As of 14 April, the Government of Indonesia reported 1,583,182 (56,566 new) confirmed cases of COVID-19, 42,906 (124 new) deaths and 1,431,892 recovered cases from 510 districts across all 34 provinces.¹

To support the laboratory cold chain system in Indonesia, WHO handed over 1,000 cold boxes worth US$ 313,000 to the Ministry of Health and the National Agency of Drug and Food Control, on 3 April (page 16).

WHO supported the Ministry of Health and the National Working Group on Infection Prevention and Control (IPC) to conduct a virtual national training of trainers on IPC for health facilities in Indonesia, from 6 to 9 April (page 17).

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 8 to 14 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
• As part of its strategy to accelerate COVID-19 vaccination of older people, the Ministry of Health (MoH) will open more vaccination centres across Indonesia to improve access and boost the vaccination coverage of this target group. As of 11 April, MoH reported that the vaccination coverage of older people is still considerably lower than that of other priority target groups. On 12 April, the DKI Jakarta Provincial Administration announced that it is preparing an offline registration system through the neighbourhood units (Rukun Tetangga (RT)) for older people, considering that not all can access the online registration platform. Assistance to register for vaccination will also be provided to older people who do not have the national ID card (Kartu Tanda Penduduk (KTP)) from DKI Jakarta.

• The Ministry of Religious Affairs issued a Circular Letter on 8 April as a guideline for Ramadan and Eid al-Fitr worships in 2021. The circular letter stated that mosques and other places of worship are allowed to conduct prayers and other religious activities with maximum 50% capacity. This is to facilitate proper physical distancing while strictly complying to health protocols. However, no such activities are permitted in areas that are considered as high-risk zones by MoH. The Ministry of Religious Affairs urged Muslim communities living in high-risk areas to worship at home during the month of Ramadan to prevent COVID-19 transmission.

• On World Health Day, 7 April 2021, WHO called for action to eliminate health inequities, as part of a year-long global campaign to bring people together to build a fairer, healthier world. The campaign highlights WHO’s constitutional principle that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. The COVID-19 pandemic has hit all countries hard, but its impact has been harshest on those communities which were already vulnerable, which are more exposed to the disease, and less likely to have access to quality healthcare services. Therefore, WHO called on leaders to ensure that communities are at the forefront in decision-making processes as the world moves forward to a new future. At the same time, WHO urged leaders to monitor health inequities and to ensure that all people are able to access quality health services depending on their needs and values within their communities.

5 https://www.who.int/indonesia/news/campaign/world-health-day-2021
• On 14 April, 5656 new and 1,583,182 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 8 to 14 April was 5115 cases per day, compared to 5095 cases per day reported in the previous week.

![Daily and cumulative number of cases reported in Indonesia, as of 14 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 5 to 11 April, the provinces of Aceh, South Sulawesi 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).^{6}

![Percentage change of weekly number of confirmed cases by province during 5 to 11 April 2021 compared to the previous week. Source of data](source)

**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.

^{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 5 to 11 April, the incidence\(^7\) of COVID-19 in Indonesia was 13.1 per 100 000 population, compared to 13.7 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 11 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 5 to 11 April, the incidence of COVID-19 per 100,000 population was 65.9 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 5 to 11 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 Banten during the week of 5 to 11 April 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 11 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](image)

![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 11 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](image)
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 11 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 11 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 11 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 11 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 11.8% on 11 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 11 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](https://www.who.int). 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: 22/03/21 to 28/03/21; Week 2: 29/03/21 to 04/01/21; Week 3: 05/04/21 to 11/04/21

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 5 to 11 April, Banten had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by East Kalimantan, Bali, 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 5 to 11 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 5 to 11 April, the number of confirmed COVID-19 deaths was 0.39 per 100 000 population\(^8\), compared to 0.36 per 100 000 in the previous week (Fig. 15).

![Graph showing weekly mortality of COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 11 April 2021.](source)

**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, DKI Jakarta, Central Java 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 population data](source)
Fig. 16. Deaths among confirmed COVID-19 cases and probable cases per week over three weeks between 21 March to 11 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 14 April, the daily number of people tested for COVID-19 was 44,286 and the cumulative number of people tested was 9,104,944 (Fig. 17).

Fig. 17. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 14 April 2021. Source of data

• As of 14 April, the proportion of people recovered among the total confirmed COVID-19 cases was 90.4% and there were 108,384 active cases (Fig. 18).

Fig. 18. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 14 April 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 3321 on 11 April (Fig. 19).

Fig. 19. Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 August 2020 to 11 April 2021. Source of data

Disclaimer: Data from Wisma Atlet are not included.

LABORATORY

• On 3 April, WHO handed over 1000 cold boxes, with an estimated cost of US$ 313 000, to MoH and the National Agency of Drug and Food Control (Badan Pengawas Obat and Makanan (BPOM)). The cold boxes were distributed to the existing COVID-19 referral laboratories across the country and will maintain the condition of specimens prior to testing, especially during transportation to laboratories.
WHO supported the MoH Directorate of Referral Health Services and the National Working Group on Infection, Prevention and Control (IPC) to conduct a virtual ‘National Training of Trainers on IPC for Health Facilities in Indonesia’. The objective of the training was to improve the capacity and knowledge of IPC staff of health facilities to implement the eight core components of IPC. The trainings were conducted in two batches, from 6 to 9 April 2021. Around 120 participants from referral hospitals (including medical doctors and nurses), National Working Group on IPC and MoH participated in the trainings. WHO highlighted that preventing harm to patients, health workers and visitors from potential infections in healthcare facilities is fundamental to achieve quality care, patient safety and health security as well as to reduce health care-associated infections (HAIs) and antimicrobial resistance (AMR). As an output of the training, it is expected that participants will be able to train or provide technical assistance on IPC to health facilities, in coordination with MoH, Provincial Health Offices (PHOs) and District Health Offices (DHOs).

According to the WHO Guidelines on Core Components of Infection Prevention and Control Programmes at the National and Acute Health Care Facility Level, the eight core components of IPC are: (i) IPC programmes, (ii) National and facility level IPC guidelines, (iii) IPC education and training, (iv) Health care-associated infection surveillance, (v) Multimodal strategies for implementing IPC activities, (vi) Monitoring and evaluation and feedback, (vii) Workload, staffing and bed occupancy at the facility level, and (viii) Built environment, materials and equipment for IPC at the facility level.
WHO continues to translate important courses designed for key partners and frontline responders into Indonesian, also available on the OpenWHO platform. As of 12 April, 27,098 participants have enrolled in the eight OpenWHO courses available in Indonesian.

Table 1. Number of participants enrolled in the OpenWHO courses that have been translated into Indonesian, as of 12 April 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>8185</td>
</tr>
<tr>
<td>2</td>
<td>ePROTECT Respiratory Infections</td>
<td>6662</td>
</tr>
<tr>
<td>3</td>
<td>COVID-19: Operational Planning Guidelines and COVID-19 Partners Platform to support country preparedness and response</td>
<td>3803</td>
</tr>
<tr>
<td>4</td>
<td>Introduction to COVID-19: methods for detection, prevention, response and control</td>
<td>3410</td>
</tr>
<tr>
<td>5</td>
<td>COVID-19 vaccination training for health workers</td>
<td>1348</td>
</tr>
</tbody>
</table>
VACCINATION

- As of 12 April, 15 602 574 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; 10 280 073 people have received the first dose and 5 322 501 people have received the second dose (Fig. 22).

![Fig. 22. Cumulative number of vaccine doses administered in Indonesia, from 22 January to 12 April 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 12 April, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1 314 396 (89.5% 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 6 735 239 (38.9% of the targeted 17 327 169); 3 336 070 (19.2% of the target population) have received the second dose of the vaccine. The number of older people who have received the first dose of the vaccine was 2 088 158 (9.7% of the targeted 21 553 118); 672 035 (3.1% of the target population) have received the second dose (Fig. 23).
As of 11 April, Bali had the highest coverage of the first dose vaccination administered to health workers, essential public service workers and older people amongst all provinces, followed by DKI Jakarta, DI Yogyakarta, Riau Islands and East Java. As of the same day, DKI Jakarta had the highest coverage of the second dose vaccination administered to the same priority target groups, followed by DI Yogyakarta, Bali, East Java and Bangka Belitung Islands (Fig. 24).

**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. 25).

Fig. 25. 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://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><strong>Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets (interim guidance)</strong>, 12 April 2021</td>
<td>To reduce the public health risks associated with the sale of live wild animals for food in traditional food markets, WHO, the World Organization of Animal Health (OIE) and United Nations Environment Programme (UNEP) have issued guidance on actions that national governments should consider adopting urgently with the aim of making traditional markets safer and recognizing their central role in providing food and livelihoods for large populations. In particular, WHO, OIE and UNEP call on national authorities to suspend the trade in live caught wild animals of mammalian species for food or breeding purposes and close sections of food markets selling such product as an emergency measure.</td>
</tr>
<tr>
<td><strong>Episode 33 of Science in 5</strong>, WHO’s series of conversations in science, 9 April 2021</td>
<td>WHO Head of Clinical Care Dr Janet Diaz explains and answers questions around medical oxygen as an essential medicine in the treatment of COVID-19.</td>
</tr>
<tr>
<td><strong>Safe Ramadan practices in the context of COVID-19 (interim guidance)</strong>, 7 April 2021</td>
<td>This document is an update to the document of the same title that was published by WHO on 15 April 2020. Updates reflect the latest guidance on COVID-19 published by WHO since then, with focus on areas of transmission of SARS-CoV-2, critical preparedness, PHSM/precautionary measures, ventilation, high-risk and vulnerable groups, vaccination and the use of masks. The advice included in this publication has been tailored to the Ramadan context.</td>
</tr>
<tr>
<td><strong>Data for action: achieving high uptake of COVID-19 vaccines (interim guidance)</strong>, 1 April 2021</td>
<td>This guidebook and the associated surveys and qualitative interview guides were developed by a multi-disciplinary group of global experts and partners as a branch of an existing expert group developing similar tools to measure behavioural and social drivers (BeSD) of childhood vaccination. These tools for COVID-19 vaccination are grounded in the overall BeSD group expertise and existing research on vaccine uptake. This guidebook will enable programmes to design, target and evaluate interventions to achieve greater impact with more efficiency and to examine and understand trends over time.</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 COVID-19 infection prevention and control (IPC) pillar - achievements. February 2020 - January 2021 (meeting report draft)
- Therapeutics and COVID-19: living guideline

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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