HIGHLIGHTS

- As of 2 June, the Government of Indonesia reported 1,831,773 (5246 new) confirmed cases of COVID-19, 50,908 (185 new) deaths and 1,680,501 recovered cases from 510 districts across all 34 provinces.¹

- WHO supported the National Institute of Health Research and Development (NIHRD) to conduct supportive supervision to provincial hospital laboratories that conduct polymerase chain reaction testing for COVID-19 in West Nusa Tenggara (page 18).

- WHO continues to support the Ministry of Health in conducting rapid response team training for Sulawesi region and presented ‘Rapid Risk Assessment of Acute Public Health Events’ during the session on 31 May (pages 19-20).

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Fig. 1. Geographic distribution of cumulative number of confirmed COVID-19 cases in Indonesia across the provinces reported from 27 May to 2 June 2021. Source of data

Disclaimer: Data are not available for Papua province for this time period due to internet connectivity issues². 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

WHO Indonesia Situation Report - 57
who.int/indonesia
Indonesia recorded a surge in the number of COVID-19 cases and clusters of COVID-19 infection, one week following the Eid al-Fitr holidays. The National COVID-19 Task Force (Satuan Tugas (Satgas)) reported that from 17 to 23 May, the weekly average number of confirmed cases increased by 36.1% compared to the previous week. As of the same week, Satgas also reported that the number of COVID-19 deaths increased by 13.8%. In addition, a low level of public compliance to health protocols was reported since the beginning of the second week of Ramadan, as many public places were crowded with visitors.³

The Government of Indonesia resumed COVID-19 vaccination using the AstraZeneca COVID-19 vaccine from the CTMAV547 batch, which was temporarily suspended over safety concerns. The batch is comprised of 448 480 vaccine doses, which was part of the 3.8 million doses from the COVAX Facility that arrived in April. On 27 May, the Ministry of Health (MoH) announced that according to the findings from further tests conducted by the National Agency of Drug and Food Control (Badan Pengawas Obat dan Makanan (BPOM)), the vaccines from this batch are safe to be used. BPOM concluded that the batch meets the requirements in terms of quality during distribution and storage.⁴

On 27 May, MoH announced that locally transmitted SARS-CoV-2 variants of concern (VoC) were detected in 19 cases across the country. These included the variants that were first identified in the United Kingdom (B.1.1.7 variant), South Africa (B.1.351) and India (B.1.617). These cases were found in North Sumatra, South Sumatra, DKI Jakarta, West Java, Bali, South Kalimantan and Central Kalimantan.⁵

On 25 May, Bio Farma reported that 77 000 doses of COVID-19 vaccine from Sinopharm have been distributed for the ‘Gotong Royong’ private vaccination programme. Around 22 000 doses have been administered. As the initial stage, Indonesia received 500 000 doses of COVID-19 vaccine from Sinopharm in May. Bio Farma stated that another one million doses of the vaccine are scheduled to be sent to the country during the first week of June. In total, Indonesia will receive 15 million doses of vaccine from Sinopharm, which will be delivered in stages.⁶

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WHO Indonesia Situation Report - 57
[who.int/indonesia](http://who.int/indonesia)
On 2 June, 5246 new and 1 831 773 cumulative confirmed COVID-19 cases were reported nationwide (Fig. 2). The average for the last seven days from 27 May to 2 June was 5793 cases per day, compared to 5446 cases per day reported in the previous week.

Fig. 2. Daily and cumulative number of cases reported in Indonesia, as of 2 June 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. 16); 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 24 to 30 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 (189%), Aceh (71%), Maluku (63%), Riau Islands (62%), Central Sulawesi (57%), Gorontalo (54%), Jambi (53%) and Central Java (51%) (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 24 to 30 May 2021 compared to the previous week. Source of data

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 24 to 30 May, the incidence\(^7\) of COVID-19 in Indonesia increased to 12.5 per 100,000 population, compared to 11.3 per 100,000 in the previous week (Fig. 4).

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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.
• During the week of 24 to 30 May, the incidence rates of COVID-19 per 100 000 population were 71.3 in Bangka Belitung Islands and 61.7 in Riau Islands; these rates correspond 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.

![Weekly case incidence graph]

Fig. 5. Data are not available for Papua province for this time period due to internet connectivity issues. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period by province in Indonesia during 24 to 30 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

WHO Indonesia Situation Report - 57
who.int/indonesia
During the week of 24 to 30 May, the weekly incidence of COVID-19 increased in most provinces in Java-Bali, compared to the incidence in the previous week (Fig. 6).

Fig. 6. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Java - Bali, from 13 April 2020 to 30 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
The weekly incidence of COVID-19 increased in all provinces in Sumatra during the week of 24 to 30 May compared to the previous week. There has been an increasing trend in case incidence since early April in most provinces in Sumatra, with a peak in incidence in Aceh and Riau Islands in the most recent week (Fig. 7).

Fig. 7. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Sumatra, from 13 April 2020 to 30 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 24 to 30 May, the weekly incidence of COVID-19 increased in all provinces in Kalimantan compared to the incidence in the previous week, except for South Kalimantan which remained the same. There has been a notable increasing trend in West Kalimantan since the beginning of 2021, with a peak in case incidence in the last week (Fig. 8).

Fig. 8. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Kalimantan, from 13 April 2020 to 30 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
In Sulawesi, the weekly incidence of COVID-19 increased in the provinces of South Sulawesi and Gorontalo during the period of 24 to 30 May compared to the previous week (Fig. 9).

Fig. 9. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in Sulawesi, from 13 April 2020 to 30 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 24 to 30 May, the weekly incidence of COVID-19 increased in West Nusa Tenggara, Maluku and North Maluku compared to the previous week (Fig. 10).

During the week of 24 to 30 May, the weekly incidence of COVID-19 increased in West Nusa Tenggara, Maluku and North Maluku compared to the previous week (Fig. 10).

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 9.9% on 30 May, which is considered as CT3 (high incidence) (Fig. 11). 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. 12).

Fig. 10. Incidence of COVID-19 per 100 000 population per week averaged over a two-week period in West Nusa Tenggara, East Nusa Tenggara, Maluku, North Maluku, Papua, and West Papua, from 13 April 2020 to 30 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 as of 13 May due to internet connectivity issues².
Fig. 11. Test positivity proportion averaged over a two-week period at the national level in Indonesia, as of 30 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. 12. Test positivity proportion and people tested per 1000 population per week at the national level and in select provinces.

Week 1: 10/05/21 to 16/05/21; Week 2: 17/05/21 to 23/05/21; Week 3: 24/05/21 to 30/05/21

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 24 to 30 May, Riau had the highest weekly number of confirmed COVID-19 deaths per 100 000 population, followed by DI Yogyakarta, DKI Jakarta, Riau Islands and Bangka Belitung Islands (Fig. 13).

Fig. 13. Number of confirmed COVID-19 deaths per 100 000 population per week averaged over a two-week period by province in Indonesia during 24 to 30 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 issues. 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 24 to 30 May, the number of confirmed COVID-19 deaths was 0.41 per 100 000 population\(^8\), compared to 0.43 per 100 000 in the previous week (Fig. 14).

During the week of 24 to 30 May, the total number of weekly confirmed COVID-19 deaths in DKI Jakarta was 102, compared to 125 in the previous week (Fig. 15).

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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](#).

**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.
As reported on 2 June, the daily number of people tested for COVID-19 was 49 731 and the cumulative number of people tested was 11 352 639 (Fig. 16).

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.

Fig. 15. Weekly number of confirmed COVID-19 deaths in DKI Jakarta, as of 30 May 2021. Source of data.
As of 2 June, the proportion of people recovered among the total confirmed COVID-19 cases was 91.7% and there were 100,364 active cases (Fig. 17).

Fig. 16. Daily and cumulative number of people tested for COVID-19 in Indonesia, as of 2 June 2021. Source of data

Fig. 17. Number of active cases of COVID-19 and recovery percentage in Indonesia, as of 2 June 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 subsequently decreased and remained relatively stable, with an average of 3362 hospitalized cases per day in March and April. There was an increasing trend in May, with 5417 hospitalized cases reported on 31 May (Fig. 18).

![Number of confirmed COVID-19 cases hospitalized in DKI Jakarta from 1 September 2020 to 31 May 2021](source_of_data)

**LABORATORY**

- As part of the effort to improve the quality of COVID-19 polymerase chain reaction (PCR) testing in the country, WHO supported the National Institute of Health Research and Development (NIHRD) to conduct field visits and supportive supervision to provincial hospital laboratories in West Nusa Tenggara from 27 to 29 May. During the visits, NIHRD conducted an evaluation of the performance of laboratories and a root cause analysis (RCA), the findings of which were discussed to formulate follow-up actions and a strategy to improve PCR testing in the province. In addition, NIHRD made arrangements for the preparation of the distribution of external quality assessment (EQA) panels for the third phase of the assessment. NIHRD plans to distribute EQA panels to 650 participating laboratories across the country in mid-July.
WHO continues to translate important courses designed for key partners and frontline responders into Indonesian, also available on the OpenWHO platform. As of 1 June, there have been 28,571 enrolments in the eight OpenWHO courses available in Indonesian.

Table 1. Number of participants enrolled in the OpenWHO courses that have been translated into Indonesian, as of 1 June 2021.

<table>
<thead>
<tr>
<th>No.</th>
<th>OpenWHO courses</th>
<th>Number of participants enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Infection Prevention and Control (IPC) for COVID-19 virus</td>
<td>8316</td>
</tr>
<tr>
<td>2.</td>
<td>ePROTECT Respiratory Infections</td>
<td>6685</td>
</tr>
<tr>
<td>4.</td>
<td>Introduction to COVID-19: methods for detection, prevention, response and control</td>
<td>3443</td>
</tr>
<tr>
<td>5.</td>
<td>COVID-19 vaccination training for health workers</td>
<td>2551</td>
</tr>
<tr>
<td>6.</td>
<td>WHO Clinical Care Severe Acute Respiratory Infection Training</td>
<td>1304</td>
</tr>
<tr>
<td>7.</td>
<td>Severe Acute Respiratory Infection (SARI) Treatment Facility Design</td>
<td>1272</td>
</tr>
<tr>
<td>8.</td>
<td>Long-term care facilities in the context of COVID-19</td>
<td>1187</td>
</tr>
</tbody>
</table>

WHO is regularly translating and sharing important health messages on its website and social media platforms – Twitter and Instagram – and continues to published Infographics useful for the public.

RISK AND NEEDS ASSESSMENT, AND PLANNING

WHO continues to support MoH in conducting rapid response team (RRT) training for the Sulawesi region. The ‘Rapid Risk Assessment of Acute Public Health Events’ guide was presented by WHO during an online training session on 31 May. A rapid risk assessment is a systematic process of gathering, assessing and documenting information to assign a level of risk based on the analysis of hazard, exposure and context to guide the response to public health events. The session was attended by 36 participants from points of entry and provincial health offices (PHOs) across the region. Through a combination of online and offline sessions, participants will be trained on surveillance, detection of emerging infectious
diseases (EID) (including field investigation and response to EID), specimen
collection, shipment and laboratory testing, case management and infection
control and risk communication. The online component of the training has been
ongoing since 24 May and will be conducted in batches until 5 June. Offline
sessions will be conducted from 7 to 11 June. At the end of the training, participants
will partake in a simulation exercise to test their capabilities to detect new
SARS-CoV-2 variants and respond to the simulated event.

VACCINATION

- As of 31 May, 27 256 388 vaccine doses have been administered in the national
COVID-19 vaccination campaign; 16 558 536 people have received the first dose
and 10 697 852 people have received the second dose (Fig. 19).

![Cumulative number of vaccine doses administered in Indonesia, from 22 January to
31 May 2021. Source of data](who.int/en)

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

- As of 31 May, the number of health workers who have received the second dose
of the COVID-19 vaccine (fully vaccinated) was 1 386 778 (94.4% of the target
population of 1 468 764). The number of older people who have received the first
dose of the vaccine was 3 340 338 (15.5% of the targeted 21 553 118); 2 198 723
(10.2% of the targeted population) have received the second dose. The number of
essential public service workers who have received the first dose of the vaccine
was 11 663 306 (67.3% of the targeted 17 327 167); 7 111 644 (41% of the target
population) have received the second dose of the vaccine (Fig. 20). As part of the
essential public service workers priority target group, 1 598 502 teachers have
received the first dose of the vaccine; 995 401 have received the second dose.
As of 31 May, the highest coverage of the first dose vaccination administered to eligible target populations in the country was in Bali, followed by DKI Jakarta, Riau Islands, DI Yogyakarta 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, Bangka Belitung Islands and East Kalimantan (Fig. 2).

- As of 31 May, the highest coverage of the first dose vaccination administered to eligible target populations in the country was in Bali, followed by DKI Jakarta, Riau Islands, DI Yogyakarta 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, Bangka Belitung Islands and East Kalimantan (Fig. 21).

Fig. 21. COVID-19 vaccination coverage among the eligible target populations by province in Indonesia, as of 31 May 2021. Source of data

Disclaimer: Vaccination coverage over 100% is due to differences in actual versus estimated target population.
• As of 31 May, the number of people vaccinated with at least one dose of the vaccine per 100 population nationwide was 6.1. As of the same day, Bali had the highest number of people vaccinated with at least one dose of the vaccine (29.2 per 100 population) amongst all provinces, followed by DKI Jakarta (23.3) (Fig. 22).

Fig. 22. Number of people vaccinated with at least one dose of the vaccine per 100 population by province in Indonesia, as of 31 May 2021. Source of data

• As of 31 May, DKI Jakarta had the highest coverage of first and second dose vaccination to older people (Fig. 23). As of the same day, provinces with the highest number of unvaccinated older people were West Java, Central Java and East Java (Fig. 24)

Fig. 23. COVID-19 vaccination coverage of older people by province in Indonesia, as of 31 May 2021. Source of data
Fig. 24. Number of unvaccinated older people (over 60 years of age) by province in Indonesia, as of 24 May 2021. Source of data
• On 28 May, WHO convened the 31st 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), United Nations Children’s Fund (UNICEF), United States Centers for Disease Control and Prevention (US CDC), the World Bank and the World Food Programme (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 potential surge of cases following the Eid holidays, updates on the SARS-CoV-2 variants detected in the country, findings from the oxygen survey and updates on COVID-19 vaccination programmes.

• 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 June 2021 (Fig. 25).

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 2: Title and details of recent WHO resource materials

Source: [https://www.who.int/](https://www.who.int/)

<table>
<thead>
<tr>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operational guide for engaging communities in contact tracing, 28 May 2021</strong></td>
<td>Contact tracing is a key component of a public health response to infectious disease outbreaks. The purpose of this guide is to reinforce the place of community engagement and participation in the contact tracing process. This guide and related products articulate best practice principles for community engagement and how they can be operationalized as part of any community-centred contact tracing strategy.</td>
</tr>
<tr>
<td><strong>Critical preparedness, readiness and response actions for COVID-19 (interim guidance), 27 May 2021</strong></td>
<td>This document is an update to the interim guidance of the same title, which was originally published on 22 March 2020 and previously updated on 5 November 2020. This current version provides updated guidance on contact tracing, laboratory testing, infection prevention and control (IPC), PHSM and health services in the context of COVID-19 vaccination implementation. This document outlines critical preparedness, readiness and response actions that are necessary, depending on the SARS-CoV-2 transmission scenario. Where possible, transmission scenario should be assessed at the lowest administrative level within each country.</td>
</tr>
<tr>
<td><strong>Episode 40 of Science in 5, WHO’s series of conversations in science, 27 May 2021</strong></td>
<td>The WHO Director of Health Emergency Information and Risk Assessment Department Dr Oliver Morgan explains SARS-CoV-2 transmission and precautionary steps to keep safe indoors and outdoors.</td>
</tr>
<tr>
<td><strong>Technical note on delayed shipments for the ChAdOx1-S [recombinant] vaccines: what are the implications for the administration of second doses? (scientific brief), 26 May 2021</strong></td>
<td>The global supply of ChAdOx1-[recombinant] vaccines is presently constrained, which impacts country access to ChAdOx1-S [recombinant] vaccine (AstraZeneca COVID-19 vaccine AZD1222, SII Covishield, SK Bioscience). The uncertainty of future supply has prompted countries to review policy and programmatic implications, as providing the second dose of the vaccine within the WHO recommended 8-12 week schedule may not be feasible in the near future. This document supplements information provided in ‘Considerations for optimizing deployment of ChAdOx1-2 [recombinant] vaccines in a time-limited constrained supply situation’ and provides updated information relevant to the provision of a second dose in the current limited supply context.</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:
- **Preventing and mitigating COVID-19 at work (policy brief)**
- **COVID-19 Vaccine Introduction and Deployment Costing tool (CVIC tool)**
- **Health worker communication for COVID-19 vaccination flow diagram**
- **Programmatic innovations to address challenges in tuberculosis prevention and care during the COVID-19 pandemic**
- **Continuity of essential health services: Facility assessment tool (interim guidance)**
- **COVID-19 natural immunity (scientific brief)**
- **Interim recommendations for use of the inactivated COVID-19 vaccine BIBP developed by China National Biotec Group (CNBG), Sinopharm - Interim guidance**

Infographics:
- **Celebrating Eid al-Fitr**
- **Self-isolation**
- **How to make a fabric mask**
- **Contact tracing**

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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