

COVID-19, Mpox, and Travel Advisories

# Situational Report in the ASEAN Region

— ASEAN BioDiaspora Virtual Center (ABVC)



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# Table of Contents

<b>COVID-19</b>	<b>1</b>
<a href="#">Highlights and Situation Overview</a>	1
<a href="#">Global Update</a>	1
<a href="#">Regional Update</a>	1
<a href="#">Research Update</a>	1
<a href="#">ASEAN Travel Advisories</a>	5
<a href="#">COVID-19 Cases and Deaths Table</a>	6
<a href="#">COVID-19 Cases in ASEAN Region Table</a>	6
<a href="#">Epi curve Among ASEAN Countries</a>	7
<a href="#">Vaccination Status in ASEAN</a>	8
<b>Mpox</b>	<b>9</b>
<a href="#">Mpox Cases Global Map</a>	9
<a href="#">Mpox Daily Trend Globally</a>	10
<a href="#">Highlights and Situation Overview</a>	11
<a href="#">Mpox Cases in ASEAN Region Table</a>	11
<a href="#">Mpox Cases in Asia-Pacific Region Table</a>	11
<a href="#">Top 5 Countries with Most Mpox Cases Globally</a>	11
<a href="#">Mpox Cases per Region</a>	12
<b><a href="#">References</a></b>	<b>13</b>



## COVID-19: Highlights and Situation Overview

### Global Update

- **Worldwide**, there have been over 687 million cases and over 6 million deaths attributed to COVID-19.
- **World Health Organization:** The COVID-19 pandemic, which has killed millions of people, caused economic chaos, and exacerbated inequality for more than three years, is no longer a global health emergency, according to the WHO on May 5. WHO chief Tedros Adhanom Ghebreyesus told reporters that "with great hope, I declare COVID-19 over as a global health emergency," claiming that the pandemic had killed "at least 20 million" people, roughly three times the under seven million deaths officially reported. The decision came after the WHO's independent emergency committee on the Covid issue decided at its 15th meeting on May 4 that the problem no longer warranted the organization's highest degree of alert. However, Tedros cautioned that the decision did not mean the threat had passed, and that the emergency status might be renewed if the circumstances changed. [\[Full article\]](#)
- **US CDC:** More than 30 people who attended a conference organized by the CDC's "disease detectives" likely were infected with COVID-19 at the event that started on April 24, 2023. The CDC hosted the 4-day conference that started on April 24 at a Crowne Plaza hotel just outside Atlanta, which is the hometown of the agency's headquarters. The conference was free and open to the public. "CDC is working with the Georgia Department of Health to conduct a rapid epidemiological assessment of confirmed COVID-19 cases that appear to be connected to the 2023 EIS Conference to determine transmission patterns," CDC spokesperson Kristen Nordlund said. About 2,000 people attended "who were likely to be fully vaccinated," the *Post* reported, and so far, there are 35 confirmed COVID cases. It was the first time the annual conference was held in person in 4 years. "Whenever there are large gatherings, especially indoors, such as at a conference, there is the possibility of COVID-19 spread, even in periods of low community spread," Nordlund said. "This is, unfortunately, the new normal," infectious disease expert Jay Varma, MD, of Weill Cornell Medicine in New York City, told the *Post*. "While it is unsettling to see widespread COVID-19 transmission at CDC's premier public health conference, it's probably the clearest example yet" of the global situation.

### Regional Update

- **Malaysia:** The Ministry of Health (MOH) is urging the public to take caution when going out as a slight increase in COVID-19 cases was reported following the Hari Raya and Wesak Day celebrations.<sup>1</sup> According to the ministry, the number of new COVID-19 cases increased by 3% in the past week to 4,963 from 4,817 recorded the previous week.<sup>1</sup> As of May 4, 2023, about 15% of all ICU beds are occupied for COVID-19 while another 23% are for non-critical patients.<sup>1</sup> [\[Full article\]](#)

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

- The study on **COVID-19 Mortality Update—United States, 2022** by the Centers for Disease Control and Prevention (CDC) researchers assessed 2022 death data from the National Center for Health Statistics National Vital Statistics System (NVSS) and compared them with those from 2021.<sup>2</sup> From 2021 to 2022, the estimated age-adjusted COVID-19 death rate has dropped by 47%, from 115.6 to 61.3 per 100,000 people.<sup>2</sup> The infection was listed as the underlying cause of death on 76% of death certificates listing the virus and was a contributing cause in the remaining 24% of COVID-19 deaths.<sup>2</sup> As in 2020 and 2021, the most common site of death was a hospital (59% in 2022), but an increasing proportion



occurred at home in 2022 (15%) or in a long-term care facility (14%).<sup>2</sup> The age-adjusted COVID-19 death rate was lowest (49.5 per 100,000 people) in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) and highest (69.3 per 100,000) in Arkansas, Louisiana, New Mexico, Oklahoma, and Texas, followed by Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee (65.5 per 100,000).<sup>2</sup> According to the authors, these data provide updated information that advances the understanding of the impact of COVID-19 on mortality and how these have continued to shift during the pandemic.<sup>2</sup> [\[Full text\]](#)

- The study on **SARS-CoV-2 Vaccine Effectiveness against Omicron Variant in Infection-Naive Population, Australia** found that a three-dose COVID-19 vaccination series was 42.0% effective against infection and 81.7% effective against hospitalization or death during Omicron wave to Australians who had never previously had COVID-19.<sup>3</sup> Vaccine effectiveness (VE) for preventing lab-confirmed infection was 24.9%, increasing to 42.0% for people who had received three doses of vaccine.<sup>3</sup> VE was highest (70.7%) among those who had gotten a booster no more than 30 days before testing.<sup>3</sup> Researchers concluded that the study definitively demonstrates that ancestral strain vaccines still provide substantial protection against severe disease caused by newer variants among a population free from potential confounding of previous immunity conferred by natural infection with an earlier variant.<sup>3</sup> [\[Full text\]](#)
- With secondary data analyzed from 40 studies, **Evaluation of Waning of SARS-CoV-2 Vaccine-Induced Immunity a Systematic Review and Meta-analysis**, quantified the progressive waning of VE associated with the Delta and Omicron variants of SARS-CoV-2 by number of received doses.<sup>4</sup> PubMed and Web of Science were searched from the databases' inception to October 19, 2022, as well as reference lists of eligible articles. Preprints were included.<sup>4</sup> Selected studies for this systematic review and meta-analysis were original articles reporting estimates of VE over time against laboratory-confirmed SARS-CoV-2 infection and symptomatic disease.<sup>4</sup> Estimates of VE at different time points from vaccination were retrieved from original studies.<sup>4</sup> Secondary data analysis was performed to project VE at any time from the last dose administration, improving the comparability across different studies and between the 2 considered variants.<sup>4</sup> Pooled estimates were obtained from a random-effects meta-analysis. A total of 799 original articles and 149 reviews were published in peer-reviewed journals and 35 preprints were identified.<sup>4</sup> Of these, 40 studies were included in the analysis.<sup>4</sup> Pooled estimates of VE of a primary vaccination cycle against laboratory-confirmed Omicron infection and symptomatic disease were both lower than 20% at 6 months from the last dose administration.<sup>4</sup> Booster doses restored VE to levels comparable to those acquired soon after the administration of the primary cycle.<sup>4</sup> However, 9 months after booster administration, VE against Omicron was lower than 30% against laboratory-confirmed infection and symptomatic disease.<sup>4</sup> The half-life of VE against symptomatic infection was estimated to be 87 days (95% CI, 67-129 days) for Omicron compared with 316 days (95% CI, 240-470 days) for Delta.<sup>4</sup> Similar waning rates of VE were found for different age segments of the population.<sup>4</sup> These findings suggest that the effectiveness of COVID-19 vaccines against laboratory-confirmed Omicron or Delta infection and symptomatic disease rapidly wanes over time after the primary vaccination cycle and booster dose.<sup>4</sup> [\[Full text\]](#)
- This multicenter, randomized, double-blind, placebo-controlled, phase 3 trial, **Efficacy and Safety of a Protein-Based SARS-CoV-2 Vaccine A Randomized Clinical Trial**, evaluated the efficacy and safety of a 2-dose regimen of FINLAY-FR-2 (cohort 1) and a 3-dose regimen of FINLAY-FR-2 with FINLAY-FR-1A (cohort 2) in Iranian adults.<sup>5</sup> Participants from 6 cities in cohort 1 and 2 cities in cohort 2 included individuals aged 18 to 80 years without uncontrolled comorbidities, coagulation disorders, pregnancy or breastfeeding, recent immunoglobulin or immunosuppressive therapy, and clinical presentation or laboratory-confirmed COVID-19 on enrollment.<sup>5</sup> The study was





conducted from April 26 to September 25, 2021.<sup>5</sup> In cohort 1, 2 doses of FINLAY-FR-2 (n = 13,857) or placebo (n = 3,462) were administered 28 days apart.<sup>5</sup> In cohort 2, 2 doses of FINLAY-FR-2 plus 1 dose of FINLAY-FR-1A (n = 4,340) or 3 placebo doses (n = 1,081) were administered 28 days apart.<sup>5</sup> Vaccinations were administered via intramuscular injection.<sup>5</sup> In cohort 1 a total 17,319 individuals received 2 doses and in cohort 2 5,521 received 3 doses of the vaccine or placebo.<sup>5</sup> Cohort 1 comprised 60.1% men in the vaccine group and 59.1% men in the placebo group; cohort 2 included 59.8% men in the vaccine group and 59.9% in the placebo group.<sup>5</sup> The mean (SD) age was 39.3 (11.9) years in cohort 1 and 39.7 (12.0) years in cohort 2, with no significant difference between the vaccine and placebo groups.<sup>5</sup> The median follow-up time in cohort 1 was 100 (IQR, 96-106) days and, in cohort 2, 142 (137-148) days.<sup>5</sup> In cohort 1, 461 (3.2%) cases of COVID-19 occurred in the vaccine group and 221 (6.1%) in the placebo group (vaccine efficacy: 49.7%; 95% CI, 40.8%-57.3%) vs. 75 (1.6%) and 51 (4.3%) in cohort 2 (vaccine efficacy: 64.9%; 95% CI, 49.7%-59.5%).<sup>5</sup> The incidence of serious adverse events was lower than 0.1%, with no vaccine-related deaths.<sup>5</sup> The findings of this trial suggest that FINLAY-FR-2, in combination with a third dose of FINLAY-FR-1A, is a safe vaccine inducing a potent immune response against COVID-19.<sup>5</sup> [\[Full text\]](#)

- Prior data have shown that Hispanic and non-Hispanic Black residents in the US experienced substantially higher COVID-19 mortality rates in 2020 than non-Hispanic White residents owing to structural racism.<sup>6</sup> In 2021, these disparities decreased. This paper, **COVID-19 Mortality by Race and Ethnicity in US Metropolitan and Nonmetropolitan Areas, March 2020 to February 2022**, assessed racial and ethnic disparities in COVID-19 mortality between the initial pandemic wave and subsequent Omicron wave.<sup>6</sup> This cross-sectional study was conducted using data from the US Centers for Disease Control and Prevention for COVID-19 deaths from March 1, 2020, through February 28, 2022, among adults aged 25 years and older residing in the US.<sup>6</sup> Deaths were examined by race and ethnicity across metropolitan and nonmetropolitan areas, and the national decrease in racial and ethnic disparities between initial and Omicron waves was decomposed.<sup>6</sup> Data were analyzed from June 2021 through March 2023.<sup>6</sup> There were death certificates for 977,018 US adults aged 25 years and older (mean [SD] age, 73.6 [14.6] years; 435,943 females [44.6%]; 156,948 Hispanic [16.1%], 140,513 non-Hispanic Black [14.4%], and 629,578 non-Hispanic White [64.4%]) that included a mention of COVID-19.<sup>6</sup> The proportion of COVID-19 deaths among adults residing in nonmetropolitan areas increased from 5,944 of 110,526 deaths (5.4%) during the initial wave to a peak of 40,360 of 172,515 deaths (23.4%) during the Delta wave; the proportion was 45,183 of 210,554 deaths (21.5%) during the Omicron wave.<sup>6</sup> The national disparity in age-standardized COVID-19 death rates per 100,000 person-years for non-Hispanic Black compared with non-Hispanic White adults decreased from 339 to 45 deaths from the initial to Omicron wave, or by 293 deaths. After standardizing for age and racial and ethnic differences by metropolitan vs. nonmetropolitan residence, increases in death rates among non-Hispanic White adults explained 120 deaths/100,000 person-years of the decrease (40.7%); 58 deaths/100,000 person-years in the decrease (19.6%) were explained by shifts in mortality to nonmetropolitan areas, where a disproportionate share of non-Hispanic White adults resides.<sup>6</sup> The remaining 116 deaths/100,000 person-years in the decrease (39.6%) were explained by decreases in death rates in non-Hispanic Black adults.<sup>6</sup> This study found that most of the national decrease in racial and ethnic disparities in COVID-19 mortality between the initial and Omicron waves was explained by increased mortality among non-Hispanic White adults and changes in the geographic spread of the pandemic.<sup>6</sup> These findings suggest that despite media reports of a decline in disparities, there is a continued need to prioritize racial health equity in the pandemic response.<sup>6</sup> [\[Full text\]](#)



## ASEAN Travel Advisories (new update/s)

as of 05 May 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
<b>Brunei Darussalam</b>	December 1, 2022	Yes	No	No	No	No	No	No
<b>Cambodia</b>	October 6, 2022	Yes	No	No	No	No	No	No
<b>Indonesia</b>	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 an RT-PCR test upon arrival	No	No	Traveler is required to download and register at the SatuSehat app ( <a href="#">Android</a> / <a href="#">iOS</a> ) before departure.
<b>Laos</b>	December 29, 2022	Yes	No	No	No	No	No	No
<b>Malaysia</b>	August 2, 2022	Yes	No	No	No	No	No	No
<b>Myanmar</b>	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 <a href="#">Myanmar Insurance</a>	Passengers must present a Health Declaration Form upon arrival.
<b>Philippines</b>	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 an <a href="#">E-arrival card</a> at most 3 days before departure for those without a visa.
<b>Singapore</b>	February 13, 2023	Yes	No	No	No	No	No	No
<b>Thailand</b>	March 1, 2023	Yes	No	No	No	No	No	No
<b>Vietnam</b>	May 16, 2022	Yes	No	No	No	No	No	No

• Reference: [IATA Travel Centre](#)

• \*Fully vaccinated – at least 14 or 15 days from 2<sup>nd</sup> dose for a two-dose vaccine or 14 or 15 days from a single-dose vaccine upon arrival.



## Cases and Deaths as of 05 May 2023

- As of 05 May 2023 (1PM, GMT+7), worldwide, there were **687,575,929** confirmed cases, including **6,869,677** deaths. Globally, Case Fatality Rate (CFR) was **1.0%**.
- 35,871,169 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	03-May-23	288,051	-	225	-	64,053	450,404	445,929	338,987	99.3
	Cambodia	27 Jan 20	29-Apr-23	138,733	-	3,056	-	841	15,244,858	14,609,937	10,433,215	87.1
	Indonesia	02 Mar 20	05-May-23	6,782,490	442	161,387	3	2,490	203,657,535	172,693,321	67,952,274	62.7
	Lao PDR	24 Mar 20	04-May-23	218,081	-	758	-	3,041	5,888,649	5,222,417		69.4
	Malaysia	25 Jan 20	30-Apr-23	5,071,840	-	37,020	-	15,788	28,125,245	27,536,657	17,056,957	81.1
	Myanmar	23 Mar 20	04-May-23	635,452	-	19,492	-	1,173	34,777,314	27,545,329	2,227,351	50.8
	Philippines	30 Jan 20	04-May-23	4,097,525	-	66,444	-	3,771	78,369,243	73,937,435	21,341,197	64.0
	Singapore	23 Jan 20	21-Apr-23	2,340,779	-	1,727	-	39,049	5,161,990	5,120,768	4,440,289	90.8
	Thailand	13 Jan 20	01-May-23	4,730,490	-	33,947	-	6,791	57,005,497	53,486,086	32,143,431	74.6
	Vietnam	23 Jan 20	04-May-23	11,567,728	-	43,195	-	11,950	90,450,881	85,848,363	57,452,750	87.4
ASEAN COUNTRIES				35,871,169	442	367,251	3	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	195,036,004	18,459	1,204,900	6
AFRICA	12,819,926		258,731	
AMERICAS	194,910,327		2,984,987	-
EUROPE	248,938,503		2,053,808	-
TOTAL	651,704,760	18,459	6,502,426	6

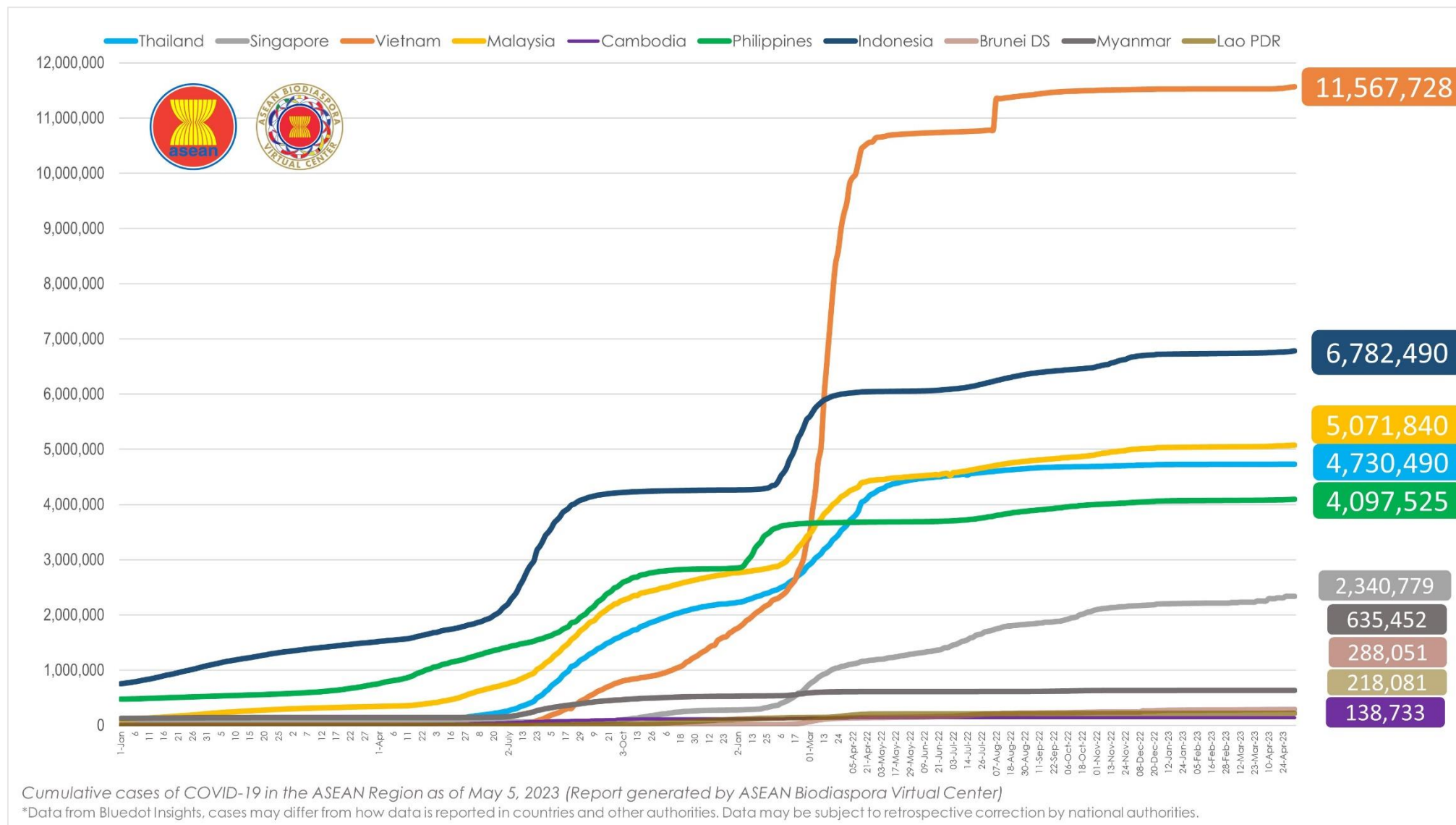
\*\*Data References: [Andra Farm](#), [Worldometer](#), [DOH Philippines](#), and the [WHO](#)





# COVID-19 Epi curve among ASEAN Countries

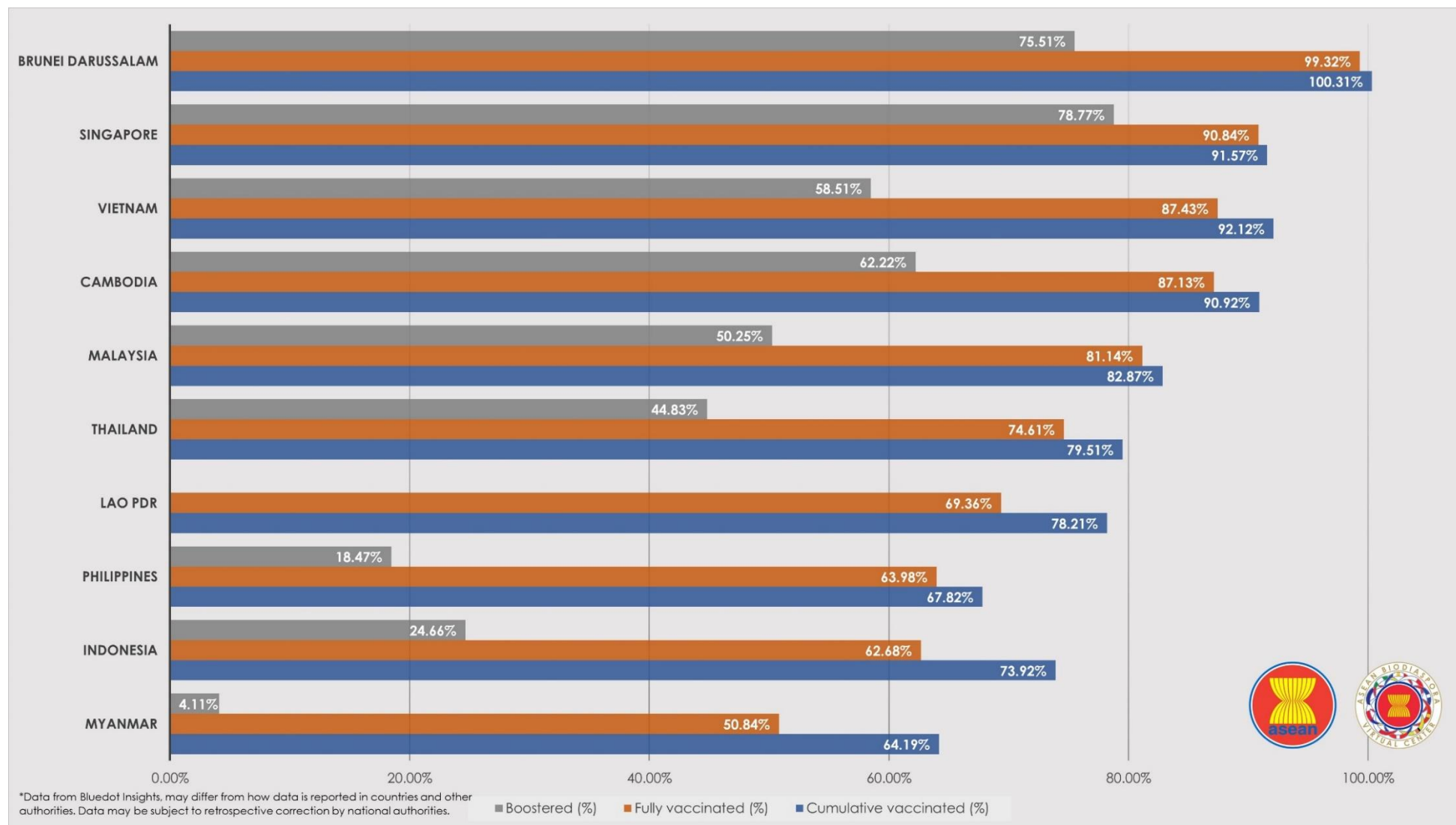
From January 1, 2022 to May 5, 2023





# 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.

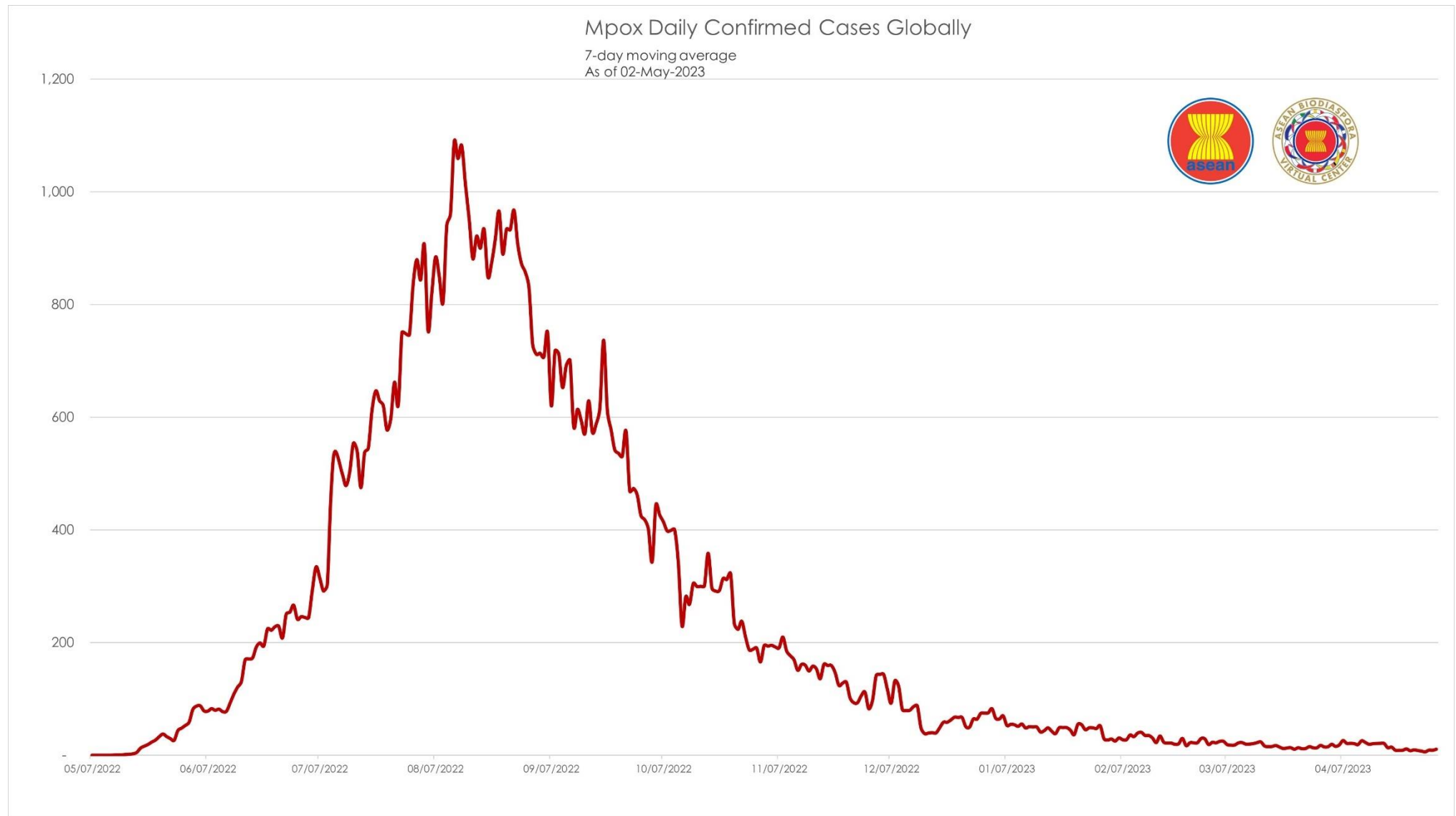
as of May 2, 2023





## Mpox Daily Trend Globally

as of May 2, 2023





## Mpox: Highlights and Situation Overview

- As of 02 May 2023 (1PM, GMT+7), worldwide, there were **87,300** confirmed cases, including **130** deaths. Globally, Case Fatality Rate (CFR) was **0.15%**.
- 51 confirmed cases** in the ASEAN region, with CFR of **0%**.
- 87,249 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	23	-	-	0.00%
Thailand	21	-	-	0.00%
Vietnam	2	-	-	0.00%
<b>ASEAN Total</b>	<b>51</b>	<b>-</b>	<b>-</b>	<b>0.00%</b>

### 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	127	7	-	0.00%
New Caledonia	1	-	-	0.00%
New Zealand	41	-	-	0.00%
People's Republic of China*	71	31	-	0.00%
Republic of Korea	49	19	-	0.00%
Sri Lanka	2	-	-	0.00%
<b>Asia-Pacific Total</b>	<b>457</b>	<b>57</b>	<b>1</b>	<b>0.22%</b>

\*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	30,154	-	44	0.15%
Brazil	10,915	-	16	0.15%
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	1,619	-	19	1.17%
AMERICAS	59,240	-	104	0.18%
ASEAN	51	-	-	0.00%
ASIA PACIFIC	457	57	1	0.22%
EUROPE	25,610	-	6	0.02%
MIDDLE EAST	323	1	-	0.00%
<b>TOTAL</b>	<b>87,300</b>	<b>58</b>	<b>130</b>	<b>0.15%</b>





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