COVID-19 Results Briefing

Indonesia

October 1, 2021

This document contains summary information on the latest projections from the IHME model on COVID-19 in Indonesia. The model was run on September 28, 2021, with data through September 27, 2021.

Current situation

Cases, hospitalizations, and deaths continue to decline in Indonesia. However, the situation remains fragile due to low vaccination coverage and the large percentage of the population at risk (susceptible). Mask wearing remains high and is helping with controlling the spread. Our models project that by January 1, 36% of people will be immune to the Delta variant – hence is a surge remains possible. The strategies to contain the epidemic remain the same: increase vaccine coverage, reduce the size of gatherings, and reduce mobility through social distancing mandates. A critical part of managing the epidemic is improving case detection to be able to respond faster when cases start rising and implement effective preventive measures.

- Daily infections in the last week decreased to 27,000 per day on average compared to 34,000 the week before (Figure 1). Daily hospital census in the last week (through September 27) decreased to 8,300 per day on average compared to 12,700 the week before.
- Daily reported cases in the last week decreased to 6,200 per day on average compared to 12,800 the week before (Figure 2).
- Reported deaths due to COVID-19 in the last week decreased to 140 per day on average compared to 200 the week before (Figure 3).
- Excess deaths due to COVID-19 in the last week decreased to 370 per day on average compared to 550 the week before (Figure 3). This makes COVID-19 the number 3 cause of death in Indonesia this week (Table 1). Estimated excess daily deaths due to COVID-19 in the past week were 2.7 times larger than the reported number of deaths.
- The daily reported COVID-19 death rate is less than 4 per million (Figure 4).
- The daily rate of excess deaths due to COVID-19 is less than 4 per million (Figure 4).
- We estimate that 29% of people in Indonesia have been infected as of September 27 (Figure 6).
- Effective R, computed using cases, hospitalizations, and deaths, was 0.7 on September 16 (Figure 7).
- The infection-detection rate in Indonesia was close to 6% on September 27 (Figure 8).
Based on the GISAID and various national databases, combined with our variant spread model, we estimate the current prevalence of variants of concern (Figure 9). We estimate that the Delta variant is circulating.

Trends in drivers of transmission

- Mobility last week was 13% lower than the pre-COVID-19 baseline (Figure 11).
- As of September 27, in the COVID-19 Trends and Impact Survey, 75% of people self-report that they always wore a mask when leaving their home compared to 76% last week (Figure 13).
- There were 36 diagnostic tests per 100,000 people on September 27 (Figure 15).
- As of September 27, about 28% of the population who have received at least one vaccine dose and 17% are fully vaccinated (Figure 17).
- In Indonesia, 76.7% of the population that is 12 years and older say they would accept or would probably accept a vaccine for COVID-19. Note that vaccine acceptance is calculated using survey data from the 18+ population. This is up by 0.4 percentage points from last week. The proportion of the population who are open to receiving a COVID-19 vaccine ranges from 62% in Maldives to 95% in Sri Lanka (Figure 19).
- In our current reference scenario, we expect that 120.3 million people will be vaccinated with at least one dose by January 1 (Figure 20). We expect that 39% of the population will be fully vaccinated by January 1.
- Based on the estimate of the population that have been infected with COVID-19 and vaccinated to date, combined with assumptions on protection against infection with the Delta variant provided by either natural infection, vaccination, or both, we estimate that 31% of the region is immune to the Delta variant. In our current reference scenario, we expect that by January 1, 36% of people will be immune to the Delta variant (Figure 21). These two calculations do not take into account waning of natural or vaccine-derived immunity.

Projections

- In our reference scenario, which represents what we think is most likely to happen, our model projects 145,000 cumulative reported deaths due to COVID-19 on January 1. This represents 4,000 additional deaths from September 27 to January 1. Daily reported deaths will decline to 20 on January 1, 2022 (Figure 22).
- Under our reference scenario, our model projects 390,000 cumulative excess deaths due to COVID-19 on January 1. This represents 11,000 additional deaths from September 27 to January 1 (Figure 22).
- If universal mask coverage (95%) were attained in the next week, our model projects 770 fewer cumulative reported deaths compared to the reference scenario on January 1.
• Under our **worse scenario**, our model projects 151,000 cumulative reported deaths on January 1, an additional 5,100 deaths compared to our reference scenario. Daily reported deaths in the **worse scenario** will decline to 50 by October 21, 2021 (Figure 22).

• Daily infections in the **reference scenario** will decline to 8,810 on January 1, 2022 (Figure 23). Daily infections in the **worse scenario** will rise to 150,520 on January 1, 2022 (Figure 23).

• Daily cases in the **reference scenario** will decline to 580 on January 1, 2022 (Figure 24). Daily cases in the **worse scenario** will decline to 1,560 by October 8, 2021 (Figure 24).

• Daily hospital census in the **reference scenario** will decline to 1,530 on January 1, 2022 (Figure 25). Daily hospital census in the **worse scenario** will decline to 4,020 by October 20, 2021 (Figure 25).

• Figure 26 compares our reference scenario forecasts to other publicly archived models. Forecasts are widely divergent.

• At some point from September through January 1, Indonesia will have moderate stress on intensive care unit (ICU) capacity (Figure 28).
Model updates

We have revised the number of reported deaths for Mexican states as well as the Russian Federation away from numbers derived from routine surveillance to those sourced from national cause of death registries. In these two countries, we have seen substantial differences between reported deaths and those assigned to COVID through the death certification review process. Given that deaths recorded in cause of death registries neither span the total time series nor provide daily values, but monthly, we have made the following assumptions to compute a new time series: (a) that the pattern in daily deaths in the cause of death data follows the patterning present in the daily reported series for days within a given month, and (b) that the ratio of monthly reported deaths to monthly deaths registered in cause of death analysis is constant from the last common time period to today. The total excess death estimate is not affected by this change to the reported time series.


Figure 1. Daily COVID-19 hospital census and infections

Figure 2. Reported daily COVID-19 cases, moving average
Table 1. Ranking of excess deaths due to COVID-19 among the leading causes of mortality this week, assuming uniform deaths of non-COVID causes throughout the year

<table>
<thead>
<tr>
<th>Cause name</th>
<th>Weekly deaths</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>6,372</td>
<td>1</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>4,718</td>
<td>2</td>
</tr>
<tr>
<td>COVID-19</td>
<td>2,602</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>2,045</td>
<td>4</td>
</tr>
<tr>
<td>Cirrhosis and other chronic liver diseases</td>
<td>1,705</td>
<td>5</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1,472</td>
<td>6</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>1,379</td>
<td>7</td>
</tr>
<tr>
<td>Diarrheal diseases</td>
<td>1,146</td>
<td>8</td>
</tr>
<tr>
<td>Hypertensive heart disease</td>
<td>973</td>
<td>9</td>
</tr>
<tr>
<td>Tracheal, bronchus, and lung cancer</td>
<td>951</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 3. Smoothed trend estimate of reported daily COVID-19 deaths (blue) and excess daily deaths due to COVID-19 (orange)
Figure 4. Daily COVID-19 death rate per 1 million on September 27, 2021

A. Daily reported COVID-19 death rate per 1 million

B. Daily excess COVID-19 death rate per 1 million
**Figure 5.** Cumulative COVID-19 deaths per 100,000 on September 27, 2021

**A. Reported cumulative COVID-19 deaths per 100,000**

**B. Excess cumulative COVID-19 deaths per 100,000**
**Figure 6.** Estimated percent of the population infected with COVID-19 on September 27, 2021

**Figure 7.** Mean effective R on September 16, 2021. Effective R less than 1 means that transmission should decline, all other things being held the same. The estimate of effective R is based on the combined analysis of deaths, case reporting, and hospitalizations where available. Current reported cases reflect infections 11-13 days prior, so estimates of effective R can only be made for the recent past.
Figure 8. Percent of COVID-19 infections detected. This is estimated as the ratio of reported daily COVID-19 cases to estimated daily COVID-19 infections based on the SEIR disease transmission model. Due to measurement errors in cases and testing rates, the infection-detection rate can exceed 100% at particular points in time.
Figure 9. Estimated percent of circulating SARS-CoV-2 for primary variant families on September 27, 2021

A. Estimated percent Alpha variant

B. Estimated percent Beta variant
C. Estimated percent Delta variant

D. Estimated percent Gamma variant
**Figure 10.** Infection-fatality rate on September 27, 2021. This is estimated as the ratio of COVID-19 deaths to estimated daily COVID-19 infections.
### Critical drivers

**Table 2. Current mandate implementation**

| Country                  | Primary school closure | Secondary school closure | Higher school closure | Borders closed to any non-resident | Borders closed to all non-residents | Individual movements restricted | Curfew for businesses | Individual curfew | Gathering limit: 6 indoor, 10 outdoor | Gathering limit: 10 indoor, 25 outdoor | Gathering limit: 25 indoor, 50 outdoor | Gathering limit: 50 indoor, 100 outdoor | Gathering limit: 100 indoor, 250 outdoor | Restaurants closed | Bars closed | Restaurants / bars curbside only | Restaurants / bars closed | Restaurants / bars curbside only | Restaurants / bars closed | Restaurants / bars curbside only | Gyms, pools, other leisure closed | Non-essential retail closed | Non-essential workplaces closed | Non-essential retail closed | Non-essential workplaces closed | Stay home order | Stay home fine | Mask mandate | Mask mandate fine |
|-------------------------|------------------------|--------------------------|-----------------------|-----------------------------------|-----------------------------------|-----------------------------------|------------------------|-------------------|---------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|----------------------|----------------|-----------------------------|-------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|---------------------|----------------|---------------|---------------------|
Figure 11. Trend in mobility as measured through smartphone app use, compared to January 2020 baseline

Figure 12. Mobility level as measured through smartphone app use, compared to January 2020 baseline (percent) on September 27, 2021
Figure 13. Trend in the proportion of the population reporting always wearing a mask when leaving home.

Figure 14. Proportion of the population reporting always wearing a mask when leaving home on September 27, 2021.
**Figure 15.** Trend in COVID-19 diagnostic tests per 100,000 people

![Trend in COVID-19 diagnostic tests per 100,000 people](image)

**Figure 16.** COVID-19 diagnostic tests per 100,000 people on September 27, 2021

![COVID-19 diagnostic tests per 100,000 people on September 27, 2021](image)
Table 3. Estimates of vaccine efficacy for specific vaccines used in the model at preventing disease and infection. The SEIR model uses variant-specific estimates of vaccine efficacy at preventing symptomatic disease and at preventing infection. We use data from clinical trials directly, where available, and make estimates otherwise. More information can be found on our website.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Efficacy at preventing disease: ancestral and Alpha</th>
<th>Efficacy at preventing infection: ancestral and Alpha</th>
<th>Efficacy at preventing disease: Beta, Delta, &amp; Gamma</th>
<th>Efficacy at preventing infection: Beta, Delta, &amp; Gamma</th>
</tr>
</thead>
<tbody>
<tr>
<td>AstraZeneca</td>
<td>90%</td>
<td>52%</td>
<td>85%</td>
<td>49%</td>
</tr>
<tr>
<td>CoronaVac</td>
<td>50%</td>
<td>44%</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>Covaxin</td>
<td>78%</td>
<td>69%</td>
<td>68%</td>
<td>60%</td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>86%</td>
<td>72%</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td>Moderna</td>
<td>94%</td>
<td>89%</td>
<td>94%</td>
<td>80%</td>
</tr>
<tr>
<td>Novavax</td>
<td>89%</td>
<td>79%</td>
<td>79%</td>
<td>69%</td>
</tr>
<tr>
<td>Pfizer/BioNTech</td>
<td>94%</td>
<td>86%</td>
<td>85%</td>
<td>78%</td>
</tr>
<tr>
<td>Sinopharm</td>
<td>73%</td>
<td>65%</td>
<td>63%</td>
<td>56%</td>
</tr>
<tr>
<td>Sputnik-V</td>
<td>92%</td>
<td>81%</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Tianjin</td>
<td>66%</td>
<td>58%</td>
<td>57%</td>
<td>50%</td>
</tr>
<tr>
<td>CanSino</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other vaccines</td>
<td>75%</td>
<td>66%</td>
<td>65%</td>
<td>57%</td>
</tr>
<tr>
<td>Other vaccines (mRNA)</td>
<td>91%</td>
<td>86%</td>
<td>85%</td>
<td>78%</td>
</tr>
</tbody>
</table>
Figure 17. Percent of the population (A) having received at least one dose and (B) fully vaccinated against SARS-CoV-2 by September 27, 2021

A. Percent of the population having received one dose of a COVID-19 vaccine

B. Percent of the population fully vaccinated against SARS-CoV-2
**Figure 18.** Trend in the estimated proportion of the population that is 12 years and older that has been vaccinated or would probably or definitely receive the COVID-19 vaccine if available. Note that vaccine acceptance is calculated using survey data from the 18+ population.

![Graph showing trend in vaccine acceptance](image)

**Figure 19.** Estimated proportion of the population that is 12 years and older that has been vaccinated or would probably or definitely receive the COVID-19 vaccine if available. Note that vaccine acceptance is calculated using survey data from the 18+ population.

![Map showing estimated vaccine acceptance](image)
**Figure 20.** Percent of people who receive at least one dose of a COVID-19 vaccine and those who are fully vaccinated

**Figure 21.** Percentage of people who are immune to non-escape variants and the percentage of people who are immune to escape variants
Projections and scenarios

We produce three scenarios when projecting COVID-19. The reference scenario is our forecast of what we think is most likely to happen:

- Vaccines are distributed at the expected pace. Brand- and variant-specific vaccine efficacy is updated using the latest available information from peer-reviewed publications and other reports.
- Future mask use is the mean of mask use over the last 7 days.
- Mobility increases as vaccine coverage increases.
- Governments adapt their response by re-imposing social distancing mandates for 6 weeks whenever daily deaths reach 8 per million, unless a location has already spent at least 7 of the last 14 days with daily deaths above this rate, and not yet re-imposed social distancing mandates. In this case, the reference scenario assumes that mandates are re-imposed when daily deaths reach 15 per million.
- Variants Alpha, Beta, Gamma, and Delta continue to spread regionally and globally from locations with sufficient transmission.

The worse scenario modifies the reference scenario assumption in four ways:

- 100% of vaccinated individuals stop using masks.
- Mobility increases in all locations to 25% above the pre-pandemic winter baseline, irrespective of vaccine coverage.
- Governments are more reluctant to re-impose social distancing mandates, waiting until the daily death rate reaches 15 per million, unless a location has already spent at least 7 of the last 14 days with daily deaths above this rate, and not yet re-imposed social distancing mandates. In this case, the reference scenario assumes that mandates are re-imposed when daily deaths reach 38 per million. In either case, we assume social distancing mandates remain in effect for 6 weeks.
- Variants Alpha, Beta, Gamma, and Delta spread between locations twice as fast when compared with our reference scenario.

The universal masks scenario makes all the same assumptions as the reference scenario but assumes all locations reach 95% mask use within 7 days.
Figure 22. Daily COVID-19 deaths until January 01, 2022 for three scenarios

A. Reported daily COVID-19 deaths per 100,000

B. Excess daily COVID-19 deaths per 100,000
**Figure 23.** Daily COVID-19 infections until January 01, 2022 for three scenarios

**Figure 24.** Daily COVID-19 reported cases until January 01, 2022 for three scenarios
Figure 25. Daily COVID-19 hospital census until January 01, 2022 for three scenarios

- **Reference scenario**
- **Universal mask use**
- **Worse**
**Figure 26.** Comparison of reference model projections with other COVID modeling groups. For this comparison, we are including projections of daily COVID-19 deaths from other modeling groups when available, last model update in brackets: Delphi from the Massachusetts Institute of Technology (Delphi) [September 22, 2021], Imperial College London (Imperial) [September 9, 2021], The Los Alamos National Laboratory (LANL) [September 19, 2021], the SI-KJalpha model from the University of Southern California (SIKJalpha) [September 22, 2021]. Daily deaths from other modeling groups are smoothed to remove inconsistencies with rounding. Regional values are aggregates from available locations in that region.
Figure 27. The estimated inpatient hospital usage is shown over time. The percent of hospital beds occupied by COVID-19 patients is color-coded based on observed quantiles of the maximum proportion of beds occupied by COVID-19 patients. Less than 5% is considered low stress, 5-9% is considered moderate stress, 10-19% is considered high stress, and 20% or greater is considered extreme stress.
Figure 28. The estimated intensive care unit (ICU) usage is shown over time. The percent of ICU beds occupied by COVID-19 patients is color-coded based on observed quantiles of the maximum proportion of ICU beds occupied by COVID-19 patients. Less than 10% is considered low stress, 10-29% is considered moderate stress, 30-59% is considered high stress, and 60% or greater is considered extreme stress.
More information

Data sources:
Mask use and vaccine confidence data are from the The Delphi Group at Carnegie Mellon University and University of Maryland COVID-19 Trends and Impact Surveys, in partnership with Facebook. Mask use data are also from Premise, the Kaiser Family Foundation, and the YouGov COVID-19 Behaviour Tracker survey.
Genetic sequence and metadata are primarily from the GISAID Initiative. Further details available on the COVID-19 model FAQ page.

A note of thanks:
We wish to warmly acknowledge the support of these and others who have made our COVID-19 estimation efforts possible.

More information:
For all COVID-19 resources at IHME, visit http://www.healthdata.org/covid.
To download our most recent results, visit our Data downloads page.