As of 3 February, the Government of Indonesia reported 1,111,671 (11,984 new) confirmed cases of COVID-19, 30,770 (189 new) deaths and 905,665 recovered cases from 510 districts across all 34 provinces.¹

WHO continues to support the Government of Indonesia to improve COVID-19 laboratory capacity. WHO handed over 248 sets of magnetic stands and a high-throughput automated sample preparation system to the National Institute of Health Research and Development on 26 and 29 January, respectively (page 19).

Supported by WHO, the Ministry of Health has revised the ‘Health sector operational response plan for COVID-19 in Indonesia’, which now includes a new pillar on COVID-19 vaccination (pages 20 and 21).

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Source of data: 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 27 January, Indonesian President Joko Widodo received the second dose of the COVID-19 vaccine at the State Palace, along with several religious leaders and public figures. According to the Presidential spokesperson, he used the opportunity to assure the public of the safety of vaccines. The President further reminded people to continue to follow health protocols after receiving the vaccination.²

Following the 1 024 298 confirmed cases reported in Indonesia as of 27 January, the President ordered the implementation of limited area quarantines down to neighbourhood or ward levels (RT/RW) to curb COVID-19 transmission. The Government has stated that this measure should be integrated with other measures of the COVID-19 response, including the implementation of the 3T strategy (tracing, tracking, and testing) as well as medical care for COVID-19 cases.³

On 15 January, MoH launched a chatbot service to facilitate registration for the COVID-19 vaccination programme across Indonesia, in partnership with WhatsApp. This is the first WhatsApp chatbot worldwide that helps healthcare workers (HCWs) connect to the nearest health facilities to receive COVID-19 vaccination.⁴

The DKI Jakarta Environment Agency (Dinas Lingkungan Hidup DKI Jakarta (DLH DKI)) has recorded a total of 12.7 tonnes of infectious waste in Jakarta since the beginning of the COVID-19 pandemic in April 2020. The majority of waste was collected from healthcare facilities, including COVID-19 referral hospitals and non-COVID 19 hospitals, and around 1.5 tonnes of the waste were medical masks from households.⁵

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• On 3 February, 11,984 new and 1,111,671 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 28 January to 3 February was 12,482 cases per day. The highest daily number of new confirmed cases reported since March was 14,518 on 30 January.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 3 February 2021. Source of data

Disclaimer: The number of cases reported daily is not 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. Therefore, caution must be taken in interpreting this figure and the epidemiological curve for further analysis.
- As of 3 February, 65.8% (731,160 cases) of the cumulative number of confirmed COVID-19 cases were in Java. DKI Jakarta had the highest number of confirmed cases per one million population, followed by East Kalimantan, North Kalimantan, West Papua, and Bali (Fig. 3).

Fig. 3. Cumulative confirmed cases of COVID-19 per one million population by province in Indonesia, as of 3 February 2021. [Source of data](https://who.int/indonesia)

Disclaimer: Data from DKI Jakarta include patients isolated or hospitalized in Wisma Atlet (RSDC: Rumah Sakit Darurat COVID-19), which is the largest national makeshift hospital for COVID-19; some patients may not be residents of DKI Jakarta. The same may apply to other provinces.
• During the week of 25 to 31 January, the incidence\(^6\) of COVID-19 in Indonesia was 30.9 per 100 000 population, compared to 28.4 per 100 000 in the previous week (Fig. 4). This was the highest weekly incidence since the first cases were reported in the country.

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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*
- The weekly incidence of COVID-19 increased in all provinces in Java during the week of 25 to 31 January compared to the previous week. All six provinces reported the highest weekly incidence since the first cases were reported (Figs. 5 to 10).

Fig. 5. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in DKI Jakarta, from 13 April 2020 to 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

Fig. 6. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in West Java, from 13 April 2020 to 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.
Fig. 7. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Central Java, from 13 April 2020 to 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

Fig. 8. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in DI Yogyakarta, from 13 April 2020 to 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.
Fig. 9. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in East Java, as of 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

Fig. 10. Incidence of COVID-19 per 100,000 population per week averaged over a two-week period in Banten, as of 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.
On 3 February, the daily numbers of specimens and people tested were 74,965 and 46,893, respectively. On the same day, the daily number of suspected cases was 76,657 (Fig. 11). There is still a wide gap between the number of people tested and suspected cases; improving testing capacity is therefore imperative, especially among suspected cases. Antigen-based rapid diagnostic tests (Ag-RDT) can be used as a diagnostic tool for SARS-CoV-2 infection under certain settings, especially in areas with limited access to laboratories with polymerase chain reaction (PCR) testing or long turnaround times for test results.

Test positivity proportion increased sharply after 23 November and reached 28.6% at a national level on 31 January 2021 (Fig 12). However, the percentage of positive samples can be interpreted 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, West Sumatra and East Kalimantan for the last three weeks, but none of these provinces had a test positivity proportion of less than 5% (Fig. 13).

Fig. 11. The daily number of specimens and people tested and suspected COVID-19 cases in Indonesia, from 1 November 2020 to 3 February 2021. *Source of data*
Fig. 12. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 31 January 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.

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 national level and in select provinces.

Week 1: 11/01/21 to 17/01/21; Week 2: 18/01/21 to 24/01/21; Week 3: 25/01/21 to 31/01/21

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

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.
As of 3 February, the mortality rate in DKI Jakarta of 413 confirmed COVID-19 deaths per one million population was the highest in the country, followed by East Kalimantan, East Java, North Sulawesi, and Bali (Fig. 14).

**Fig. 14.** Cumulative deaths per one million population by province in Indonesia, as of 3 February 2021.

Source of data

Disclaimer: Based on data availability, only confirmed COVID-19 deaths have been included. As per the 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 25 to 31 January, the number of confirmed COVID-19 deaths was 0.73 per 100 000 population\(^7\) – the highest since the first cases were reported in the country (Fig. 15).

\[\text{Deaths per 100 000 population}\]

**Fig. 15.** Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 31 January 2021. [Source of data](#)

Disclaimer: Based on data availability, only confirmed COVID-19 deaths have been included. As per the 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 level of community transmission could not be conducted due to data limitations.

None of the provinces in Java have shown a consecutive decline over the last three weeks in the number of deaths in confirmed and probable cases, except East Java (Fig. 16). In DKI Jakarta, there were more deaths in probable cases than in confirmed cases for the last two weeks from 18 to 31 January 2021. Therefore, it is important to prioritize testing for suspected cases.

\(^7\)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](#)
Fig. 16. Deaths among confirmed COVID-19 cases and probable cases per week over the three weeks between 11 to 31 January 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.
From 28 to 30 January, in collaboration with the National COVID-19 Task Force (Satuan Tugas (Satgas)) and supported by WHO and the Indonesian One Health University Network (INDOHUN), MoH conducted a series of training sessions for newly recruited contact tracers from 10 priority provinces: Aceh, Bali, Central Java, DKI Jakarta, East Java, North Sumatra, Papua, South Kalimantan, South Sulawesi, and West Java. The series was divided into six batches, attended by over 2270 newly recruited contact tracers. The four main topics during the training were: 1) basic concepts of COVID-19 transmission; 2) contact tracing practices; 3) effective communication and risk communication strategies; and 4) the use of the contact tracing application. Newly trained contact tracers will start working shortly in their assigned districts.

As reported on 3 February, the daily number of people tested by PCR for COVID-19 was 46,893 and the cumulative number of people tested was 6,280,182. The highest daily number of people tested was 54,114, reported on 28 January (Fig. 17).

Fig. 17. Daily and cumulative number of people tested with polymerase chain reaction (PCR) in Indonesia, as of 3 February 2021. Source of data
As of 3 February, the proportion of people recovered among the total confirmed COVID-19 cases was 81.5%, and there were 175,236 active cases (Fig. 18).^8

Most provinces in Indonesia experienced a slight decline in the proportion of occupied isolation beds from 25 January to 1 February. However, there were 5 provinces (Jambi, North Sumatra, East Kalimantan, Gorontalo, and Maluku) in which there was an increase in the proportion of occupied isolation beds.

On 1 February, the proportion of occupied beds in COVID-19 isolation wards in Indonesia was 58.7%. The six provinces with the highest proportion were: DKI Jakarta (80.0%), East Kalimantan (78.9%), Central Sulawesi (70.2%), DI Yogyakarta (69.6%), Banten (67.8%), and West Java (67.8%).

The proportion of occupied intensive care unit (ICU) beds for COVID-19 was 63.1% nationwide on 1 February. The six provinces with the highest proportion were DI Yogyakarta (83.8%), DKI Jakarta (82.3%), Gorontalo (77.8%), West Java (77.7%), Banten (76.6%) and East Kalimantan (73.5%) (Fig. 19).

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^8 https://covid19.go.id/
Fig. 19. Proportion of occupied beds in isolation rooms and intensive care units (ICU) in hospitals by province in Indonesia, on 25 January and 1 February 2021. Source of data
• On 1 February, the proportion of occupied hospital beds in DKI Jakarta remained high; the highest proportion of occupied isolation beds was in North Jakarta with 92.3%. On the same date, the highest proportion of occupied ICU beds was in Tangerang and Tangerang City at 100% (Fig. 20).

![Proportion of occupied beds in isolation rooms and in intensive care units (ICU) in hospitals in DKI Jakarta, as of 1 February 2021.](image)

Fig. 20. Proportion of occupied beds in isolation rooms and in intensive care units (ICU) in hospitals in DKI Jakarta, as of 1 February 2021.

• On 26 January, WHO attended a meeting convened by the MoH Directorate of Occupational Health and Sports to discuss the plan for the second phase of monitoring and evaluation activities for adherence to health protocols in offices, public places, healthcare facilities, and industries. These monitoring and evaluation activities will be conducted in 14 provinces, namely Aceh, Riau, Bengkulu, Jambi, Bangka Belitung Islands, Lampung, East Kalimantan, North Kalimantan, East Nusa Tenggara, Central Sulawesi, West Sulawesi, Gorontalo, Maluku, and Papua. MoH conducted the first phase in 20 provinces across Indonesia at the end of 2020.
As a part of the strategy to improve the COVID-19 laboratory capacity in Indonesia, WHO handed over 248 sets of magnetic stands (at an estimated cost of US$ 18,600) and a high-throughput automated sample preparation system for nucleic acid extraction (at an estimated cost of US$ 153,915) to the National Institute of Health Research and Development (NIHRD) on 26 and 29 January, respectively. The magnetic stands will be distributed to laboratories across Indonesia to be used in the manual nucleic acid extraction process. The high-throughput extraction system is expected to increase the SARS-CoV-2 testing capacity at NIHRD by reducing the required time and numbers of laboratory staff needed to conduct testing.

On 28 January, WHO supported the Indonesian Medical Association (Ikatan Dokter Indonesia (IDI)) to conduct a webinar on dissemination of the ‘Guidelines on Standardized Procedures for Doctors’ Protection in the COVID-19 Era’ and to update on the COVID-19 pandemic in East Java. The webinar was attended by around 4940 participants, including members of IDI from across the province as well as the East Java COVID-19 Task Force. IDI highlighted the importance of active participation of healthcare workers to ensure that standardized safety protocols are applied and strictly followed in all healthcare facilities to reduce COVID-19 transmission.
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 18 January, WHO had a meeting with Facebook to discuss a strategy to use social media to combat the COVID-19 infodemic in Indonesia -- including misinformation around COVID-19 vaccines -- and develop a question and answer (Q&A) document for HCWs. Several topics of misinformation around COVID-19 vaccines were identified during the discussion, including vaccine safety and efficacy, and how vaccines are developed.

On 19 January, WHO attended a meeting convened by MoH and World Bank to review and provide inputs on a ‘Risk Communication Guideline for Health Emergencies’. Supported by the World Bank, MoH is developing a risk communication guideline that is not only related to COVID-19 pandemic but will also address other emergencies. Among others, representatives from the COVID-19 Mitigation and National Economic Recovery Team (Komite Penanganan COVID-19 dan Pemulihan Ekonomi Nasional (KPCPEN)) and United Nations Children’s Fund (UNICEF) attended the meeting.

The online WHO course on ‘Standard precautions: Environmental cleaning and disinfection’ was translated into Indonesian and published on the website and on the OpenWHO platform. This course explains the role of an infection prevention and control (IPC) professional in environmental cleaning and how cleaning and disinfection prevent contamination of the healthcare environment.

In response to the evolving COVID-19 pandemic in Indonesia, WHO has supported the MoH in revisions to the ‘Health sector operational response plan for COVID-19 in Indonesia’. The revised version was released on 27 January. The revisions include three new pillars of the COVID-19 response, including large-scale social restrictions (Pembatasan Sosial Berskala Besar (PSBB)), COVID-19 vaccination, and emphasis on efforts to prevent transmission in public spaces and community involvement in improving the implementation of health protocols. The MoH Planning Bureau will upload the revised operational response plan into the WHO COVID-19 Partners.
Platform, a tool that was launched by WHO to enable all countries, implementing partners, donors, and contributors to collaborate in the global COVID-19 response.

- On 26 January, WHO had a meeting with MoH for the preparation of the second round of monitoring of the implementation of the Intra-Action Review (IAR) recommendations. This second round of monitoring is tentatively scheduled for 9 and 10 February and will cover all pillars of COVID-19 strategic preparedness and response plan including COVID-19 vaccination. WHO previously supported MoH to conduct the IAR virtually from 11 to 14 August 2020. As a follow-up to the review, on 26 and 27 November 2020, WHO facilitated a virtual meeting between MoH and relevant stakeholders to discuss and monitor the implementation of IAR recommendations.

**VACCINATION**

- As of 1 February, the cumulative number of health workers who have received the 1st dose of the COVID-19 vaccine was 539,532 (Fig. 22); 35,406 have received the 2nd dose of the vaccine (Fig. 23) out of 1,531,072 (vaccination target).

![Fig. 22. Cumulative number of health workers who have received the 1st dose of the COVID-19 vaccine in Indonesia, from 22 January to 1 February 2021. Source of data](source-url)
All vaccinated persons are observed for 30 minutes to monitor their post-vaccination condition before receiving a vaccination card that includes information on the date for the second dose and a reminder to maintain strict health protocols. A reminder through SMS blast is sent to ensure that they do not miss their second dose. As the second dose of COVID-19 vaccination has started to be rolled-out, there has been regular analysis and monitoring of the drop-out rate.

On 22 January, the Indonesian National Agency of Drug and Food Control (Badan Pengawas Obat dan Makanan (BPOM)) attended a virtual ‘Workshop on expediting regulatory pathway for approval of COVID-19 vaccines in countries of the South-East Asia Region’, which was conducted by the WHO Regional Office for South-East Asia. BPOM presented on the import permit for vaccines and the national lot release system, and explained the national process and legal framework for COVID-19 vaccine approval in Indonesia.

WHO assisted MoH to develop and submit the ‘National Deployment and Vaccination Plan (NDVP) for COVID-19 vaccines’ to the WHO COVID-19 Partners Platform. The document will be available for country users, regional users, as well as global partners and donors.

WHO is supporting MoH to establish sentinel surveillance of COVID-19 adverse events of special interest (AESI), targeting ten referral hospitals as sentinel sites. Finalization of technical guidance and information systems as well as assessment of hospitals are being conducted in parallel. WHO also supported MoH to ensure that the guidance and tools that will be used
follow global guidance and facilitated a discussion with national experts to adapt the global guidance into the national context. Further support will be provided to disseminate the guidance and train health workers at selected sentinel sites.

**CONTINUITY OF ESSENTIAL HEALTH SERVICES**

- WHO is supporting the government for programme analysis of various essential health services to maintain their continuity during the pandemic. This includes the Leprosy Elimination Programme (LEP). Previous analyses can be found in [Situation Report 17](https://www.who.int/indonesia); the latest update is highlighted below:

**Impact of COVID-19 on the LEP in Indonesia:**

i. There was a reduction in recording and reporting of new leprosy cases in 2020 compared to 2019. The number of reported new leprosy cases declined by 48% from 17,439 new cases in 2019 to 9,061 in 2020. There are currently 16,704 active leprosy cases in Indonesia that require treatment. Indonesia has maintained the status of leprosy elimination at the national level by recording less than 1 case per 10,000 population in 2020. However, delays in case finding and treatment occurred, reflected by a Grade-2 Disability (G2D) rate of 1.18/1,000,000 population and 9.14% pediatric cases among new cases.

ii. LEP activities that involved large numbers of people and mass gatherings were postponed, including active case finding (contact surveys, rapid village surveys, intensified case finding), and chemoprophylaxis. However, the National Leprosy Programme (NLP) has maintained multidrug therapy (MDT) medicine distribution, counselling, supervision, data recording and reporting, programme monitoring and evaluation, and data validation.

iii. Some of the government budget to support LEP at national and provincial levels was diverted to the COVID-19 response. Most LEP staff at the subnational level continue to be repurposed to support the pandemic response. The programmes have been integrated as much as possible, especially in high-burden leprosy areas.

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9 The complete 2020 dataset will be finalized by end of March 2021.
To mitigate the impact of COVID-19 and maintain essential LEP services, interventions are being made in the following areas:

i. Guideline: WHO, the International Federation of Anti-Leprosy Associations (ILEP), and the Global Partnership for Zero Leprosy shared advice about leprosy and COVID-19 in March 2020. The advice was adapted into an MoH circular that was released in April on ‘Implementation of Prevention and Control of Leprosy and Yaws in the Context of the COVID-19 Pandemic’ (see Situation Report 17 for details).

ii. Surveillance: WHO is providing technical support to MoH to develop the third prototype of an online-based recording and reporting system for leprosy using the District Health Information Software 2 (DHIS2) platform.

iii. Diagnosis: In the absence of any point-of-care diagnostic kits, patch examination should be used to diagnose leprosy in each suspected case in primary health care facilities (puskesmas). Alternatively, wasor kusta (dedicated healthcare workers for the leprosy programme) may use a door-to-door approach using appropriate personal protective equipment (PPE) and following the basic health protocols.

iv. Essential logistics: WHO has been providing technical support to MoH to facilitate the donation of MDT medicines from Novartis; donations continue during the pandemic.

v. Human resources: WHO provided support to the NLP in conducting two batches of capacity building on leprosy clinical case management for 40 wasor kusta at the subnational level. The capacity building was conducted from 18 November to 23 December 2020.

vi. World Leprosy Day was commemorated on 31 January 2021. The global theme this year was “Beat Leprosy, End Stigma, and Advocate for Mental Wellbeing”. Indonesia is highlighting the national theme “Find the Case, Examine the Contact, and Treat Completely” to eliminate leprosy by 2024. WHO is providing support by conducting a series of seminars and workshops from 2 February to 2 March 2021. The main topics that will be discussed during the seminars are: health promotion, surveillance, chemoprophylaxis, case management, and efforts to achieve the elimination of leprosy by 2024.
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 February 2021 (Fig. 24).

Fig. 24. WHO funding situation for COVID-19 response, February 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.
### RECENT AND UPCOMING WHO RESOURCE MATERIALS

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>Contact tracing in the context of COVID-19, 1 February 2021</td>
<td>Contact tracing is a key strategy for interrupting chains of transmission of SARS-CoV-2 and reducing mortality associated with COVID-19. This document provides updated guidance on how to establish contact tracing capacity for the control of COVID-19, and how to prioritize contact tracing activities in different settings.</td>
</tr>
<tr>
<td>Episode 23 of Science in 5, WHO’s series of conversations in science, 29 January 2021</td>
<td>The WHO Director of Immunization, Vaccines and Biologicals, Dr. Katherine O’ Brien answers common questions people may have after they receive the COVID-19 vaccine and explains why individuals need to continue to take precautions after vaccination.</td>
</tr>
<tr>
<td>Laboratory biosafety guidance related to coronavirus disease (COVID-19): Interim guidance, 28 January 2021</td>
<td>The purpose of this document is to provide interim guidance on laboratory biosafety related to the SARS-CoV-2 virus to laboratories and stakeholders involved in COVID-19 laboratory work. This also includes laboratories providing confirmatory and other testing for COVID-19.</td>
</tr>
<tr>
<td>Interim recommendations for use of the Moderna mRNA-1273 vaccine against COVID-19, 25 January 2021</td>
<td>This interim guidance on the use of the Moderna vaccine against COVID-19 has been developed on the basis of the advice issued by the Strategic Advisory Group of Experts on Immunization (SAGE) at its extraordinary meeting on 21 January 2021.</td>
</tr>
</tbody>
</table>
Online WHO COVID-19 courses:
- 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
- Infection prevention and control
- Emerging respiratory viruses, including COVID-19

WHO guidance:
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health
- SARS-CoV-2 genomic sequencing for public health goals: Interim guidance
- Aide-memoire: Infection prevention and control (IPC) principles and procedures for COVID-19 vaccination activities

Infographics:
- COVID-19 tests
- Mental health
- COVID-19 symptoms
- Social gathering
- How to protect yourself from COVID-19
- Solidarity not stigma
- Staying healthy in the workplace
- Contact tracing

Questions and answers:
- COVID-19: Vaccines
- COVID-19: Vaccine research and development
- COVID-19: Vaccine access and allocation
- How are vaccines developed?

Videos:
- Live Q&A COVID-19 vaccines
- Confused about when to wear a mask
- A properly fitted mask reduces your risk
- Life skills – with MoH

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

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