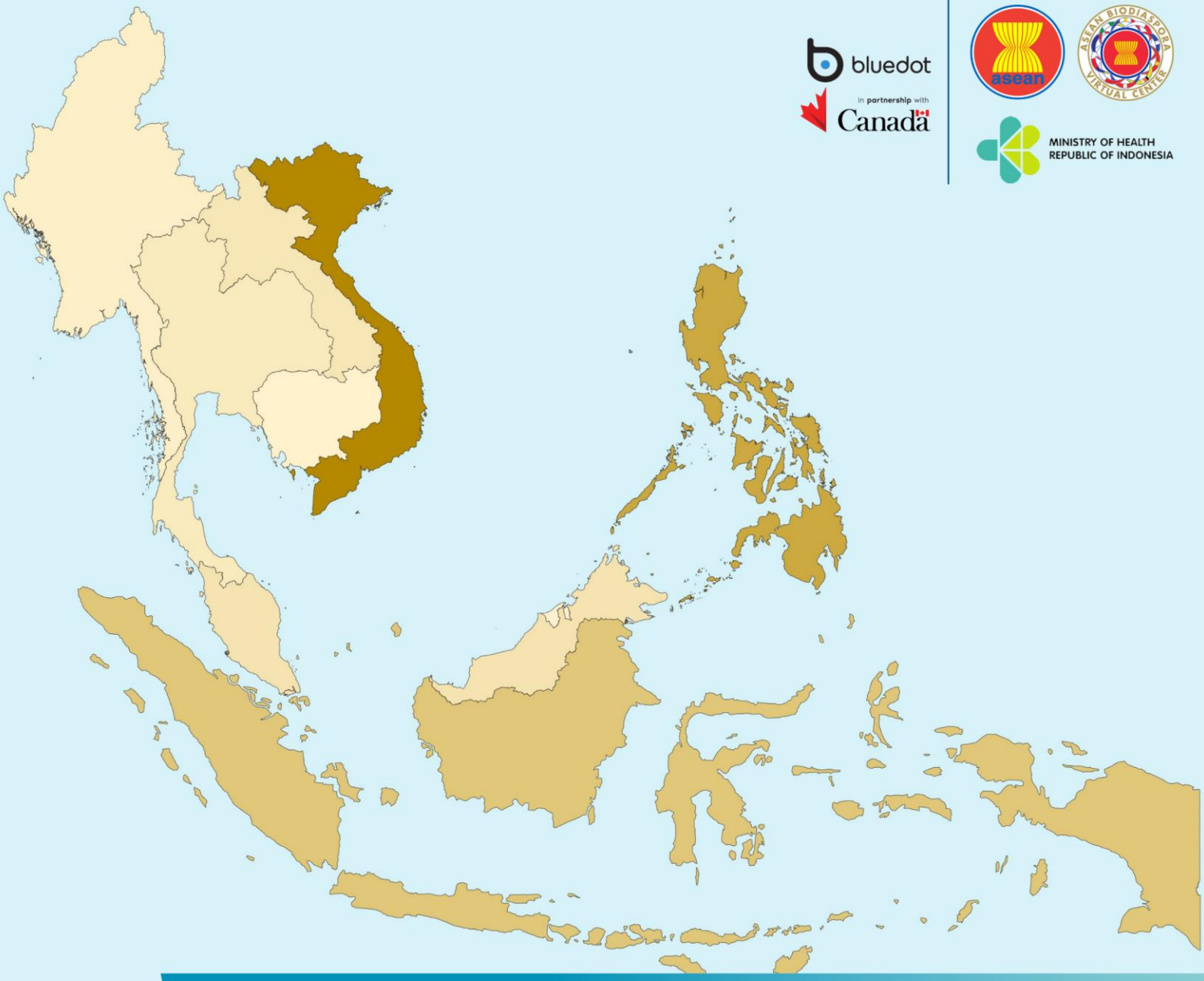

# Situational Report in the ASEAN Region

ASEAN BioDiaspora Virtual Center (ABVC)

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ASSOCIATION OF SOUTHEAST ASIAN NATIONS

ASEAN BIODIASPORA VIRTUAL CENTER

MINISTRY OF HEALTH
REPUBLIC OF INDONESIA

**GLOBAL PARTNERS**

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World Health Organization

Korea Disease Control and Prevention Agency

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# COVID-19: Highlights and Situation Overview

## *Global Update*

- **Worldwide**, over 688 million cases and over 6 million deaths have been attributed to COVID-19.
- The **World Health Organization (WHO)** and its partners will launch a global network to protect people from infectious diseases using pathogen genomics.[4] The International Pathogen Surveillance Network (IPSN) will provide a platform for countries and regions to connect and improve systems for collecting and analyzing samples.[4] This will allow for the use of data to drive public health decision-making and share information more broadly.[4] The IPSN is a key initiative in the fight against infectious diseases.[4] By connecting countries and regions, improving systems for collecting and analyzing samples, and using data to drive public health decision-making, the IPSN will help to protect people from infectious diseases and save lives.[4] The WHO said that COVID-19 highlighted the critical role of pathogen genomics in responding to pandemic threats and the rapid sequencing of the SARS-CoV-2 genome was essential for the development of effective vaccines and the identification of new virus variants.[4] [Full article]

## *Regional Update*

- **Philippines:** The Department of Health on May 21 (Sunday) reported 1,912 new COVID-19 cases, the first daily cases in four days to go below 2,000.[5] The total number of cases in the country as of Sunday is 4,127,628.[5] The region with the newest COVID-19 cases in the last 14 days is the National Capital Region with 9,902, followed by Calabarzon with 5,702, Central Luzon with 2,012, Western Visayas with 1,450, and the Bicol Region with 900.[5] [Full article]

## *Research Update (Published and peer-reviewed studies)*

- This retrospective chart review study, ***Early biochemical analysis of COVID-19 patients helps severity prediction***, attempted to generate a predictive model, based on these first-day data to efficiently predict the course of the disease.[1] This study has been conducted at the Donostia University Hospital, which covers the region of Gipuzkoa (Basque Country, Spain), with a population of 720,000 inhabitants.[1] The first blood analysis data after the COVID-19 diagnosis have been retrieved from the clinical records. The inclusion criteria were having a SARS-CoV-2 positive PCR between February and April 2020 and being admitted to the hospital.[1] Routine blood tests performed on 1,082 COVID-19 patients on the first day of hospitalization were analyzed and the patient follow-up has been done 30 days after the discharge from the hospital.[1] Using artificial intelligence, a predictive model that predicts the risk of developing severe disease with an AUC = 0.78 and an F1-score = 0.69 was generated.[1] Results showed the importance of immature granulocytes and their ratio with Lymphocytes in the disease and present an algorithm based on 5 parameters that include immature granulocytes and their ratio with lymphocytes, ferritin, troponin-T, D-dimer, and triglyceride to identify a severe course.[1] This work highlights the importance of studying routine analytical variables in the early stages of hospital admission and the benefits of applying AI to identify patients who may develop severe diseases.[1] [Full text]
- This observational, case-control, surveillance study, ***COVID-19 Booster Vaccination in Early Pregnancy and Surveillance for Spontaneous Abortion***, determined whether there is an association between COVID-19 booster vaccination during pregnancy and spontaneous abortion.[2] Participants included people aged 16 to 49 years with

pregnancies at 6 to 19 weeks gestation at 8 health systems in the Vaccine Safety Datalink from November 1, 2021, to June 12, 2022.[2] Spontaneous abortion cases and ongoing pregnancy controls were evaluated during consecutive surveillance periods, defined by calendar time.[2] The primary exposure was the receipt of a third messenger RNA (mRNA) COVID-19 vaccine dose within 28 days before spontaneous abortion or index date (midpoint of surveillance period in ongoing pregnancy controls).[2] Secondary exposures were third mRNA vaccine doses in a 42-day window or any COVID-19 booster in 28- and 42-day windows.[2] Spontaneous abortion cases and ongoing pregnancy controls were identified from electronic health data using a validated algorithm.[2] Among 112,718 unique pregnancies included in the study, the mean (SD) maternal age was 30.6 (5.5) years.[2] Across eight 28-day surveillance periods, among 270,853 ongoing pregnancy-period controls, 11,095 (4.1%) had received a third mRNA COVID-19 vaccine in a 28-day window; among 14,226 cases, 553 (3.9%) had received a third mRNA COVID-19 vaccine within 28 days of the spontaneous abortion.[2] Receipt of a third mRNA COVID-19 vaccine was not associated with spontaneous abortion in a 28-day window (AOR, 0.94; 95%CI, 0.86-1.03).[2] Results were consistent when using a 42-day window (AOR, 0.97; 95%CI, 0.90-1.05) and for any COVID-19 booster in a 28-day (AOR, 0.94; 95%CI, 0.86-1.02) or 42-day (AOR, 0.96; 95%CI, 0.89-1.04) exposure window.[2] In this case-control surveillance study, COVID-19 booster vaccination in pregnancy was not associated with spontaneous abortion.[2] These findings support the safety of recommendations for COVID-19 booster vaccination, including in pregnant populations.[2] [Full text]

- There is limited data on the use of incentives to promote COVID-19 vaccination. This survey study, ***Perceived Influence of Incentives on COVID-19 Vaccination Decision-making and Trust***, examined the prevalence of incentive receipt for COVID-19 vaccination overall and by sociodemographic group, the association of incentives with COVID-19 vaccine uptake, and the association of sociodemographic characteristics with the perceived influence of incentives on trust in the COVID-19 vaccine.[3] An online survey was conducted between June 15 and June 23, 2022, using the RAND American Life Panel, yielding nationally representative estimates from a probability-based sample of the US adult population.[3] Of the 2,042 vaccinated respondents, 136 respondents (9%) reported receiving an incentive, commonly employment-related (eg, paid time off) or a gift card.[3] Of the respondents who received an incentive, 101 (64%) reported that an incentive made no difference in their decision to get vaccinated.[3] The proportion of respondents who received an incentive varied by age group and race and ethnicity (5 Asian or Pacific Islander individuals [6%], 24 Black or African American individuals.[3] Race and ethnicity, urbanicity, income, and education were significantly associated with perceptions of incentives' influence on trust in vaccination.[3] Approximately 20%of Asian or Pacific Islander, Black, and Hispanic respondents reported that incentives increased their trust in the COVID-19 vaccine, compared to 4%of White respondents (47 respondents).[3] Rural respondents were significantly more likely than urban respondents to report that incentives eroded their trust in vaccination (166 respondents [34%] vs 351 respondents [22%]; $P < .001$).[3] As income or educational attainment increased, an increasing proportion of respondents indicated that the incentive did not have any influence on their trust.[3] This survey study found that although there has been substantial policy attention around incentivizing COVID-19 vaccination, fewer than 1 in 10 vaccinated individuals in a nationally representative sample of US adults reported receiving an incentive.[3] Most vaccinated respondents reported that an incentive did not make a difference in their decision-making to get the COVID-19 vaccine.[3] [Full text]

- In the study ***Analysis of All-Cause Hospitalization and Death Among Nonhospitalized Patients with Type 2 Diabetes and SARS-CoV-2 Infection Treated with Molnupiravir or Nirmatrelvir-Ritonavir During the Omicron Wave in Hong Kong***, researchers the University of Hong Kong analyzed the electronic medical records of 3,428 non-hospitalized patients with both type 2 diabetes and COVID-19 who received one of the two oral

antiviral drugs or no treatment (controls).[6] The study was conducted from February 26 to October 23, 2022, a period dominated by the SARS-CoV-2 Omicron variant.[6] Antiviral use was associated with a 29% lower risk of all-cause death and/or hospitalization.[6] Crude incidence rates for death and/or hospitalization were 1,024.9 per 100,000 person-days among molnupiravir users and 1,952.4 per 100,000 person-days among controls.[6] Crude incidence rates of the composite outcome were 695.8 per 100,000 person-days among Paxlovid users and 1,131.2 per 100,000 person-days among controls.[6] At a median follow-up of 102 days, relative to no treatment, molnupiravir was tied to a lower risk of all-cause death and/or hospitalization and in-hospital disease progression.[6] At a median follow-up of 85 days, Paxlovid was linked to a lower risk of all-cause death and/or hospitalization and a nonsignificant lower risk of in-hospital illness progression, compared with no treatment.[6] Researchers also said that their findings suggest that in scenarios in which patients with type 2 diabetes are not eligible to receive nirmatrelvir-ritonavir, molnupiravir may be a reasonable option.[6] [Full text]

# Cases and Deaths as of 22 May 2023

- As of 22 May 2023 (1PM, GMT+7), worldwide, there were **688,988,844** confirmed cases, including **6,880,317** deaths. Globally, the Case Fatality Rate (CFR) was **1.0%.**
- **36,049,202 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 BOOSTED | FULLY VACCINATED/ 100 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ASEAN REGION | Brunei Darussalam | 10 Mar 20 | 16-May-23 | 299,505 | - | 225 | - | 64,053 | 450,404 | 445,929 | 338,987 | 99.3 |
| | Cambodia | 27 Jan 20 | 20-May-23 | 138,739 | - | 3,056 | - | 841 | 15,244,858 | 14,609,937 | 10,433,215 | 87.1 |
| | Indonesia | 02 Mar 20 | 22-May-23 | 6,802,310 | 220 | 161,675 | 1 | 2,490 | 203,657,535 | 172,693,321 | 67,952,274 | 62.7 |
| | Lao PDR | 24 Mar 20 | 21-May-23 | 218,193 | - | 758 | - | 3,041 | 5,888,649 | 5,222,417 | | 69.4 |
| | Malaysia | 25 Jan 20 | 22-May-23 | 5,094,448 | 6,439 | 37,070 | 24 | 15,788 | 28,125,245 | 27,536,657 | 17,056,957 | 81.1 |
| | Myanmar | 23 Mar 20 | 21-May-23 | 638,034 | 3 | 19,494 | - | 1,173 | 34,777,314 | 27,545,329 | 2,227,351 | 50.8 |
| | Philippines | 30 Jan 20 | 21-May-23 | 4,127,628 | - | 66,466 | - | 3,771 | 78,369,243 | 73,937,435 | 21,341,197 | 64.0 |
| | Singapore | 23 Jan 20 | 07-May-23 | 2,391,248 | - | 1,727 | - | 39,049 | 5,161,990 | 5,120,768 | 4,440,289 | 90.8 |
| | Thailand | 13 Jan 20 | 15-May-23 | 4,736,356 | - | 33,989 | - | 6,791 | 57,005,497 | 53,486,086 | 32,143,431 | 74.6 |
| | Vietnam | 23 Jan 20 | 21-May-23 | 11,602,738 | - | 43,203 | - | 11,950 | 90,450,881 | 85,848,363 | 57,452,750 | 87.4 |
| | **ASEAN COUNTRIES** | | | **36,049,202** | **6,662** | **367,663** | **25** | **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 | 195,546,433 | 6,798 | 1,206,281 | 12 |
| AFRICA | 12,823,223 | | 258,762 | |
| AMERICAS | 195,322,121 | 217 | 2,988,128 | 1 |
| EUROPE | 249,247,865 | | 2,059,483 | - |
| TOTAL | **652,939,642** | **7,015** | **6,512,654** | **13** |

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



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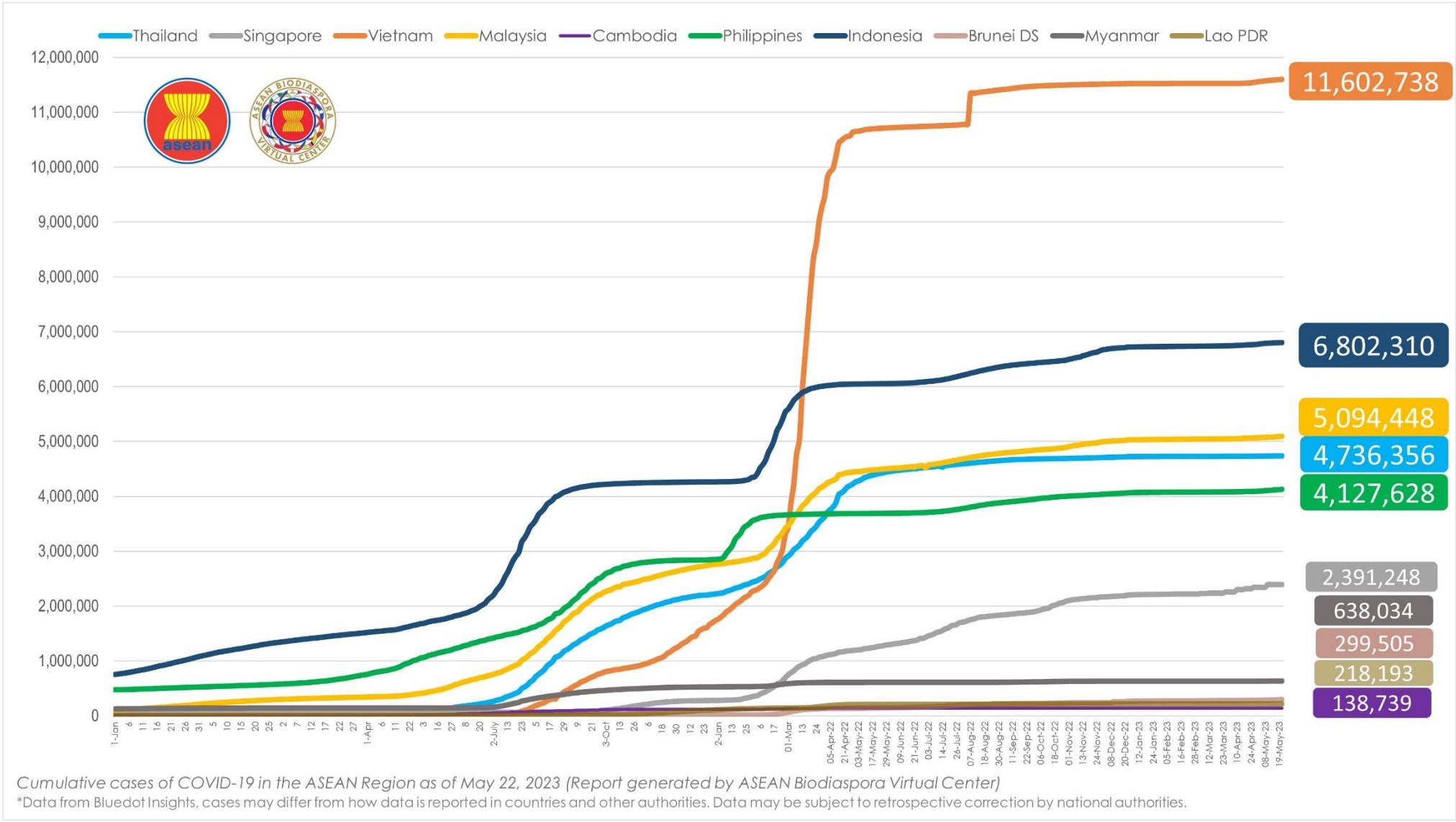
# COVID-19 Epi curve among ASEAN Countries:

*From January 1, 2022 to May 22, 2023*




*Cumulative cases of COVID-19 in the ASEAN Region as of May 22, 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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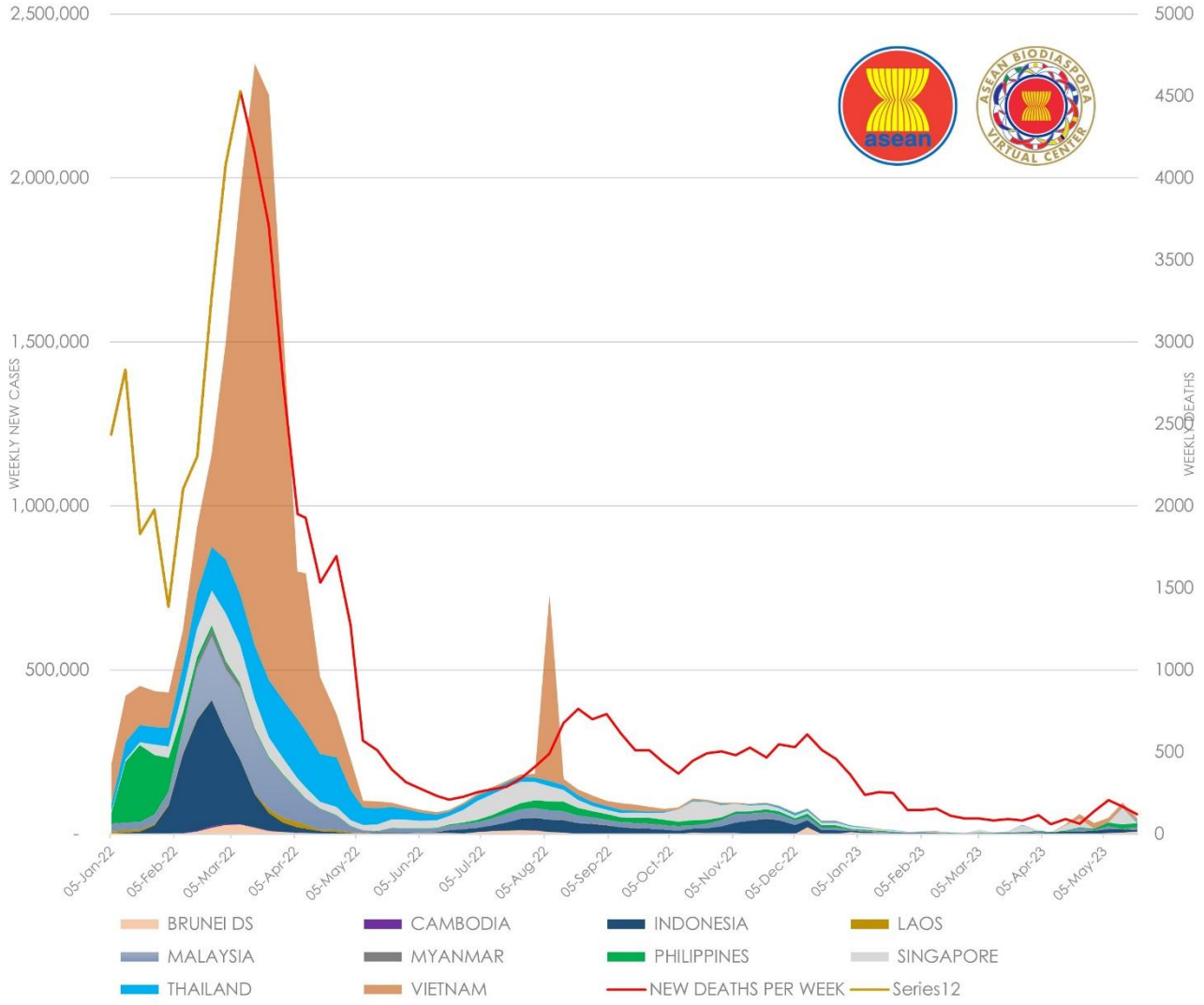
# ASEAN Weekly COVID-19 New Cases and New Deaths

*From January 1, 2022 to May 21, 2023*




| ASEAN Country | Weekly New Cases May 15-21, 2023 | Weekly Deaths May 15-21, 2023 |
|---|---|---|
| Brunei Darussalam | 6,861 | 0 |
| Cambodia | 3 | 0 |
| Indonesia | 4,754 | 65 |
| Lao PDR | 95 | 0 |
| Malaysia | 8,573 | 18 |
| Myanmar | 705 | 0 |
| Philippines | 12,426 | 13 |
| Singapore | - | 0 |
| Thailand | 2,356 | 22 |
| Vietnam | 12,121 | 2 |



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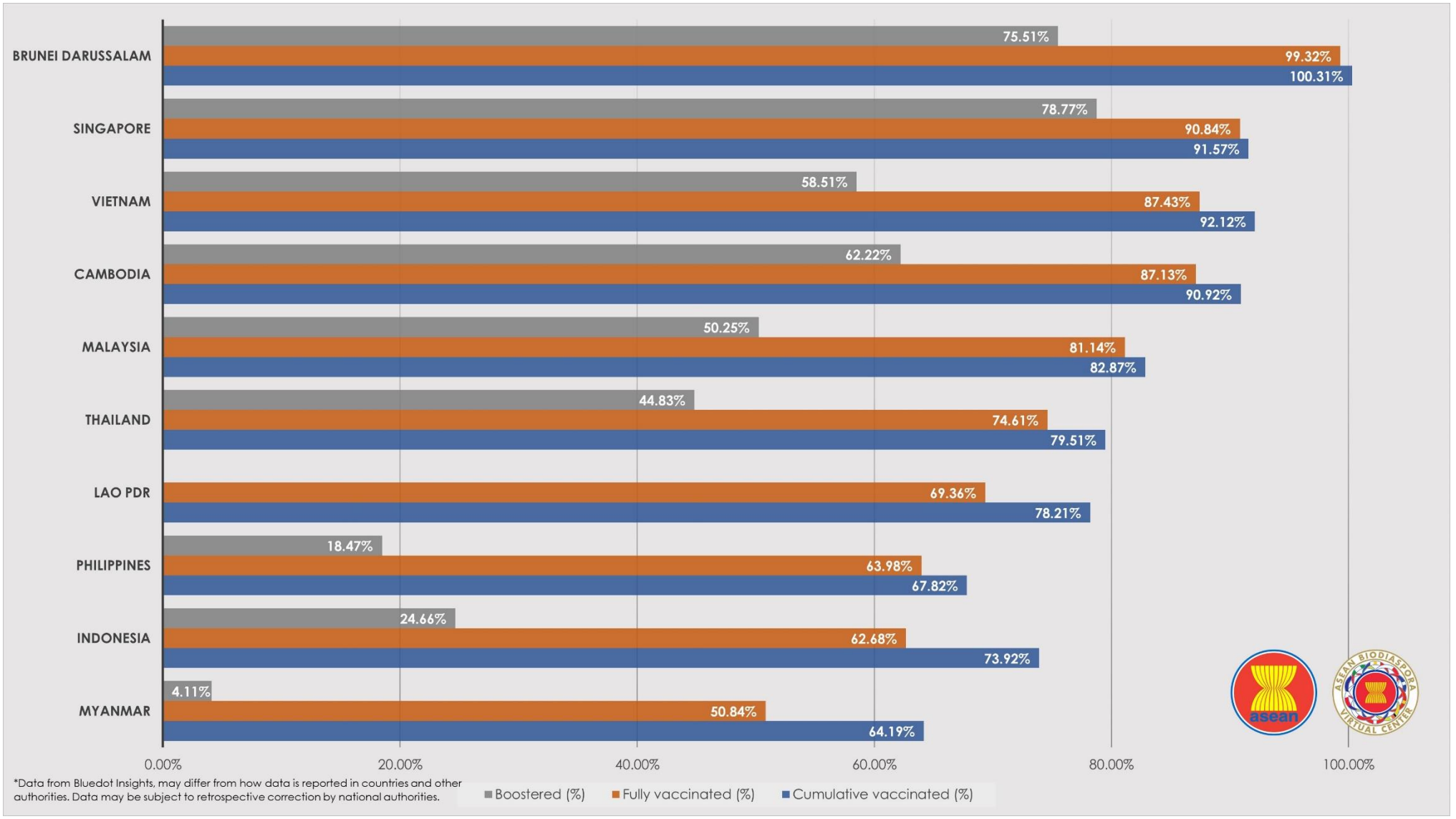
# ASEAN COVID-19 Vaccination Status

*as of 09 March 2023*




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



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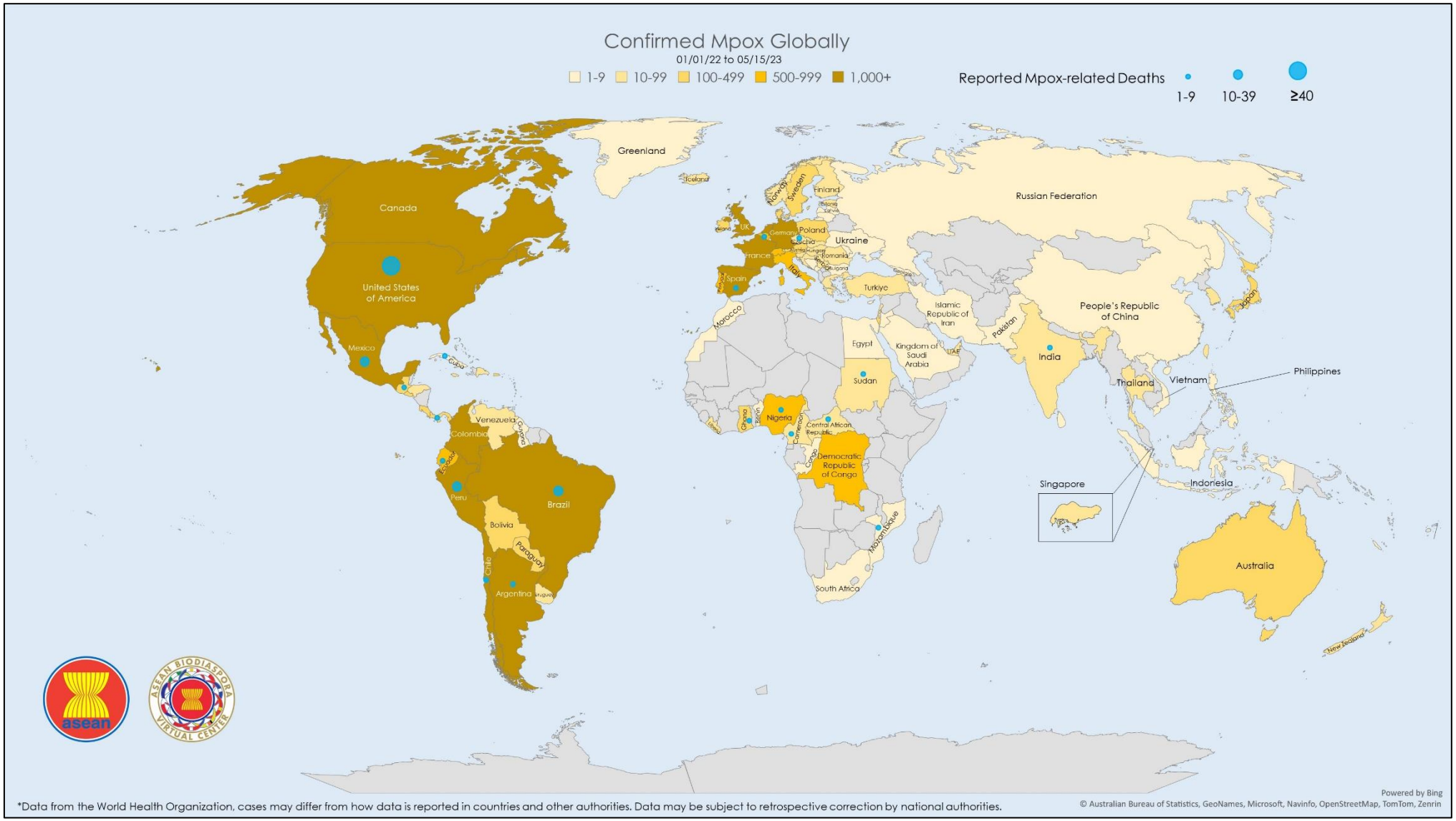
# Mpox Cases Reported Globally

*as of May 15, 2023*




*Data from the World Health Organization, 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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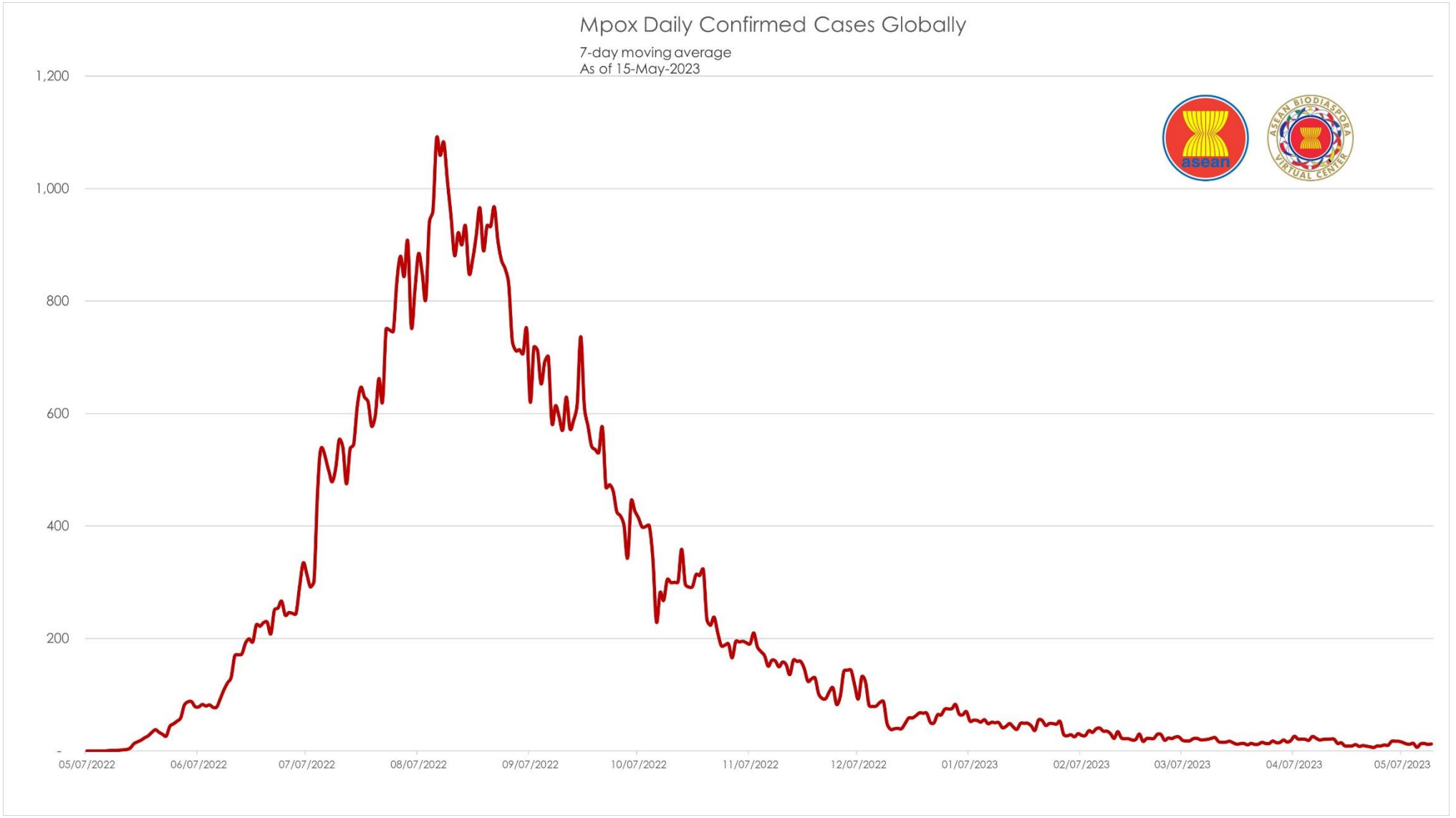
# Mpox Daily Trend Globally

*as of May 15, 2023*



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# Mpox: Highlights and Situation Overview

- As of 15 May 2023 (1PM, GMT+7), there were **87,429** confirmed cases worldwide, including **140** deaths. Globally, the Case Fatality Rate (CFR) was **0.16%.**
- **59 confirmed cases** in the ASEAN region, with a CFR of **0%.**
- **87,370 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** | 26 | - | - | 0.00% |
| **Vietnam** | 2 | - | - | 0.00% |
| **ASEAN Total** | **59** | **-** | **-** | **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** | 135 | - | - | 0.00% |
| **New Caledonia** | 1 | - | - | 0.00% |
| **New Zealand** | 41 | - | - | 0.00% |
| **People's Republic of China*** | 87 | - | - | 0.00% |
| **Republic of Korea** | 75 | - | - | 0.00% |
| **Sri Lanka** | 2 | - | - | 0.00% |
| **Asia-Pacific Total** | **508** | **-** | **1** | **0.20%** |

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

### *Top 5 countries with the most mpox cases globally*

| Country | Total Cases | New Cases | Deaths | Case Fatality Rate (CFR) |
|---|---|---|---|---|
| **United States of America** | 30,154 | - | 42 | 0.14% |
| **Brazil** | 10,920 | - | 16 | 0.15% |
| **Spain** | 7,551 | - | 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** | 1,626 | - | 19 | 1.17% |
| **AMERICAS** | 59,294 | - | 114 | 0.19% |
| **ASEAN** | 59 | - | - | 0.00% |
| **ASIA PACIFIC** | 508 | - | 1 | 0.20% |
| **EUROPE** | 25,617 | - | 6 | 0.02% |
| **MIDDLE EAST** | 325 | - | - | 0.00% |
| **TOTAL** | **87,429** | **-** | **140** | **0.16%** |



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