

COVID-19

Virtual Press conference 6 May 2020

Speaker key:

TJ	Tarik Jasarevic
TAG	Dr Tedros Adhanom Ghebreyesus
AN	Ankit
MK	Dr Maria Van Kerkhove
MR	Dr Michael Ryan
UM	Unidentified male speaker
UF	Unidentified female speaker
MI	Michael
TR	Translator
LU	Lucas
DW	Derek Walton
SA	Sadio
JO	John
PE	Pearl
KA	Kai
HI	Hillary

00:00:08

TJ Hello to everyone watching us on various WHO platforms. Also welcome to all journalists joining us through an online connection for this regular press briefing from WHO headquarters in Geneva on COVID-19. Before I give the floor to Dr Tedros I will just remind you that the question-and-answer session will start immediately after and that questions should be one per journalist and very concise. We do have interpretation, as we had on previous days. We also have sent you a number of products from different WHO offices on different topics. I will start by giving the floor to Dr Tedros.

TAG Thank you. Thank you, Tarik, hvala. Good morning, good afternoon and good evening. First of all I would like to welcome all Hindi-speaking journalists and we look forward to your questions. In total WHO press conferences are now available in eight languages; all six United Nations languages plus Portuguese and Hindi - namaste - plus closed captions for people with hearing loss.

More than 3.5 million cases of COVID-19 and almost 250,000 deaths have now been reported to WHO. Since the beginning of April an average of around 80,000 new cases have been reported to WHO every day but these are not just numbers. Every single case is a mother, a father, a son, a daughter, a brother, a sister or friend.

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Although the number of cases reported from Western Europe is declining more cases are being reported every day from eastern Europe, Africa, south-east Asia, the eastern Mediterranean and the Americas. However even within regions and within countries we see divergent trends. Every country and every region needs a tailored approach but the impact of the pandemic goes far beyond the number of cases and deaths.

Around the world the pandemic has caused serious disruption to essential health services, including to community-based healthcare. Although professional health workers like doctors and nurses play crucial roles, in many countries trained members of the community play a vital role in delivering essential health services like vaccination, prenatal screening and the detection, prevention and management of many diseases.

Today WHO, UNICEF and the International Federation of the Red Cross have published guidance for countries on how to maintain community-based healthcare in the context of COVID-19.

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It includes practical recommendations for countries on sustaining essential services at the community level, leveraging community health workers for the response to COVID-19 while keeping them safe and advice for how to adapt services for specific diseases and age groups.

For example it suggests using telemedicine wherever possible and leaving insecticide-treated nets for malaria at the doors of households instead of asking people to collect them from a central location.

It's also vital that countries pay careful attention to the most vulnerable members of their societies. Crisis can exacerbate existing inequalities, which is demonstrated in higher rates of hospitalisation and death among certain populations in many countries.

We must address this now and in the long term by prioritising diagnosis and care for those who are most at risk. This is not only the right thing to do; it is the smart thing to do. We cannot end the pandemic until we address the inequalities that are fuelling it.

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Today's guidance complements the United Nations framework for the socio-economic response to COVID-19 published last week. The framework lays out a recovery roadmap for countries to protect lives and livelihoods - I repeat, lives and livelihoods - and get businesses and economies up and running again as soon as possible.

Importantly, the framework takes a health-first approach, recognising that strong and resilient health systems must be the foundation of recovery in all countries. As more and more countries consider how to ease the so-called lock-down restrictions I want to reiterate the six criteria that WHO recommends countries consider; first that surveillance is strong, cases are declining and transmission is controlled.

Second, that health system capacities are in place to detect, isolate, test and treat every case and trace every contact. Third, that outbreak risks are minimised in special settings like health facilities and nursing homes.

Fourth, that preventive measures are in place in workplaces, schools and other places where it's essential for people to go. Fifth, that importation risks can be managed. Sixth, that communities are fully educated, engaged and empowered to adjust to the new norm.

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The risk of returning to lock-down remains very real if countries do not manage the transition extremely carefully and in a phased approach. The pandemic has highlighted the importance of strong national and subnational health systems at the foundation of global health security and universal health coverage.

Strong and resilient health systems are the best defence not only against outbreaks and pandemics but also against the multiple health threats that people around the world face every day. And yet on current trends more than five billion people will lack access to essential health services by 2030, including the ability to see a health worker, access to essential medicines and running water in hospitals.

Gaps like this don't just undermine the health of individuals, families and communities; they also put global security and economic development at risk. The world spends around US\$7.5 trillion on health each year, almost 10% of global GDP but the best investments are in promoting health and preventing disease at the primary healthcare level, which will save lives and save money.

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Prevention is not only better than cure; it's cheaper and the smartest thing to do. The COVID-19 pandemic will eventually recede but there can be no going back to business as usual. We cannot continue to rush to fund panic but let preparedness go by the wayside.

As we work on responding to this pandemic we must also work harder to prepare for the next one. Now is an opportunity to lay the foundations for resilient health systems around the world, which has been ignored for long. That includes systems to prepare, prevent and respond to emerging pathogens. If we learn anything from COVID-19 it must be that investing in health now will save lives later.

History will judge all of us not only on whether we got through this pandemic but also on the lessons we learned and the actions we took once it was over. Before I end I will just repeat something that I said many times; the antidote for this pandemic is national unity and global solidarity. Together we will defeat COVID-19. I thank you.

00:11:20

TJ Thank you very much, Dr Tedros, for these opening remarks and we do indeed welcome Hindi speakers to our press conference. Again we are working with Zoom, which has particular technical modalities so for example Arabic speakers need to go under the Korean language if they want to choose Arabic language while for Hindi speakers they have to go to Japanese language. Hopefully these things will get better as we move forward.

Also for the time being Hindi speakers can only listen and then questions will have to be said in English but we will also work on that. In any case it's very good that we can reach more and more people. Before we go to questions I would just like to remind everyone that we need to be very concise and one question per person.

I will just check with my colleague, Chris, who we have first in line. Let's go with Ankit from India Today. Ankit, you have the floor.

AN Good evening. My name is Ankit Kumar. I represent India Today. My question is on contact tracing applications. More and more countries are rolling out their own versions of these applications. Is there any data or study or can you tell from your own experience if these applications are helpful in controlling the pandemic threat? In your opinion should these apps be mandated for those going out on work during the lock-downs, as the case is in India? Thank you.

00:13:05

TJ Thank you, Ankit. This was about contact tracing applications.

MK I can start and perhaps Mike or DG would like to supplement. Thank you for the question. Contact tracing remains one of the fundamental tasks that need to be done to help control transmission of COVID-19. What we mean by contact tracing is that when you identify a case through your surveillance systems you identify all of the contacts, all of the people who are in contact with that known case and then you follow them over 14 days.

Your question was specifically about apps and apps can supplement the work that needs to be done by people, the work that needs to be done by individuals who can go out and actually interview cases and find out, who did they come in contact with just before they became symptomatic and while they were symptomatic before they were isolated.

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That needs to be done by a group of individuals and many of them are trained in epidemiology but you don't have to be trained in epidemiology. We've seen many countries use different workforces; volunteers who are trained; schoolteachers, we've heard of. We've heard of students who can help with this contact tracing.

What's important about an individual, the people that do this is that you need to find cases through personal interaction and through interviews, all done physically distanced of course. The apps can help but they don't replace people who need to do that contact tracing and what we're seeing is a lot of apps and a lot of applications that can help find people who may have been around somebody if they're using smartphones within a certain distance and that can help narrow down the number of contacts but it doesn't replace the individuals who actually have to go out and do the contact tracing.

MR Just to supplement, there are different applications out there and many countries have developed them, many consortia have developed them in academia and the private sector. There are apps out there that help people learn about the disease and there are some very useful apps out there that provide better information about the disease and good information and that also in some cases help people check their symptoms; in other words allow people to get information regarding the symptoms of the disease, check their symptoms and see if they should take further action.

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There are also mobility tracking applications where people doing modelling - and you've seen that with IHME in the US and other modelling institutions where in the background they're checking the overall mobility of the population, which helps drive the modelling and prediction of disease because clearly if people are more mobile and mixing more you can use that to make your model more accurate about the likely future incidence of the disease.

Then there are the apps that can help with contact tracing and that's the many countries... The UK, I think, has just finished testing their app. What that app allows public health authorities to do is, number one - potentially, and Korea have a similar application - is help with the tracing process.

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Once someone is sick what would normally happen is they'd be tested and isolated. As part of that process the public health authorities will ask them about who they've been in close contact with in the previous days and that is a difficult process, remembering exactly who you spent a certain amount of time with in certain settings, to see who the high-risk contacts might have been.

A way to supplement that is to have an ability to use mobile phone technology that can actually remember in a sense for the person because your mobile phone can remember who you were close to in the last number of days and it can actually calculate how long you've been close to that person.

So what it does is it provides an aid to memory for that process and that can be very good. It can also be used to notify those contacts that they have been in contact with a confirmed case, which allows them to take appropriate action.

For all of this to obviously work it involves the Bluetooth function on people's mobile phones to be activated and people to accept that they wish to use this application and I think that's where we have an opt-in process or many countries have an opt-in process for that.

00:17:39

Each country is using a slightly different application with slightly different opt-in or opt-out processes and obviously countries have to take very good care of the fact that tracking people's location needs to be done for the sole purpose of COVID-19 response and that is something that is being discussed actively in each country.

From our perspective in WHO we are working with many of these developers around the world and looking at these applications and then trying to establish applications or bots that we can offer to countries, which they can adapt for their own use should they wish to.

A good example of that is the GoData application, which is a contact tracing system that allows countries to maintain a very sophisticated database of contacts, cases, lab results and allows public health authorities to construct transmission chains and manage the whole process of contact tracing.

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We've made that application available to all countries and many countries are now using that as a way of managing all of the data around cases. That does not involve individuals' mobile phones being tracked in any way. That's just

purely to aid the process of contact tracing and the process of integrating all of the data.

One of the weaknesses in this whole response or one of the challenges has been how do you integrate data from the hospital, data from the public health system, data from the lab. You've seen the frustrations when people say, we don't have the data, or where is the data.

Very often the problem is that different parts of the health system are generating data for different purposes and that data doesn't come together in a way that helps drive the response and it takes time for that to happen so applications that are assisting with that are extremely useful.

So I would just like to clarify; this is one app, it is one way of doing things. Each and every one of these applications needs to be looked at by national authorities to see how the app can help them do a better public health job of testing, tracing, tracking.

TJ Thank you very much, Dr Ryan.

00:19:53

UM [French language].

UF [Russian language].

UM [French language].

TJ Thank you very much, Dr Ryan.

UF [Russian language].

TJ Be fixed soon. Why don't we try with CNN contributor, Michael Vosukiv? Michael, can you hear us?

MI I can hear you. Can you hear me?

TJ Yes. Please ask your question. We are trying to sort out the issue with the languages.

UF It's all right now actually. The problem's been corrected. Thank you.

MI Thank you for taking my question and greetings from Vancouver Island. Dr Tedros, Prime Minister Trudeau was one of the last world leaders to indicate that he'd like to examine the timeline for the declaration of the Global Public Health Emergency.

00:23:33

I wanted to ask you; in 2015 an independent panel of experts that included members of the Harvard Global Health Institute and London School of Hygiene and Tropical Medicine recommended that WHO consider handing over its declaration responsibility and that there be the establishment of a new global health committee within the UN Security Council.

I'm wondering, given the criticism of the White House and concerns of other world leaders would WHO consider a reform to that extent, at last to tamp down some of the concerns and criticisms coming from world leaders? Thank you.

TAG Yes, thank you. On assessments, I know WHO has a culture of assessing issues and it has a process called after-action review. WHO actually wants any assessment more than anyone and we will do the assessment when the time comes and what we call the after-action review so we will see what happened based on the timeline when we do the assessment.

But now I call upon the world to focus on fighting the fire because while fire is raging I think our focus should not be divided and we should really focus on fighting the fire and saving lives. I thank you.

00:25:26

TJ Thank you very much, Dr Tedros. Next question goes to Ben Wei, People's Daily. Please unmute yourself. Do we have someone from Ben Wei, People's Daily? Okay. Then we will go to the next one. Let's go to Jamil Chade, our friend based here in Geneva, representing a number of Brazilian press. Jamil, please.

JA Hello, Tarik. Thank you very much. This is Jamil Chade. My question is in Portuguese.

TR Dr Tedros, my question is about the specific situation of the city of Manaus in Amazonia, which has a very high number of cases and the Prefect of the city is calling for international aid. There's a great deal of concern over this issue in Amazon. Is there any specific aid from the WHO for Manaus and the Amazon region?

TAG Yes, as you know, we're working with the Government of Brazil so we will continue to work with them and address or give any support they need. Thank you.

00:27:04

MR If I may supplement that, on request of the Government of Brazil we've very often in the past worked at state level and we've done that with yellow fever in the past on many occasions so obviously we have a strong WHO country office there or a BAHQ country office and we stand willing to provide direct technical support to any state through the process of a government request to do so.

MK If I could just add, it's not specific to Brazil but just to say that in this new normal that we're in right now where we're not able to travel, we're not able to get to all of the places we'd like to get to we're finding new ways in which we can try to provide support to countries and in some countries we're doing these virtual missions where we have a set agenda and meetings where

we're having these missions over Zoom, over Skype, over whatever platform that we have.

So just to add that even if we physically can't get to a location because of the pandemic we're finding different ways to provide support where that support is needed and as that support is asked.

TJ Thank you very much. The next question is from the Wall Street Journal. We have Lucas on the phone. Lucas, please unmute yourself.

00:28:28

LU Hello, can you hear me?

TJ Yes, it's okay.

LU I think my question probably goes to Dr Tedros. This relates to the upcoming World Health Assembly and whether Taiwan will be invited to attend. Would you encourage the member states, particularly China, to allow Taiwan to attend as an observer this year?

Conversely I understand that you have the authority to invite them yourself. Would you do that if China continues to resist their participation? Thank you.

TJ Thank you very much, Lucas. I apologise that I did not introduce our guest, our fourth speaker here; it's Mr Derek Walton, who is a legal counsel of WHO. He's here with us and I think he would like to take this question.

00:29:16

DW Thank you very much. Yes, of course we have the World Health Assembly coming up on 18th and 19th May. This year it will be held virtually and it will be a de minimis session, which means it will focus principally on the COVID-19 pandemic.

The involvement, if any, of observers from Taiwan/China in that assembly is a question for the 194 members of WHO, the member governments; it's their decision and indeed a proposal has already been made, as it has been in recent years, for this matter to be considered by the Health Assembly itself and that is a question which is properly for the member states.

But whether or not Taiwanese observers participate in the Health Assembly there are well-established arrangements for health experts from Taiwan/China to work with WHO on technical health matters and I think we've already explained in some detail at previous briefings how that's worked but last year for example Taiwanese experts were included at eight expert meetings and there were six other informal technical meetings.

This year there have been contacts in response to COVID-19 involving Taiwanese experts in key groups and networks. I think we've given details of that on previous occasions but for this year, as I say, the question is for the

Health Assembly; it's for the member states rather than the Secretariat to decide that question. Thank you.

00:30:56

TJ Thank you very much, Mr Walton, for this explanation. The next question is from Sadio Rodriguez from GVAR Chronicle. Sadio.

SA Hi, can you hear me?

TJ Yes.

SA Okay. My question goes out to Dr Tedros. On January 14th WHO stated, preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission of the novel coronavirus identified in Wuhan, China. As an independent global health organisation why did WHO have to rely on China's preliminary investigations into the human-to-human transmission possibility of the coronavirus and not conduct one of its own investigations? That's my question.

TJ Thank you.

MK I can start and perhaps others would like to supplement. The 14th statement that you're referring to is a tweet in which there was the reporting of what had been reported to us from Chinese authorities. I think what is critical and what is important is how WHO acted from the moment we heard about this cluster of atypical pneumonia from Chinese colleagues in Wuhan.

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From the beginning - I'm the MERS specialist, the focal point at the organisation; Mike led the SARS response and so from the start whenever you hear of a cluster of atypical pneumonia you think respiratory and you think human-to-human transmission. It's not if, it's just what is the extent of human-to-human transmission that may be happening.

Within hours of that notification that was picked up through our EIOS system we activated our emergency systems at the three levels of the organisation, which means our headquarters, our regional office and our country office in China, where we were having discussions about what we knew, what questions needed to be asked.

We immediately posed questions to our colleagues in China to ask for more information, as we do with all clusters or all alerts or all signals that we pick up through the electronic monitoring systems. From the beginning we assumed that there would be human-to-human transmission and at our first reporting to our member states and contact points on 5th January - it's in our EIS which is Event Information System - we included detailed information about the cluster itself and also about protecting against acute respiratory infections.

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We also published on that day our first disease outbreak news. From there we worked with our international partners to develop guidance, which is around how you find cases, how you protect healthcare workers, how you treat patients. All of those guidance materials were guidance materials that we adapted from our MERS guidance materials, which included information about how to protect for human-to-human transmission because these viruses are transmitted by respiratory droplets and contact.

So our first guidance that was issued was on 10th January, which included information about how to protect against human-to-human transmission so that's important. I did a press conference on 14th with Tarik. I described what we knew and at the time there were 41 confirmed cases. The novel coronavirus had been identified, PCR assays were available in China and they'd confirmed that 41 out of the initial more than 100 suspect patients actually had what we now call COVID-19 but at the time we were calling it a novel coronavirus.

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So in those 41 cases it was described that there may be human-to-human transmission, mainly among close contacts. It's very important that you understand that we receive information from our member states but we also go back and ask lots of questions. We always do this. It's not unique to this particular situation or unique to China.

We base our actions on what we know and what our experience is with other similar pathogens, in other similar situations. From the beginning we expected that there could be human-to-human transmission. It was just a matter of how much was actually occurring, where it was occurring.

Initially we thought it would be amongst close contacts, through respiratory droplets and that is still the case today.

TJ Thank you very much.

MR Just one thing to supplement too in terms of maybe explaining to people the incident command system at WHO, we operate under a very well-documented emergency response framework, which is an organisation-wide framework for managing emergencies.

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It is constantly under review and in the process of epidemic or emergency intelligence gathering we can get up to 3,000 signals a week sometimes that require follow-up. What we're constantly doing is sifting through the various epidemic signals. We use our own expert networks to do that, seeking information from countries.

The systems have AI components for looking for unusual events and picking them out of the background noise. For many outbreaks that occur we would

generally wait for some level of confirmation of the disease before triggering our incident management system for that specific event.

We follow every event but for certain events we trigger the IMS. The IMS is a special mechanism that creates a special and dedicated multidisciplinary team across the three levels of the organisation and ensures that that event gets a dedicated response for the amount of time that it needs to bring the event to an end and to support our member states in that response.

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That incident management system was established for this event without a diagnosis of the disease, without the virus being known on 1st January and that IMS has remained in place every single day and has operated as one entity across the three levels of the organisation since that day.

TAG Just one minute; I think it has been covered properly but I wanted to clarify one aspect. The rule we have in WHO and other UN agencies is when a member state reports we post the member state report as is. What we did on January 14th on Twitter is we posted China's report as is. That doesn't mean that we agree or we disagree; we're just reporting what came.

Sir, where are you from? The person who asked the question. From India. If India reports we post India's report as is. If my own country, Ethiopia, reports we post the report that came from Ethiopia as is and we treat the same way all 194 member states.

But when we post their reports on our Twitter or website or wherever we just put it as is and we don't change anything. But at the same time if we have some differences with what is reported, as Dr Maria Van Kerkhove said, the same day or before, even January 14th we can say it. Before January 13th Dr Maria Van Kerkhove and other colleagues were saying, there is a likelihood of human-to-human transmission.

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But not only that; even on January 14th Dr Maria Van Kerkhove and other colleagues were briefing journalists and they said, there is a likelihood of human-to-human transmission. Our guidance reflected all that.

Then when China officially reported that it discovered human-to-human transmission - I don't remember the date; was it January 22nd? On January 22nd we just reported again exactly as we received it from China. That's a normal procedure and we do it for any country but that doesn't mean that we accept or not and we express our own opinion and the 14th January press conference was carried by many of the major media including Reuters, expressing the likelihood of human-to-human transmission.

But the most important thing is our guidance before, during 14th and after actually included the likelihood of human-to-human transmission. That helped

countries to prepare so we want you to have the full picture. Thank you for asking that question. Namaste. It's a very important one which is going around but this is the whole truth. Thank you.

00:40:29

MR Yes, and just to supplement the DG again to clarify that WHO has no special powers of investigation or deployment. Every time - and there are thousands of these events every year all around the world where we're picking up signals. We seek to verify the existence of an epidemic with the country. We seek further information but we always, on each and every occasion, offer the country assistance with investigation, diagnosis and response, and respond immediately to requests from our member states to do that.

In this case in addition to our 150 country offices, I think we've launched in excess of 80 surge team missions to support our member states already in this response so we're highly reactive to requests from our member states for assistance in investigation, diagnosis and control and we do that constantly.

At any one time around the world we are responding to at least 30 graded emergencies in which we have teams in the field at the request of our member states.

00:41:34

TJ Thank you very much for this explanation. The next question is from John Coyne from Science. John. Can you unmute yourself?

JO Thank you for taking my question. WHO took the lead in organising an international team of scientists to visit China. Is WHO taking the lead in organising or pushing for an international team to visit China to study origin questions and if not why not?

MK I could start and perhaps others want to supplement. There have indeed been three missions to China. The first mission was from members of our China country office and members from WIPRO [?], who went on 20th and 21st January. The second mission, which was with the Director-General and Dr Mike Ryan and others; between the first and the second Emergency Committee meetings that took place and that was on 28th or so of January.

Then there was a third mission which I was a part of, which was the joint WHO/China international mission in which we had members from many different countries including the United States, Nigeria, Russia - I'm going to forget some - Japan, Korea; thank you.

00:42:55

So we had a group of people who went and worked with our Chinese counterparts and through those two weeks that we were there we came up with a number of recommendations for China itself, for the rest of the world, for the international community.

That report is online; it remains online. It was published very soon after we came back. One of the recommendations among many for China was to look at what is the zoonotic source of this outbreak. The public health importance of this is critical because without knowing where the animal origin is it's difficult for us to attempt to prevent this from happening again.

This happens with all emerging pathogens because most emerging pathogens come from animals and there is discussion with our counterparts in China for a further mission which would be more academic in focus and really focus on looking at what happened in the beginning in terms of the exposures with different animals so that we can look to have an approach to find the zoonotic source.

That is something we are working on right now with our counterparts in China and we have offered support to do that and we will look forward to that happening.

00:44:09

TJ Thank you very much, Dr van Kerkhove. The next question comes from Pearl from Open Parliament. Pearl, can you hear us? Let me try one more time. Pearl from Open Parliament; you would need to unmute yourself.

PE Yes, thank you very much for your availability and inviting me to today's briefing, Dr Tedros. I appreciate that. For the benefit of millions of people who live in autocratic WHO member states where the democratic space is shrinking from the inevitable effects of COVID-19 can you share a clear data-driven response in terms of lower respiratory infections being ranked second after HIV and AIDS and is it ahead of tuberculosis in, say, Zimbabwe?

I ask that because... Although I'm using Zimbabwe as an example in my question please reply with reference to Mozambique, Tanzania and Zambia as well as Zimbabwe given that besides South Africa in the SADAP region these four countries are lagging behind South Africa by my weeks and no modelling information is readily available to their populations to even talk about a curve.

Moreover in Zimbabwe the rapid diagnostic test kits...

TJ Can we please get the question very shortly?

PE Sure. I'm about to finish. In particular LFO [?] are currently being sourced and yesterday there was a flurry of debate about their use in that country and their validity. Thank you.

TJ I'm not sure we really understood the question here.

PE The question I'm asking is, number one, can you speak to the lower respiratory infections? Are they ranked second behind HIV and AIDS, ahead of tuberculosis? I was using Zimbabwe as an example but I'm asking you to speak more specifically for Mozambique, Tanzania and Zambia, and to speak

a little bit about the rapid diagnostic test kits, in particular 1FO, which is being used in Zimbabwe. Thanks.

TJ These are many questions. I don't know if any of our experts can...

MR What I would suggest; your questions are important but they're very specific to individual countries in southern Africa. I do know that for the case of Zambia, Mozambique and Zimbabwe the reported numbers from those countries are low but in Zambia there's been a 50% increase in the last week though the numbers are low.

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The number of deaths remains low and obviously in that reflecting a reality that's positive but it can also reflect underdiagnosis of cases.

So what I would suggest is, given the detail of your questions, that we can try to answer them in writing to you and give you the level of detail that you actually need because to compare, I don't frankly know the background TB rates in those four countries off the top of my head and certainly for HIV and other things.

But we would be delighted to answer your question directly and if you can send an email to Tarik and the media team we'll be very happy to engage with you directly and I'll be happy to do that personally.

TJ Thank you very much, Dr Ryan. The next question; Kai Kofreshmit from Science. Kai, please.

00:47:44

KA Tarik, thanks a lot, thanks for taking my question. I'm just wondering, given that you're the World Health Organization; if you look at the global situation at the moment, can you give us an idea of what the places are at the moment or the populations that right now, you think, are seeing worrying trends and where you think the response needs to ramp up?

MK That's an important question but that question needs to be dissected because there are countries - I'm staring at a map as I talk to you - that are seeing increases in reported cases over time and when we see that that's a worrying trend.

But on the other hand many countries that are seeing increases in cases have ramped up their testing and so I don't want to equate countries that are seeing an increase in testing or an exponential growth or a rapid increase as a negative thing.

It's not good in terms of seeing cases, in terms of transmission but I don't want to equate that with something that is wrong. I want to equate that with, countries are working very hard to increase their ability to find the virus, to find

people with the virus, to have testing in place to identify who has COVID-19 and are putting into place what they need to do to care for those patients.

00:49:10

The recommendations that we have for all countries remain the same. Our recommendations include finding all cases, testing cases, caring for cases in the appropriate settings depending on the severity of their symptoms, finding all contacts, quarantining those contacts for the full 14 days, making sure the public is fully engaged so that they know what they can do.

There is some question about the use of lock-downs or these public health measures. Many countries have had to put those in place because the transmission has increased so rapidly that they were forced to do that. What we have had to do is put guidance out to support countries in lifting those measures, which needs to be done in a controlled way because this virus likes to find opportunities to spread and if these lock-down measures are lifted too quickly the virus can take off and that's a worry that we have.

But the question about countries finding cases should not be seen as a negative thing. It should be seen as a positive thing and we need to support countries through these incredibly difficult times.

00:50:21

The only way to control and suppress this virus, this COVID-19 is to actually find them, quarantine those contacts, isolate the cases and it will be brought under control.

MR If I could just supplement, certainly areas that I would be particularly concerned about... And it's not based on the absolute numbers but it's based on the underlying vulnerabilities of populations and also the underlying weaknesses of the health system and this is particularly acute in areas where there's existing humanitarian crisis.

I remind you that there'll be an update to the global humanitarian response plan for COVID-19 tomorrow, which we greatly welcome. When we look at those numbers - and again they may be small numbers but we've seen in Afghanistan a 76% increase in cases but also what we're seeing is deaths beginning to increase there by over 60%. Sudan has a 145% increase in the last week but also tracking an increase in deaths of 80%.

Palestine similarly with a 100% increase in deaths in the last week. Yemen has a very small problem in the sense of the number of cases that have been reported but we believe that the virus is spreading at community level and we need to focus on providing essential health services and COVID-19 services to all people in Yemen, as we do to all people in Syria.

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Working across lines and ensuring that we're getting and reaching all people within borders regardless of the different conflicts that are ongoing is becoming an increasing challenge for the humanitarian organisations.

There are other concerns in South America, Central America; there are still countries like Peru and Ecuador that have experienced increases in cases but again, as Maria said, some of this is down to better testing and we're seeing more cases.

We need to be tracking the proportion of tests that are positive as a way of better tracking that but also tracking the number of deaths is a good way to really look at that at that impact. We've also seen in Europe and western Europe a fundamental decrease in the number of cases but we have seen an associated increase in the number of cases reported in places like the Russian Federation.

So each region - the western Pacific areas are on the downward trend, like Korea and others but then we do see in South Asia, in places like Bangladesh and India some trends towards increase so it's very difficult to say that any particular region is improving or disimproving.

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There are individual countries within each region that are having difficulties getting on top of this disease and I am particularly concerned about those countries that have existing ongoing humanitarian crises. Haiti is another one that comes to mind that I would be very concerned about.

We need to focus on ensuring that the most vulnerable people in the world get prioritised assistance in this response.

TJ Thank you very much. We have time for one or two more questions. Now I am calling on Hillary from Business Insider. Hillary, if you can hear us and unmute yourself...

HI Hi, can you hear me?

TJ Yes, please go ahead.

HI Great. Thanks for taking my question. I just wanted to talk about a couple of new reports coming out of France and Florida, some new evidence in scientific journals and via public health departments that there might have been some of the first COVID cases in those places as early as late December. I'm wondering if, given the speed of global travel these days, if you think countries around the world might have taken a more aggressive approach to some early testing and assumed the virus might have been spreading in their countries earlier.

MK Thanks for this question. I'm not aware of the report from Florida that you mentioned but I am aware of the recent paper that came out, that was

published yesterday or overnight on a sample from an individual that tested positive by PCR for what's now known as COVID-19 on December 27th.

In this paper the authors themselves say that it could be a false positive but if it is not it is possible that this individual could have had COVID-19 in December. This was about a month before the first cases were reported in France.

We need more information about this particular case, if this is a case, to find out the different type of history that this individual may have had. It is possible that there could have been a case in France as early as December. The first symptom onset of the cluster in Wuhan was on 1st December. so it is possible that someone may have travelled for Wuhan in the month of December and travelled to other locations but I don't want to speculate. It's really important that we look further into this. h

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The second thing to mention is that some countries are now utilising their influenza-like illness and their SARI, severe respiratory illness surveillance system, which has been established across more than 100 countries for influenza.

They're sing those samples prospectively. It started in week nine of this year and is happening now. They're testing a subset of those for COVID-19 and that's important because you look for additional case. Some countries may look backwards and may look at some of those sample that were stored in January or in December and may retest those.

So it's possible that we may see some of those samples testing positive for COVID-19 but we need more information from the countries, we need to understand why this individual was tested and how this individual was tested before we can really put this into context.

MR If I could supplement in terms of understanding emerging diseases and new pathogens, what very often happens is that usually astute clinicians or others notice something unusual; they either notice an unusual syndrome...

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Atypical pneumonia for example is not an unusual syndrome. It wouldn't trigger necessarily to think there was something wrong. As happened in Wuhan the clustering of cases of atypical pneumonia where the testing that was done was negative for the normal pathogens that you would test for.

So you end put in this situation where a group of clinicians say, we know what this is not but we don't know what this is but we still have this cluster of disease that looks very similar. That's what triggers the reaction to say, is this something new, is there something wrong?

That is usually a cluster of disease that looks alike and very often when you then find a test and you go back you find that not all of the people had that disease. The testing then subsequently confirms only a proportion of them so when you detect an unusual cluster what you do is try and find every case of undiagnosed disease that looks like this and then you develop a test or find the virus and you go back and test.

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That's why some of the cases in China have dates of onset that go back to early December; because as they went and looked at this cluster of disease and then they go back and test and they say, when was your onset, and the person says, I got sick on 1st or 2nd December.

But they may have been part of a cluster that was detected at the end of December so it's not that that person was detected as an unusual case on the first day. They were detected as part of an overall cluster so from that perspective it's important to recognise that.

In this particular case I think the clinicians in France and other places very often will do this and we think this is a very prudent approach. If you have someone with a serious illness and you can't make the diagnosis very often hospitals will freeze samples as a standard practice which allows them to come back later and do further diagnostic tests should diagnosis of a new virus or anything else emerge so it's very prudent that that is done.

We look forward to any further examinations that are done by other researchers around the world who may find similar cases. So this is a good thing to do and I think we'll look forward to the peer-review publications where we can see that these tests are validated and we can discuss the implications of those results.

00:59:20

TJ Thank you very much. We will go to the last question for today and that's Gabriela Sotomayor from Mexican news agency.

Gabriela, if you can hear us, please go ahead.

TR Yes, thank you very much for taking my question. I'm going to ask in Spanish. It's for Proceso magazine. There's a great deal of contrast between the figures that are being presented by the United States with more than a million cases and the figures that we're seeing in almost all Latin America, for example in Mexico, where up to now we've had some 26,000 cases.

What is this difference due to? It's a major contrast. We know that the virus doesn't respect borders. Thank you.

MK Thank you for the question. Yes, as the Director-General said in his speech today, if you look at a region or you look at the overall numbers it

doesn't give you the true dynamic nature of this virus in terms of its ability to transmit.

Part of the challenges when you're looking at absolute numbers is that indeed they are absolute numbers. You could look at them as a population-based rate and then you won't see such drastic differences.

Part of it has to do with the testing strategy. I'm not familiar with Mexico's testing strategy to be able to comment exactly on how it is the same or different from other countries but the numbers of cases that come from countries have to do with the epidemiology and how well it transmits, how hard countries are looking and are able to test.

But we really should be comparing rates as opposed to absolute numbers and if we look at the rates - again I'm looking at a map; I don't have the rates calculated in front of me - it doesn't look as different as these absolute numbers with more than a million cases in one country and 26,000 cases in another.

TJ Thank you very much, Dr Van Kerkhove. We will conclude this press conference and I would like to thank our interpreters, who were with us today. Also I apologise for some technical issues I understand we had on streams. The audio file will be sent shortly and a transcript will be posted tomorrow. I wish everyone a very nice evening.

TAG Thank you. Thank you, Tarik, and thank you all for joining us. See you on Friday. Thank you.

01:02:14