19 cases and probable cases per week over three weeks between 15 March to 4 April 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 7 April, the daily number of people tested for COVID-19 was 53 457 and the cumulative number of people tested was 8 798 525 (Fig. 17).

![Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 7 April 2021. Source of data](source)

• As of 7 April, the proportion of people recovered among the total confirmed COVID-19 cases was 89.9% and there were 113 570 active cases (Fig. 18).

![Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 7 April 2021. Source of data](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 3392 on 4 April (Fig. 19).

Fig. 19. Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 August 2020 to 4 April 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 continues to publish infographics useful for the public.

RISK AND NEEDS ASSESSMENT, AND PLANNING

WHO continues to provide technical assistance to MoH to develop the national influenza pandemic contingency plan to strengthen Indonesia's capacity for health security. Virtual consultation meetings involving multiple sectors were conducted on 31 March and 1 April, attended by over 85 participants including representatives from the National Board for Disaster Management (Badan Nasional Penanggulangan Bencana (BNPB)), Ministry of Agriculture, Coordinating Ministry for Human Development and Cultural Affairs and the National Army. During the meetings, WHO highlighted the importance of including a contingency plan as part of a comprehensive preparedness and response cycle.

![WHO presentation on Emerging Diseases](https://www.who.int/images/en/Endang_Wulandari.jpg)

The public health objectives at all stages of the preparedness and response plan are to:
- Prevent outbreaks, delay spread, slow and stop transmission.
- Provide optimized care for all patients, especially the seriously ill.
- Minimize the impact of the epidemic on health systems, social services, and economic activity.

Fig. 20. WHO presented on ‘Emerging Diseases Affecting Global Health and Future Challenges of the Healthcare System’ in a virtual lecture hosted by Gadjah Mada University, on 30 March 2021. Credit: WHO/Endang Wulandari

### VACCINATION

• As of 5 April, 13 087 173 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; 8 856 373 people have received the first dose and 4 230 800 people have received the second dose (Fig. 21).
As of 5 April, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1,297,351 (88.3% 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 5,641,985 (32.6% of the targeted 17,327,169); 2,604,222 (15% of the targeted number) have received the second dose of the vaccine. The number of older people who have received the first dose of the vaccine was 1,771,003 (8.2% of the targeted 21,553,118); 329,227 (1.5% of the targeted number) have received the second dose (Fig. 22).
Fig. 22. Cumulative number of people who have received COVID-19 vaccine in Indonesia, as of 5 April 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.
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 April 2021 (Fig. 23).

Fig. 23. WHO funding situation for COVID-19 response, April 2021.

Data presented in this situation report have been taken from publicly available data from the MoH (https://infeksiemergering.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>
</tr>
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<tbody>
<tr>
<td><strong>WHO COVID-19 Weekly Epidemiological Update</strong>, 6 April 2021</td>
<td>The Weekly Epidemiological Update provides an overview of the global, regional and country-level COVID-19 cases and deaths, highlighting key data and trends as well as other pertinent epidemiological information concerning the COVID-19 pandemic. This edition includes data as received by WHO from national authorities, as of 4 April 2021.</td>
</tr>
<tr>
<td><strong>WHO COVID-19 infection prevention and control (IPC) pillar - achievements, February 2020 - January 2021 (meeting report draft)</strong>, 6 April 2021</td>
<td>As part of WHO’s response to the COVID-19 pandemic, the WHO Research and Development (R&amp;D) Blueprint was activated to improve coordination between scientists and global health professionals, accelerate the research and development process, and develop new norms and standards to learn from and improve upon the global response. Infection prevention and control (IPC) is one of the pillars of the WHO COVID-19 R&amp;D Blueprint, which is supported by a group of international experts convened by WHO in the COVID-19 IPC R&amp;D Expert Group. In February 2020 the WHO R&amp;D Blueprint developed a <a href="https://www.who.int/">global research roadmap</a> to accelerate research that can contribute to containing the spread of the epidemic and to facilitate receipt of optimal care by those affected. It also includes detailed knowledge gaps and research priorities identified by the IPC pillar.</td>
</tr>
<tr>
<td><strong>Episode 32 of Science in 5</strong>, WHO’s series of conversations in science, 1 April 2021</td>
<td>WHO Assistant Director-General for Access to Medicines and Health Products Dr Mariângela Simao explains the impact of inequity in the fight against COVID-19.</td>
</tr>
<tr>
<td><strong>Therapeutics and COVID-19: living guideline</strong>, 31 March 2021</td>
<td>This fourth version of the WHO Therapeutics and COVID-19: living guideline addresses the use of ivermectin in patients with COVID-19. It follows the increased international attention on ivermectin as a potential therapeutic option. While ivermectin is also being investigated for prophylaxis, this guideline only addresses its role in the treatment of COVID-19. The panel recommendation is not to use ivermectin for the management of COVID-19 except in the context of a clinical trial. This update does not include changes for any other drugs in the living guideline.</td>
</tr>
</tbody>
</table>
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:
- WHO-convened global study of origins of SARS-CoV-2: China Part (joint report)
- Operational considerations to expedite genomic sequencing component of GISRS surveillance of SARS-CoV-2
- COVID-19 new variants: Knowledge gaps and research (draft meeting report)
- Evaluation of COVID-19 vaccine effectiveness

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:
- Science in 5: Evolution of the SARS-CoV-2 virus
- Time to abide (1-10)
- Hand sanitizer routine
- COVID-19 virus variants

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