• As of 26 May, the Government of Indonesia reported 1791221 (5034 new) confirmed cases of COVID-19, 49771 (144 new) deaths and 1645263 recovered cases from 510 districts across all 34 provinces.\(^1\)

• WHO supported the Ministry of Health to conduct contact tracing training for staff of community health centres (puskesmas) in East Java from 18 to 21 May (page 14).

• On 18 and 19 May, WHO organized a global consultative meeting on COVID-19 Intra-Action Review, which included experiences from Indonesia (page 17).

Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 20 to 26 May 2021. Source of data

Disclaimer: Data are not available for Papua province for this time period due to internet connectivity issues\(^2\). 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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\(^1\) [https://covid19.go.id/peta-sebaran-covid19](https://covid19.go.id/peta-sebaran-covid19)

• On 23 May, the National COVID-19 Task Force (Satuan Tugas (Satgas)) announced that four provinces had seen an increase of over 50% in the hospital bed occupancy rate (BOR). As of 22 May, the provinces with the highest BOR were North Sumatra (57.9%), West Kalimantan (57.6%), West Sumatra (52.8%) and Riau (51.1%). In addition, Satgas reported that the hospital BOR in provinces such as DKI Jakarta, West Java, Central Java and DI Yogyakarta have also started increasing.3

• Indonesia is set to kick off the third phase of its national COVID-19 vaccination programme in June 2021. The third phase of the vaccination will mainly target vulnerable populations, including people with disabilities. On 20 May, the Ministry of Health (MoH) spokesperson for COVID-19 vaccination stated that the third phase of vaccination will prioritize around 250 000 persons with disabilities.4

• During a press conference on 20 May, the Minister of Education, Culture, Research and Technology reported that around 23% of 4.5 million teachers in Indonesia have received their COVID-19 vaccines. The Minister stated that the vaccination coverage is still relatively low due to the limited availability of vaccine stock. However, he stated that the government will continue to improve vaccination in order to reopen schools for the new term in July 2021.5

• On 20 May, the MoH spokesperson for COVID-19 vaccination stated that the distribution of only one out of the forty batches of AstraZeneca COVID-19 vaccine from the COVAX Facility has been suspended. She emphasized that the remaining batches are safe to be used. The CTMAV547 batch that was suspended for distribution, comprised of around 448 000 doses, was part of the 3.8 million doses that arrived in Indonesia in late April 2021. The National Agency of Drug and Food Control (Badan Pengawas Obat dan Makanan (BPOM)) is conducting further tests of the vaccines from this batch to ensure safety before rollout can resume.6

6 https://jakartaglobe.id/special-updates/it-is-safe-rollout-for-39-astrazeneca-batches-continues-in-indonesia
On 26 May, 5034 new and 1,791,221 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 20 to 26 May was 5446 cases per day, compared to 3557 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 26 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 17 to 23 May, the provinces that experienced an increase in the number of weekly cases of more than 50% compared to the previous week were North Kalimantan (575%), South Sulawesi (203%), Aceh (134%), Gorontalo (117%), North Maluku (113%), West Nusa Tenggara (112%), Bengkulu (95%), West Sumatra (88%), South Kalimantan (73%), Bangka Belitung Islands (68%) and Central Kalimantan (56%) (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 17 to 23 May 2021 compared to the previous week. [Source of data](https://www.who.int/indonesia)

**Disclaimer:** Data are not available for Papua province for this time period due to internet connectivity issues. 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 17 to 23 May, the incidence\(^7\) of COVID-19 in Indonesia decreased to 11.3 per 100 000 population, compared to 12.5 per 100 000 in the previous week (Fig. 4).

![Graph showing weekly incidence of COVID-19](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 23 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). 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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\(^7\) 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](https://www.who.int)
During the week of 17 to 23 May, the incidence of COVID-19 per 100,000 population was 64.1 in Bangka Belitung Islands, 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. Data are not available for Papua province for this time period due to internet connectivity issues². Incidence of COVID-19 per 100,000 population per week averaged over a two-week period by province in Indonesia during 17 to 23 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

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During the week of 17 to 23 May, the weekly incidence of COVID-19 increased in Central Java, compared 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 23 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 23 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 23 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 23 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 23 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 23 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 11.7% on 23 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 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 23 May 2021, classified by level of community transmission (CT): CT1: low incidence; CT2: moderate incidence; CT3: high incidence; CT4: very high incidence.](image)

**Disclaimer:** Caution should be exercised when interpreting this indicator due to limitations listed in the [WHO interim guidance](https://who.int/indonesia). 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: 03/05/21 to 09/05/21; Week 2: 10/05/21 to 16/05/21; Week 3: 17/05/21 to 23/05/21

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 17 to 23 May, Riau had the highest weekly number of confirmed COVID-19 deaths per 100,000 population, followed by DI Yogyakarta, DKI Jakarta, Bali, and Riau 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 17 to 23 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: Data are not available for Papua province for this time period due to internet connectivity issues². 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 17 to 23 May, the number of confirmed COVID-19 deaths was 0.43 per 100 000 population\(^8\), compared to 0.44 per 100 000 in the previous week (Fig. 15).

![Graph showing weekly mortality of COVID-19](source of data)

**Fig. 15.** Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period in Indonesia, as of 23 May 2021.  

**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 17 to 23 May, the total number of weekly confirmed COVID-19 deaths in DKI Jakarta was 125, compared to 171 in the previous week (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**

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[who.int/indonesia]
To further strengthen contact tracing activities, MoH collaborated with the Ministry of Education, Culture, Research and Technology to mobilize university students of health-related programmes to be contact tracers. As of 24 May, around 1000 students have been recruited and trained. These students will be deployed to support contact tracing activities in their respective provinces. The assignment will officially start on 1 June, for the duration of three months. Each tracer will be assigned to puskesmas by District Health Officers (DHOs) and will be given access to the ‘Silacak’ application.

From 18 to 21 May, WHO supported MoH to conduct contact tracing training for staff of community health centres (puskesmas) in East Java. Participants were trained on how to use ‘Silacak’ application to support contact tracing activities. The training was divided into eight sessions and attended by more than 3600 participants from 296 puskesmas of 12 districts in East Java.

On 20 May, MoH issued a new guideline for COVID-19 testing, tracing, quarantine and isolation. This guideline was updated based on the latest global updates and WHO recommendations on COVID-19.
• Following the report of two COVID-19 variants of concern (VoC) (B.1.351 and B.1.1.7) that were detected in several confirmed COVID-19 cases in Bali, the Governor of Bali province issued a circular letter to district heads and city mayors on 17 May. The letter urged district and city administrators to strengthen testing to identify and isolate COVID-19 cases as soon as possible and to accelerate contact tracing for COVID-19, including the implementation of proper quarantine measures to reduce transmission and control the COVID-19 pandemic. It emphasized the importance of achieving a testing benchmark of 1 per 1000 population per week, at least 25 to 30 close contacts traced per case and performing entry and exit tests as part of quarantine procedure of the national guideline.

HEALTH OPERATIONS

• As reported on 26 May, the daily number of people tested for COVID-19 was 56,318 and the cumulative number of people tested was 10,938,373 (Fig. 17).

Fig. 17. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 26 May 2021. Source of data
- As of 26 May, the proportion of people recovered among the total confirmed COVID-19 cases was 91.9% and there were 96,187 active cases (Fig. 18).

![Fig. 18. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 26 May 2021. Source of data](source)

**RISK COMMUNICATION**

- WHO is regularly translating and sharing important health messages on its website and social media platforms – [Twitter](https://twitter.com) and [Instagram](https://www.instagram.com) – and has recently published:
  
  **Infographics:**
  - [Celebrating Eid al-Fitr](https://www.who.int)
On 18 and 19 May, WHO organized a global consultative meeting and session to share experiences on COVID-19 Intra-Action Review (IAR), attended by more than 60 participants from various Member States. During the session on 18 May, the MoH Coordinator of Emerging Infectious Diseases Programme Dr Endang Budi Hastuti presented the Indonesia experience and lessons learned from IAR in the country. She highlighted the importance of IAR as a useful tool to bring together multiple sectors to review COVID-19 response to formulate recommendations to improve the overall response to the pandemic.
On 19 May, WHO participated in a meeting on health security, organized by MoH. The meeting was attended by more than 70 participants including representatives from Ministry of Foreign Affairs (MoFA), Ministry of Defence, professional organizations and representatives from the United States Centers for Disease Control and Prevention (US CDC). The main objective of the meeting was to discuss priority actions to improve health security in Indonesia. During the meeting, WHO emphasized the need to improve and monitor the implementation of the 13 International Health Regulations (IHR) core capacities\(^9\) as well as to mobilize all aspects of the society to improve the whole-of-society approach to pandemic preparedness and response. In addition, WHO highlighted the importance of taking into consideration lessons learned from the COVID-19 pandemic response to improve health security.

**VACCINATION**

- As of 24 May, 24 826 221 vaccine doses have been administered in the national COVID-19 vaccination campaign; 14 919 592 people have received the first dose and 9 906 629 people have received the second dose (Fig. 21).

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As of 24 May, the number of health workers who have received the second dose of the COVID-19 vaccine (fully vaccinated) was 1,378,328 (93.8% 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 10,358,645 (59.8% of the targeted 17,327,167); 6,490,766 (37.5% 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 3,037,155 (14.1% of the targeted 21,553,118); 2,036,828 (9.5% of the targeted population) have received the second dose (Fig. 22).
As of 24 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. 23).

**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.

- Vaccination coverage over 100% is due to differences in actual versus estimated target population.
• As of 24 May, the number of people vaccinated with at least one dose of the vaccine per 100 population nationwide was 5.5. As of the same day, Bali had the highest number of people vaccinated with at least one dose of the vaccine (26.1 per 100 population) amongst all provinces, followed by DKI Jakarta (21.7) (Fig. 24).

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

**Fig. 24.** Number of people vaccinated with at least one dose of the vaccine per 100 population by province in Indonesia, as of 24 May 2021. [Source of data](#)

• As of 24 May, DKI Jakarta had the highest coverage of first and second dose vaccination to older people (Fig. 25). As of the same day, provinces with the highest number of unvaccinated older people were West Java, Central Java and East Java (Fig. 26).

![Bar chart of vaccination coverage](image)

**Fig. 25.** COVID-19 vaccination coverage of older people by province in Indonesia, as of 24 May 2021. [Source of data](#)
Fig. 26. Number of unvaccinated older people (over 60 years of age) by province in Indonesia, as of 24 May 2021. Source of data
• On 25 May, WHO participated in the second townhall meeting for UN staff in Indonesia in 2021, which virtually connected over 600 colleagues from UN organizations across the country. The WHO Representative to Indonesia Dr Paranietharan provided updates on the COVID-19 epidemiological situation in the country, status of COVID-19 vaccines within WHO emergency use listing (EUL) evaluation process and SARS-CoV-2 VoC. He reiterated the importance of adhering to personal protective measures for COVID-19 and responded to questions.

• 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. 27).

Fig. 27. 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/), 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><strong>Episode 39</strong> of <em>Science in 5</em>, WHO’s series of conversations in science, 19 May 2021</td>
<td>The WHO Technical Lead for COVID-19 Dr Maria Van Kerkhove provides an update on SARS-CoV-2 virus variants.</td>
</tr>
<tr>
<td><strong>Preventing and mitigating COVID-19 at work (policy brief), 19 May 2021</strong></td>
<td>This joint WHO/ILO policy brief provides a summary of the evidence for transmission of COVID-19 in general workplaces and an overview of WHO and ILO recommendations for prevention and mitigation of COVID-19 and for protecting health and safety at work in the context of the pandemic. This document is intended for public health and labour authorities, businesses, employers, workers and their representatives at the national, local and workplace levels to facilitate the implementation of public health and social measures for COVID-19 while maintaining productive employment and decent work during the pandemic.</td>
</tr>
<tr>
<td><strong>COVID-19 Vaccine Introduction and Deployment Costing tool (CVIC tool), 14 May 2021</strong></td>
<td>This is an updated version of the COVID-19 Vaccine Introduction and Deployment Costing tool (CVIC tool) that was published on 20 February. The CVIC tool supports credible COVID-19 vaccination costing to facilitate a dialogue with stakeholders, while maintaining sensitivity to protect essential health services.</td>
</tr>
<tr>
<td><strong>Health worker communication for COVID-19 vaccination flow diagram, 13 May 2021</strong></td>
<td>The ‘Health Worker Communication for COVID-19 Vaccination Flow Diagram’ supports health workers by outlining key steps and messages to communicate during a COVID-19 vaccination session.</td>
</tr>
<tr>
<td><strong>Programmatic innovations to address challenges in tuberculosis prevention and care during the COVID-19 pandemic, 13 May 2021</strong></td>
<td>To avoid a reversal of progress towards eliminating tuberculosis (TB), new knowledge and lessons from successful programmatic innovations are urgently needed to improve TB prevention and care in the context of the pandemic. To support evidence-based adaptation of TB services to the context created by the pandemic, WHO Global TB Programme therefore established a compendium of resources on TB and COVID-19, which comprises a list of research projects on TB and COVID-19 in various countries reported to WHO by the investigators and an inventory of peer-reviewed or preprint</td>
</tr>
<tr>
<td><strong>Continuity of essential health services: Facility assessment tool (interim guidance), 12 May 2021</strong></td>
<td>The ‘Continuity of essential health services: Facility Assessment Tool’ can be used by countries to rapidly assess the capacity of health facilities to maintain the provision of essential health services during the COVID-19 pandemic. It can help to alert the authorities and stakeholders about where service delivery and utilization may require modification and/or investment. This tool can be used in multiple types of health facilities. It can be used on a one-time basis to provide a rapid snapshot of current service capacity, or on a regular basis for tracking and monitoring the continuity of essential health services during the different phases of the pandemic.</td>
</tr>
<tr>
<td><strong>COVID-19 natural immunity (scientific brief), 10 May 2021</strong></td>
<td>This scientific brief replaces the WHO Scientific Brief entitled ‘Immunity passports in the context of COVID-19’, published on 24 April 2020. This update focuses on what is currently understood about SARS-CoV-2 immunity from natural infection. More information about considerations on vaccine certificates or ‘passports’ will be covered in an update of WHO interim guidance.</td>
</tr>
<tr>
<td><strong>Interim recommendations for use of the inactivated COVID-19 vaccine BIBP developed by China National Biotec Group (CNBG), Sinopharm - Interim guidance, 7 May 2021</strong></td>
<td>These WHO interim recommendations for use of the COVID-19 vaccine BIBP were developed on the basis of advice issued by the Strategic Advisory Group of Experts on Immunization (SAGE) and the evidence summary included in the Background document on the inactivated COVID-19 vaccine BIBP developed by China National Biotec Group (CNBG) and GRADE and ETR tables. These interim recommendations refer to the inactivated COVID-19 vaccine (Vero cell) manufactured by the Beijing Institute of Biological Products Co., Ltd (BIBP), a subsidiary of the China National Biotec Group (CNBG).</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:
- COVID-19 home care bundle for healthcare workers
- 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
- WHO Information Note: COVID-19 considerations for tuberculosis (TB) care

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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