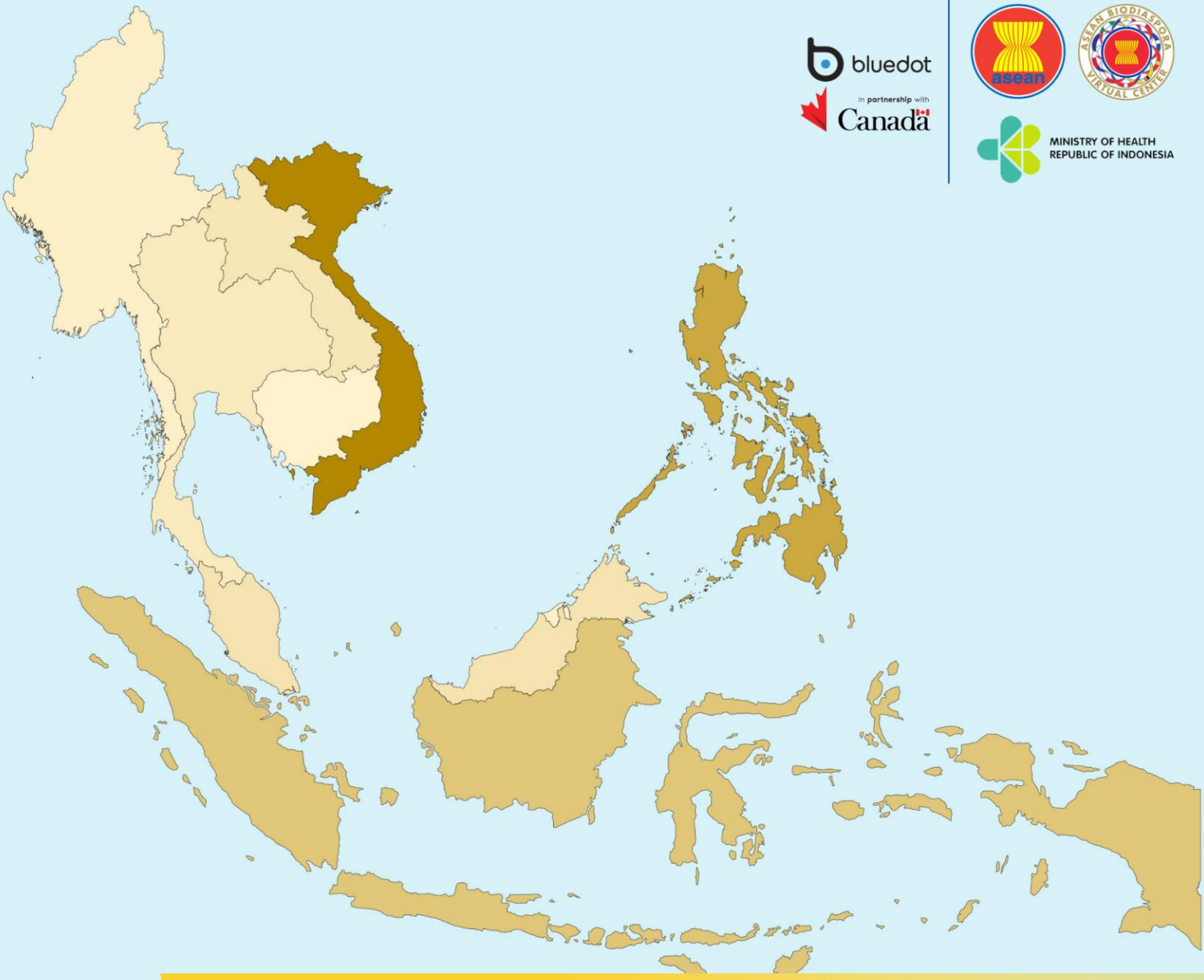

COVID-19, Mpox, and Travel Advisories

Situational Report in the ASEAN Region

ASEAN BioDiaspora Virtual Center (ABVC)

April 15, 2023 | Issue No. 471

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**, there have been over 685 million cases and over 6 million deaths attributed to COVID-19.

- **India** reported on April 14 (Friday) 11,109 new COVID-19 cases in the last 24 hours, the highest in 236 days.[1] This is the fifth consecutive day when a rise in COVID-19 cases was reported this week.[1] India reported 10,158 cases on Thursday and 7,830 on April12. According to the Union Health Ministry data updated on Friday, the country's active cases have now increased to 49,622.[1] [Full report]

  There has been an increase in the number of children aged less than 12 years contracting the virus in New Delhi. While these cases have mostly been mild, doctors caution parents of children with obesity, asthma and suffering from other immunocompromised conditions not to ignore the symptoms. There has been a significant increase in the number of children visiting pediatric OPDs with COVID-like symptoms and a rise in hospital admissions of children under two years suffering from adenovirus (quite similar to COVID-19). There is a thin line between these two viruses. It is difficult to know the difference between a common cold/fever/adenovirus and Covid-19 without a test. Dr Rahul Nagpal, director and head, pediatrics, Fortis Hospital, Vasant Kunj, said at least 10 children with COVID like symptoms were reporting to their OPD daily. Of these, 2-3 were testing positive for COVID-19 with home test (antigen self-tests). The cases were relatively mild and self-limiting. The symptoms among such children include fever, running nose and coughing. The condition improves in 48 hours and the fever also comes down in 2-3 days. Children should start wearing masks in school, he recommended. An infantile phenotype seems emerging: infants with high fever, cold, cough, and non-purulent, itchy conjunctivitis with sticky eyes, not seen in earlier waves.

Regional Update

- **Indonesia:** The Ministry of Health confirmed on April 13 (Thursday) that the country has detected two cases of Omicron XBB.1.16 based on the results of genome sequencing carried out in late March this year.[2] According to the ministry's spokesperson, there are two cases that have been reported to date, adding that the symptoms experienced by the patients are milder, thus, people must not panic over the presence of this new COVID-19 variant.[2] According to data from the COVID-19 Handling Task Force, the nation has recorded a total of 6,754,583 COVID-19 cases, 6,585,768 recoveries, and 161,096 deaths as of April 13, 2023.[2] [Full article]

- **Philippines:** Multiple cases of the Omicron XBB.1.9.1 subvariant of COVID-19 were reported by the Department of Health (DOH) from April 3 to 11.[3] According to DOH's latest biosurveillance report, a total of 54 cases of XBB.1.9.1 was reported in the country.[3] DOH added that current available evidence for XBB.1.9.1 does not suggest any differences in disease severity and/or clinical manifestations compared to the original Omicron variant.[3] [Full article]

Vaccine Update

- **Philippines**' Department of Health (DOH) announced that adult individuals are now eligible to receive second booster shots against COVID-19.[4] The move came after the Food and Drug Administration updated the emergency use authorization granted to COVID-19 vaccines and the Health Technology Assessment Council issued a positive

recommendation.[4] Initially, only health workers, immunocompromised individuals, and senior citizens were allowed to take their fourth vaccine shot.[4] DOH said that the administration of the second booster for the general population will initiate once the government releases the implementing guidelines.[4] [Full article]

Research Update (Published and peer-reviewed studies)

- This longitudinal cohort study, ***Risk factors and vectors for SARS-CoV-2 household transmission: a prospective, longitudinal cohort study***, assessed whether the presence of SARS-CoV-2 on frequently-touched surfaces and residents' hands was a predictor of SARS-CoV-2 household transmission.[7] During the pre-alpha (September to December 2020) and alpha (B.1.1.7; December 2020 to April 2021) SARS-CoV-2 variant waves, contacts from households exposed to newly diagnosed COVID-19 primary cases, in London, UK were recruited regardless of symptom status and serially tested for SARS-CoV-2 infection by RT-PCR on upper respiratory tract (URT) samples and, in a subcohort, by serial serology.[7] Contacts' hands, primary cases' hands, and frequently-touched surface-samples from communal areas were tested for SARS-CoV-2 RNA.[7] SARS-CoV-2 URT isolates from 25 primary case-contact pairs underwent whole-genome sequencing (WGS).[7] From Aug 1, 2020 until March 31, 2021, 620 contacts of PCR-confirmed SARS-CoV-2-infected primary cases were recruited.[7] 414 household contacts (from 279 households) with available serial URT PCR results were analysed in the full household contacts' cohort, and of those, 134 contacts with available longitudinal serology data and not vaccinated pre-enrolment were analysed in the serology subcohort.[7] Household infection rate was 28·4% (95% CI 20·8–37·5) for pre-alpha-exposed contacts and 51·8% (42·5–61·0) for alpha-exposed contacts (p=0·0047).[7] Primary cases' URT RNA viral load did not correlate with transmission, but was associated with detection of SARS-CoV-2 RNA on their hands (p=0·031).[7] SARS-CoV-2 detected on primary cases' hands, in turn, predicted contacts' risk of infection (adjusted relative risk [aRR]=1·70 [95% CI 1·24–2·31]), as did SARS-CoV-2 RNA presence on household surfaces (aRR=1·66 [1·09–2·55]) and contacts' hands (aRR=2·06 [1·57–2·69]).[7] In six contacts with an initial negative URT PCR result, hand-swab (n=3) and household surface-swab (n=3) PCR positivity preceded URT PCR positivity.[7] Presence of SARS-CoV-2 RNA on primary cases' and contacts' hands and on frequently-touched household surfaces associates with transmission, identifying these as potential vectors for spread in households.[7] [Full article]

- New-onset retinal vascular occlusion (RVO) occurring acutely after messenger RNA (mRNA) COVID-19 vaccination has been described in recent literature.[8] Because RVO can cause vision loss or blindness, an epidemiologic investigation evaluating this potential association is of great importance to public health.[8] This retrospective population-based cohort study, ***Risk of New Retinal Vascular Occlusion After mRNA COVID-19 Vaccination Within Aggregated Electronic Health Record Data***, determined how often patients are diagnosed with new RVO acutely after the mRNA COVID-19 vaccine compared with influenza and tetanus, diphtheria, pertussis (Tdap) vaccines.[8] A federated, aggregated electronic health record (EHR) research network containing the deidentified EHR data of more than 103 million patients, was used to examine aggregate EHR data.[8] Data were collected and analyzed on October 20, 2022.[8] Data on patients were searched for the presence of vaccination and instances of newly diagnosed RVO within 21 days of vaccination.[8] Propensity score matching based on demographic characteristics (age, sex, race and ethnicity) and comorbidities (diabetes, hypertension, and hyperlipidemia) was performed between vaccination groups for evaluation of relative risks (RRs).[8] Of 3,108,829 patients (mean [SD] age at vaccination, 50.7 [20.4] years; 56.4% women) who received the mRNA COVID-19 vaccine, 104 (0.003%; 95% CI, 0.003%-0.004%) patients had a new diagnosis of RVO within 21 days of vaccination.[8] After propensity score matching, the RR for new RVO

diagnosis after the first dose of COVID-19 vaccination was not significantly different from that after influenza (RR, 0.74; 95% CI, 0.54-1.01) or Tdap (RR, 0.78; 95% CI, 0.44-1.38) vaccinations, but was greater when compared with the second dose of the COVID-19 vaccination (RR, 2.25; 95% CI, 1.33-3.81).[8] The findings of this study suggest that RVO diagnosed acutely after mRNA COVID-19 vaccination occurs extremely rare at rates similar to those of 2 different historically used vaccinations, the influenza and Tdap vaccines.[8] No evidence suggesting an association between the mRNA COVID-19 vaccination and newly diagnosed RVO was found.[8] [Full text]

- Associations between prenatal SARS-CoV-2 exposure and neurodevelopmental outcomes have substantial public health relevance.[9] A previous study found no association between prenatal SARS-CoV-2 infection and parent-reported infant neurodevelopmental outcomes, but standardized observational assessments are needed to confirm this finding.[9] In this cohort study, ***Assessment of Neurodevelopment in Infants with and Without Exposure to Asymptomatic or Mild Maternal SARS-CoV-2 Infection During Pregnancy***, association between mild or asymptomatic maternal SARS-CoV-2 infection during pregnancy and infant neurodevelopmental differences at ages 5 to 11 months was determined.[9] This study included infants of mothers from a single-site prospective cross-sectional study (COVID-19 Mother Baby Outcomes [COMBO] Initiative) of mother-infant dyads and a multisite prospective cohort study (Epidemiology of Severe Acute Respiratory Syndrome Coronavirus 2 in Pregnancy and Infancy [ESPI]) of pregnant individuals.[9] A subset of ESPI participants was subsequently enrolled in the ESPI COMBO substudy.[9] Participants in the ongoing COMBO study were enrolled beginning on May 26, 2020; participants in the ESPI study were enrolled from May 7 to November 3, 2021; and participants in the ESPI COMBO substudy were enrolled from August 2020 to March 2021.[9] Infant neurodevelopment was assessed between March 2021 and June 2022.[9] A total of 407 infants born to 403 mothers were enrolled (204 from Columbia University Irving Medical Center in New York, New York; 167 from the University of Utah in Salt Lake City; and 36 from the University of Alabama in Birmingham).[9] Mothers of unexposed infants were approached for participation based on similar infant gestational age at birth, date of birth, sex, and mode of delivery to exposed infants. Infant neurodevelopment was assessed using the Developmental Assessment of Young Children, second edition (DAYC-2), adapted for telehealth assessment.[9] Among 403 mothers, the mean (SD) maternal age at delivery was 32.1 (5.4) years; most mothers were of White race (240 [59.6%]) and non-Hispanic ethnicity (253 [62.8%]).[9] Among 407 infants, 367 (90.2%) were born full term and 212 (52.1%) were male.[9] Overall, 258 infants (63.4%) had no documented prenatal exposure to SARS-CoV-2 infection, 112 (27.5%) had confirmed prenatal exposure, and 37 (9.1%) had exposure before pregnancy or at an indeterminate time.[9] In adjusted models, maternal SARS-CoV-2 infection during pregnancy was not associated with differences in cognitive (β = 0.31; 95% CI, −2.97 to 3.58), gross motor (β = 0.82; 95% CI, −1.34 to 2.99), fine motor (β = 0.36; 95% CI, −0.74 to 1.47), expressive language (β = −1.00; 95% CI, −4.02 to 2.02), or receptive language (β = 0.45; 95% CI, −2.15 to 3.04) DAYC-2 subdomain scores. Trimester of exposure and maternal symptom status were not associated with DAYC-2 subdomain scores.[9] In this study, results of a novel telehealth-adapted observational neurodevelopmental assessment extended a previous finding of no association between prenatal exposure to maternal SARS-CoV-2 infection and infant neurodevelopment.[9] [Full text]

- Adverse events of special interest (AESIs) were pre-specified to be monitored for the COVID-19 vaccines.[10] Some AESIs are not only associated with the vaccines, but with COVID-19.[10] This multi-national cohort study, ***Contextualising adverse events of special interest to characterise the baseline incidence rates in 24 million patients with COVID-19 across 26 databases: a multinational retrospective cohort study***, aimed to characterise the incidence rates of AESIs following SARS-CoV-2 infection in patients

and compared these to historical rates in the general population.[10] Data from primary care, electronic health records, and insurance claims were mapped to a common data model.[10] Evidence was collected between Jan 1, 2017 and the conclusion of each database (which ranged from Jul 2020 to May 2022).[10] The 16 pre-specified prevalent AESIs were: acute myocardial infarction, anaphylaxis, appendicitis, Bell's palsy, deep vein thrombosis, disseminated intravascular coagulation, encephalomyelitis, Guillain Barré syndrome, haemorrhagic stroke, non-haemorrhagic stroke, immune thrombocytopenia, myocarditis/pericarditis, narcolepsy, pulmonary embolism, transverse myelitis, and thrombosis with thrombocytopenia.[10] Age-sex standardised incidence rate ratios (SIR) were estimated to compare post-COVID-19 to pre-pandemic rates in each of the databases.[10] Substantial heterogeneity by age was seen for AESI rates, with some clearly increasing with age but others following the opposite trend.[10] Similarly, differences were also observed across databases for same health outcome and age-sex strata.[10] All studied AESIs appeared consistently more common in the post-COVID-19 compared to the historical cohorts, with related meta-analytic SIRs ranging from 1.32 (1.05 to 1.66) for narcolepsy to 11.70 (10.10 to 13.70) for pulmonary embolism.[10] Findings suggest all AESIs are more common after COVID-19 than in the general population. Thromboembolic events were particularly common, and over 10-fold.[10] [Full text]

ASEAN Travel Advisories (new update/s)

as of 15 April 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	March 6, 2022	Yes	Yes – fully vaccinated* certificate for 18 years old and above.	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 RT-PCR test upon arrival	No	No	Traveler is required to download and register at 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 – fully vaccinated* certificate for 12 years old and above.	Passengers are subject to medical screening and could be subject to a test upon arrival.	Foreign travelers who are not fully vaccinated are not allowed to enter or transit Myanmar.	No	Required to obtain Myanmar Insurance	Passengers must present a Health Declaration Form upon arrival.
Philippines	March 30, 2022	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 at E-arrival card at most 3 days before departure for those without 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 two-dose vaccine or 14 or 15 days from a single dose vaccine upon arrival.

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Cases and Deaths as of 14 April 2023

- As of 14 April 2023 (1PM, GMT+7), worldwide, there were **685,395,348** confirmed cases, including **6,841,109** deaths. Globally, Case Fatality Rate (CFR) was **1.0%.**
- **35,718,880 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	14-Apr-23	284,632	1,287	225	-	64,053	450,404	445,929	338,987	99.3
	Cambodia	27 Jan 20	04-Apr-23	138,726	-	3,056	-	841	15,244,858	14,609,937	10,433,215	87.1
	Indonesia	02 Mar 20	13-Apr-23	6,754,583	-	161,096	-	2,490	203,657,535	172,693,321	67,952,274	62.7
	Lao PDR	24 Mar 20	01-Apr-23	218,037	-	758	-	3,041	5,888,649	5,222,417		69.4
	Malaysia	25 Jan 20	14-Apr-23	5,056,911	4,574	36,994	12	15,788	28,125,245	27,536,657	17,056,957	81.1
	Myanmar	23 Mar 20	14-Apr-23	634,121	23	19,490	-	1,173	34,777,314	27,545,329	2,227,351	50.8
	Philippines	30 Jan 20	14-Apr-23	4,084,626	798	66,433	8	3,771	78,369,243	73,937,435	21,341,197	64.0
	Singapore	23 Jan 20	31-Mar-23	2,298,689	-	1,727	-	39,049	5,161,990	5,120,768	4,440,289	90.8
	Thailand	13 Jan 20	10-Apr-23	4,728,967	-	33,940	-	6,791	57,005,497	53,486,086	32,143,431	74.6
	Vietnam	23 Jan 20	14-Apr-23	11,528,800	941	43,186	-	11,950	90,450,881	85,848,363	57,452,750	87.4
	ASEAN COUNTRIES			**35,728,092**	**7,623**	**366,905**	**20**	**148,946**	**519,131,616**	**466,446,242**	**213,386,451**	

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

REGION	TOTAL CONFIRMED CASES	NEW CASES	TOTAL DEATHS	NEW DEATHS
ASIA	194,189,221	11,736	1,202,500	5
AFRICA	12,815,184	-	258,682	
AMERICAS	194,412,657	-	2,978,949	-
EUROPE	248,250,194	-	2,034,073	-
TOTAL	**649,667,256**	**11,736**	**6,474,204**	**5**

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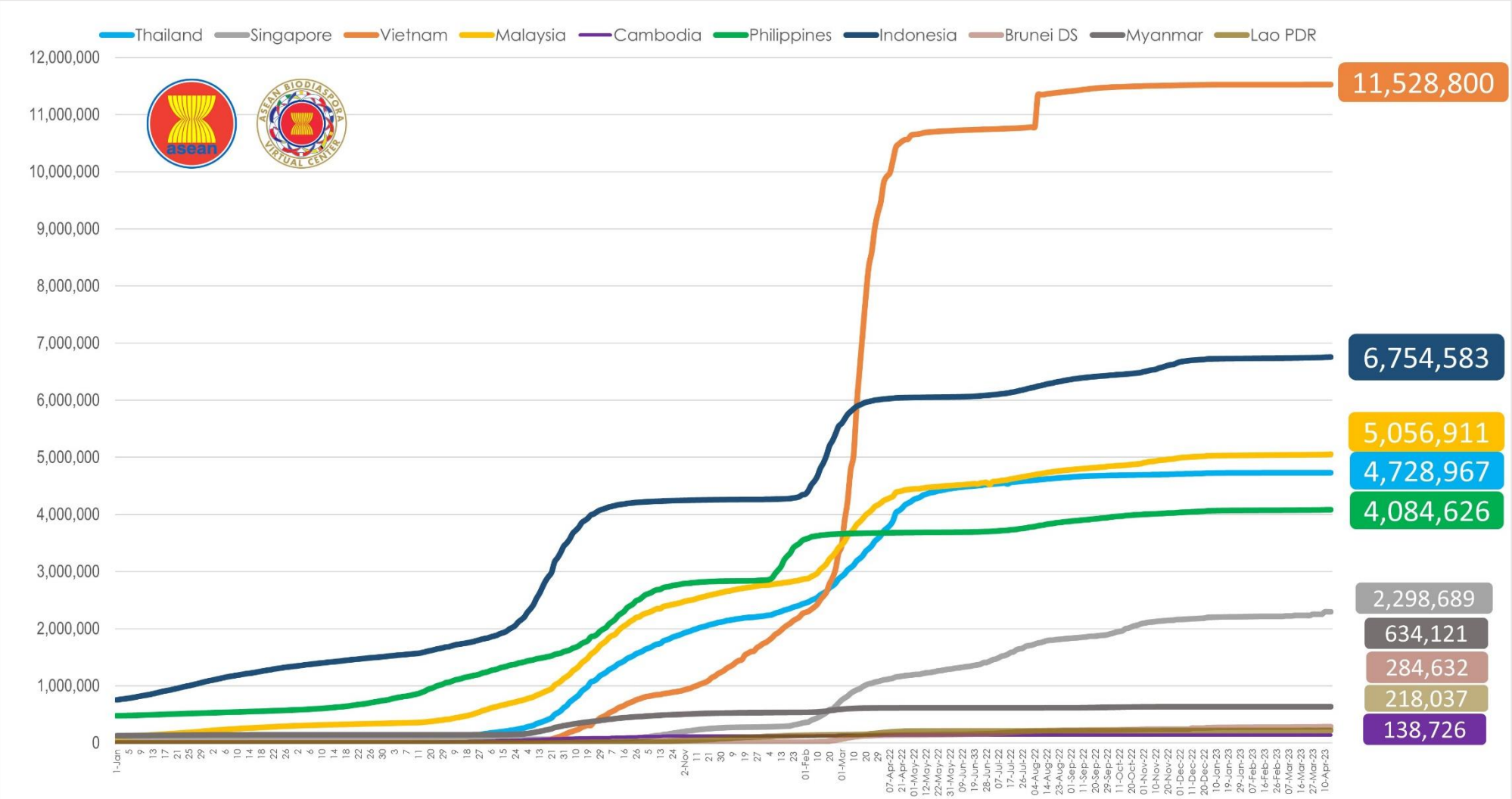
COVID-19 Epi curve among ASEAN Countries

From January 1, 2022 to April 14, 2023



Cumulative cases of COVID-19 in the ASEAN Region as of April 14, 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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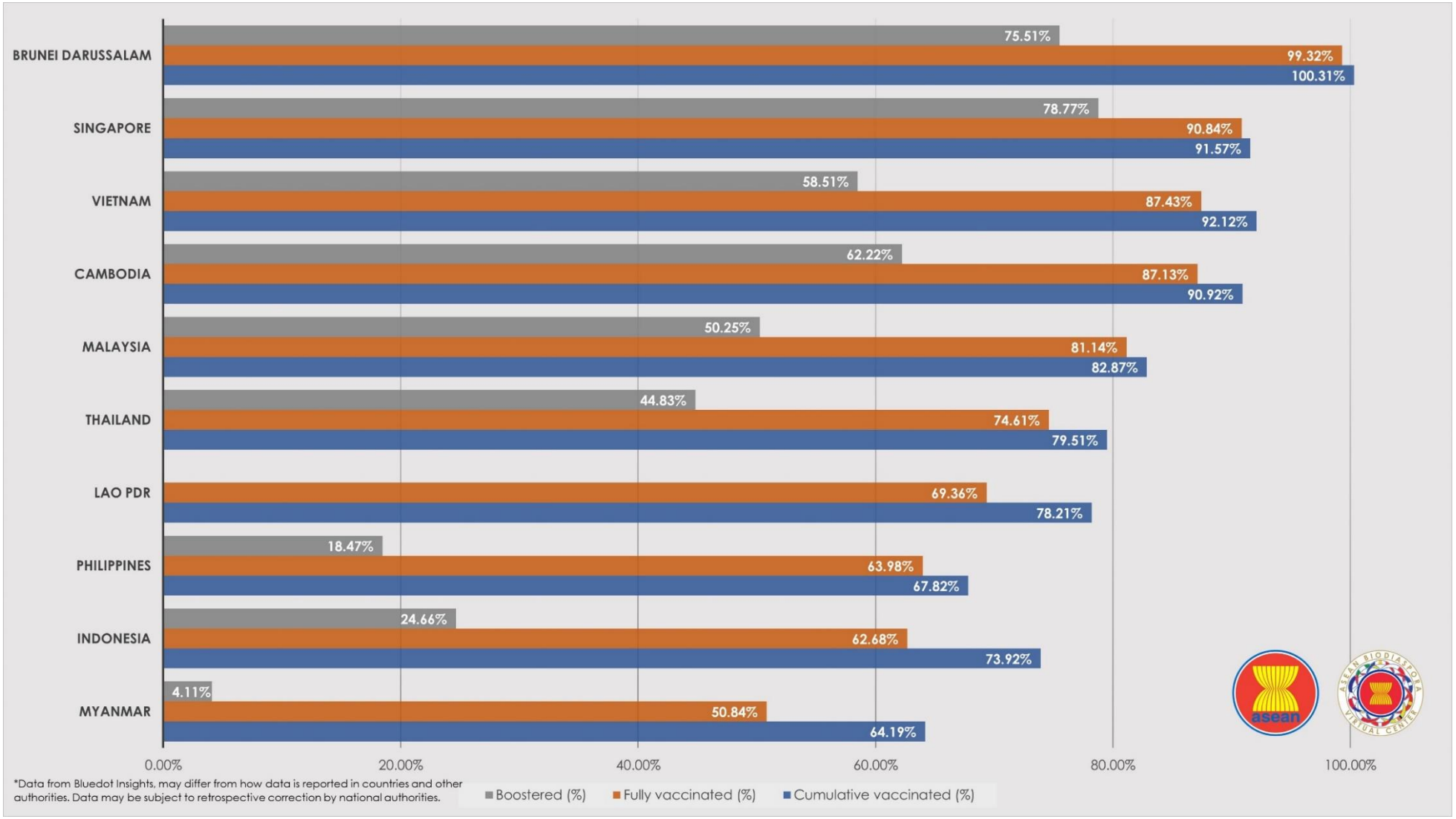
COVID-19 Vaccination Status in ASEAN

as of 09 March 2023



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

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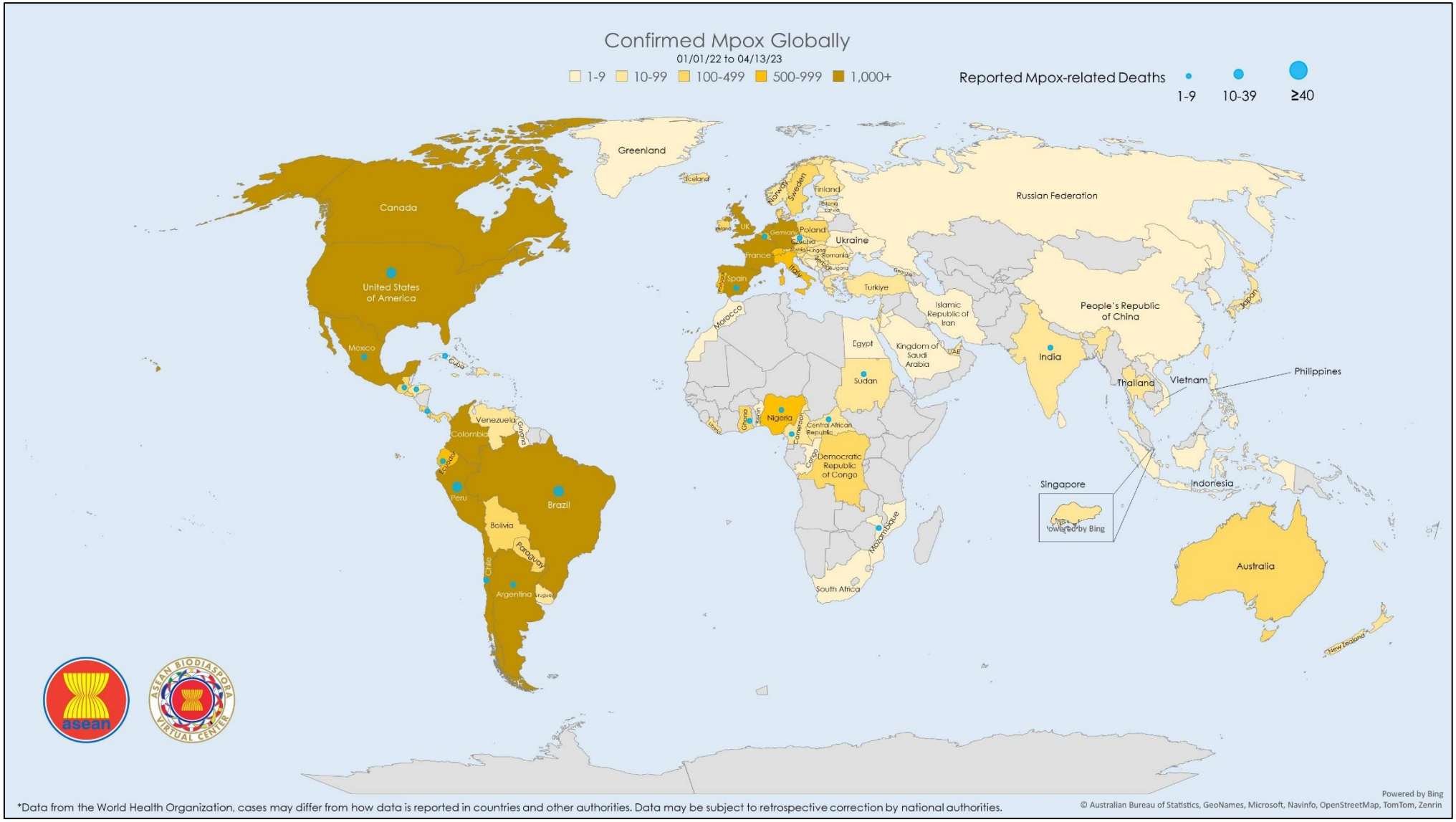
Mpox (Monkeypox) Cases Reported Globally

as of April 13, 2023



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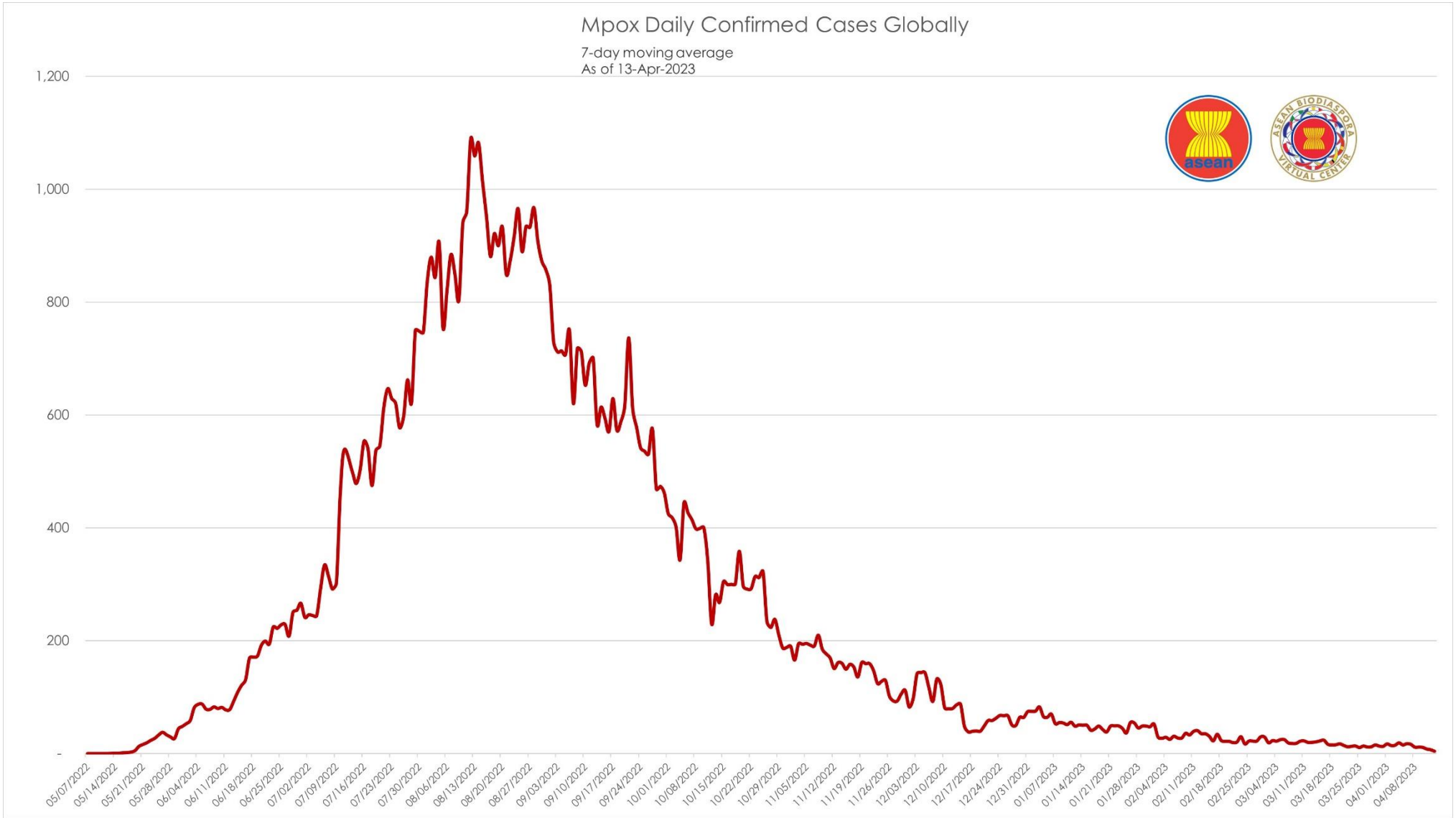
Mpox Daily Trend Globally

as of April 13, 2023



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Mpox: Highlights and Situation Overview

- As of 13 April 2023 (1PM, GMT+7), worldwide, there were **86,930** confirmed cases, including **116** deaths. Globally, Case Fatality Rate (CFR) was **0.13%.**
- **48 confirmed cases** in the ASEAN region, with CFR of **0%.**
- **86,882 confirmed cases** of Mpox have been reported in other **5 regions** (other than ASEAN region):

Mpox cases in ASEAN region

Country	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
Indonesia	1	-	-	0.00%
Philippines	4	-	-	0.00%
Singapore	22	-	-	0.00%
Thailand	19	-	-	0.00%
Vietnam	2	-	-	0.00%
ASEAN Total	**48**	**-**	**-**	**0.00%**

Mpox cases in Asia-Pacific region

Country/Territory	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
Australia	144	-	-	0.00%
India	22	-	1	4.55%
Japan	95	-	-	0.00%
New Caledonia	1	-	-	0.00%
New Zealand	41	-	-	0.00%
People's Republic of China*	24	-	-	0.00%
Republic of Korea*	5	-	-	0.00%
Sri Lanka	2	-	-	0.00%
Asia-Pacific Total	**334**	**-**	**1**	**0.30%**

*People's Republic of China – including Hong Kong (SAR), Macao (SAR), and Taiwan (Province of China)

Top 5 countries with most mpox cases globally

Country	Total Cases	New Cases	Deaths	Case Fatality Rate (CFR)
United States of America	30,091	-	39	0.13%
Brazil	10,897	-	15	0.14%
Spain	7,549	-	3	0.04%
France	4,144	-	-	0.00%
Colombia	4,089	-	-	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	1,497	-	19	1.27%
AMERICAS	59,127	-	90	0.15%
ASEAN	48	-	-	0.00%
ASIA PACIFIC	334	-	1	0.30%
EUROPE	25,603	-	6	0.02%
MIDDLE EAST	321	-	-	0.00%
TOTAL	**86,930**	**-**	**116**	**0.13%**

Research Update (Published and peer-reviewed studies)

- This report, ***Racial and Ethnic Disparities in Mpox Cases and Vaccination Among Adult Males — United States, May–December 2022***, examined racial and ethnic disparities in mpox incidence and vaccination rates, rate ratios (RRs) for incidence and vaccination rates and vaccination-to-case ratios were calculated, and trends in these measures were assessed among males aged ≥18 years.[5] There are notable disparities in mpox incidence, characterized by higher rates among males in most racial and ethnic minority groups compared with rates among White males.[5] Second, males in most racial and ethnic minority groups had slightly higher vaccination rates than White males; however, these higher vaccination rates were not sufficiently high to fully offset the disproportionate mpox incidences in these groups.[5] Vaccination-to-case ratios indicated that there is a higher unmet vaccination need among racial and ethnic minority groups, particularly among Black and Hispanic males.[5] Concerted efforts to increase vaccination among racial and ethnic groups might have contributed to increases in vaccination rates among racial and ethnic minority males.[5] The vaccination-to-case ratio, a novel measure of vaccination relative to incidence, estimated that approximately 43 White males were vaccinated for each reported mpox case among White males, whereas only nine Black and 16 Hispanic males received mpox vaccination for each reported mpox case within these groups.[5] Although overall ≥1-dose JYNNEOS vaccination rates were higher among Black and Hispanic males than White males (RR = 1.2 and 1.4, respectively), they were not commensurate with their higher mpox incidence (RRs = 5.8 and 3.6, respectively).[5] Sustained equity-based strategies, such as tailored messaging and expanding vaccination services to reach racial and ethnic minority groups, are needed to prevent disparities in future mpox outbreaks.[5] [Full text]

- As of March 7, 2023, a total of 30,235 confirmed and probable monkeypox (mpox) cases were reported in the United States, predominantly among cisgender men who reported recent sexual contact with another man.[6] Although most mpox cases during the current outbreak have been self-limited, cases of severe illness and death have been reported.[6] This report, ***Epidemiologic and Clinical Features of Mpox-Associated Deaths — United States, May 10, 2022–March 7, 2023***, described the deaths associated with mpox in the United States.[6] Jurisdictional health departments electronically reported confirmed and probable mpox cases and associated deaths as part of national case surveillance.[6] Case data were shared with CDC through a standardized case report form or through the National Notifiable Diseases Surveillance System.[6] Additional data (e.g., clinical course, co-occurring health conditions, and treatments received) about some decedents were collected during consultations between treating clinicians and CDC clinical officers.[6] Cause of death was most commonly determined by the treating health care provider

and reported on the death certificate.[6] Jurisdictional health departments shared cause-of-death data as reported on the death certificate to support classification of deaths.[6] Deaths were classified as mpox-associated if mpox was listed on Part I or Part II of the death certificate (chain of events that directly caused the death or significant conditions contributing to death, respectively).[6] Deaths were classified as non–mpox-associated if mpox was not listed on the death certificate, or if mpox appeared to be incidental to death.[6] Thirty-eight mpox-associated deaths occurred during May 10, 2022– March 7, 2023 (1.3 mpox-associated deaths per 1,000 cases in the US compared to approximately 1.2 deaths per 1,000 mpox cases worldwide).[6] Nearly all U.S. mpox decedents were immunocompromised at the time of diagnosis.[6] Most decedents were non-Hispanic Black or African American (87%) persons and cisgender men (95%).[6] Among 24 decedents with HIV for whom data were available, all had advanced HIV, typically with a CD4 count <50.[6] Equitable access to prevention, treatment, and engagement and retention in care for both mpox and HIV should be prioritized, particularly among Black men and other persons at risk for sexually associated infections.[6] These results underscore previous recommendations that providers offer HIV testing to all patients with probable or confirmed mpox and consider early mpox-directed treatment in highly immunocompromised patients.[6] [Full text]

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