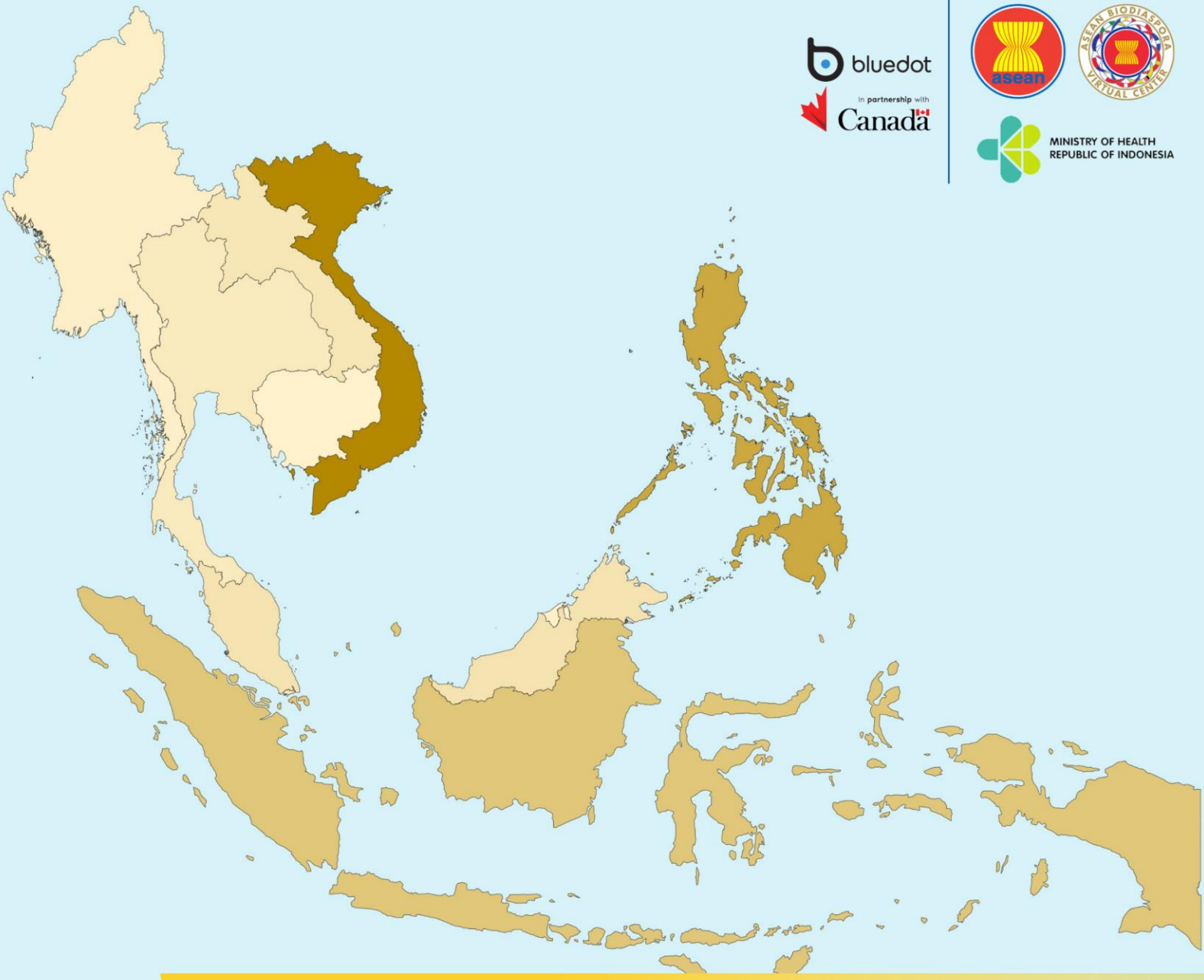

Situational Report in the ASEAN Region

ASEAN Biodiaspora Virtual Center (ABVC)

June 9, 2023 | Issue No. 494

ASSOCIATION OF SOUTHEAST ASIAN NATIONS

ASEAN BIODIASPORA VIRTUAL CENTER

MINISTRY OF HEALTH
REPUBLIC OF INDONESIA

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COVID-19: Highlights and Situation Overview

Global Update

- **Worldwide**, over 690 million cases and over 6 million deaths have been attributed to COVID-19.
- **US FDA:** A combination of oral nirmatrelvir and ritonavir tablets, marketed as Paxlovid, recently received full US Food and Drug Administration (FDA) approval for managing mild to moderate COVID-19 infections in adults who are at high risk of developing severe disease.[3] Paxlovid was previously granted Emergency Use Authorization in December 2021.[3] Children aged 12 to 18 years, who are not included under the antiviral drug's current approval, will still have access to Paxlovid which was made and packaged under the Emergency Use Authorization, as will adults, according to the FDA's statement.[3] Common adverse effects of the treatment include impaired taste and diarrhea.[3] In addition, Paxlovid's mechanism of action might interfere with the effects of some drugs.[3] Healthcare professionals should review Paxlovid's boxed warning and evaluate potential drug interactions when prescribing, the FDA noted.[3] [Full text]
- According to the **World Health Organization's (WHO)** weekly update, COVID-19 activity over the past month declined in all six world regions except for a few hot spots. Compared to the previous month, cases have dropped by 38% and deaths were down by 47%. Cases in the Western Pacific region has declined by 5% over the past 28 days except for two countries reporting rising case such as Australia and China. Elsewhere in the Western Pacific, the WHO said 13 of 35 reporting countries have noted increases over the past 4 weeks, with the highest proportional increases coming from Mongolia, Cambodia, and Laos. The WHO's Africa region had reported a slight rise in earlier weeks, and while cases are declining, a few countries still report rises, including Mauritius and Zimbabwe. WHO reported an update on the Omicron variants, stating that the proportion of XBB.1.5 subvariants is steadily decreasing, while a constellation of newer variants is rising in patterns that vary by world region. From the middle of April to the middle of May, the proportion of XBB.1.5 declined from 46.2% to 30.3% of sequences. The other variant of interest, XBB.1.16, rose from 10.2% to 16.8% over the past month. Meanwhile, levels of four variants under monitoring rose: XBB, XBB.1.9.1, XBB.1.9.2, and XBB.2.3. The WHO said that rising activity from some of the newer variants is coming with rises in hospitalizations and deaths in some countries, but at lower levels than earlier SARS-CoV-2 waves. The dominance of the various variants varies by region, with XBB.1.5 most common in Africa, the Americas, and Europe, and XBB.1.16 dominant in Southeast Asia. Elsewhere, XBB.1.9.1 is dominant in the Eastern Mediterranean region, and XBB.1.9.1 (22.7%) and XBB.1.5 (16.2%) make up the biggest proportion of viruses in the Western Pacific. The WHO stressed that the COVID-19 pandemic is not over and that people should continue to take measures to protect themselves, such as getting vaccinated, boosted, and wearing masks. [Full report]

Vaccine Update

- The **European Centre for Disease Prevention and Control (ECDC)** and the European Medicines Agency (EMA) today issued a joint statement that agrees with a recent World Health Organization (WHO) recommendation that COVID-19 vaccines be switched for the fall to a monovalent (single-strain) vaccine that contains an XBB lineage strain. The groups said though current vaccines are effective at preventing hospitalization, severe disease, and death, protection wanes over time as new SARS-CoV-2 variants emerge. They added that XBB strains are dominant in Europe and other parts of the world and that monovalent vaccines are a reasonable choice for providing protection against current and emerging strains. Also, the ECDC and EMA recommended simplified

recommendations for immunization campaigns in the fall, including a single dose for people older than 5 years, that revaccinations stick with a 3-month minimum interval, and that people with weakened immune systems may need extra doses based on national recommendations. [Full report]

Research Update (Published and peer-reviewed studies)

- As of May 7, 2023, CDC's Advisory Committee on Immunization Practices (ACIP) recommends that all children aged 6 months–5 years receive at least 1 age-appropriate bivalent mRNA COVID-19 vaccine dose.[4] Initial vaccine safety findings after primary series vaccination among children aged 6 months–5 years showed that transient local and systemic reactions were common whereas serious adverse events were rare.[4] In this report, ***Safety Monitoring of mRNA COVID-19 Vaccine Third Doses Among Children Aged 6 Months–5 Years — United States, June 17, 2022–May 7, 2023,*** CDC characterized the safety of a third mRNA COVID-19 vaccine dose among children aged 6 months–5 years.[4] CDC reviewed adverse events and health surveys reported to v-safe, a voluntary smartphone-based U.S. safety surveillance system established by CDC to monitor health after COVID-19 vaccination, and the Vaccine Adverse Event Reporting System (VAERS), a U.S. passive vaccine safety surveillance system co-managed by CDC and the Food and Drug Administration (FDA).[4] This report provides findings from v-safe and VAERS for children aged 6 months–5 years who received a third dose of mRNA COVID-19 vaccine from June 17, 2022–May 7, 2023; during this period, approximately 559,495 third doses were administered to children in this age group.[4] The findings in this report are consistent with those from post-authorization safety surveillance of the first 2 doses of mRNA COVID-19 vaccines.[4] In v-safe, 38% of children had no reported reactions after a third dose; most reported reactions were mild and transient.[4] Vaccination errors accounted for 78% of events reported to the Vaccine Adverse Event Reporting System.[4] Findings after receipt of a third mRNA vaccine dose among young children were similar to those described after receipt of 1 and 2 doses; no new safety concerns were identified.[4] [Full text]

- This cross-sectional study, ***National Trends in Physical Activity Among Adults in South Korea Before and During the COVID-19 Pandemic, 2009-2021***, described long-term trends in physical activity using the Korea Community Health Survey, a nationally representative survey in South Korea covering 2009 to 2021.[5] The trend of sufficient aerobic physical activity was measured by prevalence and mean the metabolic equivalent of task (MET) score based on World Health Organization physical activity guidelines and defined as 600 MET-min/wk or greater.[5] The variables included age, sex, body mass index (BMI), region of residence, education level, income level, smoking status, alcohol consumption level, stress status, physical activity level, and history of diabetes, hypertension, and depression.[5] Among 2,748,585 Korean adults (738,934 aged 50-64 years [29.1%] and 657,560 aged 65 years [25.9%]; 1,178,869 males [46.4%]), the prevalence of sufficient physical activity did not change significantly during the pre-pandemic period (β difference, 1.0; 95% CI, 0.6 to 1.4).[5] During the pandemic, the prevalence of sufficient physical activity decreased significantly, from 36.0% (95% CI, 35.9% to 36.1%) in 2017 to 2019 to 30.0% (95% CI, 29.8% to 30.2%) in 2020 and 29.7% (95% CI, 29.5% to 29.9%) in 2021.[5] Trends showed decreases in the prevalence of sufficient physical activity among older adults (ages 65 years) and younger adults (ages 19 to 29 years) during the pandemic.[5] In particular, the trend of sufficient physical activity declined during the pandemic in females, individuals in urban residences, healthy participants, and individuals at increased risk of stress (eg, history of a depressive episode).[5] Total mean MET score decreased from the 2017 to 2019 period (1579.1 MET-min/wk) to the 2020 to 2021 period (1191.9 MET-min/wk).[5] This cross-sectional study found that the national prevalence of physical activity was stable or consistent before the pandemic period, with a marked decrease during the pandemic, particularly among

healthy individuals and subgroups at increased risk of negative outcomes, including older adults, females, urban residents, and those with depressive episodes.[5] [Full text]

- The study ***Patterns in Child Health Outcomes Before and After the COVID-19 Outbreak in India*** found that COVID-19 took a small but significant toll on children's health in India, with a higher newborn death rate, less consumption of solid or semisolid foods, and lower rates of physical growth.[6] Researchers from Korea University and Harvard University estimated the status of 26 health indicators among 125,812 children pre-pandemic (June 17, 2019, to February 29, 2020) and after it began (March 1, 2020, to May 20, 2021).[6] After the pandemic began, there was a slight but significant increase in the newborn death rate (0.49 percentage points), a decline in feeding and nutrition (4.22-percentage-point reduction in solid or semisolid food intake), and an increase in physical growth (1.87-percentage-point increase in underweight).[6] The greatest decline was seen in vaccination rates, with 7.74- and 6.51-percentage-point reductions in receipt of the first dose of diphtheria, pertussis, and tetanus (DPT) and polio vaccines, respectively.[6] Other indicators, many related to health services, either stayed the same or improved slightly.[6] Rates of diarrhea and respiratory infection improved, and the study authors said those findings could be due to the promotion of interpersonal hygiene to quell viral transmission.[6] According to the authors, the government's initiative may explain the relatively constant or minimally worsened patterns in child nutrition status before and after the outbreak as well as underscore the need to sustain relief programs in non-pandemic times to promote children's health.[6] [Full text]

ASEAN Travel Advisories (new update/s)

as of 09 June 2023

ASEAN Country	Published	Foreign travelers allowed	COVID-19 vaccination requirement	Required COVID-19 testing for fully vaccinated	Required COVID-19 testing for NOT fully vaccinated	Quarantine upon arrival	Health insurance requirement	Arrival health declaration/ registration/ documents
Brunei Darussalam	December 1, 2022	Yes	No	No	No	No	No	No
Cambodia	October 6, 2022	Yes	No	No	No	No	No	No
Indonesia	May 3, 2023	Yes	Yes – fully vaccinated* certificate for 18 years old and above for non-Indonesian nationals.	No, but may be subject to RT-PCR upon arrival	Foreign travelers who are not fully vaccinated may not be allowed to enter Indonesia or may be subjected to an RT-PCR test upon arrival	No	No	Traveler is required to download and register at the SatuSehat app (Android/ iOS) before departure.
Laos	December 29, 2022	Yes	No	No	No	No	No	No
Malaysia	August 2, 2022	Yes	No	No	No	No	No	No
Myanmar	April 3, 2023	Yes	Yes – printed fully vaccinated* certificate for 12 years old and above.	Passengers are subject to medical screening and could be subject to a test upon arrival.	Printed negative COVID-19 RT-PCR test result in English, issued at most 48 hours before arrival.	No	Printed COVID-19 medical insurance.	Passengers must present a Health Declaration Form upon arrival.
Philippines	March 30, 2023	Yes	Yes – fully vaccinated* with booster dose certificate for 15 years old and above.	No	Yes – COVID-19 rapid antigen test upon arrival.	No	No	Traveler is required to download and register an E-arrival card at most 3 days before departure for those without a visa.
Singapore	February 13, 2023	Yes	No	No	No	No	No	No
Thailand	March 1, 2023	Yes	No	No	No	No	No	No
Vietnam	May 16, 2022	Yes	No	No	No	No	No	No

- Reference: IATA Travel Centre
- *Fully vaccinated – at least 14 or 15 days from 2nd dose for a two-dose vaccine or 14 or 15 days from a single-dose vaccine upon arrival.

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Cases and Deaths as of 09 June 2023

- As of 09 June 2023 (1PM, GMT+7), worldwide, there were **690,077,803** confirmed cases, including **6,889,508** deaths. Globally, Case Fatality Rate (CFR) was **1.0%.**
- **36,214,911 confirmed cases** of COVID-19 have been reported in the **ASEAN Region**.
- The Case Fatality Rate in the **ASEAN** Region is range between **0.1 to 3.1%**

COVID-19 cases in ASEAN region

REGION	COUNTRY	FIRST CONFIRMED CASE(S)	LATEST REPORT ON CONFIRMED CASE(S)	TOTAL CONFIRMED CASES	NEW CASES	TOTAL DEATHS	NEW DEATHS	CUMULATIVE CASES/ 100,000	CUMULATIVE VACCINATED	CUMULATIVE FULLY VACCINATED	CUMULATIVE BOOSTERED	FULLY VACCINATED/ 100
ASEAN REGION	Brunei Darussalam	10 Mar 20	08-Jun-23	307,686	-	225	-	64,053	450,404	445,929	338,987	99.3
	Cambodia	27 Jan 20	08-Jun-23	138,836		3,056	-	841	15,244,858	14,609,937	10,433,215	87.1
	Indonesia	02 Mar 20	09-Jun-23	6,809,678	47	161,815	7	2,490	203,657,535	172,693,321	67,952,274	62.7
	Lao PDR	24 Mar 20	09-Jun-23	218,310	12	758	-	3,041	5,888,649	5,222,417		69.4
	Malaysia	25 Jan 20	04-Jun-23	5,104,772		37,100		15,788	28,125,245	27,536,657	17,056,957	81.1
	Myanmar	23 Mar 20	08-Jun-23	639,475	-	19,494	-	1,173	34,777,314	27,545,329	2,227,351	50.8
	Philippines	30 Jan 20	08-Jun-23	4,152,210		66,481	-	3,771	78,369,243	73,937,435	21,341,197	64.0
	Singapore	23 Jan 20	06-Jun-23	2,481,404	-	1,727	-	39,049	5,161,990	5,120,768	4,440,289	90.8
	Thailand	13 Jan 20	05-Jun-23	4,745,043	-	34,163	-	6,791	57,005,497	53,486,086	32,143,431	74.6
	Vietnam	23 Jan 20	09-Jun-23	11,617,497	227	43,206	-	11,950	90,450,881	85,848,363	57,452,750	87.4
	ASEAN COUNTRIES			**36,214,911**	**286**	**368,025**	**7**	**148,946**	**519,131,616**	**466,446,242**	**213,386,451**	

* No tests have been reported in the ASEAN Region in the last 14 days.

REGION	TOTAL CONFIRMED CASES	NEW CASES	TOTAL DEATHS	NEW DEATHS
ASIA	195,944,064	1,910	1,207,287	7
AFRICA	12,824,652		258,781	
AMERICAS	195,568,667		2,991,775	
EUROPE	249,525,509	160	2,063,640	2
TOTAL	**653,862,892**	**2,070**	**6,521,483**	**9**

**Data References: Andra Farm, Worldometer, DOH Philippines, and the WHO

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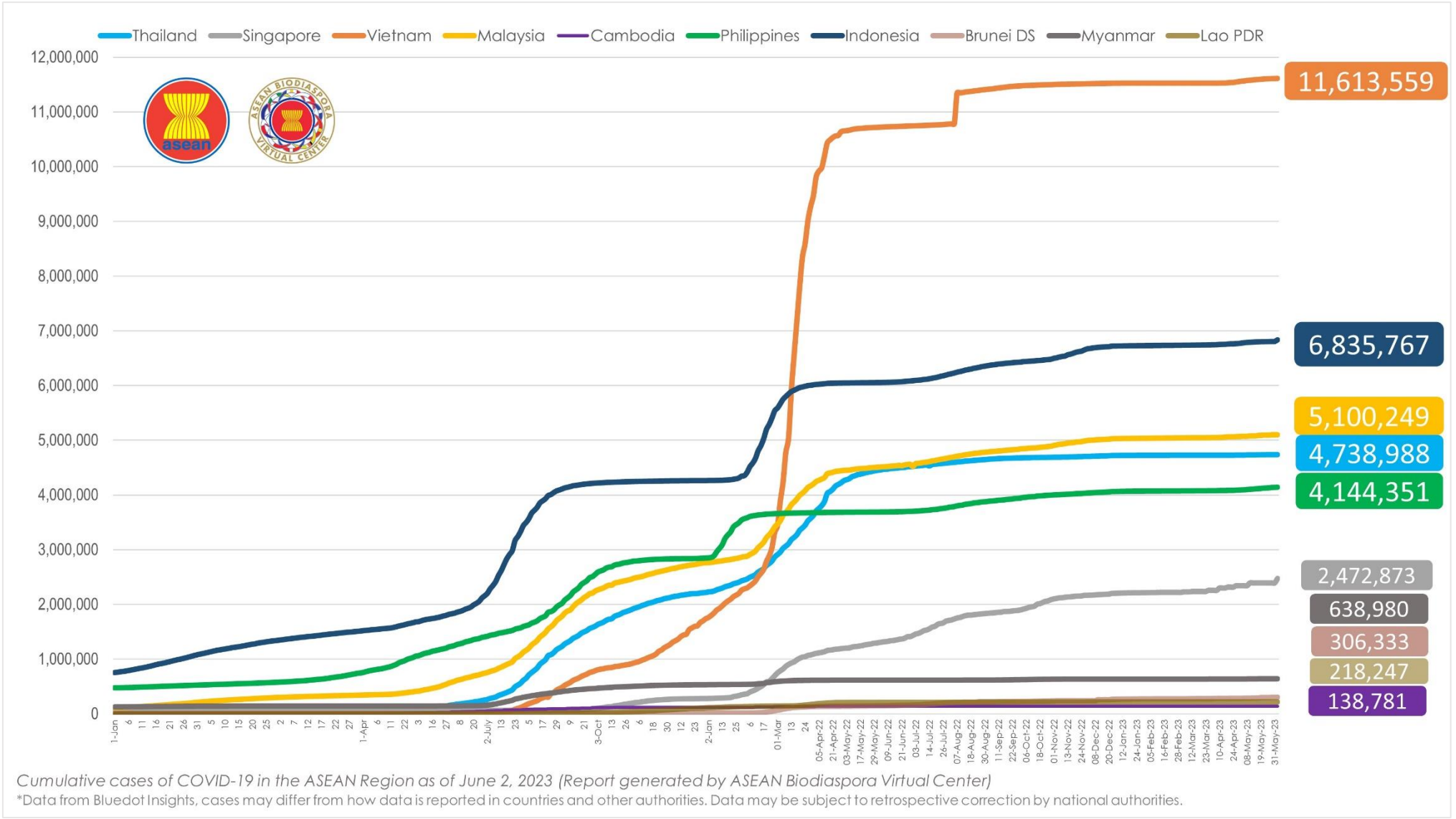
COVID-19 Epi curve among ASEAN Countries

From January 1, 2022, to June 2, 2023



Cumulative cases of COVID-19 in the ASEAN Region as of June 2, 2023 (Report generated by ASEAN Biodiaspora Virtual Center)

*Data from Bluedot Insights, cases may differ from how data is reported in countries and other authorities. Data may be subject to retrospective correction by national authorities.

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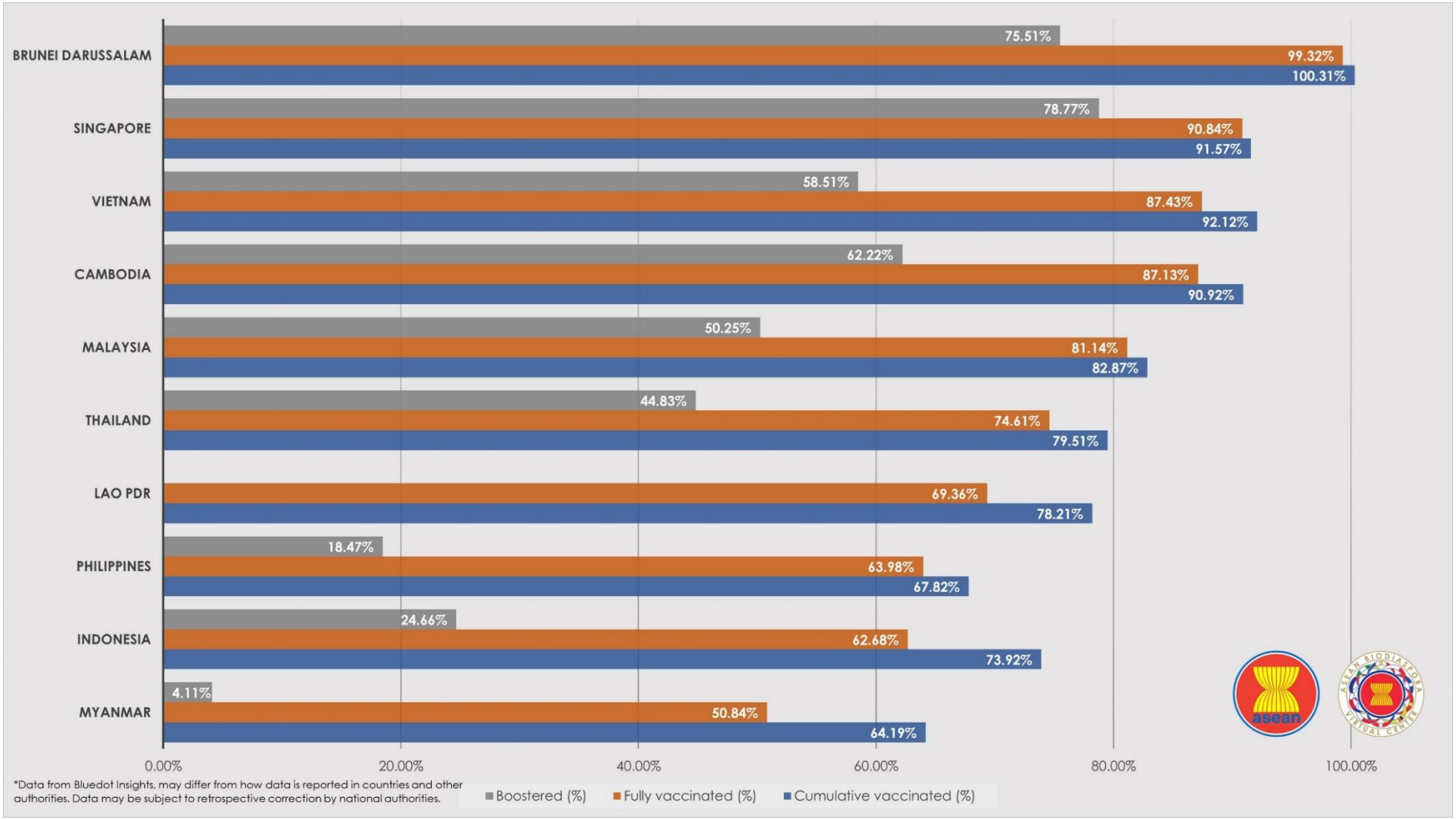
COVID-19 Vaccination Status in ASEAN

as of 09 March 2023



*Last update on COVID-19 vaccination status in ASEAN was on March 9, 2023.

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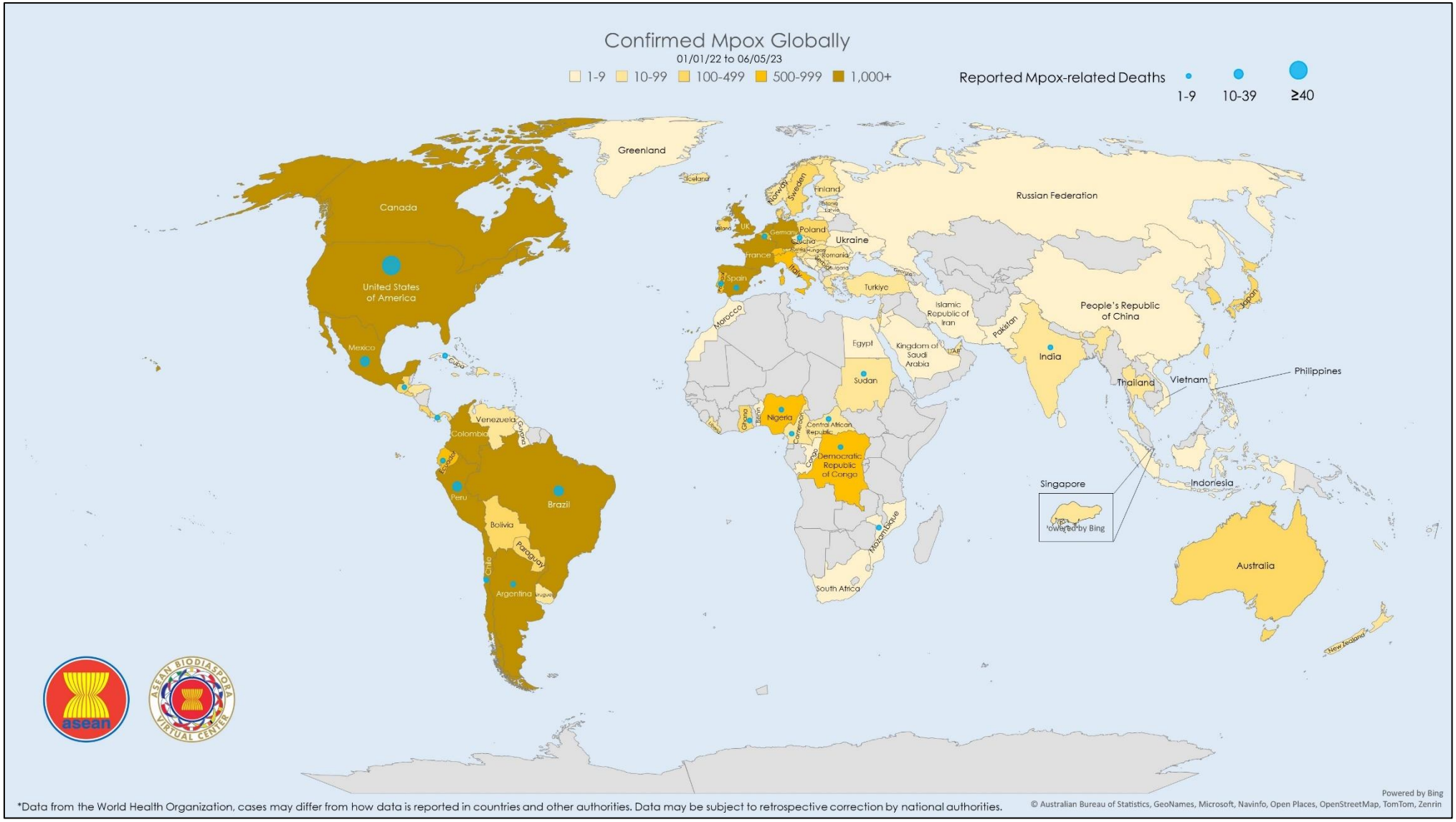
Mpox Cases Reported Globally

as of June 5, 2023



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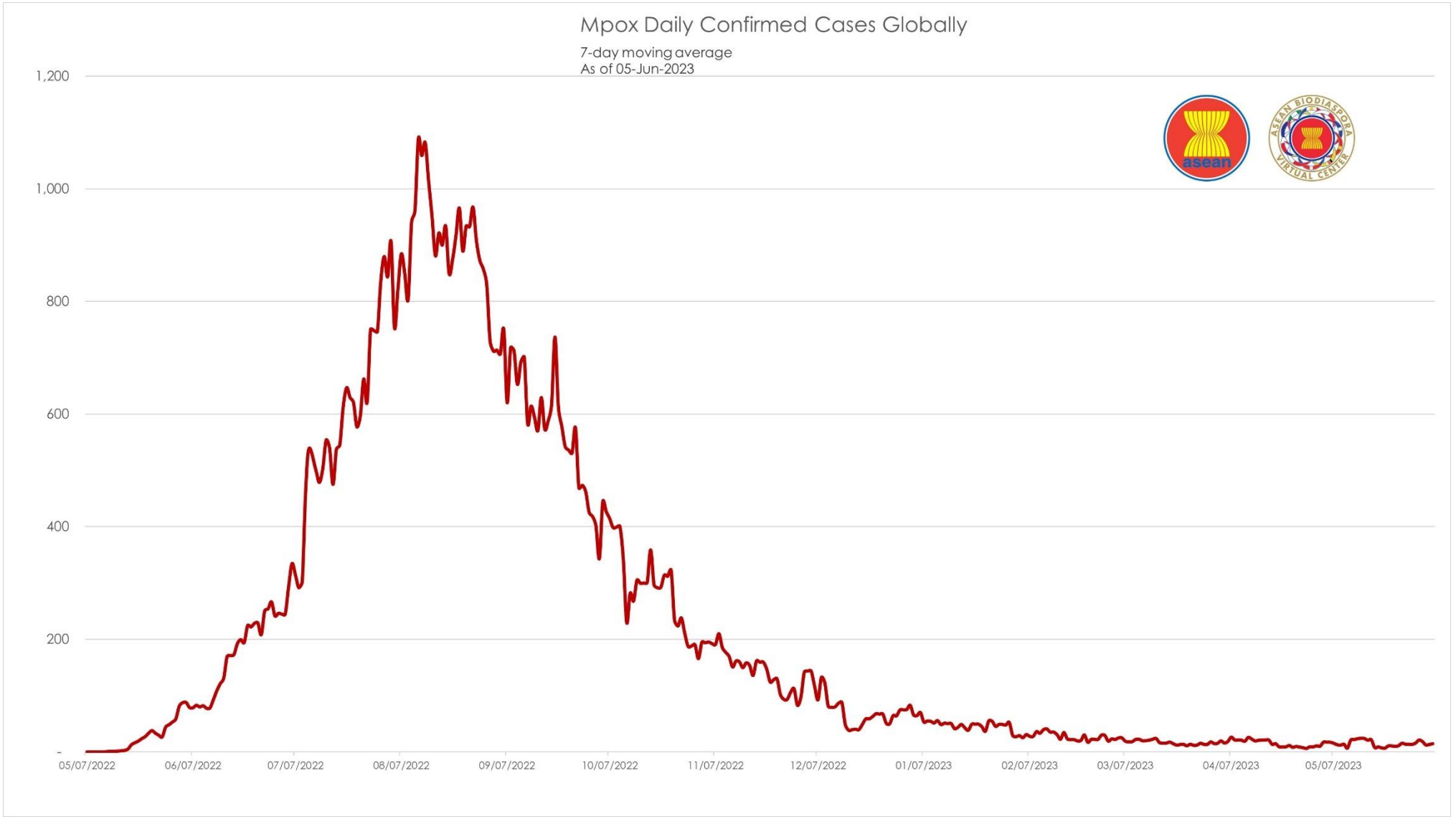
Mpox Daily Trend Globally

as of June 5, 2023



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Mpox: Highlights and Situation Overview

- As of 05 June 2023 (1PM, GMT+7), there were **87,928** confirmed cases worldwide, including **146** deaths. Globally, the Case Fatality Rate (CFR) was **0.17%.**
- **76 confirmed cases** in the ASEAN region, with a CFR of **0%.**
- **87,852 confirmed cases** of Mpox have been reported in other **5 regions** (other than the ASEAN region):

Mpox cases in the ASEAN region

Country	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
Indonesia	1	-	-	0.00%
Philippines	5	-	-	0.00%
Singapore	25	-	-	0.00%
Thailand	43	-	-	0.00%
Vietnam	2	-	-	0.00%
ASEAN Total	**76**	**-**	**-**	**0.00%**

Mpox cases in the Asia-Pacific region

Country/Territory	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
Australia	145	-	-	0.00%
India	22	-	1	4.55%
Japan	169	-	-	0.00%
New Caledonia	1	-	-	0.00%
New Zealand	41	-	-	0.00%
People's Republic of China*	8	-	-	0.00%
The Republic of China*	129	-	-	0.00%
The Republic of Korea*	102	-	-	0.00%
Sri Lanka	2	-	-	0.00%
Asia-Pacific Total	**619**	**-**	**1**	**0.16%**

*People's Republic of China – China, Hong Kong (SAR), and Macao (SAR); Republic of China – Taiwan, Republic of Korea – South Korea

Top 5 countries with the most mpox cases globally

Country	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
United States of America	30,243	-	42	0.14%
Brazil	10,948	-	16	0.15%
Spain	7,556	-	3	0.04%
France	4,146	-	-	0.00%
Colombia	4,090	-	-	0.00%

Mpox cases per region

REGION	TOTAL CONFIRMED CASES SINCE JANUARY 1, 2022	NEW CASES SINCE THE PREVIOUS REPORT	TOTAL DEATHS	CASE FATALITY RATE
AFRICA	1,828	-	21	1.15%
AMERICAS	59,371	-	117	0.20%
ASEAN	76	-	-	0.00%
ASIA PACIFIC	619	-	1	0.17%
EUROPE	25,632	-	7	0.03%
MIDDLE EAST	327	-	-	0.00%
TOTAL	**87,928**	**-**	**146**	**0.17%**

Research Update (Published and peer-reviewed studies)

- More than 30,000 monkeypox (mpox) cases were reported in the United States during the 2022 multinational outbreak; cases disproportionately affected gay, bisexual, and other men who have sex with men (MSM).[1] Substantial racial and ethnic disparities in incidence were reported.[1] The national mpox vaccination strategy emphasizes that efforts to administer the JYNNEOS mpox vaccine should be focused among the populations at elevated risk for exposure to mpox.[1] During May 2022–April 2023, a total of 748,329 first JYNNEOS vaccine doses (of the two recommended) were administered in the United States.[1] During the initial months of the outbreak, lower vaccination coverage rates among racial and ethnic minority groups were reported; however, after the implementation of initiatives developed to expand access to mpox vaccination,§ coverage among racial and ethnic minority groups increased.[1] This shortfall analysis, ***Progress Toward Equitable Mpox Vaccination Coverage: A Shortfall Analysis — United States, May 2022–April 2023***, examined whether the increase in mpox vaccination coverage was equitable across all racial and ethnic groups.[1] The shortfall was defined as the percentage of the vaccine-eligible population that did not receive the vaccine (i.e., 100% minus the percentage of the eligible population that did receive a first dose).[1] As of April 2023, two-thirds (approximately 66.0%) of mpox vaccine–eligible persons remained unvaccinated. The shortfall was largest among Black or African American (Black) persons (77.9%).[1] The largest monthly decreases in overall shortfall were in August (17.7%) and September (8.5%).[1] However, during these months, smaller shortfall reductions were achieved among Black persons (12.2% and 4.9%, respectively).[1] Vaccination coverage among racial and ethnic minority groups with the largest shortfalls needs to increase substantially to reduce disparities in vaccination coverage and increase health equity.[1] [Full text]

- From May 17–December 31, 2022, 125 probable or confirmed U.S. monkeypox (mpox)† cases were reported among patients aged <18 years, including 45 (36%) in children aged ≤12 years.[2] 83 cases in persons aged <18 years diagnosed during May 17–September 24, 2022, were previously described; 28 (34%) of these were in children aged ≤12 years, 29% of whom had no reported information on exposure.[2] Among 20 (71%) of 28 patients with documented information on exposure, most were exposed by household contact.[2] This report, ***Exposures to Mpox Among Cases in Children Aged ≤12 Years — United States, September 25– December 31, 2022***, updates the previous report using data collected during September 25–December 31, 2022, proposes possible mpox exposure routes in children aged ≤12 years, and describes three U.S. mpox cases in neonates.[2] From September 25–December 31, 2022, 17 children aged ≤12 years with probable or confirmed mpox were identified through national surveillance conducted by CDC.[2] Three of the 17 pediatric patients were aged ≤7 days and had likely perinatal exposures; all three

neonates were non-Hispanic Black or African American (Black).[2] Two of these three mpox cases in neonates were previously reported.[2] Ten of the remaining children were aged 0–4 years, and four children were aged 5–12 years.[2] Nine patients were boys, and five were girls; nine were Black, two were Hispanic or Latino, and three were non-Hispanic White.[2] Seven of the children aged 0–4 years, and two of those aged 5–12 years had known exposure to a person with mpox; in five cases, the exposure source was unknown.[2] Six of the seven children aged 0–4 years and both children aged 5–12 years known to be exposed to mpox were exposed by a caregiver or a household contact.[2] Five of nine children with known exposure to a person with mpox were reported to have had close physical contact; notably, four of five children aged 0–4 years had skin-to-skin contact.[2] Five of the nine children were exposed to a person with mpox who reported taking at least one precaution, including four persons who reported isolating.[2] Two of these household contacts reported sharing a bed, bedroom, or bathroom with the child.[2] Evidence suggests persons with mpox might transmit the virus up to 4 days before symptom onset; a review of children's case histories suggests that in at least three cases, the person with mpox (i.e., the exposure source) did not begin isolating until after had they received a diagnosis.[2] [Full text]

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