



**Australian Government**  
**Department of Health**

# COMMUNICABLE DISEASES INTELLIGENCE

2020      Volume 44  
<https://doi.org/10.33321/cdi.2020.44.30>

## **COVID-19, Australia: Epidemiology Report 10:**

Reporting week ending 23:59 AEST 5 April 2020

COVID-19 National Incident Room Surveillance Team

# Communicable Diseases Intelligence

ISSN: 2209-6051 Online

This journal is indexed by Index Medicus and Medline.

Creative Commons Licence - Attribution-NonCommercial-NoDerivatives CC BY-NC-ND

© 2020 Commonwealth of Australia as represented by the Department of Health

This publication is licensed under a Creative Commons Attribution-Non-Commercial NoDerivatives 4.0 International Licence from <https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode> (Licence). You must read and understand the Licence before using any material from this publication.

## Restrictions

The Licence does not cover, and there is no permission given for, use of any of the following material found in this publication (if any):

- the Commonwealth Coat of Arms (by way of information, the terms under which the Coat of Arms may be used can be found at [www.itsanhonour.gov.au](http://www.itsanhonour.gov.au));
- any logos (including the Department of Health's logo) and trademarks;
- any photographs and images;
- any signatures; and
- any material belonging to third parties.

## Disclaimer

Opinions expressed in Communicable Diseases Intelligence are those of the authors and not necessarily those of the Australian Government Department of Health or the Communicable Diseases Network Australia. Data may be subject to revision.

## Enquiries

Enquiries regarding any other use of this publication should be addressed to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to: [copyright@health.gov.au](mailto:copyright@health.gov.au)

## Communicable Diseases Network Australia

Communicable Diseases Intelligence contributes to the work of the Communicable Diseases Network Australia.  
<http://www.health.gov.au/cdna>



Communicable Diseases Intelligence (CDI) is a peer-reviewed scientific journal published by the Office of Health Protection, Department of Health. The journal aims to disseminate information on the epidemiology, surveillance, prevention and control of communicable diseases of relevance to Australia.

## Editor

Tanja Farmer

## Deputy Editor

Simon Petrie

## Design and Production

Kasra Yousefi

## Editorial Advisory Board

David Durrheim,  
Mark Ferson, John Kaldor,  
Martyn Kirk and Linda Selvey

## Website

<http://www.health.gov.au/cdi>

## Contacts

Communicable Diseases Intelligence is produced by:  
Health Protection Policy Branch  
Office of Health Protection  
Australian Government  
Department of Health  
GPO Box 9848, (MDP 6)  
CANBERRA ACT 2601

## Email:

[cdi.editor@health.gov.au](mailto:cdi.editor@health.gov.au)

## Submit an Article

You are invited to submit your next communicable disease related article to the Communicable Diseases Intelligence (CDI) for consideration. More information regarding CDI can be found at:  
<http://health.gov.au/cdi>.

Further enquiries should be directed to:  
[cdi.editor@health.gov.au](mailto:cdi.editor@health.gov.au).

## Weekly epidemiological report

# COVID-19, Australia: Epidemiology Report 10:

Reporting week ending 23:59 AEST 5 April 2020

COVID-19 National Incident Room Surveillance Team

*Notified cases of COVID-19 and associated deaths reported to the National Notifiable Diseases Surveillance System (NNDSS) to 5 April 2020.*

### Summary

Notifications in Australia remain predominantly among people with recent overseas travel, with some locally-acquired cases being detected. Most locally-acquired cases are able to be linked back to a confirmed case, with a small portion unable to be epidemiologically linked. The distribution of overseas-acquired cases to locally acquired cases varies by jurisdiction.

Early indications are that reduction in international travel, domestic movement, social distancing measures and public health action are slowing the spread of the disease (Figure 1).

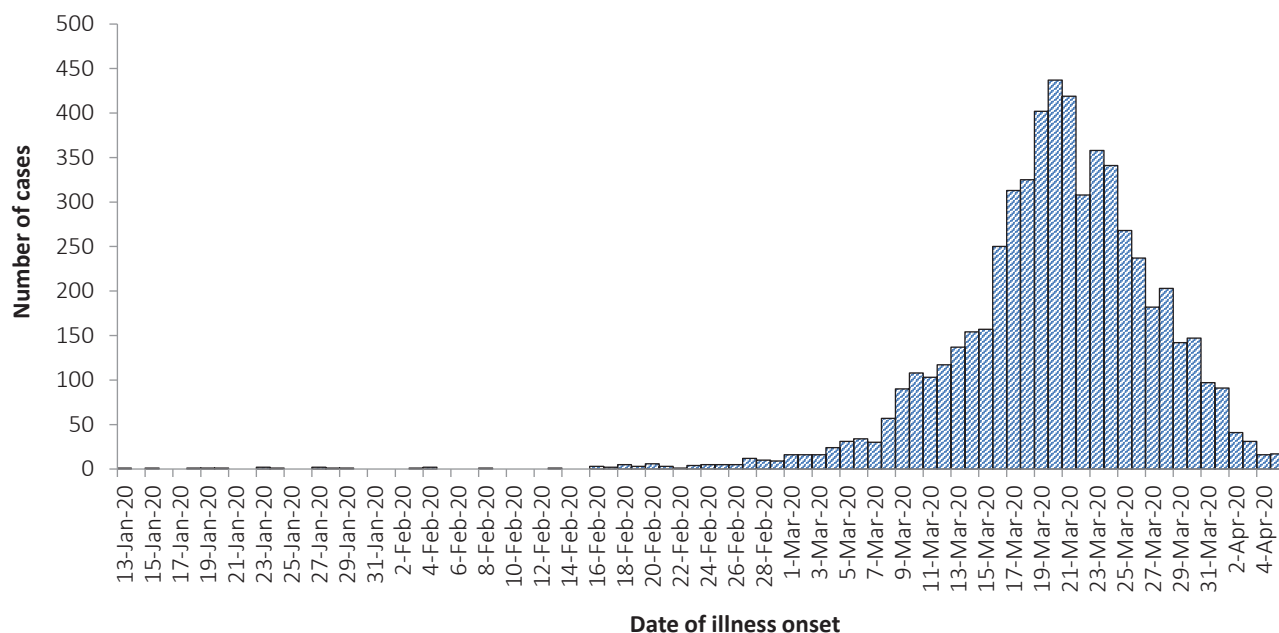
Internationally, cases continue to increase, with high rates of increase observed in the European

#### Confirmed cases in Australia notified up to 5 April 2020<sup>i</sup>

Notifications	5,805
Deaths	33

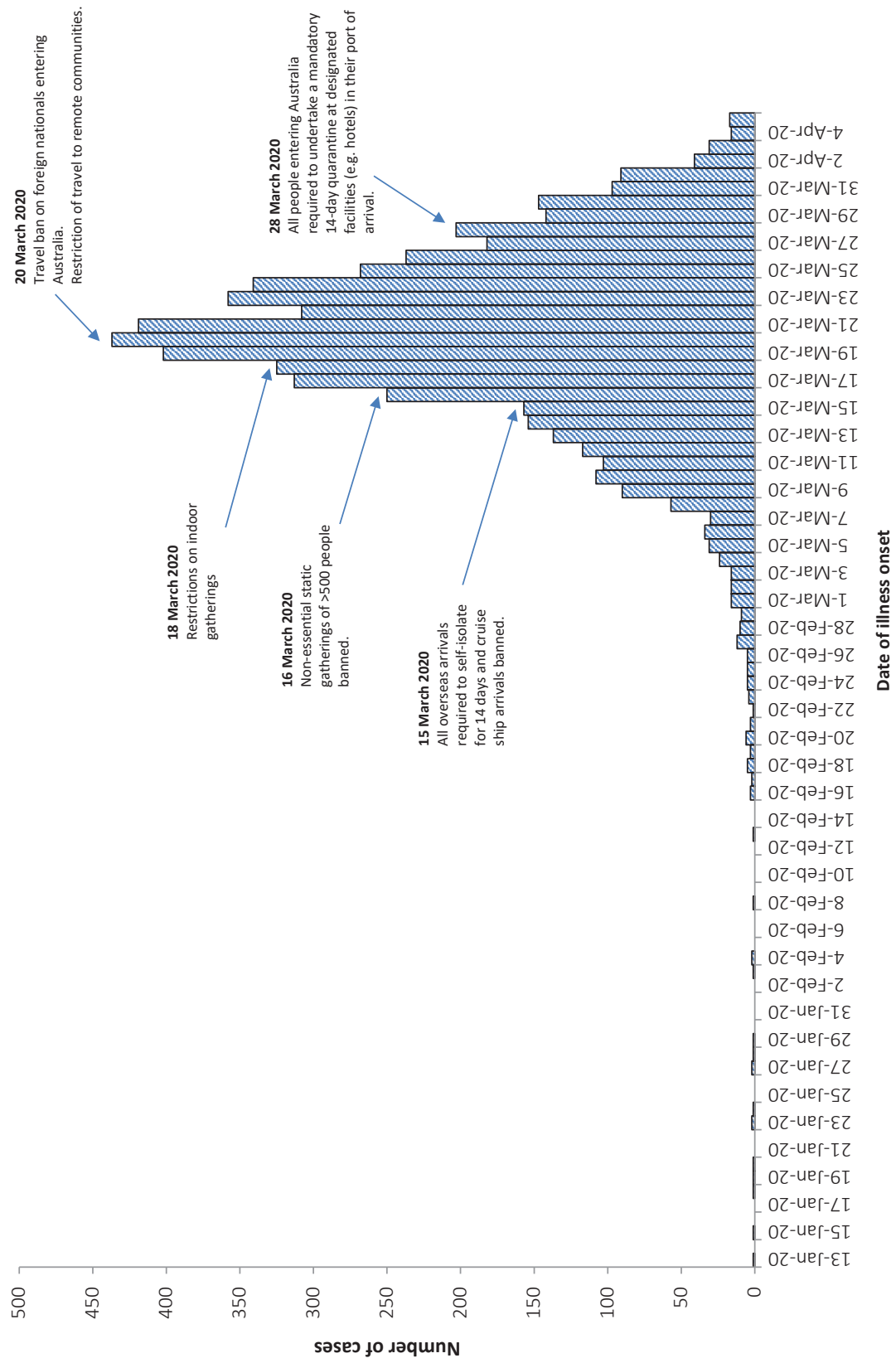
region and the United States of America. The epidemiology differs from country to country depending not only on the disease, but also on differences in case detection, testing and implemented public health measures.

Keywords: SARS-CoV-2; novel coronavirus; 2019-nCoV; coronavirus disease 2019; COVID-19; acute respiratory disease; case definition; epidemiology; Australia



<sup>i</sup> Data caveats: Based on data extracted from the National Notifiable Diseases Surveillance System (NNDSS) on 7 April 2020. Due to the dynamic nature of the NNDSS, data in this extract are subject to retrospective revision and may vary from data reported in published NNDSS reports and reports of notification data by states and territories.

**Figure 1: COVID-19 notifications in Australia by date of onset, from 13 January to 5 April 2020,<sup>a</sup> with timing of key public health measure**



<sup>a</sup> Due to reporting delays, interpret the latest days' new cases with caution.

## Australian cases: descriptive epidemiology

### National trends

- Over the past week, 1,646 cases of COVID-19 were notified to the NNDSS, bringing the total number of confirmed cases notified in Australia to 5,805 (up to 23:59 AEST 5 April 2020). This is a 30% decrease in weekly new cases compared to the previous reporting period (n = 2,355);
- Forty-one cases (0.8%) have been reported in Aboriginal and Torres Strait Islander persons since the start of the outbreak. These cases were reported across several jurisdictions, with the majority reported in areas classified as 'major cities of Australia' based on the case's usual place of residence. Across all Australian cases, completeness of the Indigenous status field was approximately 79%,

with 21% of cases with a reported value of 'unknown'; and

- The median time between onset of symptoms and laboratory testing was 3 days (range 0–42 days).

### Geographical Distribution

- Cases of COVID-19 continue to be reported at varying rates in all jurisdictions (Table 1);
- New South Wales had the highest rate of COVID-19 notifications (32.9 per 100,000) and the Northern Territory had the lowest (11.0 per 100,000); and
- Most cases were reported to reside in major metropolitan areas, with a small number of cases residing outside these areas (Figure 2 and Figure 3).

**Table 1: Notifications and rates of COVID-19 and diagnostic tests performed, Australia, by jurisdiction**

Jurisdiction	Number of new cases this reporting period (00:00 AEDT 30 March to 23:59 AEST 5 April 2020)	Total cases (to 23:59 AEST 5 April 2020)	Rate (per 100,000 population)	Cumulative number of tests performed (proportion of tests positive %)
<b>NSW</b>	678	2,659	32.9	121,443 (2.2%)
<b>Vic</b>	494	1,167	17.7	56,000 (2.1%)
<b>Qld</b>	193	931	18.3	57,795 (1.6%)
<b>WA</b>	131	444	16.9	18,197 (2.4%)
<b>SA</b>	105	409	23.3	32,863 (1.2%)
<b>Tas</b>	17	76	14.2	2,845 (2.7%)
<b>NT</b>	13	27	11.0	2,753 (1.0%)
<b>ACT</b>	15	92	21.6	5,258 (1.7%)
<b>Australia</b>	1,646	5,805	22.9	297,154 (2.0%)

## Age and gender distribution

- Cases of COVID-19 were reported across all age groups. The median age of all COVID-19 cases was 47 years (range: 0 to 100 years);
- The number of cases was highest in the 20–29 years age group, and the highest rate of disease was among those in the 60–69 years age group (Figure 4); and
- Notifications by gender were approximately equal, although there was some variation across age groups.

## Source of infection

- To date, most of the reported COVID-19 cases in Australia acquired their infection overseas;
- Of cases with a reported place of acquisition, 66% had a recent international travel history and 32% were considered to have been locally acquired (Figure 5):
  - The majority of overseas-acquired cases reported a travel history to the European Region, the Americas Region or on board cruise ships (Figure 6);
  - Of the locally-acquired cases, most were considered to be contacts of a confirmed case, with a very small proportion of cases not able to be epidemiologically linked to a confirmed case; and
  - Cases where a place of acquisition has not been reported (2%) are currently under public health investigation.

## Cluster and outbreak investigations

Investigations are taking place in states and territories in relation to a number of clusters and outbreaks of COVID-19. To date the largest outbreaks have been associated with cruise ships.

Cruise ships account for a substantial proportion of cases of COVID-19 in Australia. Of cases with a reported place of acquisition, 16% (n = 903) were acquired at sea on a cruise ship. This is a 35% increase in COVID-19 cases acquired on a cruise ship since the last reporting period. There have been 14 deaths among cases acquired on cruise ships in Australia.

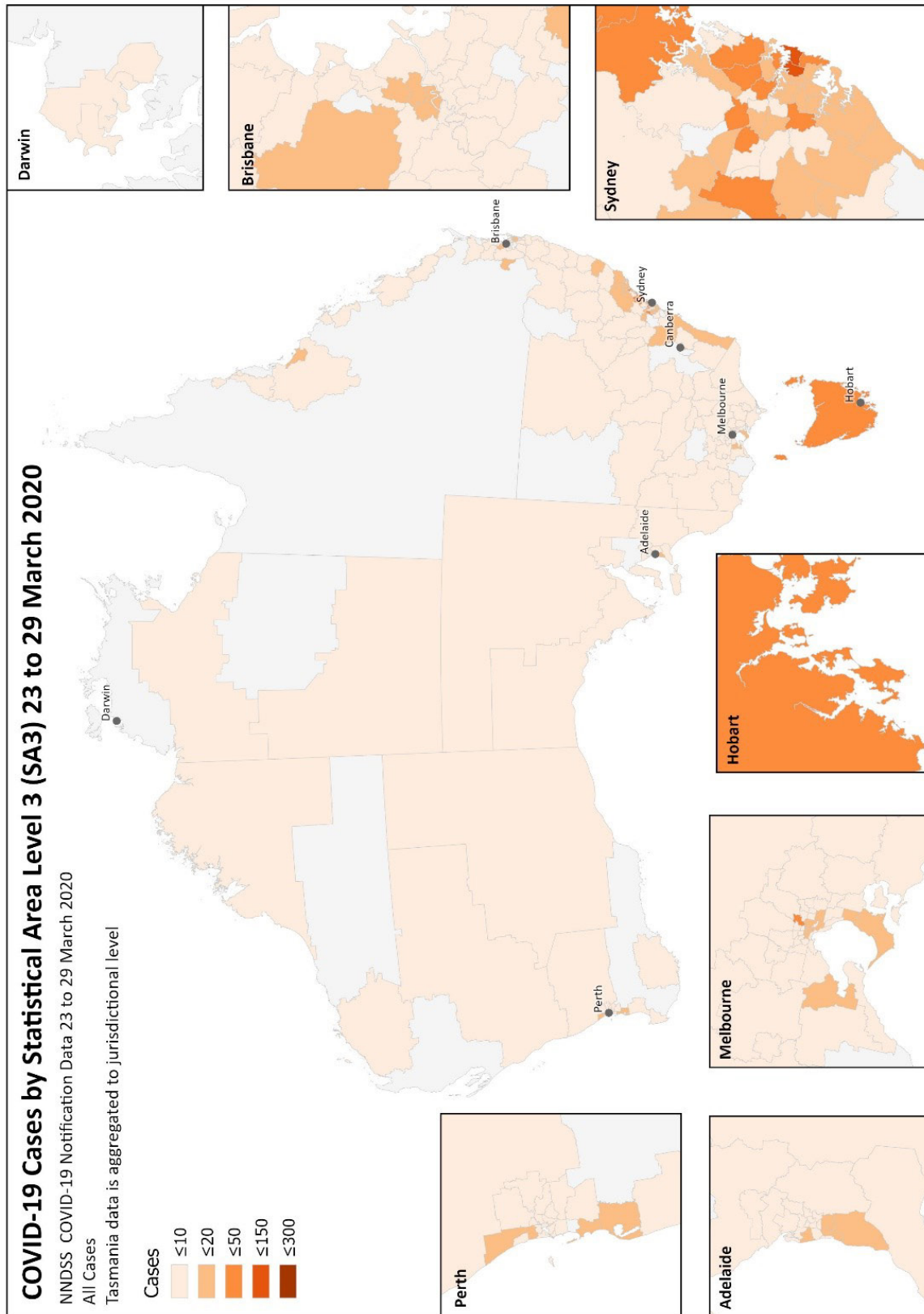
### Cluster:

- The term ‘cluster’ in relation to COVID-19 refers to two or more cases that are epidemiologically related in time, place or person where a common source (such as an event or within a community) of infection is suspected but not yet established.

### Outbreak:

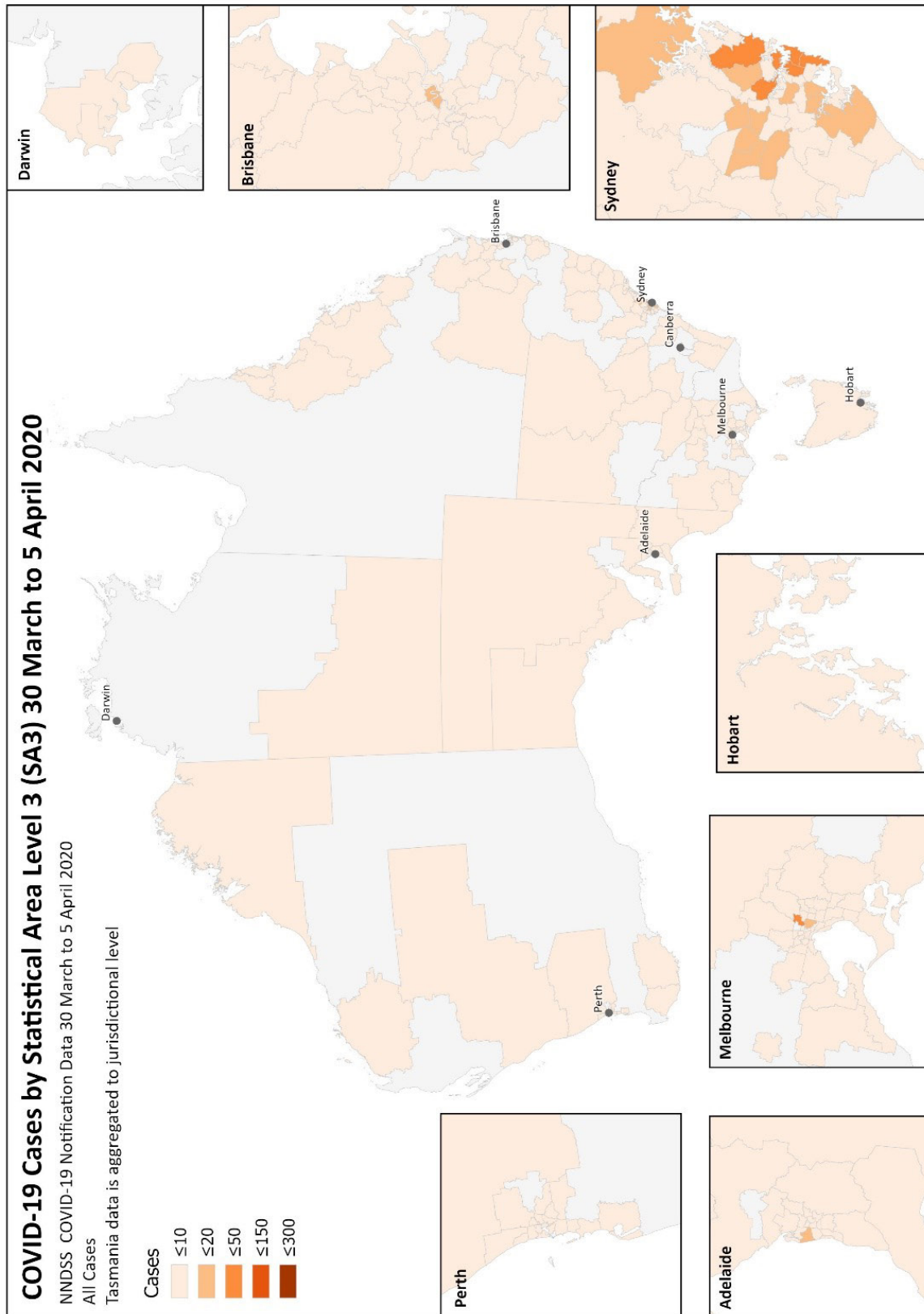
- The term ‘outbreak’ in relation to COVID-19 refers to two or more cases among a specific group of people and/or over a specific period of time where illness is associated with a common source (such as an event or within a community).

Figure 2: Confirmed cases of COVID-19, Australia, by location of usual residence and statistical area level 3,<sup>a</sup> 7 day heat map as at 29 March 2020



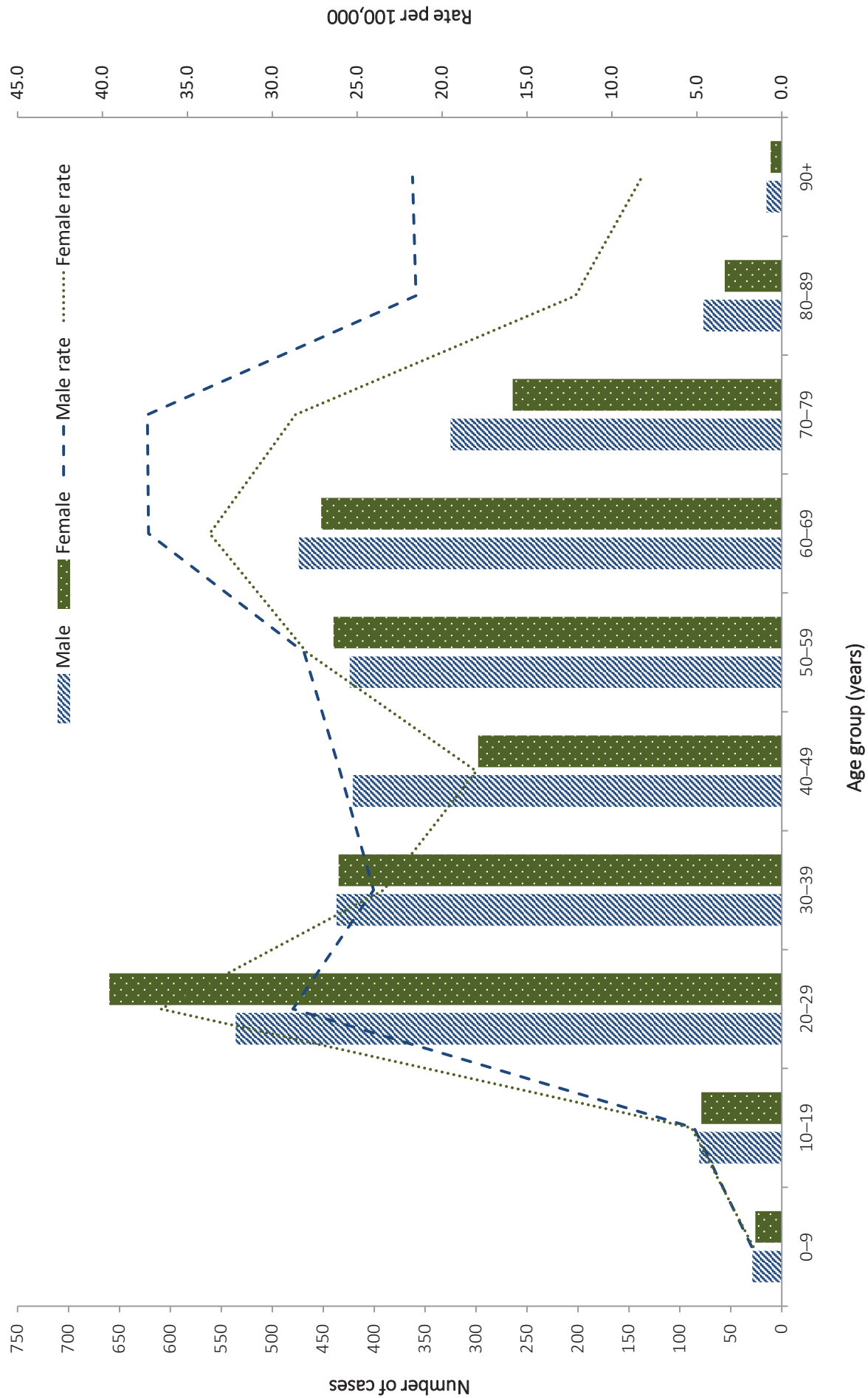
<sup>a</sup> Represents the usual location of residence of a case, which does not necessarily mean that this is the place where they acquired their infection or were diagnosed. Overseas residents who do not have a usual place of residence in Australia are not shown.

**Figure 3: Confirmed cases of COVID-19, Australia, by location of usual residence and statistical area level 3,<sup>a</sup> 7 day heat map as at 5 April 2020**

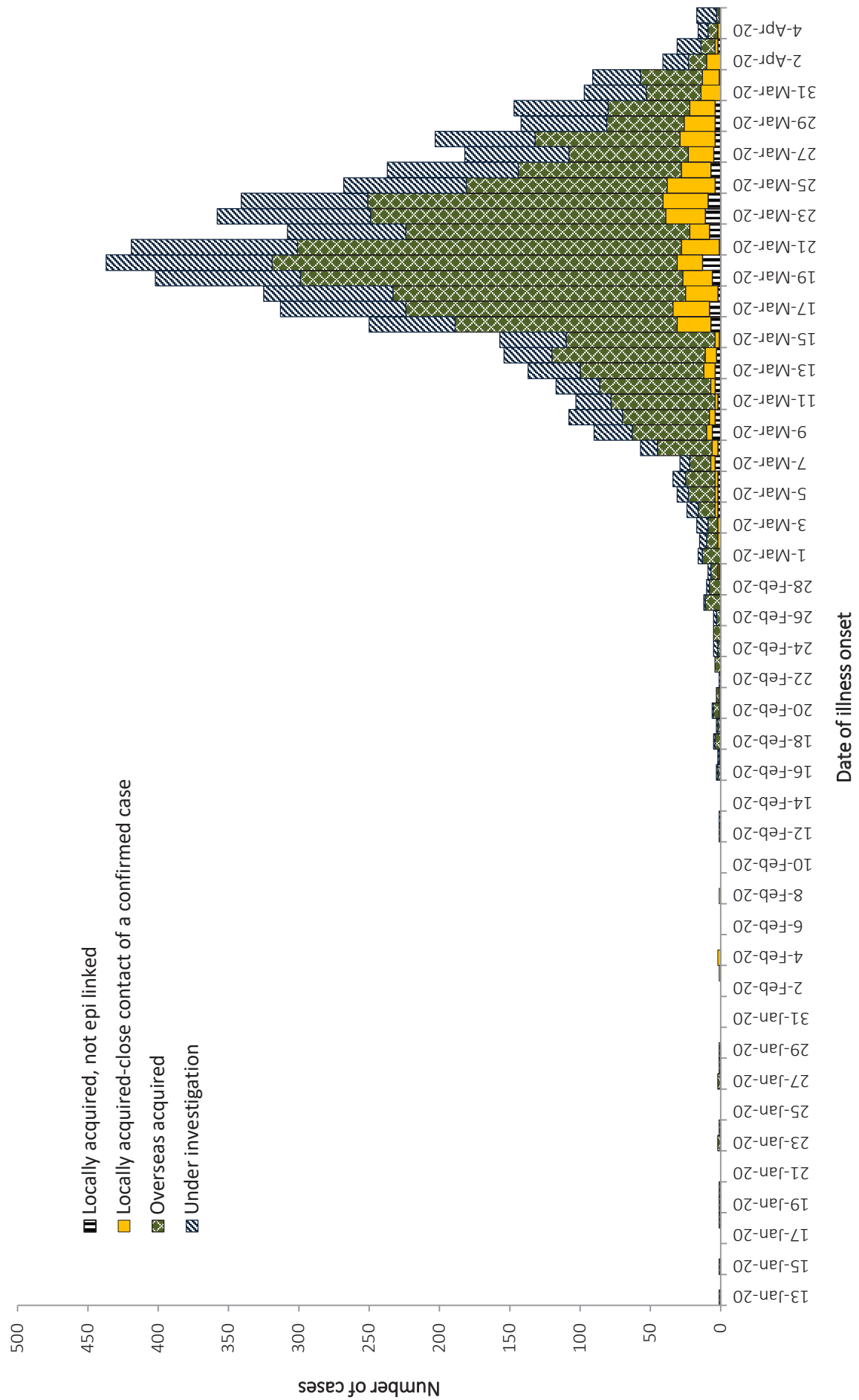


<sup>a</sup> Represents the usual location of residence of a case, which does not necessarily mean that this is the place where they acquired their infection or were diagnosed. Overseas residents who do not have a usual place of residence in Australia are not shown.

Figure 4: Notifications of COVID-19, Australia, by age group and gender

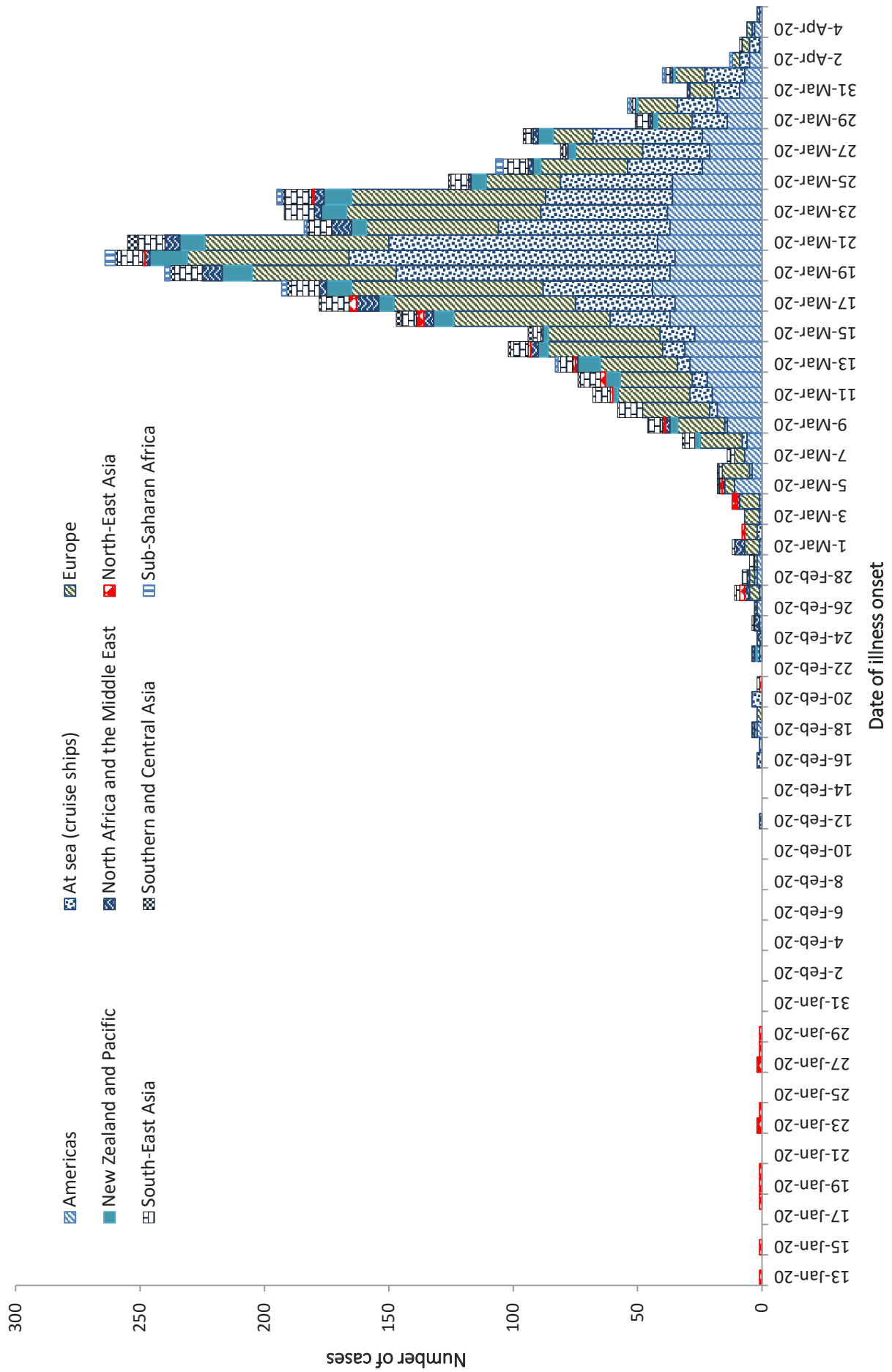


**Figure 5: Number of COVID-19 cases by place of acquisition over time, Australia (n = 5,805)<sup>a</sup>**

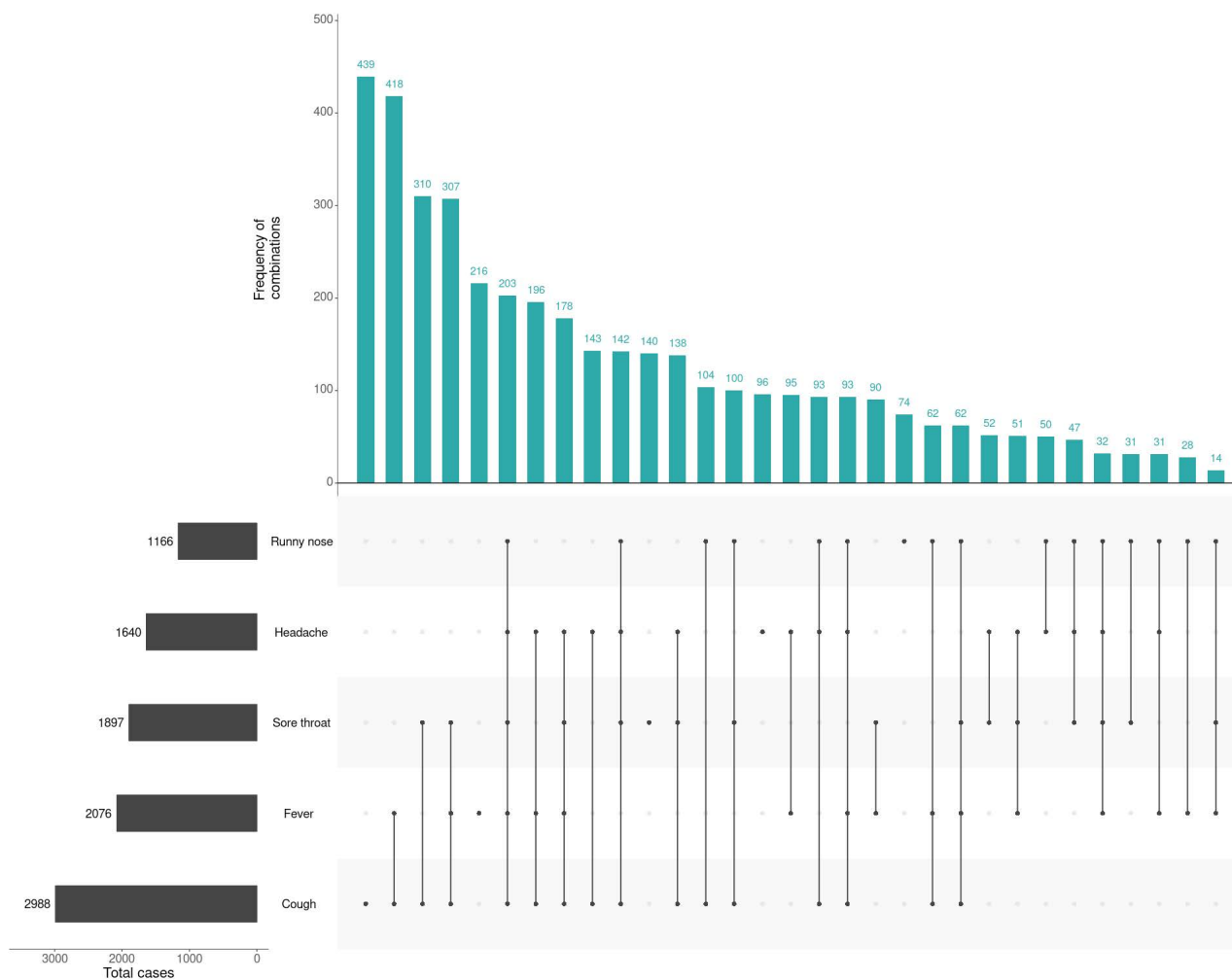


<sup>a</sup> Note that this graph is from NNDSS where there is a data completeness lag compared to more current proportions presented in text.

Figure 6: Confirmed cases of overseas-acquired COVID-19 infections (n = 3,174)



**Figure 7: Variation in combinations of COVID-19 symptoms in confirmed cases, Australia<sup>a</sup>**



a This figure shows the variation in combinations of symptoms observed in reported cases (n = 4,237) for the five most frequently observed symptoms (cough, fever, sore throat, headache, runny nose). The horizontal bars on the left show the frequency of symptom occurrence in any combination with other symptoms. The circles and lines indicate particular combinations of symptoms observed in individual patients. The vertical green bars indicate the frequency of occurrence of the corresponding combination of symptoms

## Symptom profile

- Of the symptoms reported, cough (71%) was the most common (Figure 7);
- Forty-nine percent reported fever, 44% reported sore throat, and 39% reported headache. Only 4% or fewer of all cases reported either pneumonia or acute respiratory disease (ARD); and
- In addition, loss of taste was reported from 324 cases and loss of smell from 322 cases. These conditions were reported in at least 5.5% of cases, noting that this is currently not a standard field in NNDSS, and is likely to under-represent those presenting with these symptoms.

## Severity

- Of the total cases of COVID-19 (n = 5,805) notified, 11% (n = 628) were admitted to hospital:
  - The median age of hospitalised cases was 59.5 years (range 0–94 years), with the highest proportion of hospitalised cases in the 60–69 years age group;
  - The most commonly reported comorbid condition among hospitalised cases was cardiac disease (7.5%), followed by diabetes (7.2%);
- Of the hospitalised COVID-19 cases, 13% (n = 82) were admitted to an intensive care unit (ICU), with 29 cases requiring ventilation;
- Thirty-three COVID-19 associated deaths were confirmed in Australia up to 5 April 2020:
  - The median age of cases who died was 80 years (range 60–94 years);
  - 21 of the cases were male and 12 were female; and

- The most commonly reported comorbid conditions among COVID-19 deaths were chronic respiratory conditions (15%) and diabetes (15%).

## Additional surveillance activities

### Enhanced surveillance within schools and child care settings

The National Centre for Immunisation Research and Surveillance (NCIRS) and the NSW Ministry of Health have commenced an investigation into the transmission of SARS COV-2 in school and child-care centre settings. Preliminary findings suggest low onward transmission among children with 1.9% of close contacts who were children testing positive for the virus.

This investigation includes follow up of laboratory notifications and in some settings enhanced clinical investigation including additional questionnaire, active nasopharyngeal sampling and serology testing of close contacts via school/home visiting teams.

Preliminary activities and findings to date:

- Twenty-one educational settings with COVID cases have been identified to date: eleven secondary schools, two primary schools, and eight childcare centres;
- Index cases have been adult staff in ten sites and children in eleven sites;
- Total close contacts identified were: 903 children and 179 staff from 17 sites (contact lists are pending for 4 sites);
- Enhanced investigations is underway in five sites, with three additional sites in planning stage; and
- Of the 16 sites where nasopharyngeal sampling nucleic acid testing data is available for close contacts:
  - 7/361 children tested and 7/84 adults tested have been positive for SARS-CoV-2 within the 14 days after last known exposure.

Results of serologic testing (in symptomatic and asymptomatic contacts) is pending for some sites and will be reported when available.

Results presented are preliminary and are subject to change as the study progress, and as such should be interpreted with caution.

## Public health response

Since COVID-19 first emerged internationally, Australia has implemented public health measures in response to the disease's epidemiology, both overseas and in Australia. During the current reporting period, the Australian Health Protection Principal Committee (AHPPC) has issued advice to inform the national public health response to the pandemic including management of Early Childhood and Learning Centres (ECLC) in relation to community transmission of COVID-19, special provisions to vulnerable people in the workplace, and regional additional

social distancing measures. As part of the comprehensive public health response taking place across Australia, social distancing plays a vital role in reducing transmission and flattening the curve. Additional public health responses are listed below in Table 2.

**Table 2: Timeline of key COVID-19 related events, including Australian public health response activities, from 31 December 2019 to 5 April 2020.**

Date	Event / response activity
3 April 2020	AHPPC advises against pre-emptive closures of ECLC and considers them essential services that should continue at this time, but with risk mitigation measures and entry restrictions in place. <sup>1</sup>
30 March 2020	AHPPC recommends special provisions be applied to vulnerable people in the workplace and application of additional regional social distancing measures to combat COVID-19. <sup>2</sup>
29 March 2020	Both indoor and outdoor public gatherings limited to two persons only.
28 March 2020	All people entering Australia required to undertake a mandatory 14-day quarantine at designated facilities (e.g. hotels) in their port of arrival.
26 March 2020	Restricted movement into certain remote areas to protect community members from COVID-19.
24 March 2020	<p>AHPPC recommends:</p> <ul style="list-style-type: none"> <li>• temporary suspension of all non-urgent elective procedures in both the public and private sector; and</li> <li>• progressive scale up of social distancing measures with stronger measures in relation to non-essential gatherings, and considerations of further more intense options.</li> </ul> <p>Aged care providers limit visits to a maximum of two visitors at one time per day.</p>
25 March 2020	AHPPC recommends that school-based immunisation programs, with the exception of the delivery of meningococcal ACWY vaccine, are paused at the current time. Australian citizens and Australian permanent residents are restricted from travelling overseas.
21 March 2020	Qld, WA, NT and SA close borders to non-essential travellers.
20 March 2020	<ul style="list-style-type: none"> <li>• Travel ban on foreign nationals entering Australia.</li> <li>• Restriction of travel to remote communities.</li> <li>• Tasmania closes borders to non-essential travellers.</li> </ul>
18 March 2020	<ul style="list-style-type: none"> <li>• DFAT raises travel advice for all overseas destinations to Level 4 'Do Not Travel'.</li> <li>• AHPPC recommends the continuation of a 14-day quarantine requirement for all returning travellers, as the most important public health measure in relation to case importation.</li> <li>• Restrictions on indoor gatherings.</li> </ul>

Date	Event / response activity
16 March 2020	Non-essential static gatherings of > 500 people banned.
15 March 2020	All overseas arrivals required to self-isolate for 14 days and cruise ship arrivals banned.
13 March 2020	AHPPC provides recommendations for public gatherings, testing and social distancing.
8 March 2020	AHPPC recommends restrictions on COVID-19 contacts and travellers from listed higher risk countries.
5 March 2020	Restrictions on travel from Republic of Korea.
1 March 2020	Restrictions on travel from Islamic Republic of Iran.

Figure 8: Number of COVID-19 cases (logarithmic scale) by selected country or region and days since passing 100 cases, up to 5 April 2020

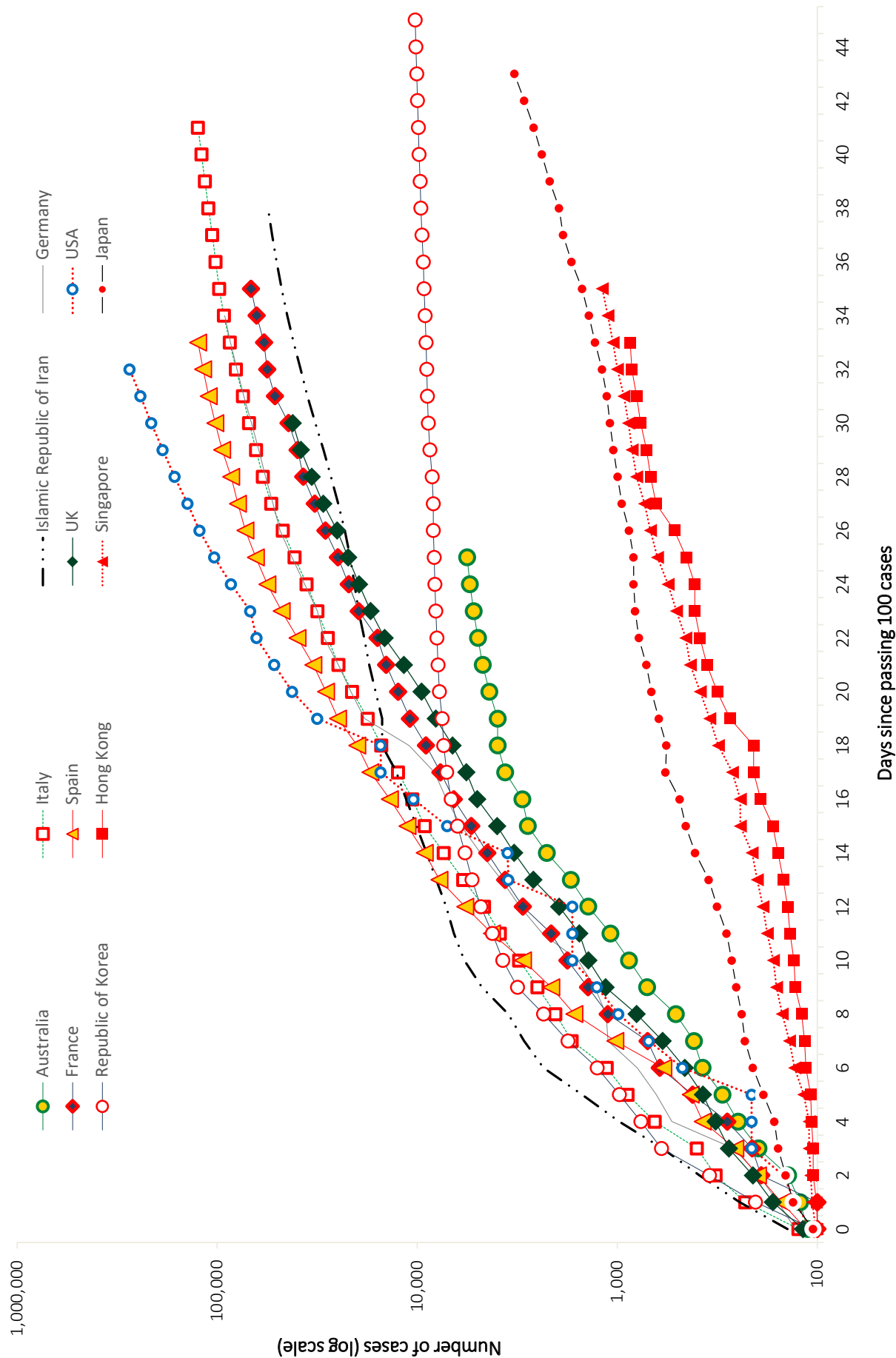
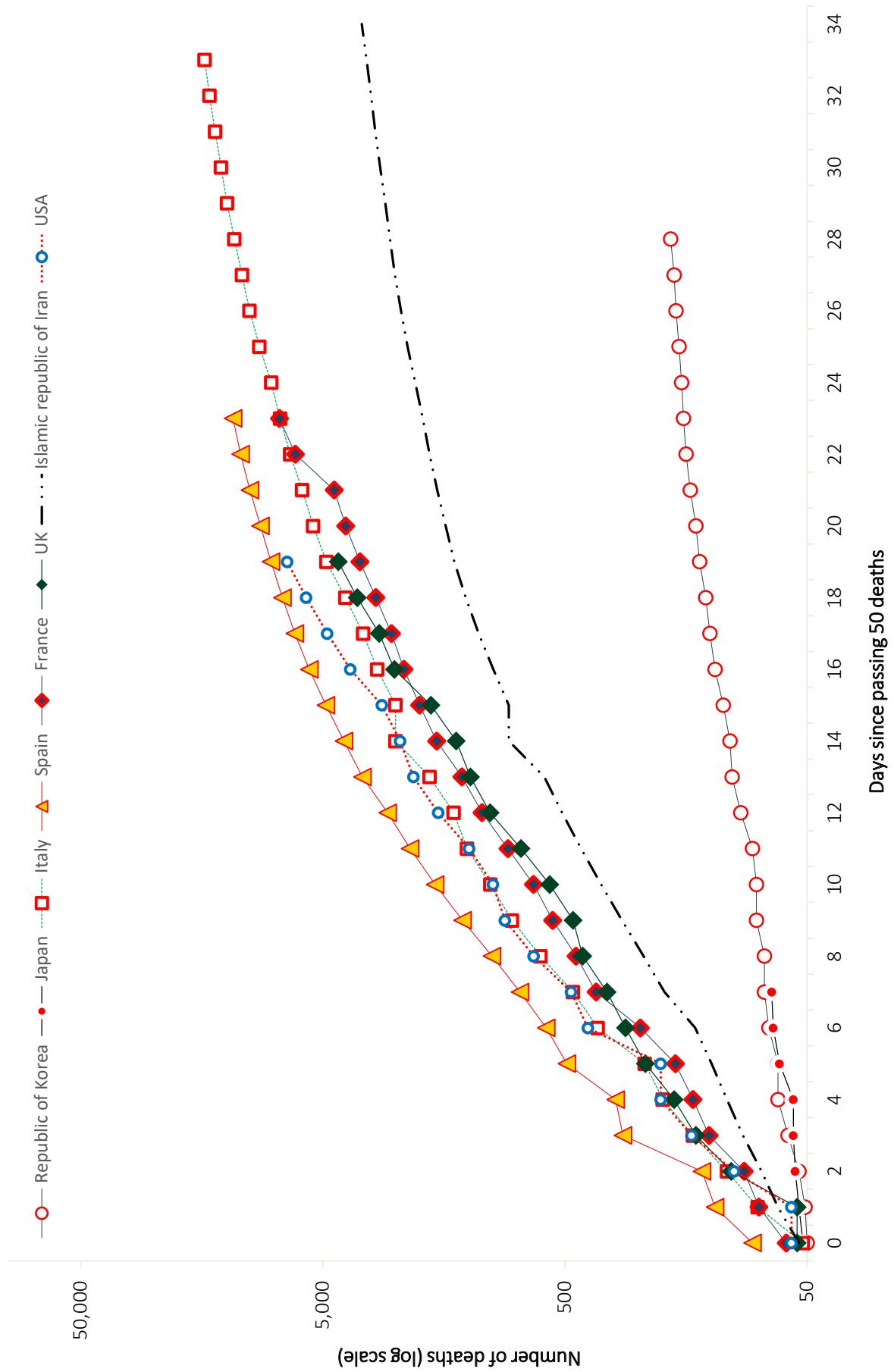


Figure 9: Number of COVID-19 deaths (logarithmic scale) by selected country and days since passing 50 deaths, up to 5 April 2020



## International situation<sup>3</sup>

- As at 23:59 AEST 5 April 2020, the number of confirmed COVID-19 cases reported to the World Health Organization (WHO) was 1,133,758 globally;
- The number of new cases reported globally has continued to increase. As of the last reporting week, with COVID-19 reported across a total of 199 countries, territories and areas;
- The reported epidemiology varies by country with different trajectories of outbreaks after their first 100 cases. Figure 8 highlights that for a number of countries outside of mainland China which have reported more than 100 cases, their rates of increase continue to be high, particularly USA, Spain and Italy. For several other countries or regions including Hong Kong, Singapore and Japan, there continues to be a slow rate of increase in their number of new cases, with the Republic of Korea reporting very few new cases each day. Reported case numbers will be influenced by rates of testing, case definition, and case detection as well as overall health system capacity;
- Globally, 62,784 deaths have been reported. The risk of death is reported to increase with age; and
- The case fatality rate is reported as approximately 6%. This is highly likely to be an overestimate due to variable levels of under-ascertainment of cases, especially those with mild infections. For several other countries or regions including Japan and Republic of Korea, there continues to be a slow increase in their number of deaths, with both countries reporting few new deaths each day (Figure 9).

## Background

*The current estimates on epidemiological parameters including severity, transmissibility and incubation period are uncertain. Estimates are likely to change as more information becomes available.*

## Transmission

- Human-to-human transmission of SARS-CoV-2 is via droplets and fomites from an infected person to a close contact;<sup>4</sup>
- A virological analysis of nine hospitalised cases found active virus replication in upper respiratory tract tissues, with pharyngeal virus shedding during the first week of symptoms. However, current evidence does not support airborne or faecal-oral spread as major factors in transmission;
- A study in China showed an association between household contacts and travel with a confirmed COVID-19 case and an increased risk of infection;<sup>5</sup> and
- A recent study suggests that children do not play a key role in household transmission and are unlikely to be the primary source of household infections.<sup>6</sup>

## Incubation period

- Estimates of median incubation period, based on seven published studies, are 5 to 6 days (ranging from 0 to 14 days). Patients with long incubation periods do occasionally occur, however they are likely to be 'outliers' who should be studied further but are unlikely to represent a change in epidemiology of the virus.<sup>7,8</sup>

## Molecular epidemiology

- Since December 2019, the virus has diversified into multiple lineages as it has spread globally with some degree of geographical clustering;
- The whole genome sequences currently available from Australian cases are mostly in returned travellers from China, the Islamic Republic of Iran, Europe and the USA, and thereby reflect this global diversity; and
- Recent work describes an emerging clade linked to the epidemic in the Islamic Republic of Iran.<sup>9</sup>

## Clinical features

- COVID-19 presents as mild illness in the majority of cases with cough and fever being the most commonly reported symptoms. Severe or fatal outcomes are more likely to occur in the elderly or those with comorbid conditions;<sup>4,10</sup>
- Some COVID-19 patients show neurological signs such as headache, nausea and vomiting. There is evidence that SARS-CoV-2 viruses are not always confined to the respiratory tract and may invade the central nervous system inducing neurological symptoms. As such, it is possible that invasion of the central nervous system is partially responsible for the acute respiratory failure of COVID-19 patients;<sup>11</sup>
- There is some evidence to suggest that reduction or loss of the sense of smell (hyposmia/anosmia) or taste (hypoguesia/ageusia) is associated with COVID-19.<sup>12,13</sup> This is supported by research finding a biological mechanism for the SARS-CoV-2 virus to cause olfactory dysfunction;<sup>14,15</sup>
- Examination of cases and their close contacts in China found a positive association between age and time from symptom onset to recovery. The study also found an associa-

tion between clinical severity and time from symptom onset to time to recovery. Compared to people with mild disease, those with moderate and severe disease were associated with a 19% and 58% increase in time to recovery, respectively;<sup>5</sup> and

- Several studies have identified cardiovascular implications resulting from COVID-19 infection. Vascular inflammation has been observed in a number of cases and may be a potential mechanism for myocardial injury which can result in cardiac dysfunction and arrhythmias.

## Treatment

- Current clinical management of COVID-19 cases focuses on early recognition, isolation, appropriate infection control measures and provision of supportive care.<sup>16</sup> Whilst there is no specific antiviral treatment currently recommended for patients with suspected or confirmed SARS-CoV-2 infection, multiple clinical trials are underway to evaluate a number of therapeutic agents, including remdesivir, lopinavir/ritonavir, and chloroquine.<sup>17</sup>

## Data considerations

Data were extracted from the NNDSS on 7 April 2020, by diagnosis date. Due to the dynamic nature of the NNDSS, data in this extract are subject to retrospective revision and may vary from data reported in published NNDSS reports and reports of notification data by states and territories.

## Acknowledgements

This report represents surveillance data reported through CDNA as part of the nationally-coordinated response to COVID-19. We thank public health staff from incident emergency operations centres in state and territory health departments, and the Australian Government Department of Health, along with state and territory public health laboratories. We thank John Grewar for providing the R-code to produce Figure 7.

## Author details

### Corresponding author

COVID-19 National Incident Room  
Surveillance Team, Communicable Disease  
Epidemiology and Surveillance Section,  
Health Protection Policy Branch, Australian  
Government Department of Health, GPO Box  
9484, MDP 14, Canberra, ACT 2601.

Email: [epi.coronavirus@health.gov.au](mailto:epi.coronavirus@health.gov.au)

## References

1. Australian Government Department of Health. Australian Health Protection Principal Committee (AHPPC) coronavirus (COVID-19) statement on 3 April 2020. [Internet.] Canberra: Australian Government Department of Health; 2020. [Accessed 8 April 2020.] Available from: <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-coronavirus-covid-19-statement-on-3-april-2020>.
2. Australian Government Department of Health. Australian Health Protection Principal Committee (AHPPC) Advice to National Cabinet on 30 March 2020. [Internet.] Canberra: Australian Government Department of Health; 2020. [Accessed 8 April 2020.] Available from: <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-to-national-cabinet-on-30-march-2020>.
3. World Health Organization (WHO). Coronavirus disease 2019 (COVID-19) situation report – 76. [Internet.] Geneva: WHO; 2020. [Accessed 8 April 2020.] Available from: <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200405-sitrep-76-covid-19.pdf>.
4. WHO. Report of the WHO-China joint mission on coronavirus disease 2019 (COVID-19). [Internet.] Geneva: WHO; 2020. [Accessed 1 Mar 2020.] Available from: <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>.
5. Bi Q, Wu Y, Mei S, Ye C, Zou X, Zhang Z et al. Epidemiology and transmission of COVID-19 in Shenzhen China: analysis of 391 cases and 1286 of their close contacts. *medRxiv*. 2020. doi: <https://doi.org/10.1101/2020.03.03.20028423>.
6. Zhu Y, Bloxham CJ, Hulme KD, Sinclair JE, Tong ZW, Steele LE et al. Children are un-

- likely to have been the primary source of household SARS-CoV-2 infections. *medRxiv*. 2020. doi: <https://doi.org/10.1101/2020.03.26.20044826>.
7. WHO. Coronavirus disease 2019 (COVID-19) situation report – 29. [Internet.] Geneva: WHO; 2020. [Accessed 22 Feb 2020.] Available from: <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200218-sitrep-29-covid-19.pdf>.
  8. Pung R, Chiew CJ, Young BE, Chin S, Chen M, Clapham HE. Investigation of three clusters of COVID-19 in Singapore: implications for surveillance and response measures. *Lancet*. 2020;395(10229):1039–46.
  9. Eden JS, Rockett R, Carter I, Rahman H, de Ligt J, Hadfield J. An emergent clade of SARS-CoV-2 linked to returned travellers from Iran. *bioRxiv*. 2020. doi: <https://doi.org/10.1101/2020.03.15.992818>.
  10. Sun P, Qiu S, Liu Z, Ren J, Xi JJ. Clinical characteristics of 50466 patients with 2019-nCoV infection. *medRxiv*. 2020. doi: <https://doi.org/10.1101/2020.02.18.20024539>.
  11. Li B, Bai W, Hashikawa T. The neuroinvasive potential of SARS-CoV-2 may be at least partially responsible for the respiratory failure of COVID-19 patients. *J Med Virol*. 2020. doi: <https://doi.org/10.1002/jmv.25728>.
  12. Mao L, Wang M, Chen S, He Q, Chang J, Hong C et al. Neurological Manifestations of Hospitalized Patients with COVID-19 in Wuhan, China: a retrospective case series study. *medRxiv*. 2020. doi: <https://doi.org/10.1101/2020.02.22.20026500>.
  13. Drew DA, Nguyen LH, Steves CJ, Wolf J, Spector TC, Chan AT. Rapid implementation of mobile technology for real-time epidemiology of COVID-19. *medRxiv*. 2020. doi: <https://doi.org/10.1101/2020.04.02.20051334>.
  14. Venkatakrisnan AJ, Puranik A, Anand A, Zemmour D, Yao X, Wu X et al. Knowledge synthesis from 100 million biomedical documents augments the deep expression profiling of coronavirus receptors. *bioRxiv*. 2020. doi: <https://doi.org/10.1101/2020.03.24.005702>.
  15. Brann DH, Tsukahara T, Weinreb C, Logan DW, Datta SR. Non-neural expression of SARS-CoV-2 entry genes in the olfactory epithelium suggests mechanisms underlying anosmia in COVID-19 patients. *bioRxiv*. 2020. doi: <https://doi.org/10.1101/2020.03.25.009084>.
  16. WHO. Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected. [Internet.] Geneva: WHO; 2020. [Accessed 23 Feb 2020.] Available from: [https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-\(ncov\)-infection-is-suspected](https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected).
  17. Harrison C. Coronavirus puts drug repurposing on the fast track. *Nat Biotechnol*. 2020. doi: <https://doi.org/10.1038/d41587-020-00003-1>.

## Appendix A: Frequently asked questions

### Q: Can I request access to the COVID-19 data behind your CDI weekly reports?

A: National notification data on COVID-19 confirmed cases is collated in the National Notifiable Disease Surveillance System (NNDSS) based on notifications made to state and territory health authorities under the provisions of their relevant public health legislation.

Normally, requests for the release of data from the NNDSS requires agreement from states and territories via the Communicable Diseases Network Australia, and, depending on the sensitivity of the data sought and proposed, ethics approval may also be required.

Due to the COVID-19 response, unfortunately, specific requests for NNDSS data have been put on hold. We are currently looking into options to be able to respond to data requests in the near future.

We will continue to publish regular summaries and analyses of the NNDSS dataset and recommend the following resources be referred to in the meantime:

- NNDSS summary tables: <http://www9.health.gov.au/cda/source/cda-index.cfm>
- Daily case summary of cases: <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers>
- Communicable Diseases Intelligence COVID-19 weekly epidemiology report: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel\\_coronavirus\\_2019\\_ncov\\_weekly\\_epidemiology\\_reports\\_australia\\_2020.htm](https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel_coronavirus_2019_ncov_weekly_epidemiology_reports_australia_2020.htm)
- State and territory public health websites.

### Q: Can I request access to data at post-code level of confirmed cases?

A: Data at this level cannot be released without ethics approval and permission would need to be sought from all states and territories via the Communicable Diseases Network Australia. As noted above, specific requests for NNDSS data are currently on hold.

A GIS/mapping analysis of cases will be included in each Communicable Diseases Intelligence COVID-19 weekly epidemiology report. In order to protect privacy of confirmed cases, data in this map will be presented at SA3 level.

### Q. Where can I find more detailed data on COVID-19 cases?

A: We are currently looking into ways to provide more in-depth epidemiological analyses of COVID-19 cases, with regard to transmission and severity, including hospitalisation. These analyses will continue to be built upon in future iterations of the weekly Communicable Diseases Intelligence report.