As of 12 May, the Government of Indonesia reported 1,728,204 (4,608 new) confirmed cases of COVID-19, 47,617 (152 new) deaths and 1,584,878 recovered cases from 510 districts across all 34 provinces.¹

The WHO course ‘Occupational health and safety for health workers in the context of COVID-19’ has been translated into Indonesian and is now available on the OpenWHO platform (page 16).

WHO supported the Ministry of Health to conduct the third monitoring meeting on the implementation of the Intra-Action Review recommendations (page 17).

**HIGHLIGHTS**

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**Situation in Indonesia**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total confirmed cases</td>
<td>1,728,204</td>
</tr>
<tr>
<td>Total deaths</td>
<td>47,617</td>
</tr>
<tr>
<td>Total cases recovered</td>
<td>1,584,878</td>
</tr>
<tr>
<td>Total people tested</td>
<td>10,321,361</td>
</tr>
</tbody>
</table>

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Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 6 to 12 May 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.

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On 10 May, the Minister of Health reported that bed occupancy rates (BOR) in COVID-19 referral hospitals of eight provinces have increased sharply due to a spike in COVID-19 cases. The Head of the COVID-19 Mitigation and National Economic Recovery Team (Komite Penanganan COVID-19 dan Pemulihan Ekonomi Nasional (KPCPEN)) reported that most of the provinces reporting a BOR over 50% were in Sumatra, namely North Sumatra, Riau Islands, Riau, South Sumatra, Jambi and Lampung. The Minister advised provincial governments to stay vigilant and take extra measures to prepare for a potential surge of COVID-19 cases after Eid holidays. In addition, he stated that the Ministry of Health (MoH) has taken several steps to ensure the availability of hospital beds and intensive care unit (ICU) rooms, as well as sufficient stock of medicines and oxygen supplies for care of COVID-19 patients.

On 8 May, Indonesia received a shipment of 1.3 million doses of AstraZeneca COVID-19 vaccine from the COVAX Facility. In total, Indonesia has received around 6.4 million doses of the AstraZeneca vaccine since the first batch arrived in early March. During the press conference on the arrival of the vaccine, the Minister of Foreign Affairs reminded the public to strictly adhere to the health protocols to curb COVID-19 transmission, referring to a potential surge in cases as seen in many countries around the world.

'World Hand Hygiene Day' was celebrated on 5 May, with the aim to maintain global promotion, visibility and sustainability of hand hygiene in healthcare and to bring people together in support of hand hygiene improvements around the world. Hand hygiene is one of the most effective actions to reduce the spread of pathogens and prevent infections, including COVID-19. To commemorate World Hand Hygiene Day 2021, WHO called on healthcare workers and facilities to carry out effective hand hygiene actions at the point of care. WHO also published a technical guidance note on WHO's global hand hygiene campaign in the context of COVID-19.
• On 12 May, 4608 new and 1,728,204 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 6 to 12 May was 5221 cases per day, compared to 4946 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 12 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 3 to 9 May, the provinces that experienced an increase in the number of weekly cases of more than 50% compared to the previous week were North Maluku (325%) and Maluku (205%) (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 3 to 9 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 3 to 9 May, the incidence\(^6\) of COVID-19 in Indonesia decreased to 13.2 per 100,000 population, compared to 13.6 per 100,000 in the previous week (Fig. 4).

![Graph showing weekly incidence of COVID-19 in Indonesia](image)

**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 9 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:** 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](https://www.who.int/publications/i/item/who-internationalemergencies-dossier-2020-138). Other epidemiological indicators also need to be evaluated to decide on the level of community transmission. This disclaimer applies to indicators at national (Fig. 4) and subnational levels (Figs. 5 to 11).

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\(^6\) Weekly incidence of COVID-19 is calculated as the number of new cases per 100,000 population per week averaged over a two-week period. [Source of population data](https://www.who.int/countries/idn)
During the week of 3 to 9 May, the incidence of COVID-19 per 100 000 population was 83.4 in Bangka Belitung Islands and 51.4 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 3 to 9 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 3 to 9 May, the weekly incidence of COVID-19 in most provinces in Java was similar to the incidence in the previous week (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 9 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 9 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 9 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 9 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 9 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 9 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 11.9% on 9 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, DI Yogyakarta and West Sumatra for the last three weeks. Nevertheless, these provinces still have a test positivity proportion 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 9 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: 19/04/21 to 25/04/21; Week 2: 26/04/21 to 02/05/21; Week 3: 03/05/21 to 09/05/21

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 3 to 9 May, Riau had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by Bali, Bangka Belitung Islands, DKI Jakarta and DI Yogyakarta (Fig. 14).

![Chart showing weekly number of confirmed COVID-19 deaths per 100,000 population by province in Indonesia during 26 April to 9 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 3 to 9 May, the number of confirmed COVID-19 deaths was 0.43 per 100 000 population, compared to 0.42 per 100 000 in the previous week (Fig. 15).

Fig. 15. Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 9 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 3 to 9 May, the total number of weekly confirmed COVID-19 deaths in DKI Jakarta was 144, compared to 122 in the previous week (Fig. 16).

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7 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 12 May, the daily number of people tested for COVID-19 was 38 640 and the cumulative number of people tested was 10 321 361 (Fig. 17).
As of 12 May, the proportion of people recovered among the total confirmed COVID-19 cases was 91.7% and there were 95,709 active cases (Fig. 18).

Fig. 18. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 12 May 2021. Source of data
On 6 May, WHO supported the Indonesian Information and Communication Technologies (ICT) Partnership Association (ICT Watch) to conduct a podcast on ‘Hoaxes and the impact to vaccination programme’. The session was organized as a strategy to engage Indonesian youth in combating hoaxes related to COVID-19, including vaccines and vaccination. During the session, listeners shared their experiences and challenges in tackling hoaxes in family settings. WHO shared the results of a global study jointly conducted by Wunderman Thompson, University of Melbourne, Pollfish and WHO on ‘Social Media and COVID-19: A Global Study of Digital Crisis Interaction among Gen Z and Millennials’. In addition, WHO shared several tips from the WHO guideline on how to respond to vaccine refusals in the family and community due to hoaxes.

The WHO online course ‘Occupational health and safety for health workers in the context of COVID-19’ was translated into Indonesian and is available on the OpenWHO platform. The objective of this course is to provide information on common occupational risks (infectious, physical and psychosocial) to which health workers are exposed while responding to the COVID-19 pandemic as well as guidance on measures to ensure protection and safety of health workers.
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**

Between 11 to 14 August 2020, WHO supported MoH to conduct the Intra-Action Review (IAR), a comprehensive multisectoral review to identify gaps and opportunities to learn from and improve the COVID-19 response. As a follow up of the IAR, WHO continues to assist MoH in conducting monitoring of the implementation of IAR recommendations. From 27 to 29 April, WHO supported MoH to conduct the third virtual monitoring meeting to review the progress made in implementation of IAR recommendations. More than 60 participants attended the meeting, including representatives from the Cabinet Secretariat, National Board for Disaster Management (Badan Nasional Penanggulangan Bencana (BNPB)), Coordinating Ministry for Human Development and Cultural Affairs, Ministry of Home Affairs (MoHA), Ministry of Communications and Informatics, National Agency of Drug and Food Control (Badan Pengawas Obat dan Makanan (BPOM)), Ministry of Defence, provincial health offices (PHOs), points of entry, professional organizations, hospitals and development partners. The meeting highlighted the importance of strict implementation of health protocols to prevent COVID-19 transmission and a potential surge of cases and discussed increasing concerns around new SARS-CoV-2 variants detected in Indonesia. Some of the recommendations from the meeting were to: (i) support the review and monitoring of implementation of provincial COVID-19 response plans; (ii) evaluate the COVID-19 surveillance system and provide training to address knowledge gaps; (iii) enhance contact tracing for COVID-19 including monitoring of contacts through implementation of appropriate quarantine measures; (iv) improve the implementation of whole-genome sequencing (WGS) for surveillance of SARS-CoV-2 by involving multiple stakeholders; (v) evaluate the use of antigen-detecting rapid diagnostic tests (Ag-RDTs); and (vi) improve the COVID-19 vaccination coverage.
As of 10 May, 22 318 567 vaccine doses have been administered in the national COVID-19 vaccination campaign; 13 513 606 people have received the first dose and 8 804 961 people have received the second dose (Fig. 20).

Fig. 20. Cumulative number of vaccine doses administered in Indonesia, from 22 January to 10 May 2021. Source of data

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

As of 10 May, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1 366 419 (93.0% 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 9 251 201 (53.4% of the targeted 17 327 167); 5 643 009 (32.6% 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 2 760 561 (12.8% of the targeted 21 553 118); 1 794 839 (8.3% of the targeted population) have received the second dose (Fig. 21).
As of 10 May, the highest coverage of the first dose vaccination administered to eligible target populations in the country was in Bali, followed by DKI Jakarta, DI Yogyakarta, Riau Islands and East Java. As of the same day, Bali had the highest coverage of the second dose vaccination administered, followed by DKI Jakarta, DI Yogyakarta, East Kalimantan and Bangka Belitung Islands (Fig. 2).

- As of 10 May, the highest coverage of the first dose vaccination administered to eligible target populations in the country was in Bali, followed by DKI Jakarta, DI Yogyakarta, Riau Islands and East Java. As of the same day, Bali had the highest coverage of the second dose vaccination administered, followed by DKI Jakarta, DI Yogyakarta, East Kalimantan and Bangka Belitung Islands (Fig. 2).

Fig. 21. Cumulative number of people who have received COVID-19 vaccine in Indonesia, as of 10 May 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.

Fig. 22. COVID-19 vaccination coverage among the eligible target populations by province in Indonesia, as of 10 May 2021. [Source of data]
• As of 10 May, the number of people vaccinated with at least one dose of the vaccine per 100 population nationwide was 5.0. As of the same day, DKI Jakarta had the highest number of people vaccinated with at least one dose of the vaccine (20.3 per 100 people) amongst all provinces, followed by Bali (20.1) (Fig. 23).

![Map of Indonesia showing vaccination coverage](image)

Fig. 23. Number of people vaccinated with at least one dose of the vaccine per 100 population by province in Indonesia, as of 10 May 2021. [Source of data](who.int/indonesia)

• As of 10 May, DKI Jakarta has the highest coverages of first and second dose vaccination to older people (Fig. 24). As of the same day, provinces with the highest number of unvaccinated older people were West Java, Central Java and East Java (Fig. 25).

![Bar chart showing vaccination coverage](image)

Fig. 24. COVID-19 vaccination coverage of older people by province in Indonesia, as of 10 May 2021. [Source of data](who.int/indonesia)
On 20 and 21 April, WHO supported the MoH Directorate General of Disease Prevention and Control to conduct an integrated review of the implementation of COVID-19 vaccination and routine immunization (RI). The meeting was attended by more than 70 participants from MoH, National Committee for Adverse Events following Immunization (AEFI) (Komite Nasional Kejadian Ikutan Pasca Imunisasi (Komnas KIPI)), Clinton Health Access Initiative (CHAI), United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP) and United States Centers for Disease Control and Prevention (US CDC). Some of the key points of discussion included: (i) current COVID-19 epidemiological situation at national and subnational levels; (ii) bed occupancy rate (BOR); (iii) AEFIs of

Fig. 25. Number of unvaccinated older people (over 60 years of age) by province in Indonesia, as of 10 May 2021. Source of data
COVID-19 vaccination and RI; (iv) surveillance of vaccine-preventable diseases (VPDs) and (v) vaccination information system. WHO presented the global monitoring of COVID-19 vaccination and routine immunization as well as findings from WHO assisted provinces, including Papua.

**PARTNER COORDINATION**

- 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).

Fig. 26. WHO funding situation for COVID-19 response, May 2021.

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><strong>COVID-19 home care bundle for healthcare workers, 7 May 2021</strong></td>
<td>The WHO Mild COVID-19 Home Care Bundle is intended for healthcare workers and is a derivative product related to the WHO COVID-19 Living Clinical Management Guidance, WHO Living Guidelines for Therapeutics and COVID-19, WHO Home Care for patients with suspected or confirmed COVID-19 and OpenWHO Advice for health workers that are caring for COVID-19 patients at home.</td>
</tr>
<tr>
<td><strong>Episode 37 of Science in 5, WHO’s series of conversations in science, 6 May 2021</strong></td>
<td>WHO Head of Clinical Care Dr Janet Diaz explains self-care and how to prevent COVID-19 infection at home.</td>
</tr>
<tr>
<td><strong>Estimating COVID 19 vaccine effectiveness against severe acute respiratory infections (SARI) hospitalizations associated with laboratory-confirmed SARS-CoV-2: an evaluation using the test-negative design (guidance document), 6 May 2021</strong></td>
<td>This guidance document outlines an approach to leverage existing surveillance systems for Severe Acute Respiratory Infection (SARI) to estimate COVID-19 vaccine effectiveness (VE) in preventing SARI associated with laboratory-confirmed SARS-CoV-2. The document proposes that this enhanced SARI surveillance be implemented for at least 6 months. It also proposes that a pooled data analysis be conducted for the WHO Europe region, which requires that SARI surveillance systems collect a minimum data set of similar variables.</td>
</tr>
<tr>
<td><strong>WHO Information Note: COVID-19 considerations for tuberculosis (TB) care, 5 May 2021</strong></td>
<td>This Information Note is intended to assist national tuberculosis (TB) programmes and health personnel worldwide to maintain essential TB services during the COVID-19 pandemic and in the recovery phase. It is important that recent progress made in TB prevention and care is not reversed by the pandemic. The note includes references to other published WHO information products relevant to TB practitioners. WHO continues to monitor the situation closely for any changes that may influence this note and will issue updates should any factors change.</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:
- COVID-19 Exercise Programme - Drills for Vaccine Deployment
- Oxygen Cylinder Safety
- Medical Gas Piping Systems Safety
- Medical Oxygen Fire Risk - Mitigation Measures
- Guidance for conducting a country COVID-19 intra-action review (IAR): Addendum 1
- Conducting safe onsite COVID-19 intra-action reviews during the pandemic
- Conducting effective online COVID-19 intra-action reviews during the pandemic

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
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