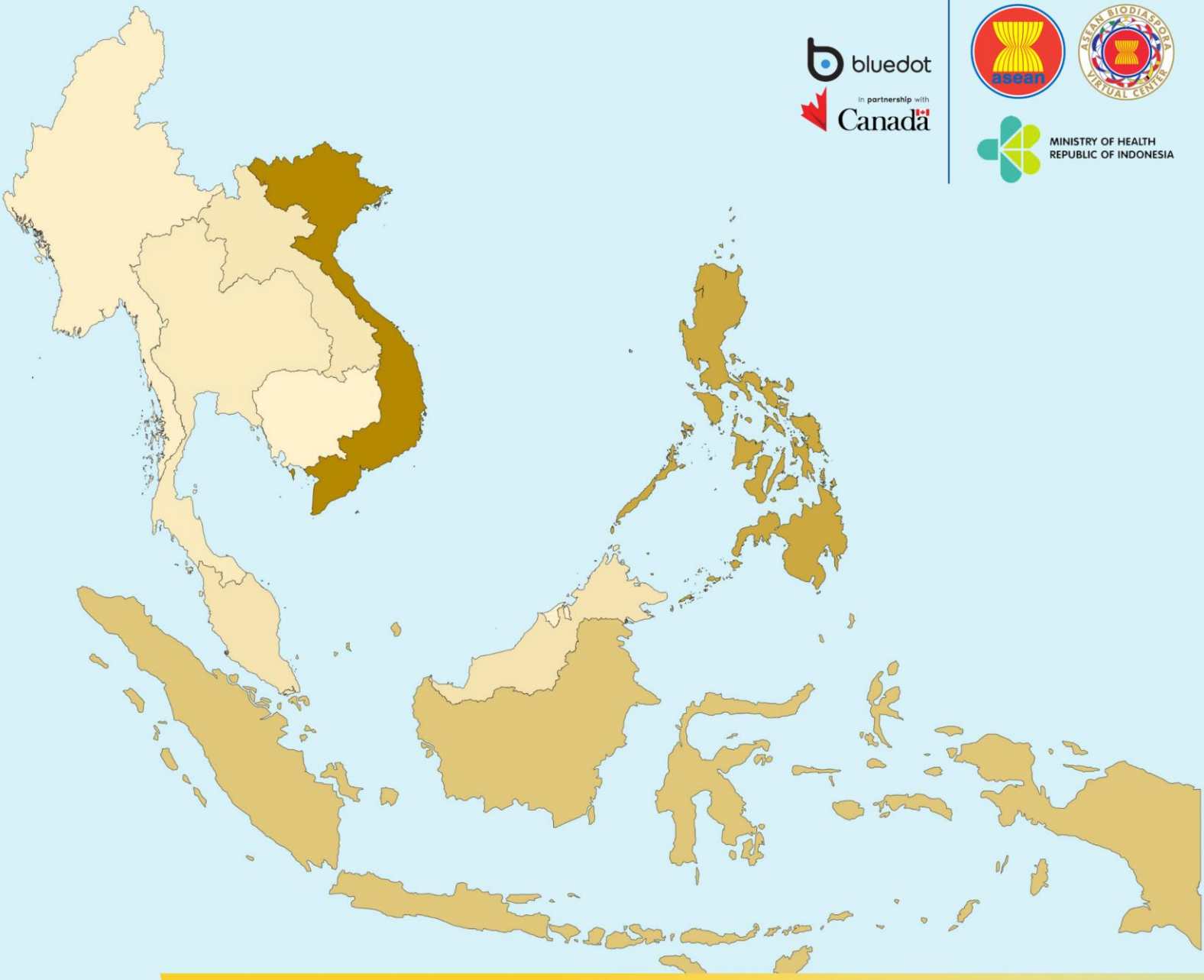

COVID-19, Mpox, and Travel Advisories

Situational Report in the ASEAN Region

ASEAN BioDiaspora Virtual Center (ABVC)

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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 686 million cases and over 6 million deaths attributed to COVID-19.
- **India** on April 21 (Friday) reported 12,591 new COVID-19 cases within 24 hours, the highest number of cases in nearly 8 months.[1] The country has also reported 29 new COVID-19-related deaths which were also the highest since September 2022.[1] Delhi has reported 6 deaths, followed by Uttar Pradesh (4) and Maharashtra (4).[1] The country has seen a surge in cases since March and the data showed that the positivity rate is currently above 5%.[1] [Full article]

Vaccine Update

- The **U.S. Centers for Disease Control and Prevention (CDC)** finalized a plan to simplify COVID-19 mRNA vaccine recommendations, which allows seniors and adults with weakened immune systems to receive a second dose of bivalent vaccine.[2] The announcement came just after its Advisory Committee on Immunization (ACIP) met to discuss the changes.[2] Aside from simplifying vaccine administration and recommendations, the changes are also designed to boost immunity in vulnerable groups until fall.[2] The FDA's vaccine advisors will meet in June to assess if changes are needed to the vaccines to cover emerging SARS-CoV-2 subvariants.[3] Meanwhile, CDC officials acknowledged that recommendations for children ages 4 to 6 are still relatively complex and vary by vaccine and number of doses previously received.[2] They also said they'd release more resources to help navigate vaccination and added that they will host a clinician's outreach and communication activity (COCA) call on the policy updates on May 11.[2] [Full article 2, 3]

Research Update (Published and peer-reviewed studies)

- The study on the **Use of COVIDTests.gov At-Home Test Kits Among Adults in a National Household Probability Sample — United States, 2022** found that one-third of US households used free at-home COVID-19 diagnostic tests from the COVIDTests.gov program and suggests that, without the kits, one in four adults who used a test would likely otherwise have gone untested. Emory University researchers analyzed data from a national probability survey to estimate awareness, acceptability, and use of the COVIDTests.gov program in April and May 2022.[4] More than 70 million test kits were shipped by May 2022 and most households (93.8%) indicated they were aware of the COVID-19 test program, and more than half (59.9%) had ordered kits.[4] In 32.1% of households, a household or non-household member had used at least one government test, wherein a total of 27.8% of households had ordered kits but had not yet used them.[4] A total of 38.3% of those who tested for COVID-19 used a COVIDTests.gov kit, and 22.2% of users reported testing positive at least once during the study period.[4] Among test users, 95.5% rated their experience as acceptable, and 23.6% said they probably wouldn't have tested if they didn't have the free tests.[4] According to the authors, the provision of tests through a well-publicized program is likely to improve use of COVID-19 home testing and health equity in the United States.[4] [Full text]
- Emerging evidence suggests a higher risk of diabetes after COVID19 infection, but population-based evidence is still sparse.[5] This population-based cohort study, ***Association of COVID-19 Infection with Incident Diabetes*** determined the association between COVID-19 infection, including severity of infection, and risk of diabetes.[5] This study was conducted in British Columbia, Canada, from January 1, 2020, to December

31, 2021, using the British Columbia COVID-19 Cohort, a surveillance platform that integrates COVID-19 data with population-based registries and administrative data sets.[5] Individuals tested for SARS-CoV-2 by RT-PCR were included.[5] Those who tested positive for SARS-CoV-2 were matched by sex, age, and collection date of RT-PCR test at a 1:4 ratio to those who tested negative.[5] The primary outcome was incident diabetes identified more than 30 days after the specimen collection date for the SARS-CoV-2 test with a validated algorithm based on medical visits, hospitalization records, chronic disease registry, and prescription drugs for diabetes management.[5] Multivariable Cox proportional hazard modeling was performed to evaluate the association between SARS-CoV-2 infection and diabetes risk.[5] Stratified analyses were performed to assess the interaction of SARSCoV-2 infection with diabetes risk by sex, age, and vaccination status.[5] Among 629,935 individuals, 125,987 individuals tested positive and 503 948 individuals were negative for SARS-CoV-2.[5] During the median (IQR) follow-up of 257 (102-356) days, events of incident diabetes were observed among 608 individuals who were were positive (0.5%) and 1864 individuals who were negative (0.4%).[5] The incident diabetes rate per 100,000 person years was significantly higher in the positive vs negative group (672.2 incidents; 95% CI, 618.7- 725.6 incidents vs 508.7 incidents; 95% CI, 485.6-531.8 incidents; P < .001).[5] The risk of incident diabetes was also higher in the positive group (hazard ratio [HR], 1.17; 95% CI, 1.06-1.28) and among males (adjusted HR, 1.22; 95% CI, 1.06-1.40).[5] The risk of diabetes was higher among people with severe disease vs those without COVID-19, including individuals admitted to the intensive care unit (HR, 3.29; 95% CI, 1.98-5.48) or hospital (HR, 2.42; 95% CI, 1.87-3.15).[5] The fraction of incident diabetes cases attributable to SARS-CoV-2 infection was 3.41% (95% CI, 1.20%-5.61%) overall and 4.75% (95% CI, 1.30%-8.20%) among males.[5] In this cohort study, SARS-CoV-2 infection was associated with a higher risk of diabetes and may have contributed to a 3% to 5% excess burden of diabetes at a population level.[5] [Full text]

- Limited effective therapeutics are available to hospitalized patients with COVID-19.[6] This retrospective, cohort study, ***Dexamethasone for Inpatients With COVID-19 in a National Cohort***, described the clinical use of dexamethasone for hospitalized patients with COVID-19 respiratory illness and explored the heterogeneity of treatment outcomes across different subgroups.[6] This study included adult patients hospitalized for at least 48 hours for COVID-19 respiratory illness between July 1, 2020, and October 31, 2021 and given systemic dexamethasone within 48 hours of either admission or escalation in oxygen support, at a large health care network of 156 hospitals across the US.[6] Data analysis was performed from March 2022 to February 2023.[6] A total of 80,699 patients who met the eligibility criteria were identified (median [IQR] age, 64 [52-76] years; 37,606 women [46.6%]); 13,230 patients (16.4%) identified as Black, 49,222 (60.9%) as White, 18 247 (22.6%) as other race, and 20,340 (25.2%) as Hispanic ethnicity.[6] Of these patients, 13,040 (16.2%) did not require supplemental oxygen within 48 hours of admission, 56,368 (69.8%) required supplemental oxygen, 7,618 (9.4%) required noninvasive positive pressure ventilation (NIPPV), and 3,673 (4.6%) required mechanical ventilation (MV) and/or extracorporeal membrane oxygenation (ECMO).[6] After adjustment by propensity score overlap weighting, early use of dexamethasone was associated with reduction in a composite outcome of in-hospital mortality or discharge to hospice for patients receiving supplemental oxygen (aOR, 0.92; 95% CI, 0.86-0.98) and MV and/or ECMO (aOR, 0.82; 95% CI, 0.68-0.99).[6] In contrast, all-cause inpatient mortality or discharge to hospice was not lower for patients who received dexamethasone in the no supplemental oxygen group (aOR, 0.90; 95% CI, 0.78-1.03) and in the NIPPV group (aOR, 0.87; 95% CI, 0.73-1.04). Importantly, patients with more comorbidities had greater benefit from dexamethasone use.[6] In this national multicenter cohort study of inpatients with COVID-19, early administration of dexamethasone was associated with significantly reduced odds of mortality or discharge to hospice in those requiring supplemental oxygen or MV and/or ECMO but not in those requiring no supplemental oxygen or

NIPPV.[6] These results support the continued use of systemic dexamethasone in patients hospitalized with COVID-19.[6] [Full text]

- Although high rates of COVID-19-related deaths have been reported for people with intellectual disabilities during the first 2 years of the pandemic, it is unknown to what extent the pandemic has impacted existing mortality disparities for people with intellectual disabilities.[7] This study, ***All-cause and cause-specific mortality among people with and without intellectual disabilities during the COVID-19 pandemic in the Netherlands: a population-based cohort study***, linked a Dutch population-based cohort that contained information about intellectual disability statuses with the national mortality registry to analyse both cause-specific and all-cause mortality in people with and without intellectual disabilities, and to make comparisons with pre-pandemic mortality patterns.[7] For each individual in the cohort, information was available about demographics (sex and date of birth), indicators of intellectual disability, if any, based on chronic care and (social) services use, and in case of death, the date and underlying cause of death.[7] Data from the first 2 years of the COVID-19 pandemic (2020 and 2021) was comparedwith the pre-pandemic period (2015–19).[7] At the start of follow-up in 2015, 187,149 Dutch adults with indicators of intellectual disability were enrolled and 12·6 million adults from the general population were included.[7] Mortality from COVID-19 was significantly higher in the population with intellectual disabilities than in the general population (HR 4·92, 95% CI 4·58–5·29), with a particularly large disparity at younger ages that declined with increasing age.[7] The overall mortality disparity during the COVID-19 pandemic (HR 3·38, 95% CI 3·29–3·47) was wider than before the pandemic (3·23, 3·17–3·29).[7] For five disease groups (neoplasms; mental, behavioural, and nervous system; circulatory system; external causes; and other natural causes) higher mortality rates were observed in the population with intellectual disabilities during the pandemic than before the pandemic, and the pre-pandemic to during the pandemic difference in mortality rates was greater in the population with intellectual disabilities than in the general population, although relative mortality risks for most other causes remained within similar ranges compared with pre-pandemic years.[7] The impact of the COVID-19 pandemic on people with intellectual disabilities has been greater than reflected by COVID-19-related deaths alone.[7] Not only was the mortality risk from COVID-19 higher in people with intellectual disabilities than in the general population, but overall mortality disparities were also further exacerbated during the first 2 years of the pandemic.[7] For disability-inclusive future pandemic preparedness this excess mortality risk for people with intellectual disabilities should be addressed.[7] [Full article]

- In late 2022, the SARS-CoV-2 omicron (B.1.1.529) BA.5 sublineage accounted for most of the sequenced viral genomes worldwide.[8] Bivalent mRNA vaccines contain an ancestral SARS-CoV-2 strain component plus an updated component of the omicron BA.4 and BA.5 sublineages.[8] Since September, 2022, a single bivalent mRNA vaccine booster dose has been recommended for adults who have completed a primary SARS-CoV-2 vaccination series and are at high risk of severe COVID-19.[8] This retrospective, population-based, cohort study in Israel, ***Effectiveness of a bivalent mRNA vaccine booster dose to prevent severe COVID-19 outcomes: a retrospective cohort study***, evaluated the effectiveness of a bivalent mRNA vaccine booster dose to reduce hospitalizations and deaths due to COVID-19.[8] Data from electronic medical records in Clalit Health Services (CHS) were used and included all members of CHS who were aged 65 years or older and eligible for a bivalent mRNA COVID-19 booster vaccination.[8] Between Sept 27, 2022, and Jan 25, 2023, 569,519 eligible participants were identified.[8] Of those, 134,215 (24%) participants received a bivalent mRNA booster vaccination during the study period.[8] Hospitalisation due to COVID-19 occurred in 32 participants who received a bivalent mRNA booster vaccination and 541 who did not receive a bivalent booster vaccination (adjusted hazard ratio 0·28, 95% CI 0·19–0·40).[8] The absolute risk reduction for hospitalizations due to COVID-19 in bivalent mRNA booster

recipients versus non-recipients was 0·089% (95% CI 0·075–0·101), and the number needed to vaccinate to prevent one hospitalisation due to COVID-19 was 1118 people (95% CI 993–1341).[8] Participants who received a bivalent mRNA booster vaccine dose had lower rates of hospitalization due to COVID-19 than participants who did not receive a bivalent booster vaccination, for up to 120 days after vaccination.[8] These findings highlight the importance of bivalent mRNA booster vaccination in populations at high risk of severe COVID-19.[8] [Full text]

ASEAN Travel Advisories (new update/s)

as of 21 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 21 April 2023

- As of 21 April 2023 (1PM, GMT+7), worldwide, there were **686,193,327** confirmed cases, including **6,858,212** deaths. Globally, Case Fatality Rate (CFR) was **1.0%.**
- **35,770,807 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	18-Apr-23	285,740	-	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	21-Apr-23	6,762,130	230	161,165	-	2,490	203,657,535	172,693,321	67,952,274	62.7
	Lao PDR	24 Mar 20	21-Apr-23	218,065	13	758	-	3,041	5,888,649	5,222,417		69.4
	Malaysia	25 Jan 20	17-Apr-23	5,062,060	-	37,000	-	15,788	28,125,245	27,536,657	17,056,957	81.1
	Myanmar	23 Mar 20	20-Apr-23	634,243	-	19,490	-	1,173	34,777,314	27,545,329	2,227,351	50.8
	Philippines	30 Jan 20	20-Apr-23	4,087,486	-	66,444	-	3,771	78,369,243	73,937,435	21,341,197	64.0
	Singapore	23 Jan 20	07-Apr-23	2,314,707	-	1,727	-	39,049	5,161,990	5,120,768	4,440,289	90.8
	Thailand	13 Jan 20	15-Apr-23	4,729,402	-	33,940	-	6,791	57,005,497	53,486,086	32,143,431	74.6
	Vietnam	23 Jan 20	20-Apr-23	11,538,248	-	43,186	-	11,950	90,450,881	85,848,363	57,452,750	87.4
	ASEAN COUNTRIES			**35,770,807**	**243**	**366,991**	**-**	**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	194,472,432	13,629	1,203,391	7
AFRICA	12,817,465	-	258,705	
AMERICAS	194,554,930	-	2,980,398	-
EUROPE	248,577,693	-	2,048,727	-
TOTAL	**650,422,520**	**13,629**	**6,491,221**	**7**

**Data Reference: Worldometer

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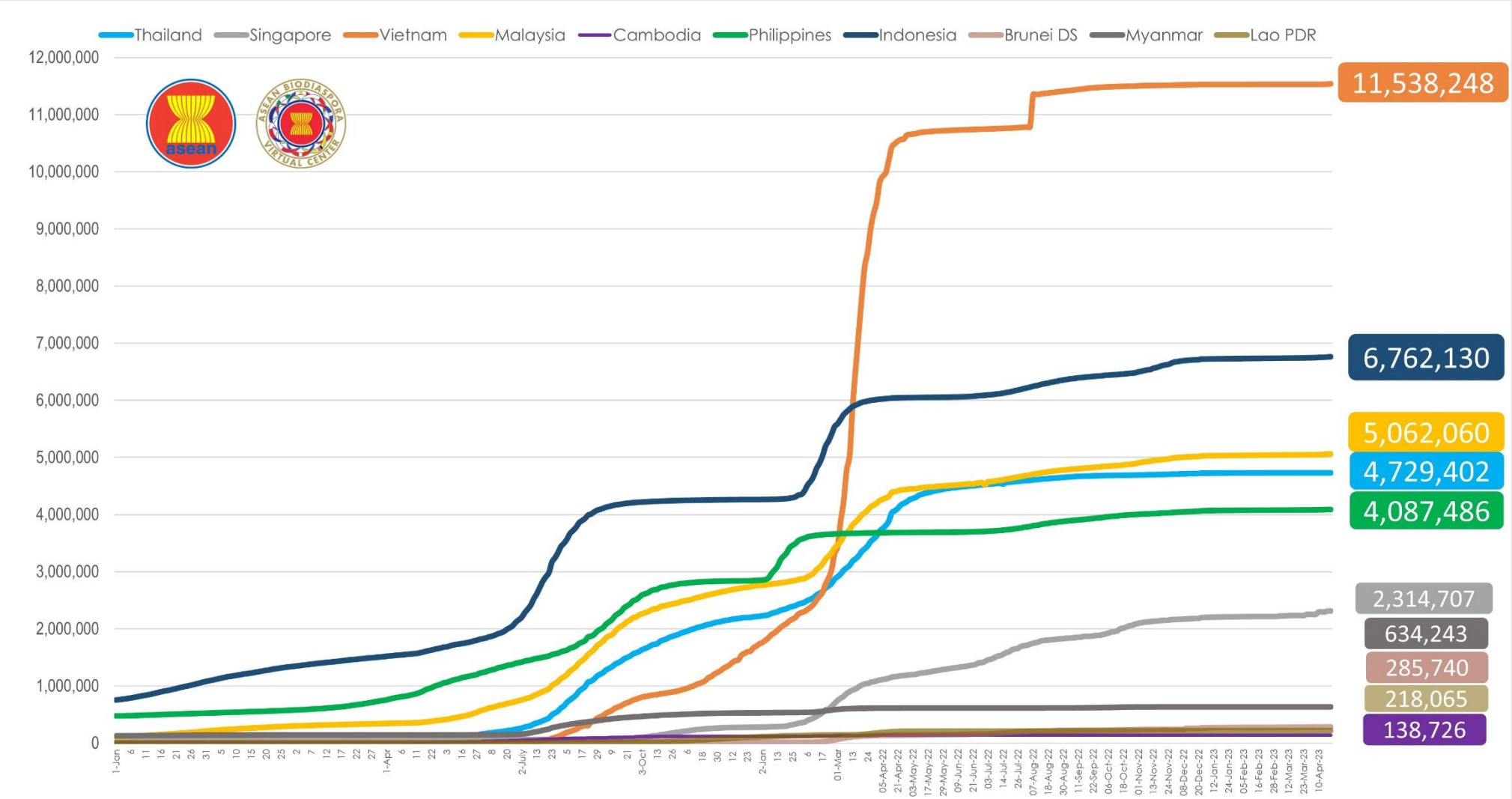
COVID-19 Epi curve among ASEAN Countries

From January 1, 2022 to April 21, 2023



Cumulative cases of COVID-19 in the ASEAN Region as of April 21, 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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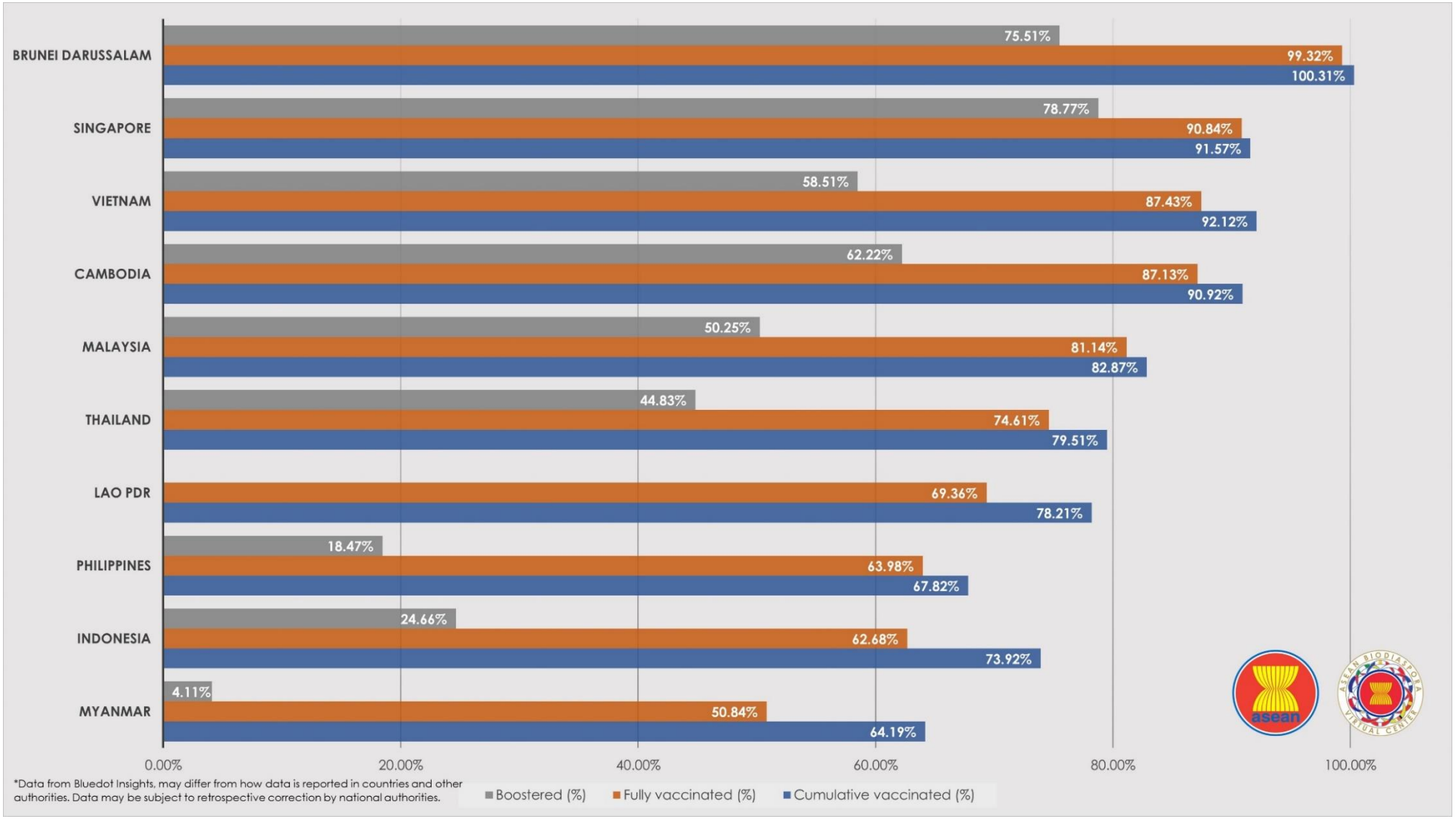
COVID-19 Vaccination Status in ASEAN

as of 09 March 2023



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

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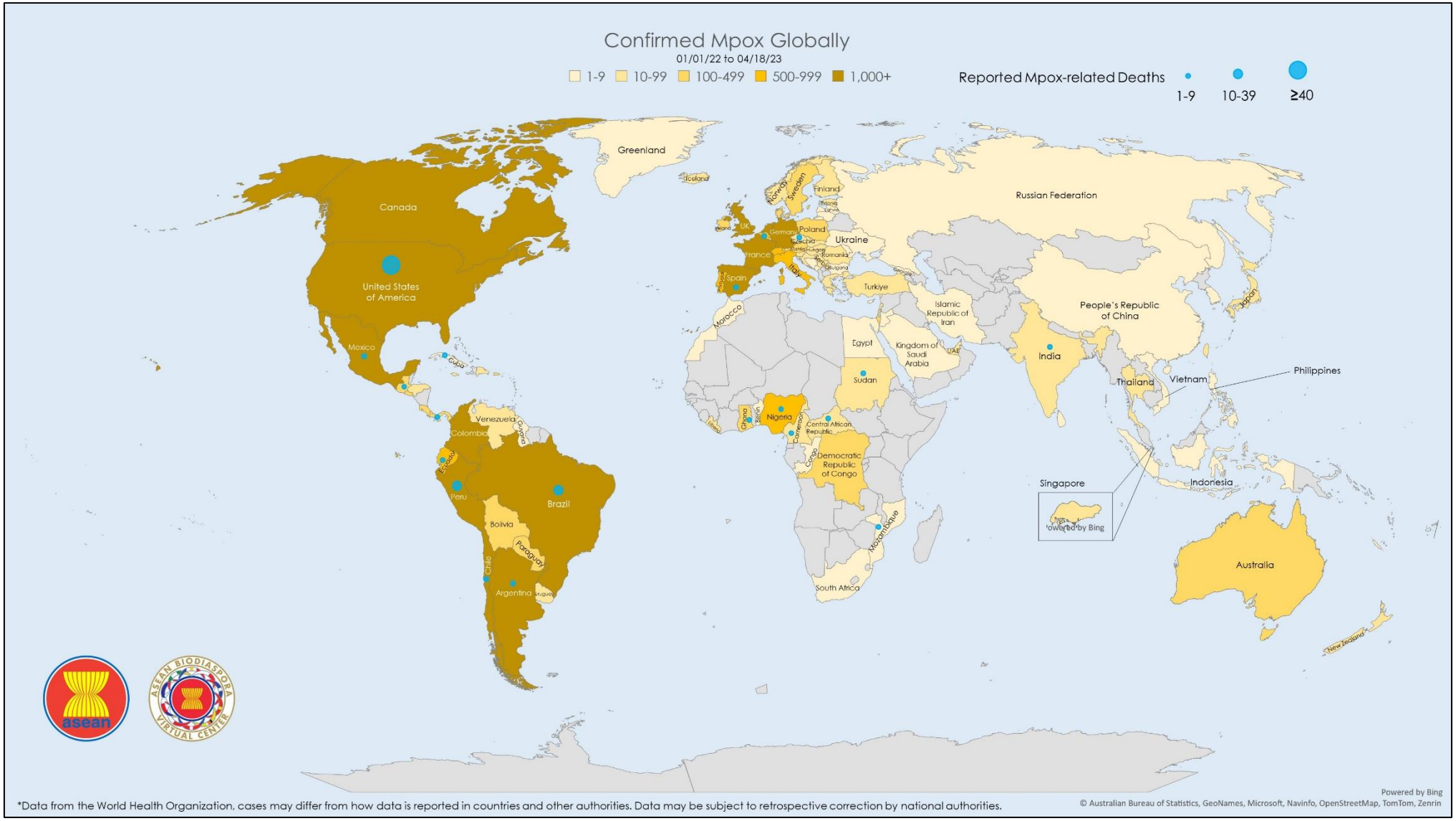
Mpox (Monkeypox) Cases Reported Globally

as of April 18, 2023



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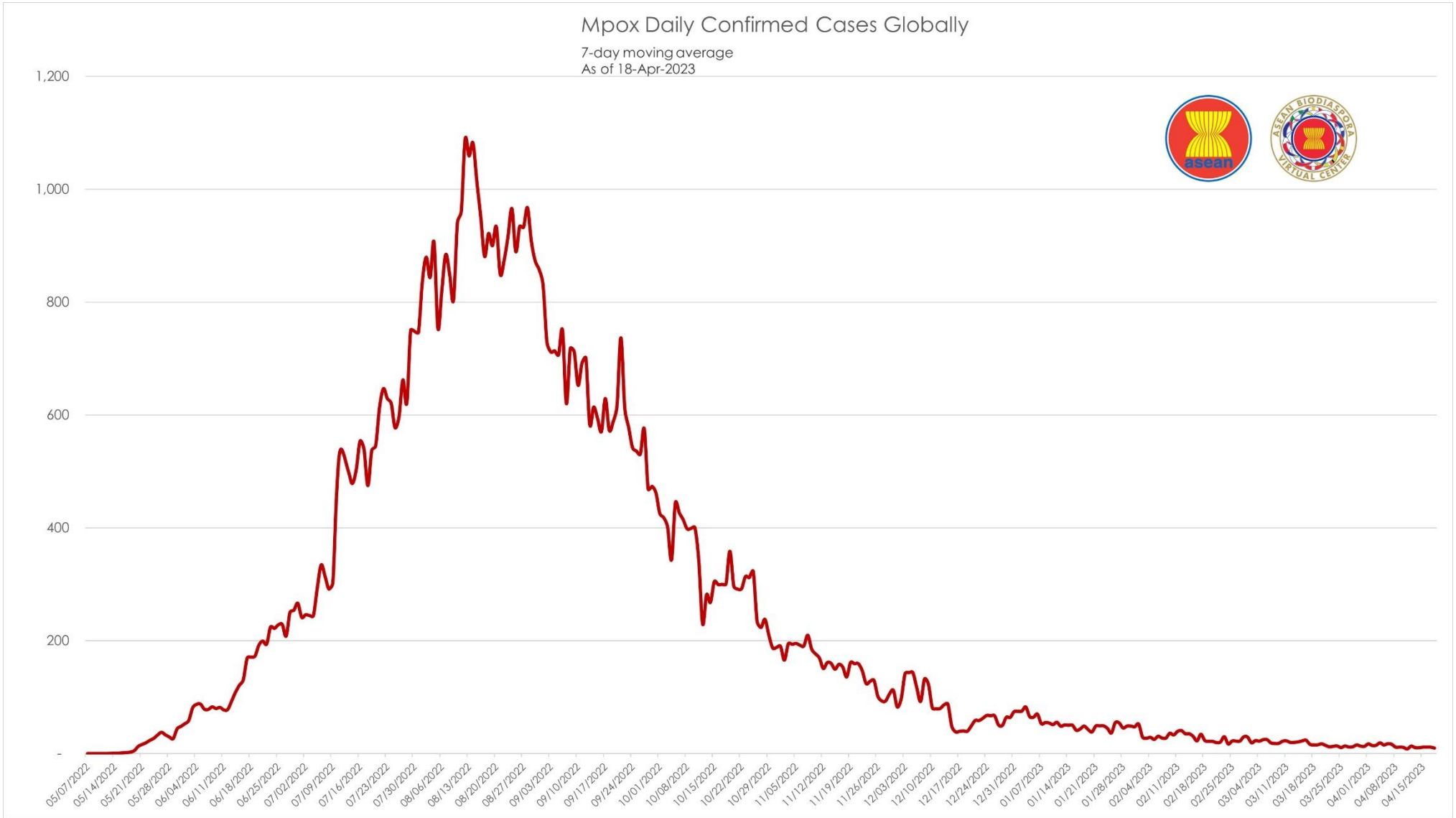
Mpox Daily Trend Globally

as of April 18, 2023



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Mpox: Highlights and Situation Overview

- As of 18 April 2023 (1PM, GMT+7), worldwide, there were **87,000** confirmed cases, including **120** deaths. Globally, Case Fatality Rate (CFR) was **0.14%.**
- **48 confirmed cases** in the ASEAN region, with CFR of **0%.**
- **86,952 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	96	-	-	0.00%
New Caledonia	1	-	-	0.00%
New Zealand	41	-	-	0.00%
People's Republic of China*	25	-	-	0.00%
Republic of Korea	6	-	-	0.00%
Sri Lanka	2	-	-	0.00%
Asia-Pacific Total	**337**	**-**	**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	30,140	-	44	0.15%
Brazil	10,900	-	15	0.14%
Spain	7,549	-	3	0.04%
France	4,144	-	-	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	1,497	-	19	1.27%
AMERICAS	59,194	-	94	0.16%
ASEAN	48	-	-	0.00%
ASIA PACIFIC	337	-	1	0.30%
EUROPE	25,603	-	6	0.02%
MIDDLE EAST	321	-	-	0.00%
TOTAL	**87,000**	**-**	**120**	**0.14%**

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