As of 5 May, the Government of Indonesia reported 1,691,658 (5285 new) confirmed cases of COVID-19, 46,349 (212 new) deaths and 1,547,092 recovered cases from 510 districts across all 34 provinces.¹

WHO supported a virtual session to celebrate the first anniversary of the ‘Sehat Jiwa’ (SEJIWA) hotline, a mental health support and counselling service launched by the Ministry of Health, organized by the Indonesian Association of Psychologists on 30 April (page 16).

WHO facilitated a virtual training on emergency response during the COVID-19 pandemic for volunteers in East and West Nusa Tenggara provinces on 27 April (page 17).

---

¹ 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.
• On 30 April, the National COVID-19 Task Force (Satuan Tugas (Satgas)) stated that together with the state-owned airport operator PT Angkasa Pura II and relevant stakeholders, it had established new procedures for the arrival of international travellers at Soekarno-Hatta International Airport. According to the new procedures, international travellers are required to pass nine security checkpoints upon arrival at the airport, with the aim of tightening the implementation of health protocols at points of entry. At the last stage of the checkpoint, travellers will be picked up by designated buses to quarantine sites, under monitoring of the Satgas.2

• The first phase of a pilot programme for school reopening in DKI Jakarta was finalized on 29 April. The pilot programme was conducted in a three-week trial run involving 85 public and private schools. It allowed selected schools to conduct in-class teaching using a mix of offline and online learning methods. Classrooms were restricted to 50% capacity, with everyone on campus required to wear masks and practice physical distancing. Prior to the programme, participating schools were required to have teachers and staff members vaccinated. The province plans to start the second phase of the same pilot programme in early June.3

• On 27 April, the Ministry of Health (MoH) Director of Disease Prevention and Control stated that MoH is conducting whole-genome sequencing (WGS) on samples from confirmed COVID-19 cases who arrived in the country from India. The WGS was conducted by the National Institute of Health Research and Development (NIHRD) in collaboration with 17 laboratories across Indonesia. The Minister of Health urged Indonesians to be more vigilant and continue to adhere to health protocols to prevent resurgence of transmission, as has been observed in other countries. Furthermore, to support overall response activities, the Government is strengthening WGS for surveillance of SARS-CoV-2 virus mutations and variants at points of entry.4

3 https://www.thejakartapost.com/paper/2021/05/02/jakarta-sets-june-target-for-school-reopening-trials.html
• On 5 May, 5285 new and 1 691 658 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 29 April to 5 May was 4946 cases per day, compared to 5209 cases per day reported in the previous week.

**Fig. 2.** Daily and cumulative number of cases reported in Indonesia, as of 5 May 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 26 April to 2 May, the provinces that experienced an increase in the number of weekly cases of more than 50% compared to the previous week were: West Nusa Tenggara (138%), Gorontalo (135%) and Riau Islands (57%). (Fig. 3). It is critical to investigate reasons for the increase in new confirmed cases to guide response decisions and inform the adjustment of public health and social measures (PHSM).

Fig. 3. Percentage change of weekly number of confirmed cases by province during 26 April to 2 May 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. It is important to conduct further investigation if there is a substantial change in new cases, especially in provinces with a change of 50% or more. Other factors, such as testing and contact tracing, may help elucidate the reasons behind substantial changes. Additional indicators, including case incidence and mortality, should be considered to guide adjustment of PHSM.
During the week of 26 April to 2 May, the incidence\(^5\) of COVID-19 in Indonesia increased to 13.6 per 100,000 population, compared to 13.5 per 100,000 in the previous week (Fig. 4).

\[\text{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 data}\

\textbf{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 \textit{WHO interim guidance}. 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).

---

\(^5\) 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. \textit{Source of population data}
- During the week of 26 April to 2 May, the incidence of COVID-19 per 100,000 population was 80.0 in Bangka Belitung Islands and 55.5 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 number 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 26 April to 2 May 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. 
Source of data
During the week of 26 April to 2 May, the weekly incidence of COVID-19 increased marginally compared to the previous week in West Java and DI Yogyakarta (Figs. 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 2 May 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 2 May 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 2 May 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 2 May 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 2 May 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 3 May 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence. 

Source of data
Nationwide test positivity proportion increased sharply after 23 November and reached a peak of 30.5% in mid-February. Subsequently, the positivity proportion declined and stood at 12.1% on 2 May, which is considered as CT3 (high incidence) (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 and DI Yogyakarta for the last three weeks. Nevertheless, these provinces still have a test positivity rate of more than 5%, which means that transmission is still high in the community (Fig. 13).

Fig. 12. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 2 May 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: 12/04/21 to 18/04/21; Week 2: 19/04/21 to 25/04/21; Week 3: 26/04/21 to 02/05/21

- 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 26 April to 2 May, Bali had the highest weekly number of confirmed COVID-19 deaths per 100 000 population, followed by Bangka Belitung Islands, Riau, DI Yogyakarta and DKI Jakarta (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 26 April to 2 May 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.
• At the national level, during the week of 26 April to 2 May, the number of confirmed COVID-19 deaths was 0.42 per 100 000 population\(^6\), compared to 0.36 per 100 000 in the previous week (Fig. 15).

![Graph showing deaths per 100,000 population per week](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 2 May 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.

• During the week of 26 April to 2 May, the total number of weekly confirmed COVID-19 deaths in DKI Jakarta was 122, compared to 109 in the previous week (Fig. 16).

\(^6\) 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**
As reported on 5 May, the daily number of people tested for COVID-19 was 51,176 and the cumulative number of people tested was 10,033,957 (Fig. 17).
As of 5 May, the proportion of people recovered among the total confirmed COVID-19 cases was 91.5% and there were 98,217 active cases (Fig. 18).

Fig. 17. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 5 May 2021. Source of data

Fig. 18. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 5 May 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 3589 on 2 May (Fig. 19).

Fig. 19. Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 September 2020 to 2 May 2021. *Source of data*

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

On 30 April, WHO supported the Indonesian Association of Psychologists (Himpunan Psikologi Indonesia (HIMPSI)) to conduct a virtual launch of the HIMPSI fifth book series and to celebrate the first anniversary of ‘Sehat Jiwa’ (SEJIWA) psychology services hotline (119 extension 8), a mental health support and counselling service which was launched with the aim to maintain wellbeing during the COVID-19 pandemic. Around 150 participants attended the session including the Chief of the Presidential Staff Office, MoH Director of Mental Health and Substance Abuse, Minister of Women Empowerment and Child Protection, and SEJIWA volunteers from across the country. During the session, it was reported that in the one year of its service, SEJIWA has provided counselling service to more than 170 000 people in Indonesia. In addition to mental health support and counselling, SEJIWA also provides information related to COVID-19 and vaccination. As one of the key speakers, WHO presented ‘Digital Health and Universal Health Coverage (UHC)’, highlighting the importance of promoting digital health services as part of the health system rather than as a supplementary service. In the context of emergency response, digital health services may provide support to the implementation of response activities by reaching more people. In addition, digital health will enable countries to promote equality and non-stigmatized mental health service towards achieving the UHC and the health-related targets of the Sustainable Development Goals (SDGs).
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.

On 27 April, together with the International Federation of Red Cross and Red Crescent Societies (IFRC) and United Nations World Food Programme (WFP), WHO supported the Secretariat of Indonesian Civil Society Organization (CSO)/Non-Governmental Organization (NGO) Networks (Sekretariat Jaringan-Antar-Jaringan Organisasi Masyarakat Sipil – Lembaga Swadaya Masyarakat (SEJAHR) and Indonesian CSO Koalisi Semesta to conduct a virtual training on how to conduct emergency response during the COVID-19 pandemic. The training was attended by around 70 Seroja volunteers, a group of volunteers for disaster response in East and West Nusa Tenggara provinces. During the training, WHO facilitated a session on personal protective measures (such as hand hygiene, physical distancing, respiratory etiquette and use of masks) to limit person-to-person spread of COVID-19 based on WHO interim guidelines.

As of 3 May, 20,422,518 vaccine doses have been administered in the national COVID-19 vaccination campaign; 12,572,111 people have received the first dose and 7,850,407 people have received the second dose (Fig. 20).
As of 3 May, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1,355,942 (92.3% 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 8,503,507 (49.1% of the targeted 17,327,167); 4,935,457 (28.5% 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 2,574,276 (11.9% of the targeted 21,553,118); 1,559,008 (7.2% of the targeted population) 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 3 May, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1,355,942 (92.3% 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 8,503,507 (49.1% of the targeted 17,327,167); 4,935,457 (28.5% 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 2,574,276 (11.9% of the targeted 21,553,118); 1,559,008 (7.2% of the targeted population) have received the second dose (Fig. 21).

**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.
• As of 3 May, 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 Bali, DI Yogyakarta, Bangka Belitung Islands and East Java (Fig. 22).

![Fig. 22. COVID-19 vaccination coverage of health workers, essential public service workers and older people by province in Indonesia, as of 3 May 2021. Source of data](source_of_data)

• On 24 April, WHO supported Widya Mandala Catholic University to conduct a virtual seminar on ‘Care for older people during the COVID-19 pandemic’. The seminar was attended by more than 500 participants including medical students, doctors and the general public. As one of the key speakers, WHO presented the global perspective on COVID-19 vaccination for older people, highlighting the importance of identifying suitable strategies to reach and vaccinate older people taking into consideration their needs and expectation.
WHO continues to support the Government to maintain essential health services and ensure the continuity of malaria services during the pandemic. Previous updates on the National Malaria Programme (NMP) can be seen in WHO Situation Report 15 (pages 17-20) and Situation Report 25 (pages 20-22). Complementary updates from malaria vector surveillance can be found in Situation Report 47 (pages 21-23). Current updates from the NMP are presented below:

i. As of April 2021, 192 of 196 malaria-endemic districts in Indonesia (98%) have reported confirmed COVID-19 cases. The greatest decline in malaria case finding (number of suspected malaria cases tested through active and passive case finding) occurred in the first two months after the first cases of COVID-19 were reported in the country in March 2020. After issuing protocols to continue malaria services during the COVID-19 pandemic on 23 April 2020 and to adapt to the new normal policy in Indonesia in June 2020, case finding activities improved. The activities were also facilitated by the distribution of personal protective equipment (PPE) to health staff and Village Malaria Workers (VMWs) (Juru Malaria Desa (JMD)) in September 2020.
ii. The number of confirmed malaria cases increased slightly from January to March and June to August 2020 compared to the same periods in 2019, despite the decrease in case finding in 2020. This indicates that malaria transmission increased in the community. Overall, case finding activities were reduced as indicated by a 27% decrease in suspected malaria cases tested in 2020 compared to 2019, while the number of confirmed cases increased by 1%. Coverage of malaria treatment using the national standard treatment protocol increased in 2020. This was due to extensive virtual workshops that were conducted to disseminate the national treatment protocol and a protocol on continuity of malaria services during the COVID-19 pandemic.

![Graph showing trend of malaria case finding and confirmed cases from January to December 2019 compared to the same periods in 2020.](source: 'National Malaria Control Programme Indonesia', data presented in the monitoring and evaluation meeting conducted by the Ministry of Health in the first quarter of April 2021.)

Fig. 24. Trend of malaria case finding and confirmed cases from January to December 2019 compared to the same periods in 2020. Source: 'National Malaria Control Programme Indonesia', data presented in the monitoring and evaluation meeting conducted by the Ministry of Health in the first quarter of April 2021.

iii. The provinces of Papua and East Nusa Tenggara are the highest contributors of malaria incidence in Indonesia and have been the most affected by disruptions in routine malaria services. Case finding activities were affected by the pandemic, as indicated by a reduction in the number of suspected malaria cases (over 300,000) tested by parasitological examination in 2020 compared to 2019; in the same time period, the number of confirmed malaria cases increased by over 500 in both provinces. The disruptions were caused by local-level movement restrictions in provinces and districts.
iv. Malaria services for vulnerable populations (pregnant women and children under five years of age) have also been affected during the pandemic. In comparison to 2019, the number of pregnant women screened for malaria during integrated antenatal care (ANC) services decreased by 18% with a slight increase in the number of confirmed malaria cases in pregnant women in 2020. Meanwhile, malaria screening for children under five years of age through Integrated Management of Childhood Illness (IMCI) dropped by 6% and the number of cases also declined by 3%. The National Maternal and Child Health Programme (NMCHP) increased home visits for pregnant women and children under five to replace community-based integrated health services (Pos pelayanan terpadu (Posyandu)). In collaboration with NMCHP, the NMP will increase the number of home visits for both groups especially in high malaria-endemic districts.

v. Human resources: WHO continues to support the NMP, other relevant sub-directorates of MoH and partners to conduct virtual capacity-building activities during the pandemic. A series of webinars and virtual trainings on vector and animal reservoir control and surveillance, operationalization of vector information system (SILANTOR) and malaria microscopy for diagnosis were conducted in four provinces in Java, from 13 June 2020 to 30 March 2021. During the same period, coaching on the operationalization of the malaria information system (SISMAL) was conducted for the same provinces. As a result of these capacity-building activities, the knowledge of participants improved as reflected in pre- and post-test assessments. Targets of vector surveillance indicators of the National Health Strategic Plan (NHSP) 2020-2024 have been met and even exceeded for 2020; for example, malaria reporting completeness increased between 65% and 644% in four provinces in Java, and the completeness of national level reporting improved by 27%.

vi. Prevention: In 2020, all target areas received long-lasting insecticidal nets (LLINs); 80 of 91 districts distributed the LLINs to the community. The remaining districts delayed distribution to 2021 due to the late arrival of LLINs and local security concerns. The NMP modified the mass campaign from gathering people at distribution points to door-to-door, followed by monitoring visits after distribution to ensure that LLINs were utilized by the communities. WHO supported the development of MoH technical guideline on LLINs distribution, consistent with WHO recommendations. Based on the report as of April 2021, 2,818,716 of 3,402,465 (83%) LLINs have been distributed to communities.
vii. Surveillance: WHO is supporting the NMP and the National Vector Control Programme (NVCP) in monitoring activities related to: insecticide resistance of malaria and dengue vectors in 18 districts; durability and efficacy of LLINs; and antimalarial drug efficacy in Papua. The findings of monitoring of insecticide resistance showed that 18 of 33 sites in 18 districts had possible or confirmed resistance to at least one insecticide used for malaria and dengue vectors. The findings of monitoring of durability and efficacy of LLINs indicated that two LLINs measured (Yarkool® and Royal Sentry®) demonstrated reduction of efficacy from 100% to 39% and 85%, respectively, 12 month after baseline. These findings will be used as a reference to discuss a policy change in the LLIN strategy taking into consideration insecticide resistance. In collaboration with the Eijkman Institute for Molecular Biology, monitoring of drug efficacy of first-line antimalarial drug currently being used in the national treatment protocol, i.e. (dihydroartemisinin-piperaquine (DHA-PPQ)) is ongoing in Keerom District.

viii. Programme management: The NMP plans to achieve malaria elimination on the islands of Sulawesi and Kalimantan by 2025 and 2027, respectively. WHO is supporting the NMP to conduct bottleneck analyses in 14 low malaria-endemic districts that have stagnated in their progress to achieve elimination over a period of five years. WHO is supporting the NMP by providing technical assistance to selected districts in Java-Bali, Sumatra, Kalimantan and Sulawesi-West Nusa Tenggara regions to accelerate malaria elimination.

ix. Commemoration of World Malaria Day (WMD) 2021: With the theme of ‘reaching the zero-malaria target’, WHO raised the awareness of stakeholders, including researchers, scientists and communities, on the achievement of malaria elimination in the E-2020 countries and in Indonesia. At the national level, MoH dedicated the year 2021 to engage the community in achieving malaria-free Indonesia. The main WMD event was conducted on 27 April, at which time the Minister of Health delivered malaria-free certificates to the heads of 12 districts that successfully achieved elimination despite disruptions during the pandemic. In addition, a series of events were held, such as photography competitions, microscopy examination, short documentary videos, as well as a coaching class on how to make a documentary video for university students. From 26 to 30 April, the NMP conducted several webinars on malaria, in collaboration with many universities and hospitals. To acknowledge the role of VMWs from many districts, learn from their experience in supporting malaria elimination and share best practices from village leaders across the country, the NMP will organize a webinar on 10 May, with support from the United Nations Children’s Fund (UNICEF) and WHO. In addition, WHO recognized the effort from Purworejo District of Central Java Province towards elimination. The strong leadership and active involvement of
community in the district had proved that harmonized collaboration could result in success towards malaria elimination.

On 30 April, WHO convened the 30th meeting of key development partners to discuss and coordinate the COVID-19 response among partners in Indonesia. The meeting was attended by partners, including the Asian Development Bank (ADB), British Embassy, the Australian Government Department of Foreign Affairs and Trade (DFAT), the European Union (EU), Japan International Cooperation Agency (JICA), UNICEF, United States Centers for Disease Control and Prevention (US CDC), the World Bank and WFP. WHO presented COVID-19 updates, discussed the latest epidemiological situation at national and subnational levels, and explained the key WHO interventions to support the national pandemic response. Several key points of discussion among partners included the key findings and recommendations of the Intra-Action Review (IAR) monitoring meeting that was conducted from 27 to 29 April, WHO Emergency Use Listing Procedure (EUL) for COVID-19 vaccines, vaccine effectiveness studies, and updates of WGS for surveillance of SARS-CoV-2 variants.
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 May 2021 (Fig. 26).

Data presented in this situation report have been taken from publicly available data from the MoH ([https://infeksiemerging.kemkes.go.id/](https://infeksiemerging.kemkes.go.id/)), COVID-19 Mitigation and National Economic Recovery Team (KPCPEN) ([http://covid19.go.id](http://covid19.go.id)) and provincial websites. There may be differences in national and provincial data depending on the source used. All data are provisional and subject to change.
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>
</thead>
<tbody>
<tr>
<td>COVID-19 Exercise Programme - Drills for Vaccine Deployment, 3 May 2021</td>
<td>This drill package is part of a broader COVID-19 simulation exercise package, including vaccine table top exercises (TTX). For exercises to be most effective, it is recommended that they should be part of a comprehensive programme made up of progressively complex exercises, each exercise building on the previous one until they are as close to reality as possible. In this regard, before conducting these drills, it is advised to first conduct the COVID-19 vaccine table top exercises.</td>
</tr>
<tr>
<td>Episode 36 of Science in 5, WHO's series of conversations in science, 30 April 2021</td>
<td>WHO Infection Prevention and Control Expert Dr April Baller explains self-care and how to prevent COVID-19 infection at home.</td>
</tr>
<tr>
<td>Oxygen Cylinder Safety, 29 April 2021</td>
<td>This poster is intended for health workers and other personnel on the safety and mitigation measures that need to be adhered to when dealing with medical oxygen. Medical oxygen, either in liquid or gas form, is an oxidizing agent that can result in a fire or explosion if not handled properly. WHO also published similar posters on Medical Gas Piping Systems Safety and Medical Oxygen Fire Risk - Mitigation Measures.</td>
</tr>
<tr>
<td>Guidance for conducting a country COVID-19 intra-action review (IAR): Addendum 1, 28 April 2021</td>
<td>This publication (Addendum 1) is a supplement to the Guidance for conducting a country COVID-19 intra-action review (IAR) that was published on 23 July 2020.</td>
</tr>
<tr>
<td>Conducting safe onsite COVID-19 intra-action reviews during the pandemic, 28 April 2021</td>
<td>The considerations presented in this document have been identified through reviews of various sources, including emerging scientific and grey literature as well as websites of international and non-governmental organizations. It should be tailored to country regulations.</td>
</tr>
<tr>
<td>Conducting effective online COVID-19 intra-action reviews during the pandemic, 28 April 2021</td>
<td>This document has been adapted based on the guidance on how to run online meetings and workshops in the time of COVID-19 from Resolve to Save Lives, a global public health initiative.</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:
- Expanding our understanding of post COVID-19 condition: report of a WHO webinar - 9 February 2021
- WHO COVID-19 Clinical care bundle
- Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic (interim report)
- Interim recommendations for use of the ChAdOx1-S [recombinant] vaccine against COVID-19 (AstraZeneca COVID-19 vaccine AZD1222, SII Covishield, SK Bioscience)

Infographics:
- Self-isolation
- How to make a fabric mask
- Religious celebration
- Contact tracing
- COVID-19 new variants

Questions and answers:
- COVID-19: Vaccines
- COVID-19: Vaccine research and development
- COVID-19: Vaccine access and allocation

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

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