COVID-19 Results Briefing

Indonesia

July 22, 2021

This document contains summary information on the latest projections from the IHME model on COVID-19 in Indonesia. The model was run on July 20, 2021, with data through July 19, 2021.

Current situation

Cases and deaths are increasing in Indonesia due to low mask wearing, high mobility, low vaccination coverage, and the introduction of the Delta variant.

Taking into account vaccination rates and the vaccines efficacies against the Delta variant, along with the 26% of the population having been previously infected and the partial protection past infection gives against the Delta variant, we estimate that only 45% of the population is currently immune to the Delta variant. This number, due mostly to the ongoing Delta surge, will increase to 58% immune by November 1. Our model projects about 225,000 cumulative reported deaths due to COVID-19 on November 1. This represents about 151,000 additional deaths from July 19 to November 1. Daily reported deaths will rise to about 2,570 by August 17, 2021. If universal mask coverage (95%) were attained in the next week, our model projects about 25,000 fewer cumulative reported deaths compared to the reference scenario on November 1.

We believe there are three main strategies to respond to the Delta surge that each state should consider. First, every effort should be taken to reduce vaccine hesitancy and increase vaccination coverage. This likely should include targeting communities where vaccine hesitancy is high for messaging, outreach, and enhanced access. Second, mask mandates for both the unvaccinated and vaccinated should be considered in communities with rapid increases in transmission. Third, enhanced surveillance of transmission is needed to track the epidemic, including in the vaccinated. Reporting of data on deaths, hospitalizations, and cases by vaccine status should be implemented in every state to help track the evolution of the epidemic and the role of immune escape in ongoing transmission.

- Daily reported cases in the last week (through July 19) increased to about 49,200 per day on average compared to about 36,300 the week before (Figure 1).
- Reported deaths due to COVID-19 in the last week increased to about 1,000 per day on average compared to about 860 the week before (Figure 2).
- Excess deaths due to COVID-19 in the last week increased to about 2,800 per day on average compared to about 2,300 the week before (Figure 2). This makes COVID-19 the number 1 cause of death in Indonesia this week (Table 1). Estimated excess daily deaths due to COVID-19 were 2.7 times larger than the reported number of deaths.
- The daily reported COVID-19 death rate is greater than 4 per million (Figure 3).
The daily rate of excess deaths due to COVID-19 is greater than 4 per million (Figure 3).

We estimated that 26% of people in Indonesia have been infected as of July 19 (Figure 5).

Effective R, computed using cases, hospitalizations, and deaths, was 1.25 on July 8 (Figure 6).

The infection-detection rate in Indonesia was close to 7% on July 19 (Figure 7).

Based on the GISAID and various national databases, combined with our variant spread model, we estimate the current prevalence of variants of concern (Figure 8). We estimate that B.1.617 is circulating in the country.

Trends in drivers of transmission

Mobility last week was 22% lower than the pre-COVID-19 baseline (Figure 10).

As of July 19, in the COVID-19 Trends and Impact Survey, 77% of people self-report that they always wore a mask when leaving their home, unchanged from last week (Figure 12).

There were 33 diagnostic tests per 100,000 people on July 19 (Figure 14).

In Indonesia 74.3% of people say they would accept or would probably accept a vaccine for COVID-19. This is down by 0.7 percentage points from last week. The fraction of the population who are open to receiving a COVID-19 vaccine in the region ranges from 58% in Maldives to 87% in Thailand (Figure 18).

In our current reference scenario, we expect that about 94 million people will be vaccinated by November 1 (Figure 19).

In our current reference scenario, we expect that by November 1, 72% of people will be immune to non-escape variants and 58% of people will be immune to escape variants (Figure 20).

Projections

In our reference scenario, which represents what we think is most likely to happen, our model projects about 225,000 cumulative reported deaths due to COVID-19 on November 1. This represents about 151,000 additional deaths from July 19 to November 1. Daily reported deaths will rise to about 2,570 by August 17, 2021 (Figure 21).

Under our reference scenario, our model projects about 604,000 cumulative excess deaths due to COVID-19 on November 1. This represents about 404,000 additional deaths from July 19 to November 1. Daily excess deaths due to COVID-19 will rise to about 6,890 by August 17, 2021 (Figure 21).
• If universal mask coverage (95%) were attained in the next week, our model projects about 25,000 fewer cumulative reported deaths compared to the reference scenario on November 1.

• If universal mask coverage (95%) were attained in the next week, our model projects about 68,000 fewer cumulative excess deaths due to COVID-19 compared to the reference scenario on November 1.

• Under our worse scenario, our model projects about 243,000 cumulative reported deaths on November 1, an additional about 18,000 deaths compared to our reference scenario. Daily reported deaths in the worse scenario will rise to about 2,810 by August 18, 2021 (Figure 21).

• Under our worse scenario, our model projects about 650,000 cumulative excess deaths due to COVID-19 on November 1, an additional about 46,000 deaths compared to our reference scenario. Daily excess deaths due to COVID-19 in the worse scenario will rise to about 7,520 by August 18, 2021 (Figure 21).

• Daily infections in the reference scenario will rise to about 1,246,600 by July 24, 2021 (Figure 26). Daily infections in the worse scenario will rise to about 1,362,790 by July 25, 2021 (Figure 26).

• By November 1, we project that about 40,400 lives will be saved by the projected vaccine rollout. This does not include lives saved through vaccination that has already been delivered.

• Figure 23 compares our reference scenario forecasts to other publicly archived models. Forecasts are widely divergent.

• At some point from July through November 1, Indonesia will have high or extreme stress on its hospital beds and ICU capacity (Figures 24 and 25).
Model updates

Our mobility covariate that is used in the projections of COVID infections and deaths was updated to account for observed sustained levels of high mobility. Specifically, the mobility forecasts used in both the reference and universal mask coverage projection scenarios were adjusted upward according to vaccine uptake. This is equivalent to what was previously used in the worse projection scenario. To produce vaccine-adjusted mobility forecasts, we assume that social distancing mandates decline exponentially with respect to increasing vaccine uptake such that all mandates are lifted 30 days after vaccine coverage reaches 75%. In locations where vaccine uptake is already high, projected mandates are ramped down linearly from the current value to the vaccine-adjusted value over a 30-day period. As a final change, for locations whose last day of data indicates mobility levels above baseline (defined as average mobility during the period 1/3/2020 to 2/6/2020), we no longer cap forecasted mobility at zero. The variant spread model was updated to allow for spread to have occurred in the past in locations with some variant surveillance when there was little to no sequence data to confirm or reject the potential invasion.
Figure 1. Reported daily COVID-19 cases

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>COVID-19</td>
<td>19,482</td>
<td>1</td>
</tr>
<tr>
<td>Stroke</td>
<td>6,372</td>
<td>2</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>4,718</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 2. Smoothed trend estimate of reported daily COVID-19 deaths (blue) and excess daily deaths due to COVID-19 (orange)
**Figure 3.** Daily COVID-19 death rate per 1 million on July 19, 2021

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

B. Daily excess COVID-19 death rate per 1 million
Figure 4. Cumulative COVID-19 deaths per 100,000 on July 19, 2021

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

B. Excess cumulative COVID-19 deaths per 100,000
**Figure 5.** Estimated percent of the population infected with COVID-19 on July 19, 2021

**Figure 6.** Mean effective R on July 8, 2021. 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. Effective R less than 1 means that transmission should decline, all other things being held the same.
Figure 7. 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 8. Estimated percent of circulating SARS-CoV-2 for primary variant families on July 19, 2021

A. Estimated percent B.1.1.7 variant

B. Estimated percent B.1.351 variant
C. Estimated percent B.1.617 variant

D. Estimated percent P.1 variant
Figure 9. Infection-fatality ratio on July 19, 2021
Critical drivers

Table 2. Current mandate implementation

| Countries            | Primary school closure | Secondary school closure | Higher school closure | Borders closed to any non-resident | Borders closed to all non-residents | Individual movements restricted | 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 | Curfew for businesses | Curfew for restaurants / bars | Restaurants / bars curbside only | G Yam, pools, other leisure | Gyms, pools, other leisure closed | Non-essential retail closed | Non-essential workplaces closed | Non-essential retail curbside only | Restaurants closed | Bars closed | Restaurants / bars closed | Restaurants / bars curbside only | Bars closed | Storm home order | Stay home fine | Stay home fine | Stay home order | Stay home fine | Stay home order | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fine | Stay home fin
Figure 10. Trend in mobility as measured through smartphone app use compared to January 2020 baseline

Figure 11. Mobility level as measured through smartphone app use compared to January 2020 baseline (percent) on July 19, 2021
Figure 12. Trend in the proportion of the population reporting always wearing a mask when leaving home.

Figure 13. Proportion of the population reporting always wearing a mask when leaving home on July 19, 2021.
**Figure 14.** Trend in COVID-19 diagnostic tests per 100,000 people

![Graph showing trend in COVID-19 diagnostic tests per 100,000 population from February 20 to August 21. The trend indicates a significant increase in tests from March 20 to May 20, followed by a gradual decrease.](image)

**Figure 15.** COVID-19 diagnostic tests per 100,000 people on July 19, 2021

![Map showing distribution of COVID-19 diagnostic tests across different countries on July 19, 2021. The map highlights varying test rates across regions with Indonesia, Myanmar, Thailand, Bangladesh, and India indicated.](image)
Figure 16. Increase in the risk of death due to pneumonia on February 1 compared to August 1
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: D614G &amp; B.1.1.7</th>
<th>Efficacy at preventing infection: D614G &amp; B.1.1.7</th>
<th>Efficacy at preventing disease: B.1.351, B.1.617, &amp; P.1</th>
<th>Efficacy at preventing infection: B.1.351, B.1.617, &amp; P.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>AstraZeneca</td>
<td>74%</td>
<td>52%</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>CoronaVac</td>
<td>50%</td>
<td>44%</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>Covaxin</td>
<td>78%</td>
<td>69%</td>
<td>62%</td>
<td>55%</td>
</tr>
<tr>
<td>Janssen</td>
<td>72%</td>
<td>72%</td>
<td>64%</td>
<td>56%</td>
</tr>
<tr>
<td>Moderna</td>
<td>94%</td>
<td>89%</td>
<td>83%</td>
<td>79%</td>
</tr>
<tr>
<td>Novavax</td>
<td>89%</td>
<td>79%</td>
<td>73%</td>
<td>64%</td>
</tr>
<tr>
<td>Pfizer/BioNTech</td>
<td>91%</td>
<td>86%</td>
<td>81%</td>
<td>77%</td>
</tr>
<tr>
<td>Sinopharm</td>
<td>73%</td>
<td>65%</td>
<td>47%</td>
<td>41%</td>
</tr>
<tr>
<td>Sputnik-V</td>
<td>92%</td>
<td>81%</td>
<td>73%</td>
<td>65%</td>
</tr>
<tr>
<td>Tianjin</td>
<td>66%</td>
<td>58%</td>
<td>53%</td>
<td>47%</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>60%</td>
<td>53%</td>
</tr>
<tr>
<td>Other vaccines (mRNA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>91%</td>
<td>86%</td>
<td>81%</td>
<td>77%</td>
</tr>
</tbody>
</table>
Figure 17. Trend in the estimated proportion of the adult (18+) population that have been vaccinated or would probably or definitely receive the COVID-19 vaccine if available.

Figure 18. This figure shows the estimated proportion of the adult (18+) population that has been vaccinated or would probably or definitely receive the COVID-19 vaccine if available.
**Figure 19.** Number of people who receive any vaccine and those who are effectively vaccinated and protected against disease, accounting for efficacy, loss to follow up for two-dose vaccines, partial immunity after one dose, and immunity after two doses

**Figure 20.** 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.
- 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 scenario assumes that mandates are re-imposed when daily deaths reach 15 per million.
- Variants B.1.1.7 (first identified in the UK), B.1.351 (first identified in South Africa), and P1 (first identified in Brazil) continue to spread from locations with (a) more than 5 sequenced variants, and (b) reports of community transmission, to adjacent locations following the speed of variant scale-up observed in the regions of the United Kingdom.
- In one-quarter of those vaccinated, mobility increases toward pre-COVID-19 levels.

The **worse scenario** modifies the reference scenario assumptions in three ways:

- First, it assumes that variants B.1.351 or P.1 begin to spread within three weeks in adjacent locations that do not already have B.1.351 or P.1 community transmission.
- Second, it assumes that all those vaccinated increase their mobility toward pre-COVID-19 levels.
- Third, it assumes that among those vaccinated, mask use starts to decline exponentially one month after completed vaccination.

The **universal masks scenario** makes all the same assumptions as the reference scenario but also assumes 95% of the population wear masks in public in every location.
Figure 21. Daily COVID-19 deaths until November 01, 2021 for three scenarios

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

B. Excess daily COVID-19 deaths per 100,000
**Figure 22.** Daily COVID-19 infections until November 01, 2021 for three scenarios

The graph shows three scenarios of daily COVID-19 infections until November 01, 2021. The scenarios include:

- **Reference scenario**
- **Universal mask use**
- **Worse**

The y-axis represents daily infections, while the x-axis represents the months from January 2020 to November 2021. The graph indicates a significant peak in infections during the summer months for the worst-case scenario, followed by a decline.
Figure 23. 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: Delphi from the Massachusetts Institute of Technology (Delphi), Imperial College London (Imperial), The Los Alamos National Laboratory (LANL), and the SI-KJalpha model from the University of Southern California (SIKJalpha). Daily deaths from other modeling groups are smoothed to remove inconsistencies with rounding. Regional values are aggregates from available locations in that region.
Figure 24. 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 25. 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.