COVID-19 Country Analyses: May Update 1

This update covers the period April 25 to May 1.

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Global trends[1]

- As of 1 May, 4 pm AEST, 3,303,000 cases and 233,875 deaths have been reported globally.
- The average number of new global daily cases is around 75,000.
- Trends of new daily cases continue to decline in Spain, Italy and France while highly unstable in the US and the UK.
- Germany reported a significant spike in cases (1,627) on 29 April, which has led to a slowdown In easing restrictions.
- Russia has the fastest growing epidemic in the world followed by Brazil and Peru.
- The number of new cases in Belarus continues to increase exponentially while having implemented very few restrictions.
- Singapore now has the third highest number of cases in Asia, after China and India, surpassing more populous countries such as Korea and Japan. It has by far the highest per capita attack rate in Asia at 267 per 100,000, which is also higher than France, the UK and Germany. Singapore's testing rate (2,460 per 100,000) is lower than Germany but higher than France and the UK.
- Singapore, Qatar, United Arab Emirates, and Saudi Arabia continue to report high numbers of cases among migrant workers.
- The global cumulative CFR is 7.1%. The highest CFRs are in the UK and Belgium (15.7%), France (14.5%), Italy (13.6%), Sweden (12.3%) and the Netherlands (12.1%).
- The UK now includes deaths in care homes in the official figures. The country has the third highest number of deaths in the world after the US and Italy.
- Among countries with more than 5,000 cases, the UAE has the highest rate of testing (11,344 per 100,000 -- more than 10% of the population), followed by Israel (4,211), Portugal (3,881), Denmark (3,335), Qatar (3,280), Italy (3,274), and Norway (3,184).
- Australia ranks #16 in the world at 2,210 per 100,000.
- The lowest testing rates are in Indonesia (35 per 100,000), Bangladesh (39), India (60), Mexico (64), Pakistan (79), and the Philippines (95).

Australian trends

- The number of new daily cases has remained below 20 every day since 23 April, reaching a new low of 8 cases on 27 April.
- There are now 931 active cases of COVID-19.
- The number of coronavirus tests in Australia reached an all-time high of 13,855 on 30 April, a daily test rate of 55 per 100,000, which is higher than that recommended by the Harvard Global Health Centre. The positivity rate was 0.1% on that day.
- Victoria has the second lowest cumulative testing rate in the country at 1,736 per 100,000. The highest rate is in South Australia at 3,269 per 100,000 and Western Australia the lowest at 1,437 per 100,000.
- The CFR has crept up a little to 1.4%, reflecting the 7-10 day interval between infection and the onset of severe symptoms.

[1] https://coronavirus.jhu.edu/data/new-cases

Case Study: COVID-19 in Indonesia

- 10,118 reported cases and 792 deaths, for a CFR of 7.8%.
- Testing rate of 35 per 100,000. Test positivity 10.7%.

Almost no-one thinks Indonesia is handling the COVID-19 pandemic well. Until early March, the government claimed it had no cases of infection, something the health minister attributed to prayer. The Home Affairs Minister urged the public to eat more bean sprouts and broccoli, while President Joko Widodo (Jokowi) sang the praises of *jamu*, traditional herbal remedies[2].

The government had been in denial. The home affairs minister dismissed as "insulting" a report by Harvard University researchers saying Indonesia must have unreported cases. As recently as early April, another minister was still arguing the virus cannot survive in tropical climates. The president was apparently more concerned about the threat the virus posed to trade, investment and tourism. In February, when many countries were imposing tough travel restrictions, he planned to offer discounts of up to 30 per cent to attract tourists. His government even allocated almost $8 million to pay social media influencers for tourism promotions. The government finally acknowledged its first case on 2 March.

The limited testing that has been done, and the spread of verified cases in neighbouring countries, such as Singapore and Malaysia, suggest the virus has a much larger presence in Indonesia than claimed. In a model seen by Reuters the week of 18 April, researchers at the University of Indonesia forecast there could be 1 million infections by July on Java, the country's most populous island and home to the capital, Jakarta[3].

Health researchers have said the number of infections could spike because of the traditional exodus from cities, known in Indonesia as *mudik*, after the Muslim fasting month of Ramadan. President Joko Widodo has resisted pressure for a total ban on *mudik*, though the head of the government's COVID-19 task force said those going would have to undergo a14-day quarantine.

President Joko Widodo declared a national public emergency on 1 April. While he shied away from implementing a total lockdown in response to the coronavirus pandemic, Mr Widodo imposed "large-scale social restrictions", granted police additional powers and announced a $40 billion economic stimulus package. The Government also announced all foreign nationals except for diplomats, humanitarian workers and those with residency permits would be barred from entering Indonesia for 14 days; this travel ban has since been extended. Muhammadiyah, Indonesia's second-largest Muslim organisation has called for the devout to avoid participating in special night-time prayers during Ramadan, which began in late April.

The relatively high CFR reported by Indonesia could be due to low health system capacity. In 2017 the World Bank found Indonesia only had four doctors for every 10,000 people. It is estimated to have less than three intensive care beds per 100,000[4]. An extreme shortage of ventilators will likely result in many avoidable deaths, especially in regional areas. There is also a serious lack of protective equipment for health care workers. Some have been told they can turn up to work in raincoats. At least 24 doctors have died so far (as of 8 April), about 11 per cent of all recorded deaths.

Indonesia is beginning to increase measures to slow the spread of the virus. Mr Widodo has inaugurated a specialist COVID-19 hospital in Jakarta capable of treating 3,000 patients. And the Government has constructed a hospital in a former refugee camp for Vietnamese on Galang Island, off Sumatra, dedicated to treating people infected with COVID-19.

[2] https://www.abc.net.au/news/2020-04-08/coronavirus-could-cause-240,000-deaths-in-indonesia/12131778
[3] https://www.abc.net.au/news/2020-04-18/indonesia-has-the-highest-number-of-coronavirus-deaths-in-asia/12161638
[4] https://www.abc.net.au/news/2020-04-01/coronavirus-indonesia-ban-foreigners-death-toll/12109262

In addition, authorities have released about 30,000 prisoners to avoid the rapid spread of the disease in overcrowded jails across the country. This represents around 11 per cent of the national prison population, according to the Jakarta-based Institute for Criminal Justice Reform, which welcomed the move but called for the release of greater numbers of non-violent offenders.

Local authorities across Indonesia have implemented tougher prevention measures than the central Government, despite Mr Widodo's requests for them to only act in accordance with directives from the national COVID-19 task force. Bali's provincial authorities have declared a state of emergency under which all people entering the island, including Indonesians, are forced to self-quarantine for two weeks.

In late March, the Mayor of Tegal in Central Java announced he was shutting off the city to prevent the spread of COVID-19, including by building concrete barriers across roads leading into the town. Jakarta Governor Anies Baswedan announced a state of emergency on March 20, telling all commercial offices and entertainment venues to remain shut for at least two weeks.

Many of the standard prevention measures will be difficult to implement. Even social isolation will be extraordinarily difficult in such a densely populated country with a laissez-faire attitude to rules and a tradition of bribing police. Moreover, up to 70 per cent of the workforce is employed in the informal sector and many live hand-to-mouth. Working from home may simply not be an option for them.

Stricter regional quarantines or lockdowns would undoubtedly depress economic activity. What's more, under the 2018 Health Quarantine Law, the government would then incur the huge costs of being responsible for all the basic needs of citizens in those areas. It would also concern the president that the virus has triggered an outburst of anti-Chinese hate speech, never far below the surface in Indonesia. Online trolls are accusing the Chinese of introducing the virus to Indonesia and wealthier Chinese of fleeing to Singapore.

The Diplomat has highlighted some positive responses to COVID-19 by civil society[5]. Many crowdfunding campaigns have been launched on local platforms like kitabisa.com to help those in need. This includes raising funds to support informal sector workers, such as street food sellers, scavengers, and motorcycle taxi drivers, and to purchase personal protective equipment (PPE) for healthcare workers. By late March, 15,000 medical students from 158 universities had also signed up to volunteer.

The level of innovation in Indonesia is also underestimated, with universities and tech companies contributing greatly to the country's fight against COVID-19. For example, the University of Indonesia has developed ultraviolet-based disinfection booths for medical equipment, and is continuing research and development into PPE, COVID-19 rapid testing instruments, and treatments.

The Surabaya Institute of Technology (ITS) has worked in cooperation with Airlangga University Hospital to develop a disinfectant chamber that uses ozone (O3) rather than unsafe chemical disinfectants, as well as a robot that can be used to remotely communicate with patients, monitor their condition, and deliver items such as food and clothes. Many manufacturing companies have also begun producing PPE and hand sanitizer, while others have partnered with universities to produce ventilators.

Papuan provinces

In Papua province, bordering Papua New Guinea, there have been 205 reported cases and 6 deaths. In West Papua, there have been 37 cases and one death. Papua province has one of the highest per capita attack rates in Indonesia.

According to the *Mongabay* journal, local authorities and indigenous communities in Indonesia's Papua region have imposed a sweeping lockdown to minimize the spread of the novel coronavirus[6]. The region, which

[5] https://thediplomat.com/2020/04/indonesia-and-covid-19-what-the-world-is-missing/
[6] https://news.mongabay.com/2020/04/indigenous-papuans-initiate-own-lockdowns-in-face-of-covid-19/

comprises the provinces of West Papua and Papua, is the least developed in Indonesia, with scant public health facilities, poor road connectivity, and the highest rates of maternal and infant mortality in the country.

Faced with the challenge of containing a COVID-19 outbreak in these circumstances, the provincial governments have temporarily restricted air and sea traffic into the region, with the exception of the freight traffic. In the Papuan hinterland, indigenous communities have blocked road access into their villages for outsiders.

In Papua province, where the travel restriction came into force on March 26, Governor Lukas Enembe said a full closure could be implemented for three indigenous territories in the province: Lapago, Meepago and Animha. He said these communities were particularly "vulnerable" to infection. In West Papua, authorities followed with their own travel restriction on March 30.

Activists have welcomed the measures to restrict arrivals from outside and to close off vulnerable areas, given the lack of adequate health care facilities in the region. The government has designated just five hospitals to treat COVID-19 patients in the region — an area double the size of Great Britain and home to 4 million people. Between them, the hospitals have access to a combined 60 ventilators, and have had to rely on the national government for supplies of personal protective equipment for health workers.

Many communities have taken the initiative to shut down road access to their villages. Franky Samperante, the executive director of the Pusaka Foundation, which works with indigenous communities, said residents in Papua's Boven Digoel and Maybrat districts had closed off their villages to people from other areas. He added that indigenous communities were also carrying out traditional rituals that they believed could deflect bad energy.

Case Study: COVID-19 in Africa

On 15 February, 2020, Egypt recorded Africa's first case of COVID-19 and 12 days later, Nigeria recorded the first sub-Saharan African case. As of 30 April, 23,254 COVID-19 cases had been reported in the African Region of the World Health Organization (WHO). In addition, the following African countries, which are members of the Western Mediterranean Region of WHO had reported 12,248 cases: Egypt, Morocco, Djibouti, Tunisia, Somalia, Sudan and Libya. The only African countries that have not reported any coronavirus cases are Lesotho and Comoros.

South Africa (5,350) and Egypt (5,268) have the highest number of reported cases followed by Morocco (4,252) and Algeria (3,649). Other countries with more than 1,000 cases are Cameroon, Ghana, Nigeria, Guinea, Côte d'Ivoire and Djibouti. Djibouti, with a population of 980,000 has by far the highest per capita attack rate at 109 per 100,000. However, Djibouti also has the highest testing rate on the continent at 1,314 per 100,000 followed by South Africa and Ghana both at 324 per 100,000, and Kenya (335). Several sub-Saharan countries have testing rates below 100 per 100,000 including Senegal (28) and Nigeria (62). Many more have not reported the number of tests that they have conducted.

Between 22 and 28 April, there has been a 52% increase in the number of confirmed COVID-19 cases (7 982 additional cases) and a 26% increase in the number of COVID-19 related deaths (183 additional deaths) reported in the WHO African Region[7]. The cumulative case-fatality ratio (CFR) is 4%, which is lower than the global CFR of 7%. Among countries with widespread transmission, the highest CFRs were observed in Algeria (12.0%), Liberia (11.3%), Burkina Faso (6.6%), Democratic Republic of the Congo (DRC) (6.1%) and Mali (5.7%). Algeria alone accounted for 49% of COVID-19 deaths reported in the region.

Early COVID-19 cases in Africa were mostly imported from Europe, due to the higher volume of business and tourism airline traffic between African countries and Europe, and less from China[8]. The first confirmed case was

[7] https://apps.who.int/iris/bitstream/handle/10665/331935/SITREP_COVID-19_WHOAFRO_20200429-eng.pdf
[8] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30212-6/fulltext

reported in Egypt on Feb 14, 2020, (an adult male whose 17 contacts tested negative) and prompted African preparedness efforts.

In South Africa, on Feb 29, 2020, a group of nine adult travellers returned from a skiing holiday in Italy, where the COVID-19 epidemic was rampant. After developing a flu-like illness, one traveller tested positive for COVID-19, which was confirmed by RT-PCR on March 5, 2020; his wife was asymptomatic but tested positive on March 8, 2020. Overall, seven of the nine travellers were positive for COVID-19, five of whom were asymptomatic.

In Senegal, the first COVID-19 case was reported on March 7, 2020, in a traveller returning from Italy. Contact tracing identified a cluster of transmission of 20 cases within his immediate household. DRC confirmed its first case of COVID-19 on March 10, 2020: an adult male who tested positive in the capital city of Kinshasa after developing a cough and fever, 2 days after returning from France. These early index cases show the imported nature of the epidemic in Africa among young affluent adult travellers from Europe. However, the majority of COVID-19 cases currently being identified and reported from African countries are due to local transmission.

Considering the global toll, COVID-19 has been slow to take hold in Africa. Unproven theories contend that Africa's youthful population, low population density, and warmer climate may render the virus less vicious. Yet even comparatively lower rates of infection can wreak havoc on African countries fragile health systems, and could trigger widespread socio-economic or political turmoil.

A number of reviews of responses by African governments to COVID-19 have been positive; however, the response has been far from uniform. In much of Africa, and in spite of severe budgetary constraints, policy has been well co-ordinated and, so far at least, surprisingly effective. On the 1st of May, South Africa will begin to ease its lockdown, among the most stringent in the world, after signs that early and decisive action has flattened the curve of new infections. Ghana and Kenya, two other countries that imposed a mix of social distancing, travel restrictions, mask-wearing and curfews, are also moving back towards some kind of normality.

African governments have followed measures backed by scientific advice, such as quarantine of people exposed to confirmed cases. One Cochrane review found that quarantine might avert high proportions of infection and deaths compared with no measures. Modelling studies that were reviewed consistently reported a benefit of the simulated quarantine measures, for example, quarantine of people exposed to confirmed or suspected cases averted 44% to 81% incident cases and 31% to 63% of deaths compared to no measures based on different scenarios[9].

The Africa Centre for Disease Control and Prevention, which only came into being in 2017 following the West African Ebola epidemic, has been instrumental in the response; it stitched together a co-ordinated strategy through videoconferences with heads of state[10]. Leaders were quick to take scientific advice on frontier closures, screening and lockdowns. The Africa CDC will now help pull together a continent-wide effort to test, trace and treat involving a million-strong army of health workers. Thanks to Africa CDC, 43 laboratories from 43 African countries are now able to test for COVID-19. Chinese billionaire Jack Ma, Alibaba's founder, has donated 1.1 million test kits to be distributed to all 54 African countries; this will support Africa CDC's efforts to expand testing and tracing.

There may be two reasons for Africa's relative success. First, it is familiar with the ravages of infectious diseases. Some 15 million Africans have died of AIDS, against which there was little defence before cheap antiretroviral drugs became available 15 years ago. In South Africa, the resolute action against Covid-19 taken by President Cyril Ramaphosa almost certainly has its origins in the ruinously slow response to HIV by Thabo Mbeki, a predecessor. More recently, the Ebola outbreak in West Africa, which killed 11,300 people from 2013 to 2016, imparted indelible lessons in both the cost of epidemics and the strategies required to end them.

[9] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013574/full
[10] https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30219-8/fulltext

Second, Africa had an early warning. Its leaders watched awestruck as health systems in China, and then Italy, Spain, the UK and the US crumpled. They understood that, if the virus slipped out of control in Africa, their own weak health systems could not cope. Countries had little choice but to act early. Nigeria was already screening airport passengers in February. Rwanda closed its frontiers on March 19. South Africa locked down before it had suffered a single death. In the absence of money, ingenuity rushed in: solar-powered oxygen units in Uganda, rapid tests in Senegal, mask-making textile factories in Kenya.

Case study: Somalia

Six weeks after registering its first coronavirus case, Somalia early this week had confirmed 480 infections out of 764 people tested for COVID-19. This is a test positivity rate of 63%, compared with just over 1% in Australia, indicating that only symptomatic persons are being tested. By 29 April the number of cases had risen to 582, with 28 reported deaths. The figures, given to Al Jazeera by Dr Abdirizak Yusuf Ahmed, the person leading Somalia's COVID-19 response, raised major concerns that the actual tally could be much higher[11].

The country does not have the capacity to mass test. There are currently only three labs equipped to safely test for the disease, including one in the semi-autonomous state of Puntland and one in the breakaway region of Somaliland. In Somalia, the challenge to contain COVID-19 is staggering. The country's health infrastructure has been gutted by decades of conflict and instability.

A large part of the population lives in close quarters, while millions reside in decrepit settlements for internally displaced people without money to buy soap or access to regular running water. At the same time, staying at home is not a practical option for most informal workers who need to leave their homes daily to earn money and put food on the table.

"With a health system already at breaking point, shortage of personal protective equipment for health staff and deep-rooted stigma of those affected, if no urgent attention is given to this looming crisis, Somalia will likely suffer the effects of the pandemic more severely than many other countries - which has already been shown by the rapid spike in reported cases on a daily basis," Iman Abdullahi, the CARE country director said.

Martini Hospital in Mogadishu is the only medical facility dedicated to treating COVID-19 patients. Due to its limited capacity, the hospital only caters to the most severe cases.

Ali, the Benadir regional coordinator, said she believed the spread of the virus was in part due to a lack of education on the sickness and how to manage it, and in part because it was impossible to physically distance in a crowded city where most people have to go outside to make ends meet.

She expressed frustration that her team of 370 community health workers trained to sensitise communities do not have protective equipment to travel to neighbourhoods to follow up on suspected cases and spread basic awareness about coronavirus.

The government has set up a call centre where citizens can reach out for free to get information and advice - and the system has been widely successful; the centre got more than 8,800 calls in a period of 24 hours.

Many areas outside the capital are held by al-Shabab, an al-Qaeda-linked group fighting to overthrow the country's internationally recognised government. This makes it nearly impossible for medical and humanitarian workers to carry out operations in those areas. In the past al-Shabab has prohibited child vaccinations in the areas that they control.

[11] https://www.aljazeera.com/news/2020/04/somalia-struggles-coronavirus-infections-undetected-200428193056599.html