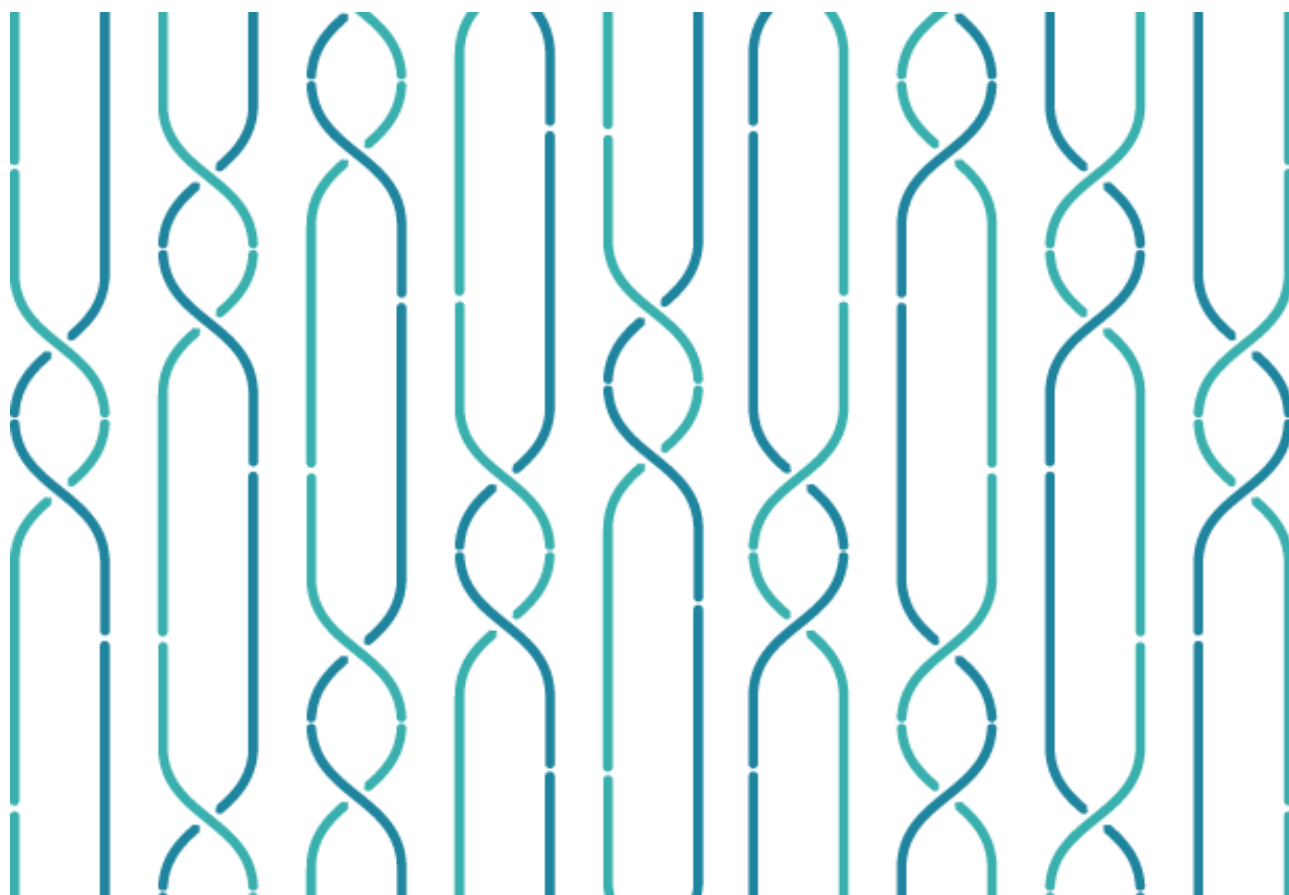


COVID-19 TRENDS AND INSIGHTS REPORT

11 November 2022



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Purpose of report

This report comments on trends in the New Zealand COVID-19 outbreak, including cases, hospitalisations and mortality. It also comments on international COVID-19 trends and the latest scientific insights related to outbreak management. The report relies on data that may be subject to change or are incomplete. An unknown proportion of infections are not reported as cases, this proportion may differ by characteristics such as ethnicity or deprivation group. Therefore, any differences in reported case rates must be interpreted with caution.

Executive summary

Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic are stabilising, after substantially increasing since early October. Following a similar trend to case rates, hospital admission and occupancy rates have also started to stabilise. Meanwhile, mortality counts have also been relatively stable; however, both measures (hospital admission and mortality rates) lag behind changes in infection rates.

BA.5 was the dominant subvariant accounting for an estimated 78% of cases, with the proportion of BA.5 declining slowly over the previous weeks, as detections of BA.2.75 and BQ.1.1 are trending upward, both in WGS and wastewater. Both XBB and BA.2.75 variants are over-represented in reinfections.

It is likely that over the next few weeks cases, hospitalisations and mortality will continue to increase to a new peak of the third wave. However, the size, timing, and duration of the peak and new baseline trends of cases, hospitalisations and mortality is currently uncertain.



Key insights

National Trends

Cases	The 7-day rolling average of reported case rates was 56.7 per 100,000 population for the week ending 06 November. This was very similar to the previous week, which was 55.9 per 100,000. Rates were highest in the 65+ age group (66.9 per 100,000).
Wastewater	Wastewater quantification indicated a decrease in transmission in the past week and suggests that approximately three quarters of infections are being reported as cases.
Hospitalisations	The COVID-19 hospital admissions rate has been increasing since early October, with a 7-day rolling average of 1.1 per 100,000 for the week ending 30 October. The rate was highest in the 65+ age group (3.5 per 100,000).
Mortality	As of 06 November, there were 2,065 deaths attributed to COVID-19 in 2022. The weekly number of deaths attributed to COVID-19 has continued to decrease. The 80+ age group had the highest mortality rate across all age groups (0.7 per 100,000).
Variants of Concern	<p>Prevalence of non-BA.5 variants continues to increase slowly. BA.5 accounts for 78% of sequenced community cases seen in the week 21 to 28 October, followed by BA.2.75 (9%), BQ.1.1 (8%), BA.2 (3%) and BA.4.6 (2%). Currently 15 XBB cases have been detected in the most recently reported fortnight, increasing from one in the fortnight prior.</p> <p>Wastewater variant analysis for the fortnight ending 30 October reports the following proportions: BA.4/5 88%, BA.1/BA.2.75 8% and BQ.1.1 4%.</p>

Māori

Cases	The 7-day rolling average of age-standardised reported case rates was 39.6 per 100,000 population on 06 November, lower than for European or Other, however there may be case ascertainment biases. Rates were highest in those aged 45-64 and 25-44 (55.7 and 50.2 per 100,000, respectively).
Hospitalisations	The age-standardised cumulative hospital admission risk for 2022 was 1.8 times higher in Māori than European or Other. The 7-day rolling average to 30 October was 0.7 per 100,000 and highest in those aged 80+ (6.2 per 100,000), followed by those aged 70-79 (4.8 per 100,000).
Mortality	The age-standardised cumulative mortality rate for Māori was 1.9 times higher than European or Other in 2022.



Pacific peoples

Cases	The 7-day rolling average of age-standardised reported case rates was 35.7 per 100,000 population on 30 06 November, lower than for European or Other, however there may be case ascertainment biases. Rates were highest in those aged 65+ and 25-44 (50.6 and 48.8 per 100,000, respectively).
Hospitalisations	Pacific peoples have the highest age-standardised cumulative risk of hospital admission in 2022, 2.3 times higher than European or Other. The 7-day rolling average to 30 October was 1.0 per 100,000 and highest in those aged 80+ (6.8 per 100,000) followed by those aged 70-79 (2.4 per 100,000).
Mortality	Pacific peoples have the highest age-standardised cumulative mortality risk of any ethnicity in 2022, 2.4 times that of European or Other.

International Insights

Globally, in the week ending 06 November, the number of new weekly cases decreased by 15% compared to the previous week, with over 2.1 million new cases reported. The number of new weekly deaths decreased by 10% compared to the previous week with over 9,400 fatalities reported.

BA.5 Omicron descendent lineages continue to be dominant globally, with a stable weekly prevalence of approximately 74.5% as of 23 October. Proportions of BQ.1.1 and XBB and other subvariants of Omicron remain low but are increasing globally.

At the country level, the highest numbers of new weekly cases were reported from Japan, the Republic of Korea, the United States of America, Germany and China.

In Australia, cases and hospitalisations increased slightly as of 04 November.



National summary of epidemic trends

Case trends

Evidence supports a stabilisation in incidence in the community: Reported¹ case rates have been stable in the past week while levels of viral ribonucleic acid (RNA) in wastewater have decreased (see **Figure 1**). Recent wastewater data to 0 October suggested that approximately 72-75% of infections were reported as cases.

Cases have been tracking above the modelled median since early October and have been relatively stable in the week ending 06 November. Updated model scenarios accounting for a 10% increase in transmissibility caused by new variants, waning immunity, changes in masking and contact quarantine on 12 September, indicate that case rates are expected to increase (see **Figure 2**)². The variant model is hypothetical but based on the properties of lineages recently reported overseas.

The general population reported case rate for the week ending 06 November was 56.7 per 100,000, similar to the previous week (55.9 per 100,000). The case rate was highest in Central region (70.5 per 100,000), having decreased by 1.3%, and lowest in Te Manawa Taki (44.4 per 100,000), having increased by 2.8% compared with the week prior (see **Figure 3**).

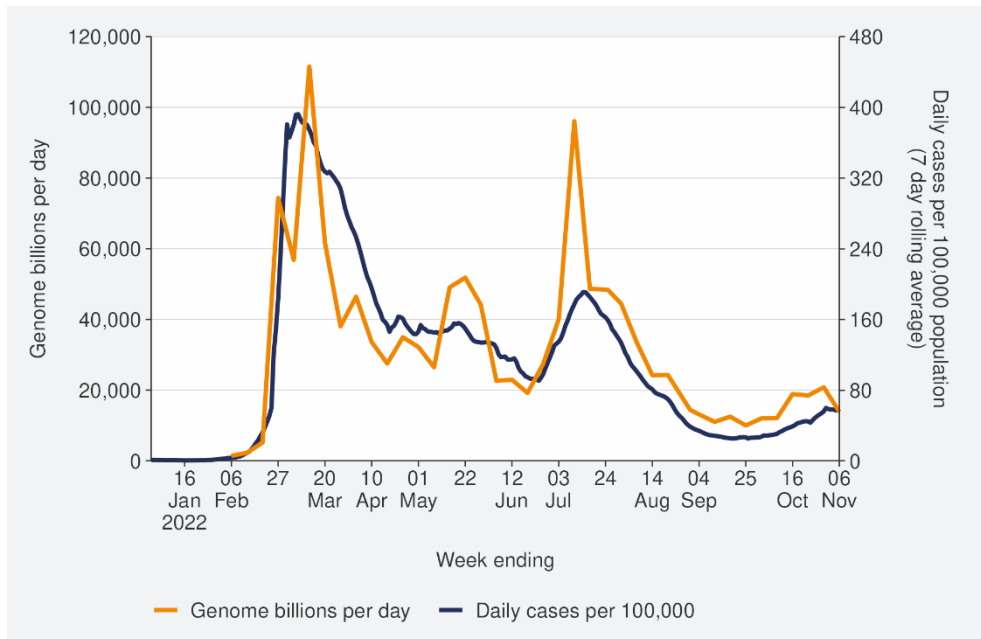
Increases were seen in younger age groups (<5, 5-14 and 15-24) while older age groups remained relatively stable (25-44 and 65+) or decreased (45-64). The highest rate across all age groups was in those aged over 65 years (66.9 per 100,000). The lowest rate was among under 5 years and 5-14-year-olds (29.8 and 33.6 per 100,000 respectively) (see **Figure 4**).

The appendix provides information on specific rates.

¹ Since 24 February 2022, most testing has been through self-administered rapid antigen tests (RATs) which require self-reporting of results. Therefore, it is likely that many infections are not detected or reported, and the proportion of infections reported ('reported cases') may differ by age, ethnicity, and deprivation.

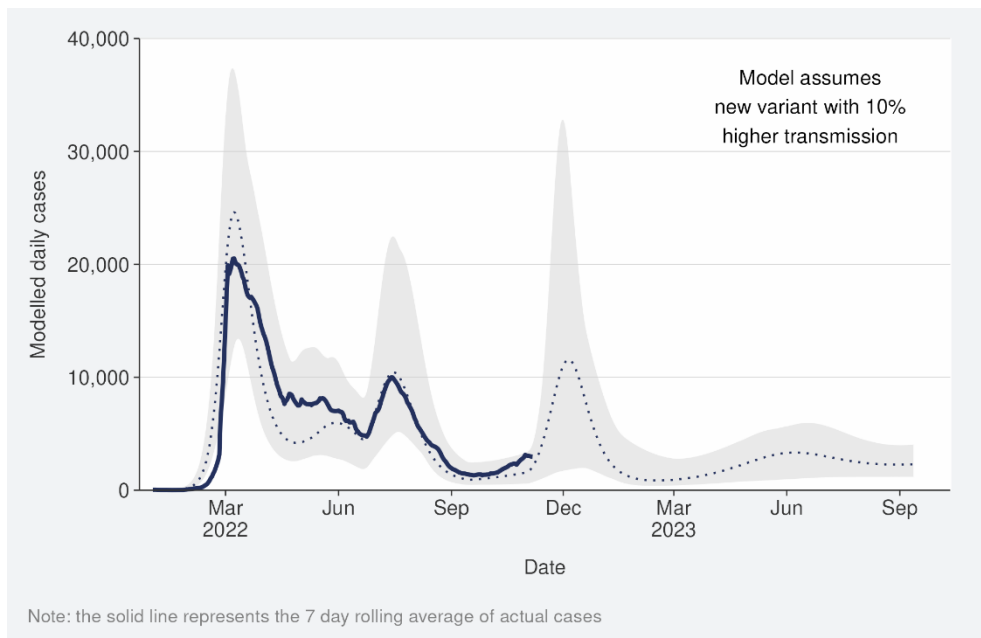
² See the online glossary for modelling assumptions.

Figure 1: National wastewater trends (SARS-CoV-2 genome copies)³ compared with reported cases



Sources: ESR SARS-CoV-2 in wastewater update for week ending 06 November 2022 and NCTS/EpiSurv as at 2359hrs 09 November 2022

Figure 2: COVID-19 Modelling Aotearoa scenarios⁴ compared with national reported case numbers



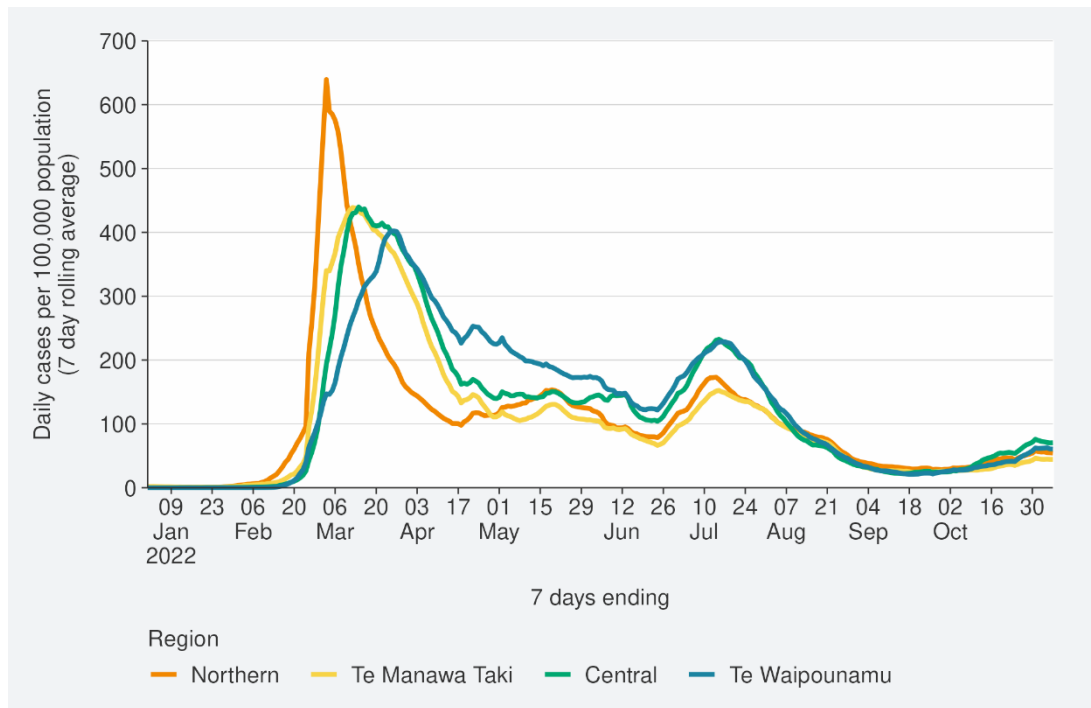
Sources: COVID-19 Modelling Aotearoa, ordinary differential equation model, October 2022, and NCTS/EpiSurv as at 2359hrs 06 November 2022

³ Wastewater levels cannot be used to predict numbers of cases but do indicate trends in the infection rates.

⁴ The 'July' BA.5 scenario assumes that previous infection provides greater protection against reinfection and severe disease, this is consistent with emerging international evidence. It also incorporates updated data and future projections of uptake of second boosters, and an earlier transition to BA.5, consistent with the timing of cases and hospitalisations in New Zealand.

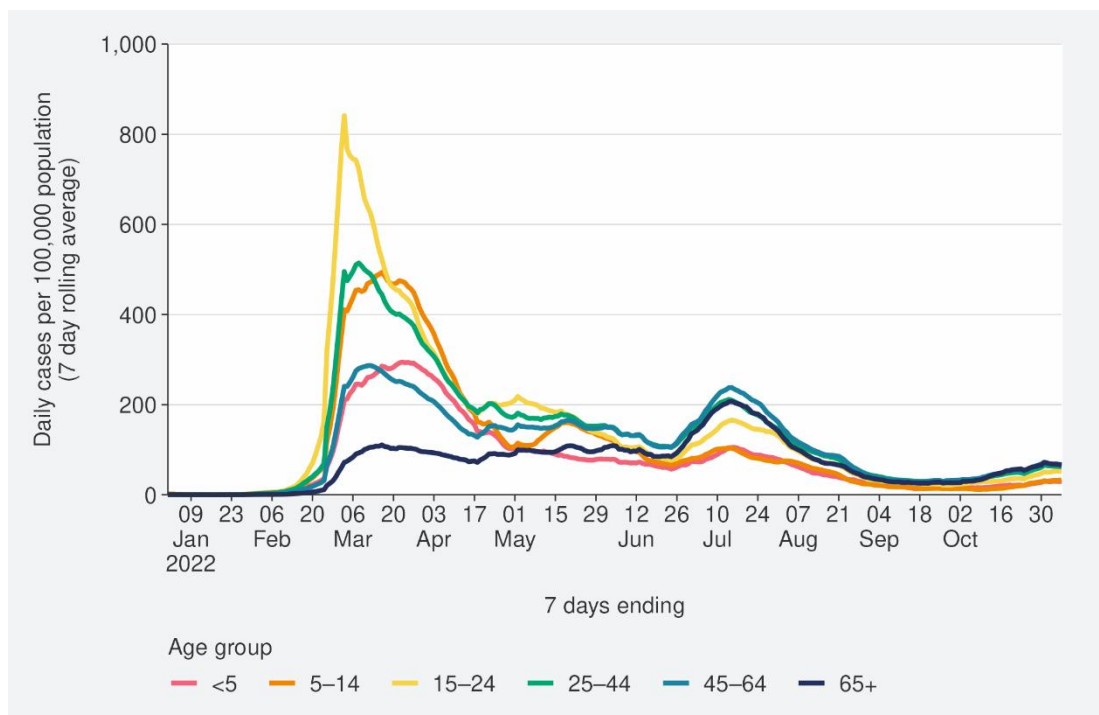


Figure 3: Regional reported case rates from January to 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022

Figure 4: National reported case rates by age from January to 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022



Hospitalisation and mortality trends

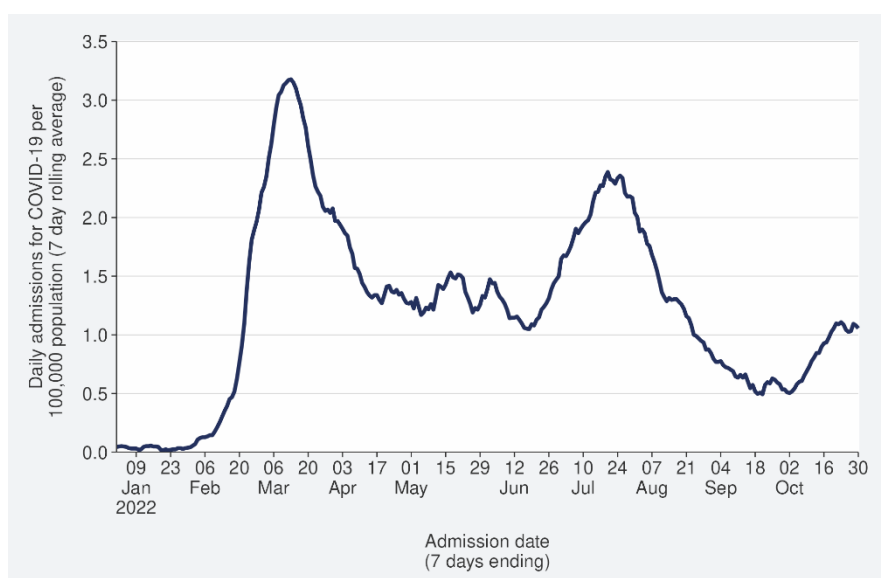
Hospitalisation

As seen in **Figure 5**, the national COVID-19 hospital admissions rate 'for' COVID-19 decreased substantially from mid-July but increased since mid-September and have been plateaued from the last week of October. Hospital admission rate slightly decreased by 4.7% with a 7-day rolling average of 1.1 per 100,000 population for the week ending 30 October.⁵

Despite reported case rates in the most recent July peak being half that of the March peak (201.2 and 413.2 per 100,000, respectively), the hospitalisation rate in the July peak was not substantially lower than the hospitalisation rate in March. This can be explained by the strong association between age and poor outcomes after infection. The reported case rates in those aged >65 years peaked at 75% higher in July than in March (refer back to **Figure 4**).

Modelling scenarios suggest current hospital admissions are tracking above the higher range of the prediction and indicate admissions are expected to increase. The variant model is hypothetical but based on the properties of lineages recently reported overseas (**Figure 6**).

Figure 5: National⁶ hospital admissions rate for COVID-19, January to 30 October 2022



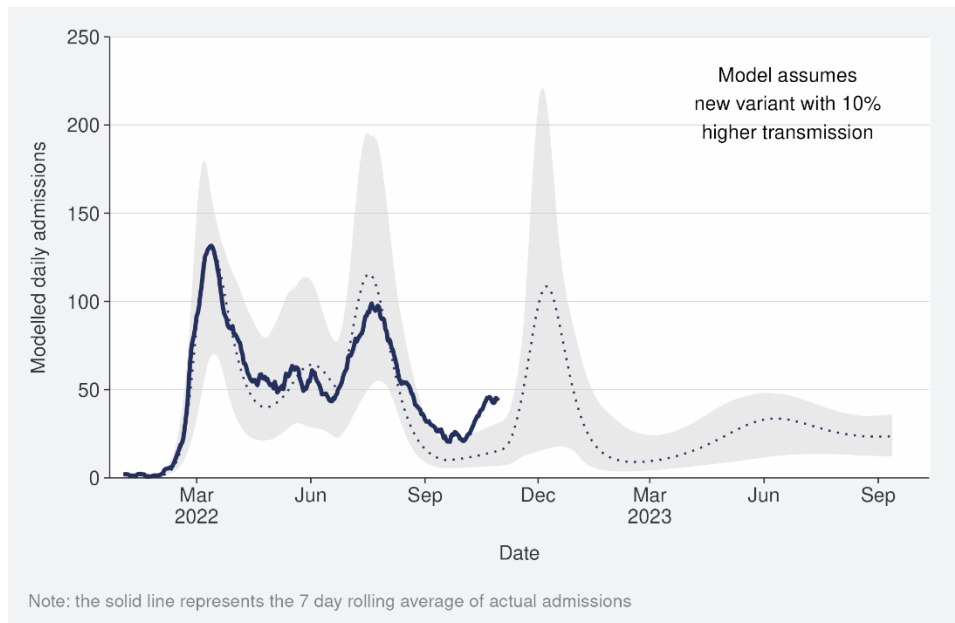
⁵New hospital admissions who had COVID-19 at the time of admission or while in hospital; excluding hospitalisations that were admitted and discharged within 24hrs. The 'for' measure excludes those who are identified as incidental with COVID-19, such as injuries. Recent trends are subject to revision. Please see glossary for further caveats.

⁶Data are from Districts with tertiary hospitals; these Districts are Auckland, Canterbury, Southern, Counties Manukau, Waikato, Capital & Coast, Waitemata, and Northland.



Source: NMDS/Inpatient's admissions feed as of 06 November 2022 data up to 30 October 2022

Figure 6: COVID-19 Modelling Aotearoa hospital admissions scenario⁷ compared with national admissions



Sources: COVID-19 Modelling Aotearoa, ordinary differential equation model, October 2022, and Ministry of Health reported hospital admission data 31 October 2022

Mortality

From the first week of January to 06 November 2022, there were 3,166 deaths among people who died within 28 days of being reported as a case and/or with the cause being attributable to COVID-19 (that is an underlying or contributory cause) (see **Figure 7**)⁸.

Of the deaths in 2022, that have been formally coded as COVID-19 as the cause of death, 1,302 (47%) were determined to have COVID-19 as the main underlying cause. COVID-19 contributed to a further 763 (28%) deaths and another 693 (25%) people died of an unrelated cause (**Figure 7**). Deaths have been declining since peaking in the last week of July, though in the past few weeks this decline has slowed. As seen with hospitalisations, due to the strong association of increasing age and increasing mortality risk, the patterns in mortality over time strongly reflect the case rates in those aged >65 years.

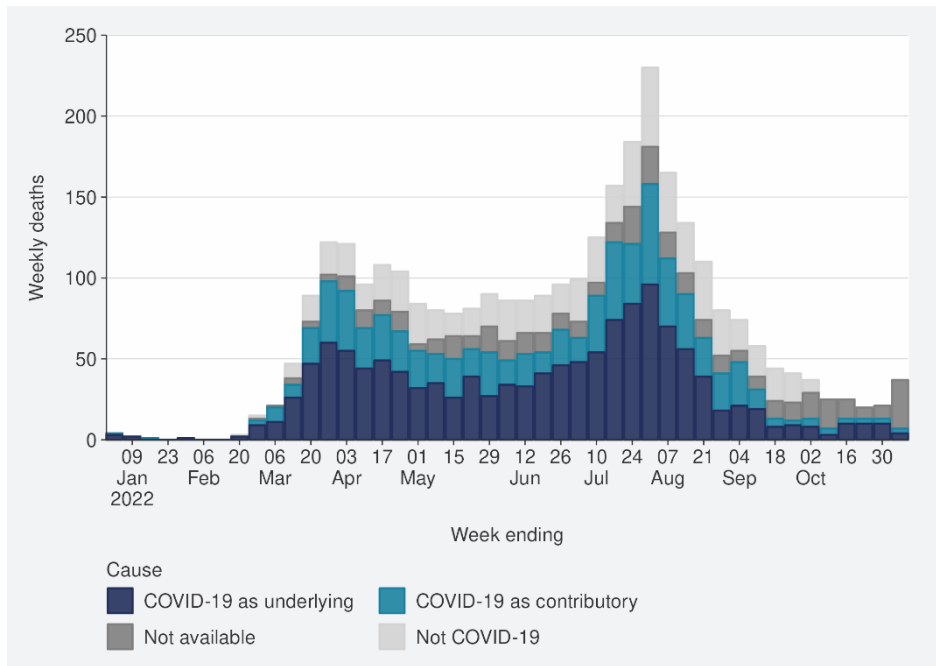
Deaths are currently tracking close to the lower range of the modelled scenario and are predicted to slightly increase in the coming months (see **Figure 8**).

⁷ The 'October' scenario assumes previous infection provides greater protection against reinfection, severe disease, consistent with emerging international evidence, and transmissibility of an emerging variant is increased by 10%. It also incorporates updated data and future projections of uptake of second boosters, and an earlier transition to BA.5, consistent with the timing of cases and hospitalisations in New Zealand.

⁸ There were 55 deaths before the first week of 2022.

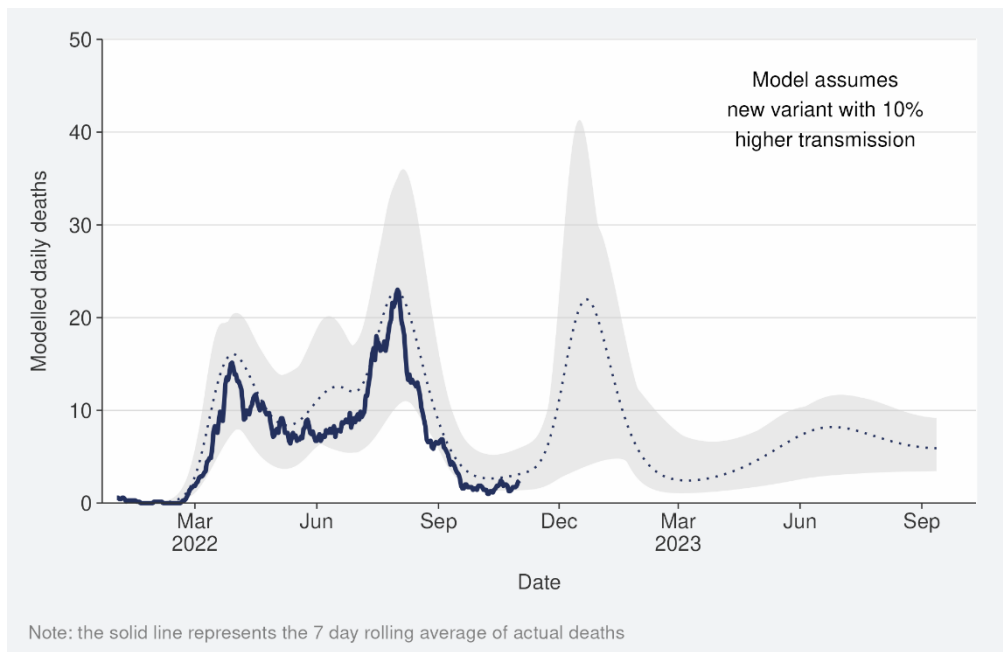


Figure 7: National weekly death counts by cause of death⁹, February to 06 November 2022



Source: Ministry of Health, 06 November 2022

Figure 8: COVID-19 Modelling Aotearoa death count compared with national observed deaths attributed to COVID-19



Sources: COVID-19 Modelling Aotearoa, ordinary differential equation model, October 2022, and Ministry of Health reported attributed deaths data 06 November 2022

⁹ Mortality data are affected by a delay due to time taken for reporting and death coding, the most recent weeks should be interpreted with caution.



Whole Genomic Sequencing

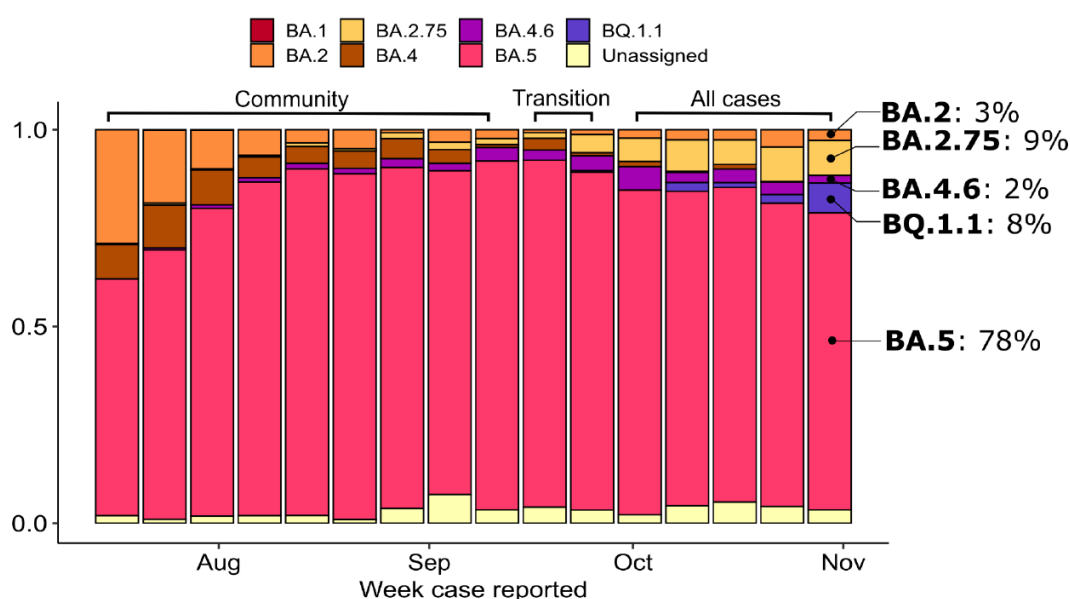
Community cases and wastewater

Whole Genomic Sequencing data is updated on a fortnightly basis; the data has not been updated in this week's report.

Figure 9 shows the proportions of variants in community cases, with BA.5 accounting for 78% of sequenced cases in the week to 28 October. Proportions of the BA.5 subvariant in the community have decreased over the last few weeks, as community cases of variants BQ.1.1 (26 cases), XBB (15 cases) and BA.2.75 have been increasing. Watchlist variants BA.2.75 (9%) and BA.4.6 (2%) continue to be detected.

Wastewater variant analysis for the fortnight ending 30 October reports the following proportions: BA.4/5 88%, BA.1/BA.2.75 8% and BQ.1.1 4%; XBB was also detected.

Figure 9: Proportion of Variants of Concern in community cases¹⁰



Source: ESR COVID-19 Genomics Insights Report #26, EpiSurv/Microreact 0900hrs 02 November 2022

Hospitalised cases

In the fortnight ending 28 October 197/308 PCR-positive samples were received from which 138 were sequenced. As of 1 November; 80% were BA.5, 11% BA.2.75, 6% BA.4.6, 3% BQ.1.1, and <1% were BA.2.

¹⁰ Before the end of the COVID-19 Protection Framework, only data from community cases are presented. In the period marked as "transition", cases known to be associated with the border were removed, but not all such cases can be reliably identified. Since the transition, data from all cases is used. Results before and after this transition are not directly comparable.



Variant risk assessments for BQ.1.1 and XBB

BQ.1.1 is increasing in prevalence in New Zealand relative to BA.5 (the previous predominant variant). BQ.1.1. is also increasing in frequency overseas and appears to have increased immune evasion compared to previous variants, causing an increase in cases internationally. There is not yet sufficient evidence to assess the performance of testing, therapeutic efficacy, or the severity of disease. Therefore, it is considered to pose a moderate risk though increasing cases rates (compared with BA.5) leading to further hospitalisations and deaths.

XBB has also been detected in recent weeks, and there is some evidence of increased immune evasion, and only weak evidence of a growth advantage and loss of therapeutic efficacy compared with BA.5. However, there is insufficient evidence regarding transmissibility, performance of testing or severity of disease. Overall, the current evidence is not sufficient to support that there is any increase in risk from XBB compared with BA.5.

Refer to the appendix for further details on the risk assessments for BQ.1.1 and XBB, respectively. Further information on variants of concern is also available on the **Ministry of Health COVID-19 Science News Webpage**.



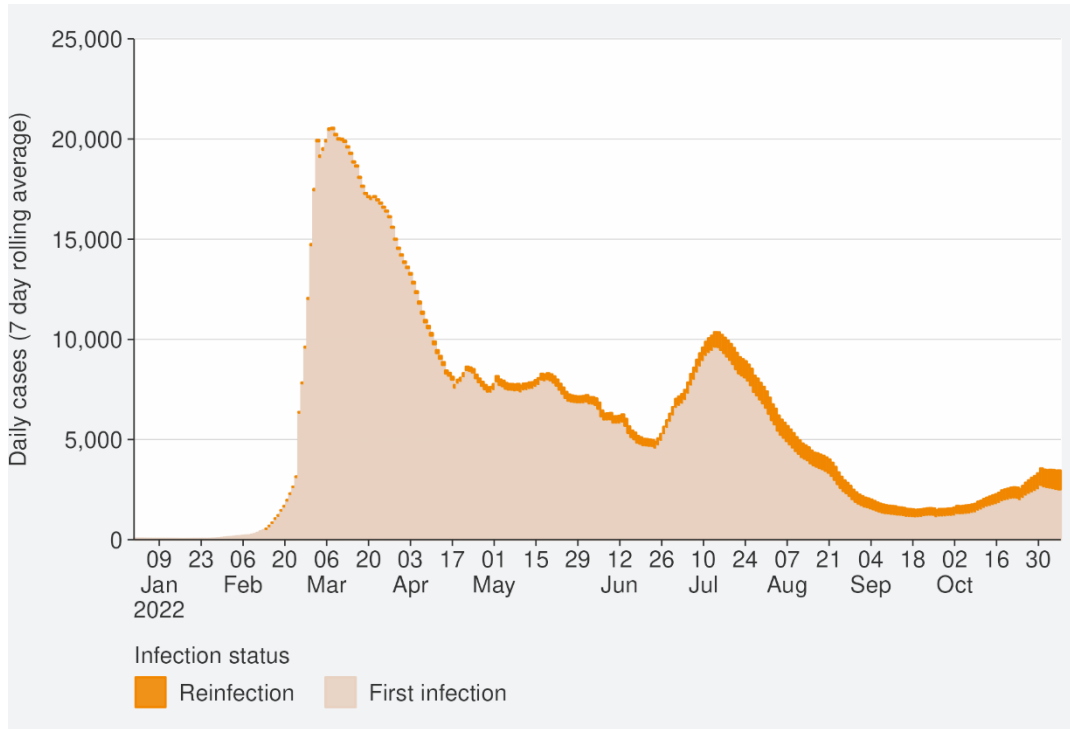
Reinfection

'Reinfection' is now defined as a case reported at least 29 days after the last time a person reported a positive test for COVID-19. The definition of reinfection changed on 30 June; prior to this, reinfection was based on reports at least 90 days apart (based on the international literature at the time). Up until 30 June 2022, the vast majority of positive results detected within 90 days of the prior infection were not recorded in the system. Some potential reinfections within 90 days were recorded but were not representative of the general population.

In general, reinfection refers to a second or subsequent infection after the prior infection has cleared. In this analysis, we are not able to distinguish between reinfection with the same variant or different variants. Reinfection with a different variant to the first infection is more likely than reinfection with the same variant. Technically, these data report on 'redetections' rather than true reinfections. True reinfections cannot be definitively captured in the data for a range of reasons. For example, a person with persistent infection due to being immunocompromised, who undergoes repeated testing due to regular hospital or clinical visits, would appear in the data as a 'reinfection' when they may have a chronic or persistent infection.

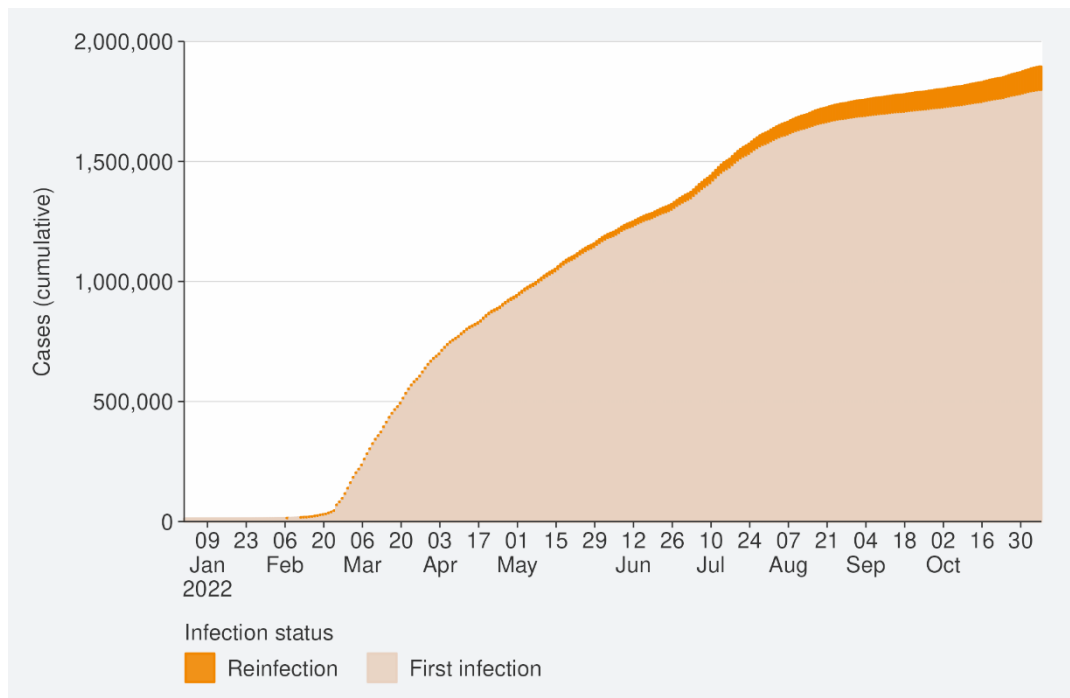
Figure 10 characterises the average number of cases per week by first infection and reinfection. Reinfections made up 14.9% of reported cases in the week ending 06 November. The proportion of reported cases that were reinfections has increased this week, after being stable in the past seven weeks. **Figure 11** shows how many first infections and reinfections have been reported cumulatively over time. Cumulatively, reinfections have made up 2.6% of total cases reported in 2022. The proportion of cases that are reinfections is expected to increase over time. The true number of reinfections is likely higher than reported here. In general, reporting of cases is expected to decline over time. Due to under-ascertainment of the first infection and subsequent infections and, as both are required to detect a reinfection, there is likely to be under-reporting of reinfections.

Figure 10: Reinfections 7 day rolling average from 01 January to 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022

Figure 11: Reinfections cumulatively from 01 January to 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022



Comparison of epidemic trends by ethnicity

The age-standardised reported case rates have slightly increased for all ethnicities, except Asian (see **Figure 12**), in the week to 6 November. The highest rates were in European or Other and Asian (57.6 and 54.6 per 100,000 respectively) and the lowest were in Māori and Pacific peoples (39.6 and 35.7 per 100,000, respectively). Among Māori, rates were highest in those aged 45-64 and 25-44 (55.7 and 50.2 per 100,000, respectively). Among European or Other, case rates were highest in those aged 45-64 and 65+ (68.2 and 71.1 per 100,000, respectively). Rates in Pacific peoples were unlike Māori and European or Other ethnicity. Among Pacific peoples, rates were highest in those aged 65+ and 25-44 (50.6 and 48.8 per 100,000, respectively). Refer to in the appendix for non-age-standardised rates by ethnicity.

Figure 13 shows that the age standardised rates for hospitalisation for COVID-19 increased for Pacific peoples and decreased or remained stable for all other ethnicities in the week ending 30 October. Pacific peoples and Asian ethnicities had the highest hospitalisation rates in the week ending 30 October, with Pacific peoples being almost 2-fold higher than European or Other.

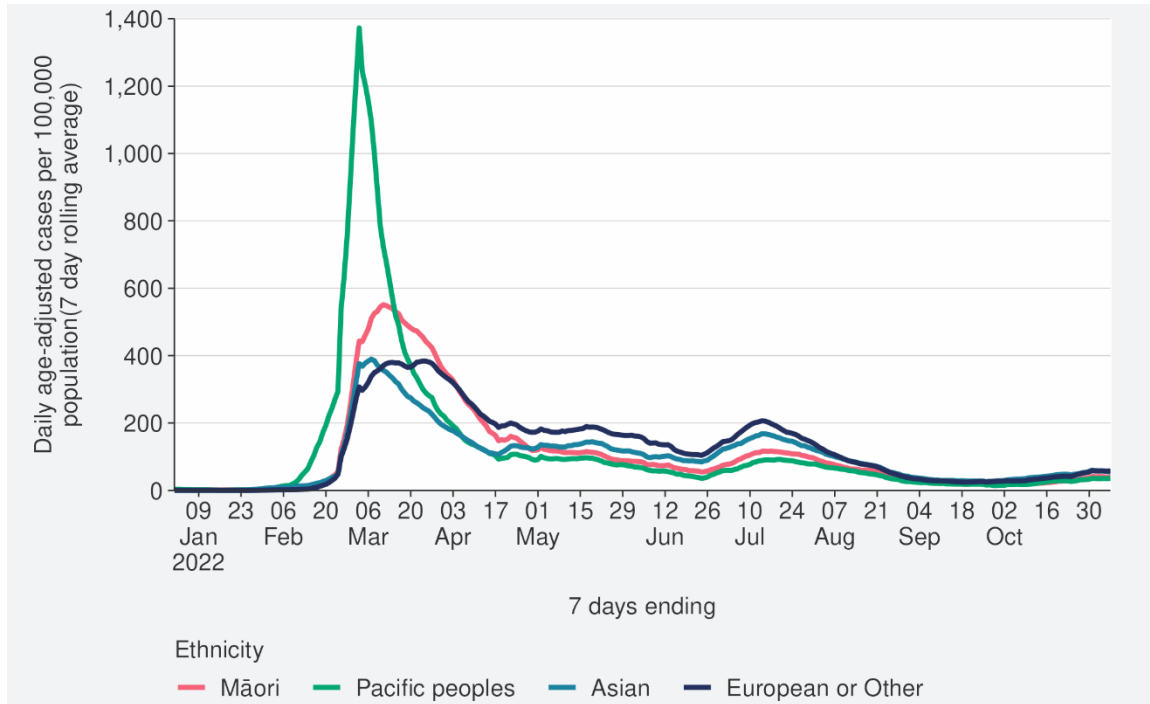
The cumulative total for the year shows that overall, Pacific peoples and Māori have had the highest risks of hospitalisation for COVID-19, 2.3 and 1.8 times the risk of European or Other, respectively for 01 January to 06 November. The Asian ethnicity has had a hospitalisation rate almost 12% lower than European or Other (**Figure 14**).

The cumulative age-standardised mortality rate for 01 January to 06 November shows that Pacific peoples have had the highest risk, 2.4 times that of European or Other, followed by Māori at 1.9 times that of European or Other. Asian people have had the lowest risk of Mortality, 36% lower than European or Other (see **Figure 15**).¹¹

The lower reported case rates and higher hospitalisation and death rates for Māori and Pacific peoples suggests they may have lower levels of case ascertainment and/or a higher risk of poor outcomes after infection compared with Asian and European or Other ethnicities.

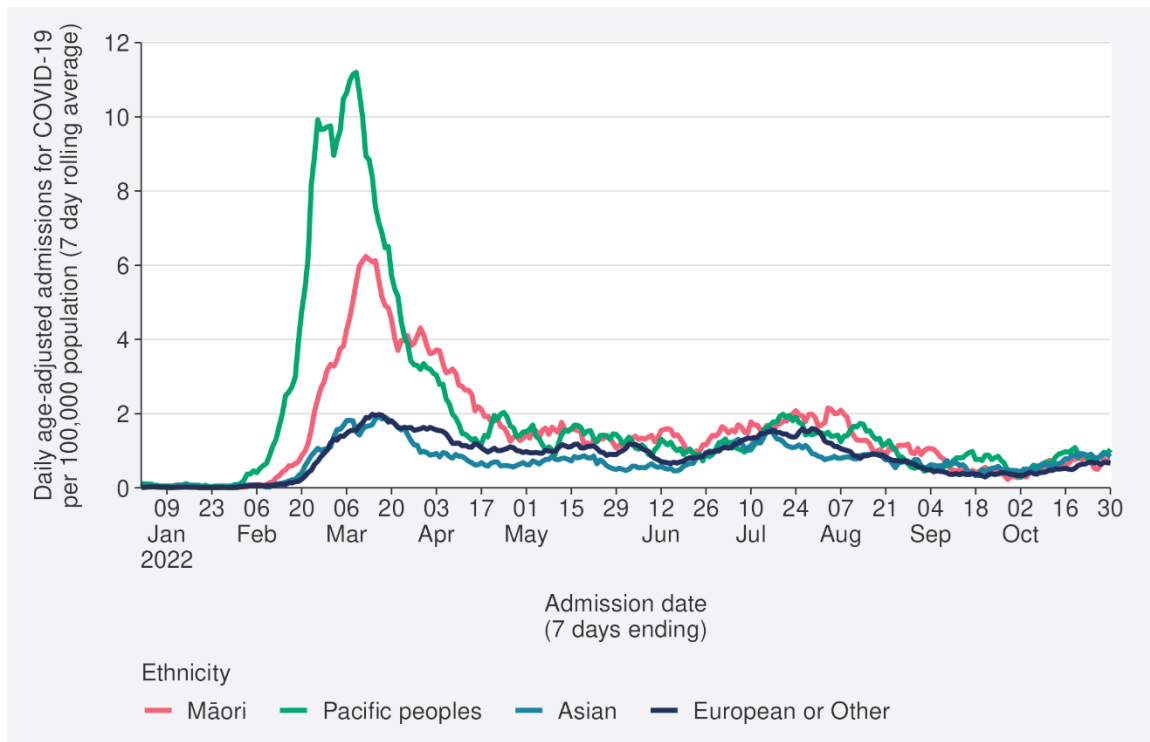
¹¹ These calculations are based on 1,896 deaths occurring between January 2022 and 02 October 2022 (excludes deaths in the last 2 weeks and deaths where ethnicity was unknown).

Figure 12: National age-standardised reported case rates by ethnicity from January to 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022

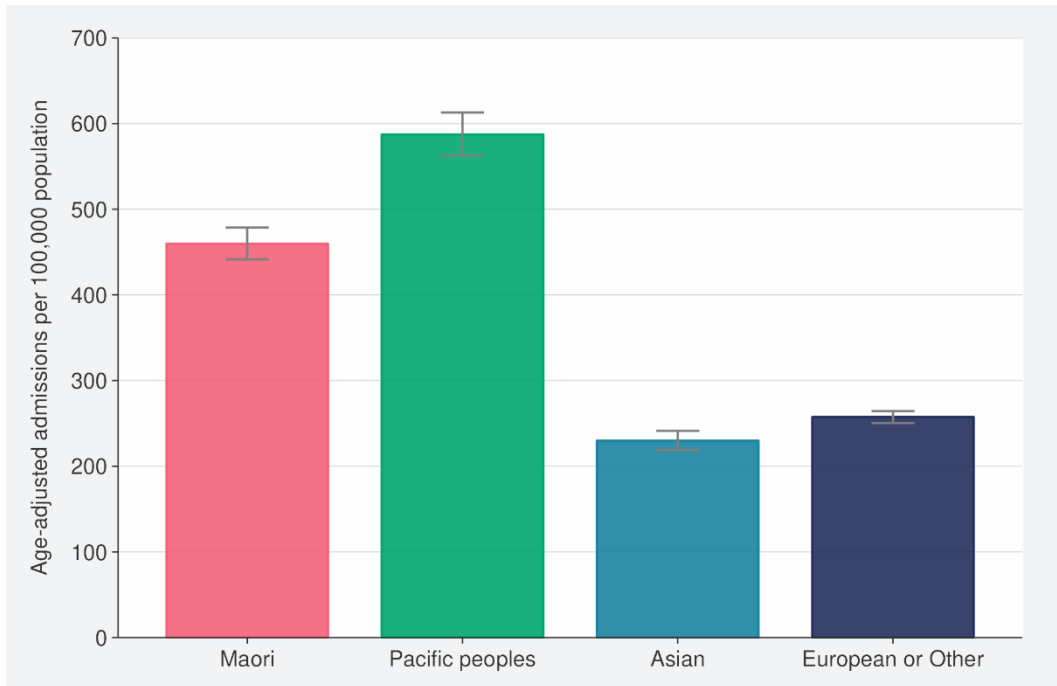
Figure 13: National age-standardised hospitalisation rates by ethnicity from January to 30 October 2022



Source: NCTS/EpiSurv as at 2359hrs 30 October 2022

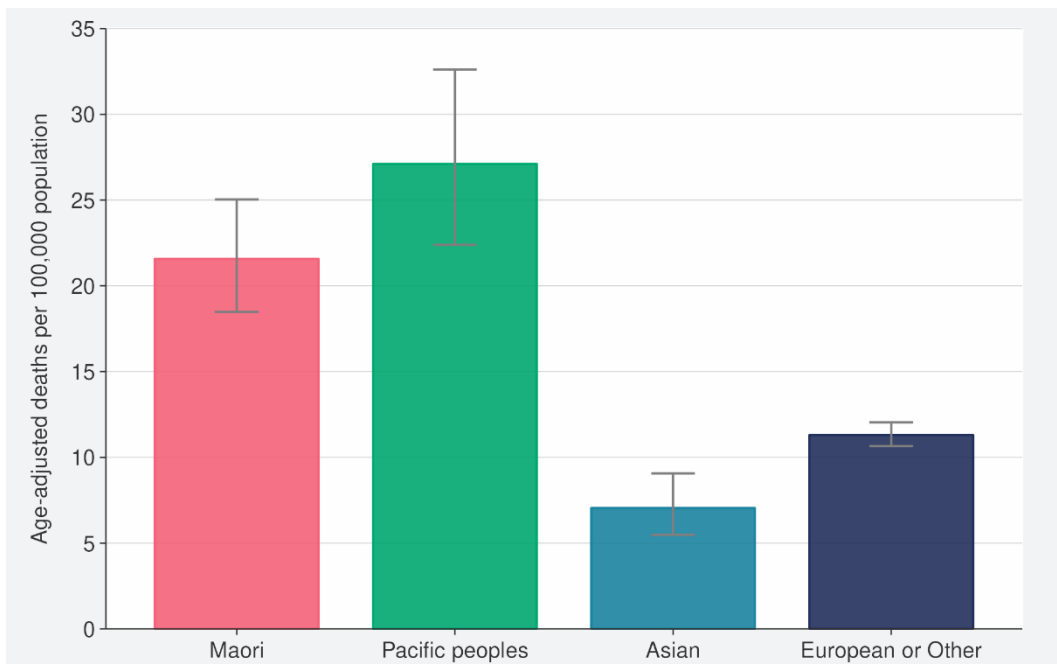


Figure 14: Age-standardised cumulative incidence (and 95% confidence intervals) of hospitalisation for COVID-19 by ethnicity, 01 January 2022 to 06 November 2022



Source: NCTS/EpiSurv, NMDS, Inpatient Admissions dataset and CVIP population estimates, 01 January 2022 to 06 November 2022

Figure 15: Age-standardised cumulative incidence (and 95% confidence intervals) of mortality attributed to COVID-19 by ethnicity, 01 January 2022 to 06 November 2022



Source: NCTS/EpiSurv, NMDS, Inpatient Admissions dataset and CVIP population estimates, 01 January 2022 to 06 November 2022

Comparison of epidemic trends by deprivation

Figure 16 shows the 7-day rolling average for reported case rates by residential area deprivation level (based on NZDep2018)¹². Age-standardised rates for those in areas with the least and most deprivation levels increased in the week ending 06 November; rates in mid-ranged deprivation were stable. Rates in the week to 06 November were slightly higher in areas of least and mid-range deprivation. Refer to the appendix for non-age-standardised rates by deprivation.

Figure 17 and **Figure 18** show that those most deprived have had, and continue to have, the highest rates of hospitalisation, both recently and cumulatively during 2022. Those most deprived have had 2 times the risk of hospitalisation compared with those who are least deprived.

Cumulative rates of mortality are also highest for those most deprived; 2.4 times higher than the risk of those least deprived (**Figure 19**).¹³

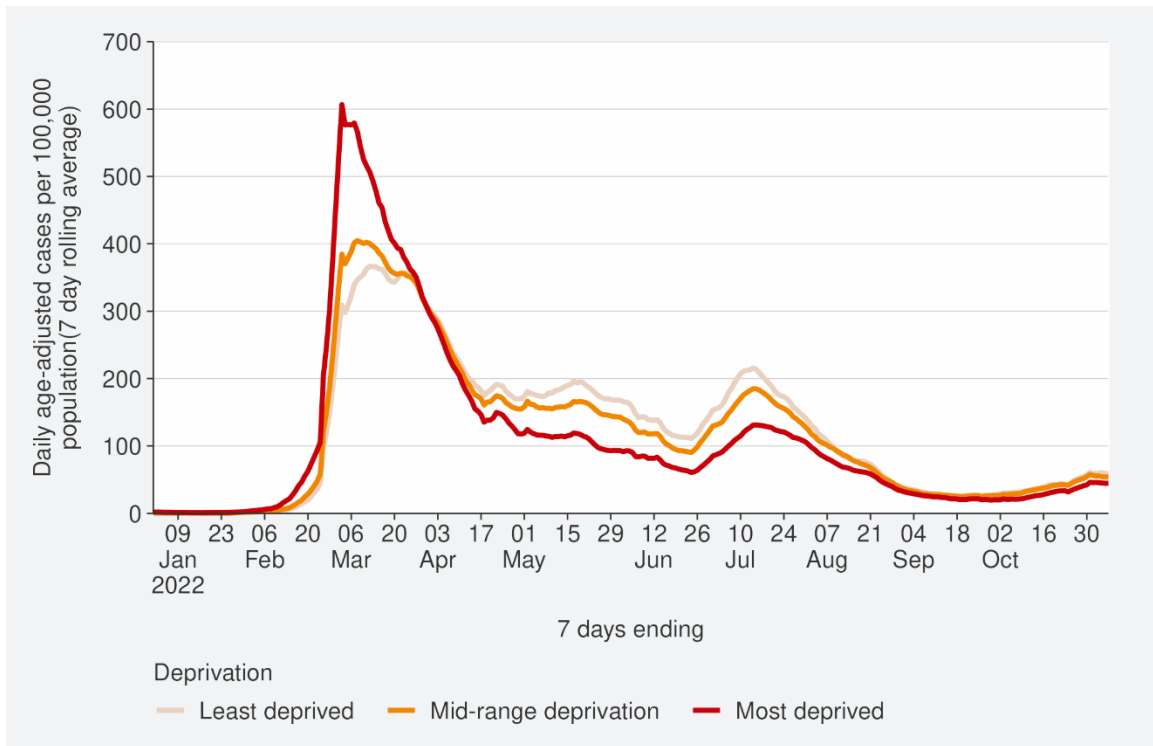
As lower case rates have been reported among those most deprived, continued higher hospitalisation and death rates suggest those who are most deprived may have lower levels of case ascertainment and/or a higher risk of poor outcomes after infection compared with those who are least deprived.

¹² Atkinson J, Salmond C, Crampton P (2019). NZDep2018 Index of Deprivation, Final Research Report, December 2020. Wellington: University of Otago.

¹³ These calculations are based on 1,833 deaths occurring between January 2022 and 02 October 2022 (excludes deaths in the last 2 weeks and deaths where the level of deprivation was unknown).

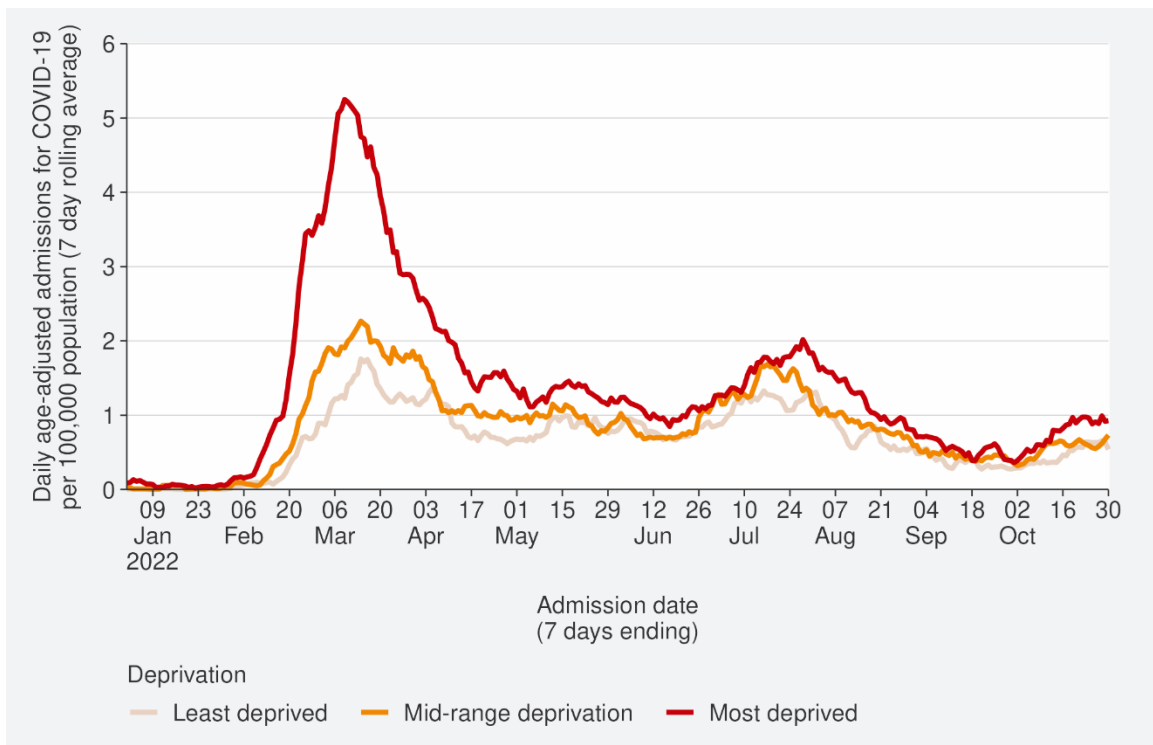


Figure 16: National age-standardised reported case rates by deprivation status for weeks 01 January – 06 November 2022



Source: NCTS/EpiSurv as at 2359hrs 06 November 2022

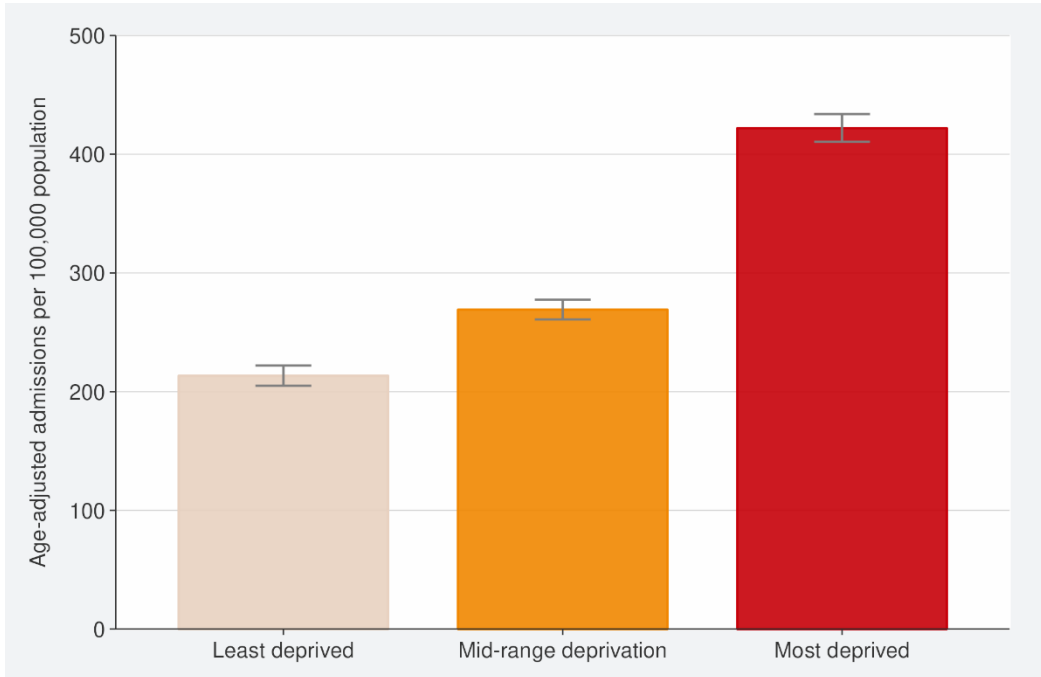
Figure 17: Age-standardised hospital admission rates for COVID-19 by deprivation from January to 30 October 2022



Source: NMDS/Inpatients admissions feed as of 30 October 2022 data up to 30 October 2022

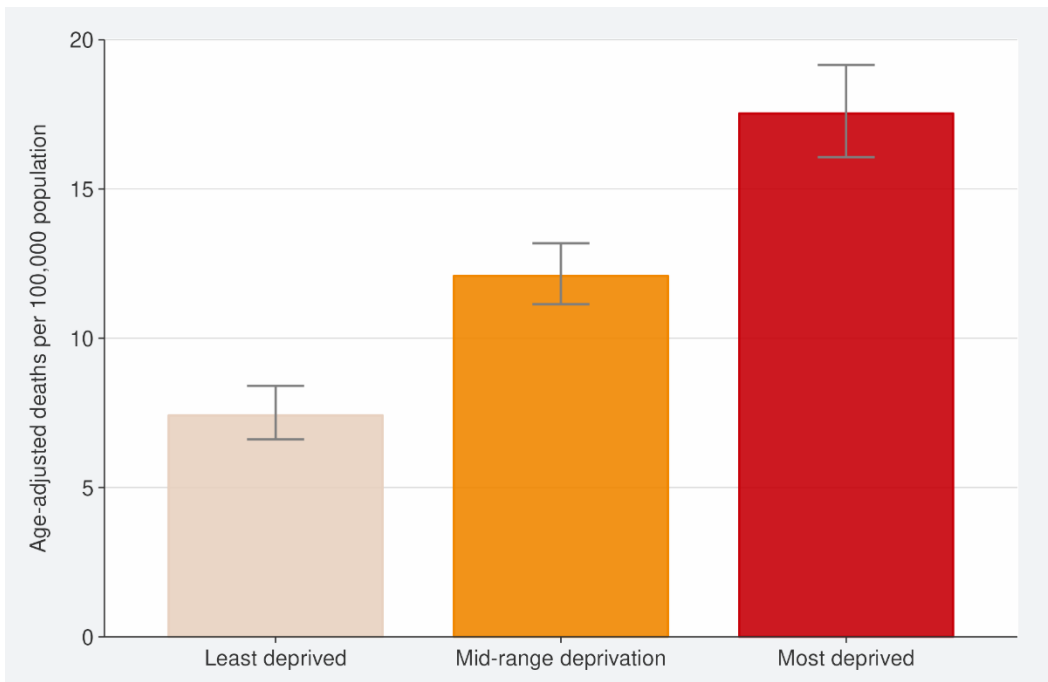


Figure 18: Age-standardised cumulative incidence (and 95% confidence intervals) of hospitalisation for COVID-19 by deprivation, 01 January 2022 to 06 November 2022



Source: NCTS/EpiSurv, NMDS, Inpatient Admissions dataset and CVIP population estimates 01 January 2022 to 06 November 2022

Figure 19: Age-standardised cumulative incidence (and 95% confidence intervals) of mortality attributed to COVID-19 by deprivation, 01 January 2022 to 06 November 2022



Source: EpiSurv, Death Documents, The Healthcare User database, Mortality Collections database and CVIP population estimates, 01 January 2020 to 06 November 2022



Global pandemic summary

Over the next few months, we expect the global situation for the COVID-19 pandemic to be driven by the ongoing emergence of new variants, waning immunity, and the Northern Hemisphere heading towards the winter season.

- Globally, in the week ending 06 November, the number of new weekly cases decreased by 15% as compared to the previous week with over 2.1 million new cases reported. However, the true number of incident cases is likely to be underestimated due to a decline in testing internationally.
- The number of new weekly deaths decreased by 10% compared to the previous week with over 9,400 fatalities reported.
- As of 06 November 2022, over 629 million confirmed cases and over 6.5 million deaths have been reported globally.
- The global variant circulation indicates a replacement of previously dominating BA.5 descendent lineages by the most recently emerging variants BQ.1 and BA.5 + R346X.
- BA.5 and its descendent lineages continued to be dominant globally, accounting for 74.5% of sequences submitted to GISAID.
- BA.4 descendent lineages accounted for 4.1% of all cases, a slight decrease from last week as of 23 October.
- BA.2 descendent shows a rise in sequence prevalence from 5.8% to 7.3% for the week ending 16 October from the previous week.
- Unassigned sequences (presumed to be Omicron) account for 11.9% of sequences submitted to GISAID as of 23 October.
- At the country level, the highest numbers of new weekly cases were reported from Japan (401,693 new cases; +42%), the Republic of Korea (299,440 new cases; +24%), the United States of America (266,104 new cases; +5%), Germany (224,099 new cases; -40%) and China (219,102 new cases; -15%).
- In Australia, as of 04 November, cases and hospitalisations increased slightly. In the 14 days to 04 November 2022, there were 248 new cases per 100,000 population, increased by 11% from the week prior (14 days to 21 October 2022). There were 1,358 current cases in hospital with 39 in ICU, it is a 2% increase from when last reported (04 November 2022).

Sources: **Weekly epidemiological update on COVID-19 - 9 November 2022 (who.int)** / **Australian Government: Coronavirus (COVID-19) common operating picture**

Please note, global trends in cases, hospitalisations and deaths should be interpreted with caution as several countries have been progressively changing COVID-19 testing strategies, resulting in lower overall numbers of tests performed and consequently



lower numbers of cases detected. Furthermore, approaches of counting hospitalisations and deaths can differ from country to country.



Appendix: Table of summary statistics

Table 1: Reported 7-day rolling average of case rates and hospital admissions by region, age group, ethnicity, and deprivation

	Reported Cases (7-day rolling average)					Hospital admissions (7-day rolling average)				
	Week ending 30/10/2022		Week ending 06/11/2022		% Change	Week ending 23/10/2022		Week ending 30/10/2022		% Change
	Number	Rate (per 100,000 population)	Number	Rate (per 100,000 population)		Number	Rate (per 100,000 population)	Number	Rate (per 100,000 population)	
National	2926.0	55.9	2967.0	56.7	1.4%	45.9	1.1	43.7	1.1	-4.7%
Region										
Northern	1083.3	54.2	1086.0	54.4	0.3%	22.4	1.1	21.1	1.1	-5.7%
Te Manawa Taki	441.7	43.2	454.1	44.4	2.8%	4.7	1.0	5.3	1.2	12.1%
Central	698.6	71.4	689.6	70.5	-1.3%	3.7	0.8	3.3	0.7	-11.5%
Te Waipounamu	697.9	57.8	732.1	60.6	4.9%	15.0	1.2	14.0	1.2	-6.7%
Age group										
<5	85.7	27.6	92.7	29.8	8.2%	3.4	1.4	3.1	1.3	-8.3%
5-14	196.1	28.9	228.1	33.6	16.3%	0.3	0.1	0.9	0.2	200.0%
15-24	311.3	47.6	344	52.6	10.5%	2.6	0.5	2.0	0.4	-22.2%
25-44	902	61.4	915	62.2	1.4%	4.7	0.4	5.3	0.4	12.1%



45-64	882.1	68.4	831.3	64.5	-5.8%	7.6	0.7	10.1	1.0	34.0%
65+	548.7	66.1	555.9	66.9	1.3%	27.3	4.3	22.3	3.5	-18.3%
Ethnicity										
Māori	303.9	37.9	318	39.6	4.7%	4.3	0.8	3.9	0.7	-10.0%
Pacific peoples	133.6	34.2	144.9	37.1	8.4%	3.0	0.8	3.7	1.0	23.8%
Asian	502.6	60.3	480.4	57.6	-4.4%	6.9	0.9	6.3	0.8	-8.3%
European or Other ¹⁴	1965.4	62.1	2001.3	63.2	1.8%	31.7	1.3	29.7	1.2	-6.3%
Deprivation										
Least deprived	963.6	63.6	992.4	65.6	3.0%	12.6	1.0	9.7	0.8	-22.7%
Mid-range deprivation	1200.0	59.8	1171.7	58.4	-2.4%	15.6	1.0	18.1	1.1	16.5%
Most deprived	715.0	45.6	756.0	48.2	5.7%	16.1	1.4	14.4	1.2	-10.6%

¹⁴ 'Other' referring to all ethnicities other than Māori, Pacific peoples, Asian and European, specifically MELAA; Middle Eastern, Latin American and African. See Table 2 for breakdowns of MELAA ethnicities.



Table 2: Cumulative reported cases and hospitalisations admissions from January 2022 to 06 November by level 2 ethnicity.

Ethnicity	Level 2 Ethnicity	Cumulative reported cases of COVID-19	Cases per 1,000 population	Cumulative hospitalisation for COVID-19	Hospitalisations per 1,000 population	Population
Asian	Asian NFD	8,998.0	403.0	28.0	1.0	22,320.0
Asian	Chinese	61,273.0	260.0	482.0	2.0	235,331.0
Asian	Indian	97,784.0	399.0	822.0	3.0	245,079.0
Asian	Other Asian	47,291.0	388.0	323.0	3.0	121,732.0
Asian	Southeast Asian	54,500.0	500.0	260.0	2.0	108,939.0
Māori	Māori	273,794.0	359.0	3,212.0	4.0	762,780.0
MELAA	African	9,931.0	377.0	120.0	5.0	26,364.0
MELAA	Latin American / Hispanic	13,748.0	474.0	76.0	3.0	28,998.0
MELAA	Middle Eastern	9,834.0	304.0	166.0	5.0	32,395.0
Pacific Peoples	Cook Island Māori	19,265.0	361.0	285.0	5.0	53,299.0
Pacific Peoples	Fijian	17,504.0	427.0	194.0	5.0	40,956.0
Pacific Peoples	Niuean	7,894.0	405.0	119.0	6.0	19,477.0
Pacific Peoples	Other Pacific Island	6,955.0	481.0	74.0	5.0	14,466.0
Pacific Peoples	Pacific Island NFD	1,636.0	447.0	6.0	2.0	3,663.0
Pacific Peoples	Samoan	67,933.0	438.0	1,062.0	7.0	154,997.0
Pacific Peoples	Tokelauan	2,865.0	417.0	44.0	6.0	6,863.0
Pacific Peoples	Tongan	29,798.0	410.0	506.0	7.0	72,703.0

Public Health Risk assessment for BQ.1.1 (Cerberus) and XBB (Gryphon)

The 'Overall risk assessment' is presented in comparison to the prior or current predominant variant, in this case, BA.5. 'Increased risk' indicates the assessed variant as worse than the previous predominant variant with regards to that characteristic; 'no change' means that the assessed variant poses equivalent risk; and 'decreased risk' means that the assessed variant is better than the previous predominant variant.

'Confidence level' indicates the overall quality of data that are available to make the risk assessment: 'High' (high quality, robust data); 'Moderate' (good data with limitations); 'Low' (very little data available). 'Insufficient data' indicates that there are no data of reasonable quality on which to base an assessment at this time.

Table 3: Public Health Risk assessment for BQ.1.1 (Cerberus), 02 November 2022

	Overall risk assessment	Confidence level	Assessment and rationale
Overall growth advantage	Increased risk	Moderate	Evidence of a growth advantage compared to BA.5. Currently present in New Zealand and is growing relative to BA.5.
Transmissibility	Insufficient data	Insufficient data	No direct data on intrinsic transmissibility and there is no current ability to measure from surveillance data. There is some laboratory evidence that ACE2 binding is increased for BQ.1.1 compared to prior Omicron variants which may affect transmissibility/infectivity.
Immune evasion	Increased risk	Moderate	Evidence of increased immune evasion. More resistant to neutralisation from sera of vaccinated and breakthrough infected individuals.
Severity	Insufficient data	Insufficient data	No evidence of a change in severity compared to BA.5 Too few cases have been detected internationally or in New Zealand to evaluate severity.
Therapeutics	Increased risk	Low	One <i>in vitro</i> study showed loss of efficacy of all currently approved clinical monoclonal antibody therapies including Evusheld and Bectelovimab.



Testing	Insufficient data	Insufficient data	Currently there is some emerging evidence that suggests a clinically relevant decrease in the performance of RATs for detection of the Omicron variant. (7, 8) However, it is uncertain how this will affect sensitivity specifically for BQ.1.1
Overall Assessment	There is an increase in overall risk from the previous predominant variant, BA.5. (Moderate confidence) BQ.1.1 is increasing in frequency overseas and appears to be more transmissible and immune evasive.		

Source: SARS-CoV-2 Variants of Concern Update – Manatū Hauora, Ministry of Health

Table 4: Public Health Risk assessment for XBB (Gryphon), 02 November 2022

	Overall risk assessment	Confidence level	Assessment and rationale
Overall growth advantage	Increased risk	Low	Evidence of a growth advantage compared to BA.5 Cases are increasing in Singapore against a background of BA.5. Cases of XBB have been detected in New Zealand.
Transmissibility	Insufficient data	Insufficient data	No direct data on intrinsic transmissibility and there is no current ability to measure from surveillance data. There is some laboratory evidence that ACE2 binding is increased for XBB compared to prior Omicron variants which may affect transmissibility/infectivity.
Immune evasion	Increased risk	Moderate	Evidence of increased immune evasion. More resistant to neutralisation from sera of vaccinated and breakthrough infected individuals.
Severity	Insufficient data	Insufficient data	In late October the WHO TAG-VE noted that current (limited) information does not indicate an increase in severity for XBB. A divergence and weakening of the correlation between the number of cases and new hospitalisations has been observed in Singapore.
Therapeutics	Increased risk	Low	One <i>in vitro</i> study showed loss of efficacy of all currently approved clinical monoclonal antibody therapies including Evusheld and Bebtelovimab.



Testing	Insufficient data	Insufficient data	Currently there is some emerging evidence that suggests a clinically relevant decrease in the performance of RATs for detection of the Omicron variant. However, it is uncertain how this will affect sensitivity specifically for XBB.
Overall Assessment	No change in risk		

Source: SARS-CoV-2 Variants of Concern Update – Manatū Hauora, Ministry of Health

