World Health Organization

COVID-19

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00:00:00

TJ Hello to everyone. Welcome to our regular press conference on COVID-19 from Geneva headquarters, here in a rainy Geneva. We hear the rain falling on the room when we are so if you hear some noise that's just the storm that we are going through. Today with us we have Dr Tedros, WHO Director-General, Dr Maria Van Kerkhove, Dr Mike Ryan and Mr Steve Solomon, who is our Principal Legal Officer and may be asked to answer some of your questions.

Before I give the floor to Dr Tedros, just to remind everyone, if you are raising your hand to ask a question you will have to unmute yourself. We have simultaneous interpretation in six UN languages plus Portuguese and Hindi and I thank the interpreters for being with us. We also sent you a number of

press releases and the information from our regional offices, including about a press conference tomorrow at, I think, 11:00 from our regional office for the Eastern Mediterranean in Cairo. I will give the floor now to Dr Tedros for his opening remarks.

TAG Thank you. Thank you, Tarik, and thank you, all joining today's press conference. Good morning, good afternoon and good evening. There have now been more than four million cases of COVID-19 across the world. Over the past week several countries have started lifting stay-at-home orders and other restrictions in a phased way.

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Countries put these stringent measures in places, sometimes called lock-downs, in response to intense transmission. Many have used the time to ramp up their ability to test, trace, isolate and care for patients, which is the best way to track the virus, slow the spread and take pressure off the health systems.

The good news is that there has been a great deal of success in slowing the virus and ultimately saving lives. However such strong measures have come at a cost and we recognise the serious socio-economic impact of the lock-downs, which have had a detrimental effect on many people's lives.

Therefore to protect lives and livelihoods a slow, steady lifting of lock-downs is key to both stimulating economies and also keeping a vigilant eye on the virus so that control measures can be quickly implemented if an upswing in cases is identified.

I have previously outlined the six criteria countries need to consider before lifting stay-at-home orders and other restrictions. Over the weekend further guidance was published that outlines the three key questions countries should ask prior to lifting of lock-downs.

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First, is the epidemic under control? Second, is the healthcare system able to cope with a resurgence of cases that may arise after relaxing certain measures? Third, is the public health surveillance system able to detect and manage the cases and their contacts and identify a resurgence of cases These three questions can help determine whether lock-down can be relaxed slowly or not.

However even with three positive answers releasing lock-downs is both complex and difficult. Over the weekend we saw signs of the challenges that may lie ahead. In the Republic of Korea bars and clubs were shut as a confirmed case led to many contacts being traced.

In Wuhan, China the first cluster of cases since their lock-down was lifted was identified. Germany has also reported an increase in cases since an easing of

restrictions. Fortunately all three countries have systems in place to detect and respond to a resurgence in cases.

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Early serological studies reflect that a relatively low percentage of the population has antibodies to COVID-19, which means most of the population is still susceptible to the virus. WHO is working closely with governments to ensure that key public health measures remain in place to deal with the challenge of lifting lock-downs.

Until there is a vaccine the comprehensive package of measures is our most effective set of tools to tackle the virus. In this vein new guidance was released over the weekend regarding both schools and workplaces reopening. On children going back to school decision-makers should reflect on a number of key factors when deciding on whether and how to reopen the schools.

First, a clearer understanding about current COVID transition and severity of the virus in children is needed. Second, the epidemiology of COVID-19, where the school is geographically located needs to be considered.

Third, the ability to maintain COVID-19 prevention and control measures within the school setting. When reflecting on the decision to reopen schools the local governments should assess the capacity of the schools to maintain infection prevention and control measures.

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Last week I also spoke to the International Labour Organization, ILO, and the International Organisation of Employees, IOE, about the reopening of workplaces and how to do this safely. Over the weekend WHO issued details new workplace guidelines which recommended all places of work carry out a risk assessment for workers' potential exposure to COVID-19.

This includes the implementation of measures to prevent the spread of the virus. Workplaces should develop action plans for prevention and mitigation of COVID-19 as part of their overall business plan. The plan should also include measures for protecting health,s safety and security and reopening, closing and modifying workplaces.

Today saw the use of new modelling on HIV by the World Health Organization and UNAIDS. It highlights the importance of taking immediate steps to minimise interruptions in health services and supplier of antiretroviral drugs during the COVID-19 pandemic

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The group's worst-case scenario, a six-month disruption of antiretroviral therapy, suggested that there could be 500,000 extra deaths from AIDS-related illnesses, including from tuberculosis, in sub-Saharan Africa over the

next year. This could effectively set the clock back by more than a decade to 2008 when more than 950,000 AIDS deaths were observed in the region.

This is an avoidable worst-case scenario and not a prediction. This model acts as a wake-up call to identify ways to sustain all vital health services. Despite attention being focused on the COVID-19 pandemic we must still ensure that global supplies of tests and treatment for both HIV and TB reach the countries and communities that need them most.

We should save people from both COVID and HIV and other illnesses. Even relatively short-term interruptions to treatment pose a significant threat to a person's health and potential to transmit HIV. COVID-19 has exposed the uneven distribution of life-saving medical equipment across the world.

Tomorrow the Tech Access Partnership will be launched to increase local production of essential health technologies like mask and ventilators in developing countries. This partnership is another great example of solidarity that builds on the solidarity flights, Solidarity trials and access to COVID-19 tools accelerator, which all aim to ensure the latest health innovations are reaching those communities that need them most.

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Only together can we get through this pandemic in national unity and global solidarity. I repeat, only together can we get through this pandemic in national unity and global solidarity. Thank you.

TJ Thank you, Dr Tedros, for this. We will now open the floor to questions. I will remind journalists that you can ask questions in one of six UN language plus Portuguese or Hindi and our interpreters will be willing to translate that. Please, short and concise and one question. If you go into too many questions we will have to pick on that we like the most.

We will start with Peter Kenny, Geneva-based correspondent for a number of South African - I think - media. Peter, can you hear us?

PE Yes, I can hear you. I'd like to ask my question to Dr Tedros. You've spoken about the importance of keeping health workers healthy. Tomorrow is International Nurses' Day and last week we had a statement from the International Council of Nurses that 90,000 nurses or health workers have been infected and 260 have died. Do you have accurate statistics on this and can you comment on it, please?

00:12:10

MK Thank you for this very, very important question. Healthcare workers who are on the front lines of caring for patients and caring for our loved ones who are infected with COVID-19 are a priority to ensure that they stay healthy.

We are working with our Infection Prevention and control specialists across the world to ensure that the guidance that we have out ensures that they're protected when caring for patients.

We are looking at the number of healthcare worker infections that have been reported globally and there is an alarming number of healthcare worker infections. In some countries up to 10% of the reported cases are among healthcare workers.

What we've done and what we are continuing to do is to better understand where health care workers are getting infected, why health care workers are getting infected and how can we ensure that this is reduced and this stops.

What we understand from the studies that are being reported and from our teleconferences that we are having with clinicians and with infection control specialists is that many healthcare workers have had contact with a known case that is among a family member, which indicates that many of them have been infected outside of a healthcare facility.

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Some healthcare workers are getting infected inside the healthcare facilities and the studies that are coming out are giving us a clearer picture of why this may be. First is that early on in the pandemic and early on in countries where they're starting to see initial cases many of those cases are identified in wards that aren't used to infectious diseases, they're not used to respiratory infectious diseases.

In many of those wards long-term-care living facilities or geriatric wards they're not wearing contact personal protective equipment protecting against respiratory droplets. Once a COVIOD patient is identified and the appropriate PPE is used then you can prevent transmission.

The other reasons why we're seeing healthcare worker infections are extended periods in wards where individuals are working very long shifts. In some situations they have not had adequate PPE, which includes masks, goggles, face shields, gowns, gloves. In some hospitals there have been reports of suboptimal hand hygiene so making sure that healthcare workers use hand hygiene is very, very important.

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What we also see from these studies is that when healthcare workers do wear appropriate PPE, which includes protecting against respiratory droplets and contact transmission and in situations where aerosol-generating procedures are conducted and airborne precautions are necessary we're not seeing that transmission take place so that is really critical.

But we are constantly looking at the literature that is coming out to better understand how we can better protect healthcare workers, we can ensure that

their shifts are shorter, that they have adequate rest periods, that we look out for their mental health and their well-being and that they have adequate supplies of personal protective equipment.

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MR If I could just add, when we define healthcare worker we sometimes imagine that's healthcare workers working in very sophisticated tertiary facilities. A lot of healthcare workers have been infected in the front lines in long-term care facilities as well and in primary healthcare too, general practitioners and others.

So protecting workers who work in COVID-19 isolation units and intensive care can work extremely well if they have the right equipment and training but we also have to look at the risk management for those other front-line workers who may come into contact with COVID-19 cases to ensure that they're adequately protected too.

So it's a complex issue and the definition of health worker in this case is very broad.

TJ Thank you very much for this answer. Before we go to the next question, just to remind you, we're operating with Zoom so people wanting to listen to Hindi interpretation will have to go to settings and choose Japanese language and those who would like to listen in Arabic have to choose Korean language.

Next question; Nicola Slater from Telegraph. Nicola.

NI Hi. Can you hear me?

TJ Yes, it's okay.

00:16:58

NI Can you hear me?

TJ Yes.

NI Thanks for the question. It's on the subject of Taiwan's invitation to the WHA as an observer, to Dr Tedros. Last week the WHO advised that a sticking point was based in UN resolutions that recognised only representatives of the PRC to represent China at the WHA. However Taiwan's Foreign Ministry and Taiwan's lawyers say that the resolutions only address the question of China's representation and not the separate issue of Taiwan's attendance.

Given that Beijing's One China principle is not international law and not universally recognised critics of the WHO and the Director-General's reluctance to invite Taiwan say that you're making a political call if you fall into line with Beijing's views not the issue. How would you respond to that?

SS Thank you for the question. There are five points I'd like to make to respond to that question. First, the Secretariat works within the framework of rules and policies decided by the 194 member states of WHO. These include the decision you mentioned, the decision by WHO member states made 49 years ago that still applies, where the Health Assembly decided that the People's Republic of China is the - and I'm quoting here - only legitimate representative of China to the World Health Organization - close quote.

They further decided - and I'm quoting again; quote - to expel the representatives of Chiang Kai-shek from the place which they unlawfully occupied at the World Health Organization - close quote.

Second point is, turning to the issue of technical work, WHO experts recognise and have publicly said here at these press conferences and otherwise that Taiwanese health authorities have mounted a very successful response to the outbreak and have good experience to offer.

Their technical contributions to WHO's COVID response expert processes including three WHO networks - the clinical network, the infection prevention and control network and recently the vaccine network - their work with the WHO global research and innovation forum where they sent two experts, and their IHR EIS system connectivity all are examples of where they have contributed significantly and their contributions there are appreciated.

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Third, WHO is premised on the principle that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. This is in the WHO constitution. It's part of our DNA as an organisation.

Fourth, the DG, the Director-General is the Secretary of the Health Assembly according to the constitution. Member states and only member states determine the policies of the organisation at those meetings, make the final decision on what they will discuss and they themselves determine who attends as observers.

To put it crisply, Director-Generals only extend invitations when it's clear that member states support doing so, that Director-Generals have a mandate, a basis to do so. So for example the Holy See was invited by the then Director-General in 1949 when the Health Assembly was held in Rome.

Then in 1950 the ICRC was invited and then in successive years a number of examples; the IFRC, the Global Fund, GAVI among a few others. For all of these member state support was very clear and from 2009 to 2016 Taiwan was invited by the then Director-General as an observer at the Health Assembly as Chinese Taipei on the same basis.

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Then too member state support was clear. It was clear then because a diplomatically agreeable solution had been found and member states supported that solution. Therefore on that basis the then Director-General could and did send an invitation.

Today however the situation is not the same. Instead of clear support there are divergent views among member states and no basis, therefore no mandate for the DG to extend an invitation.

Fifth and final point, a practical one; a proposal has been made by 13 member states now that the Assembly itself make a decision on an invitation. That is procedurally how it is supposed to work under the constitution. All 194 member states will consider the issue collectively in accordance with the rules of procedure.

Member states can also choose to look for a diplomatically agreeable solution for handling this issue. They have done so many times in the past, working cooperatively together. Success on that depends on political will and political engagement, which underscores the point that this is a political issue that is properly in the hands of member states. Thank you.

00:22:59

TJ Thank you very much, Mr Solomon, for this explanation. We will now go to Kamran Kasimov from Azerbaijani TV, Harel TV. Kamran, unmute yourself if possible, please. Hello, do we have Kamran Kasimov online? I think... We may come back to Kamran later. Let's try Imogen from the BBC. Imogen.

IM Hi, Tarik, thanks for taking my question. It's about the... You can hear me. Yes?

TJ Yes.

IM Okay. It's about the guidance for reopening of schools and workplaces, schools in particular. At the opening Dr Tedros said schools need to have a clear understanding of virus transmission in relation to children and the extent of how the virus affects children.

Unless I've missed something we don't understand that yet so is the implication that schools shouldn't reopen?

00:24:16

MK I can start with that and perhaps Mike or DG would like to supplement. The considerations for reopening or adjusting any of the measures are based on our understanding of this virus and how this virus behaves. One of the considerations for schools where children are is our understanding of the virus in children and that is something we are learning more and more about every single day.

We've talked about this at some of the pressers previously, about our understanding of the reports of cases among children by countries and that ranges between one and 5% of the reported cases by country.

We're trying to understand why there's a low attack rate in the children and why a smaller proportion of children are being reported among the total number of cases being reported and we're trying to understand on transmission in children from the available studies that we have, looking at household transmission and these are very detailed studies that follow all of the people in the household and they test all of those people in the households.

We've seen transmission from adults to children, primarily from adults to children. There have been some instances of transmission the other way around, from children to adults, but too a much lesser extent.

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There are some seroepidemiologic studies that are currently underway that are looking at the extent of infection as measured by antibody level - so this is measuring past infection - among children. We have very few of these studies available yet so we don't know if children are being infected and we're missing them through the current surveillance systems.

We do know with regard to severity that the vast majority of children who are reported to be infected with COVID-19 experience a mild disease although there are a small number of children that have had severe disease, critical disease and some children have died.

In terms of making the decisions about opening schools it's very important to understand the virus circulation in the area where the schools are; what does it look like, is there intense transmission in that geographic area, is it not?

Are the schools able to practise physical distancing within the school system itself? Are there different ways that they can set up the classroom for example or the playtime or lunchtime so that they can keep children physically separate?

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We know that there are challenges with that for younger children versus older children. There're a lot of considerations that need to be taken into account when deciding whether and how to open schools. It's not just a matter of if they should open; it's how they should open.

There're a lot of detrimental effects to children who are not in school and these are well-known. We are working very closely with our counterparts at UNICEF - and we're very grateful to be working with them - to really understand the whole impact of children not being in school.

So there are a lot of considerations that need to take place. The DG has highlighted a few considerations but the guidance itself has a lot more in there

and in fact in the guidance itself there are a lot of questions that decision-makers need to evaluate to see how they can safely reopen schools.

TJ Let's try one more time to get Kamran Kasimov from Azerbaijan. Kamran.

00:27:43

KA Do you hear me?

TJ Yes.

KA Hello. Greetings from Azerbaijan, from Real TV. I want to say that the first [unclear] hospital was opened last week in Azerbaijan under the leadership of the President of the Azerbaijani Republic. Dr Tedros every time appreciates all of Azerbaijan's struggle against the coronavirus.

But from 9th May we have had very bad information; satisfactory [sic]. For example on 9th May the number of infected people was 143 and on 10th May the number was 97. Is this a signal of the second wave for our country, please?

MR I can't relate my figures to yours right now but Azerbaijan has had a relatively low number of cases but the number of cases has grown steadily so I think it's difficult to distinguish between first waves, second waves. Azerbaijan is still very much in a risky position, like many other countries in central Asia, with the possibility of increasing cases.

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You may see - and sometimes people see this as waves; you see a small number of cases beginning and then it gradually and slowly builds and then there's a point at which things accelerate. We've seen that in many, many countries. That would not be the classic second wave that other countries now who've had large numbers of cases may be facing in weeks' to months' time.

So certainly Azerbaijan needs to be very wary and very alert right now in terms of the incidence of cases and ensuring that things don't take off in a very extreme way.

With regard to the future of the pandemic and epidemics around the world many countries now have a sustained falling in the number of cases and the number of deaths and as we enter into a low-transmission period - the Director-General has alluded to it in his speech - those countries who are exiting more stringent public health and social measures or so-called lock-downs will do better and may avoid major second waves if they can shut down transmission early in clusters that are identified, much as Korea has done or is doing with regard to its latest clusters of infection.

What we would hope is that countries applying strong public health surveillance with sustained physical distancing and hygiene measures amongst populations, with an alert and educated population capable of being

able to take control of their own risks but also a strong public health system capable of detecting and terracing and isolating we may avoid a major second wave.

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But if disease persists in countries at a low level without the capacity to investigate clusters, identify clusters then there is always the risk that the disease will take off again, particularly where we have large groups of people together in major cities, in refugee camps and other places where people don't have the possibility of large-scale social or physical distancing.

So I think now we're seeing some hope as many countries exit these so-called lock-downs and this is good; it allows economic life to return. But extreme vigilance is require and not just vigilance; many countries - as the DG has said - have made very systematic investments in building up their public health capacities during the lock-down.

Others have not and we need every country now to put in place the necessary public health measures or the public health surveillance in order to be able to at least have a chance of avoiding larger second waves later.

00:31:59

TJ Thank you very much. The next question is from China Radio and that's Zhang Yingao. Mr Yingao, can you hear us?

ZH [Chinese language].

TJ Thank you very much, Ms Yingao; my apologies.

TAG Thank you. First of all I am an honorary nurse so I would like to announce that. Second, happy International Nurse Day for tomorrow. Of course we should pay tribute to our nurses, midwives and all health professionals every single day but at the same time tomorrow is a very, very important day and we have to celebrate our nurses.

As you know, during this COVID-19 they're in the front line and they're risking their lives to save others but not only during COVID-19; I know nurses are a bridge between the health system and the community and they have been doing so ever since the nursing profession started. So all our respect and appreciation - not only respect and appreciation; actually our greatest respect and appreciation from WHO to all nurses.

On the Year of the Nursing, of course, as you said, 2020 is the Year of the Nurse and the Midwife and we have been preparing to celebrate it in a big way but unfortunately because of COVID, especially during the Assembly, which is going to be virtual, we will not be able to celebrate it as we planned.

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Of course still virtually celebrating it will be very important but at the same time there is a consensus from the Nursing Association and the Midwifery Association that the year of the nurse and the midwife be postponed to 2021; that's one.

But at the same time instead of having the Year of the Nurse and the Midwife in 2020 or 2021 the other consensus is to have the 2020s as the Decade of the Nurse and of the Midwife. That fits very well with what I said earlier; that celebrating our nurses and midwives should be every single day.

Then the celebration is not just a celebration for the sake of television, it's not just to pay tribute to them. It's also to recognise their important role in achieving universal health coverage and to invest in universal health coverage and to use the nurses, the midwives and another front-line health workers to achieve universal health coverage.

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But the numbers we have; if you take nurses for instance we have a gap of six million globally and it also means, when we say the year or the decade of the nurse or the midwife, filling the gap in order to achieve the UHC.

So for WHO celebrating nurse and midwives is also preparing ourselves to achieve our commitment of universal health coverage and health for all. It's not just recognising nurses and midwives but using this opportunity and using this sacrifice, the committent of the nurses to achieve universal health for all.

TJ Thank you very much, Dr Tedros. The next question is Financial Times, Camilla. Camilla, please go ahead if you hear us.

CA Hello, can you hear me?

TJ Yes.

CA Great, thanks so much for taking my questions. There've been some reports recently of people suffering from symptoms for many weeks, up to six or even more, which can get more or less severe in waves. I wonder if that's something that the WHO is aware of and how common you think it might be.

00:38:30

MK Thanks for the question. The question is if we aware of individuals who are experiencing symptoms for long periods of time and in waves. We are working with our clinical network and we're looking at the literature to really understand how disease progresses.

A lot of this requires... We need to ensure that people with symptoms are tested so that we know that these symptoms are associated with COVID-19 or not. You have to remember that being in the Northern Hemisphere we've just finished the flu season and there are many circulating viruses that can cause flu or flu-like symptoms.

So what we're trying to do is get a clear picture of what disease looks like; when people start to feel unwell what do those symptoms look like, how many days does it take them to develop a fever if they don't start with a fever; for those who start out a little bit unwell how many progress to pneumonia that might not need hospital; how many people then progress to even more severe disease?

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What we understand is there're a large number of symptoms that people are exhibiting, including fever, dry cough and shortness of breath. You can have other symptoms; people have a loss of smell or a loss of taste and there're more symptoms that are being reported.

What's very important for us and what we're working with countries and hospitals on is to have a sanitised data collection so that from some of the patients or a proportion of the patients we have a robust set of information.

We are working with the United Kingdom for example and this group called ISARIC; it's the International Severe Acute Respiratory Infection Consortium. This is just one of many, which is using a standardised data collection form and collecting symptoms from tens of thousands of patients and it is very helpful for us to get that picture.

From the data that we have from countries we still are seeing about 40% of patients who are exhibiting mild disease and will recover just fine. We have another 40% that are exhibiting more moderate symptoms, which would include pneumonia but not needing hospitalisation or respiratory support.

We see a further 15% that are experiencing severe disease and needing respiratory support and hospitalisation and another 5% that are critical and require ICU and ventilator support.

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We are trying to get a picture that's consistent across all countries and from the data we've seen that is a fairly consistent picture and so that's important. That helps us for planning purposes; it helps us get hospitals ready to know how to care for patients and what type of supplies they may need.

But it still is early days; you've heard us say that a lot. We're learning every day more and more about this virus and the diseases that it causes and if it's different for young people or old people or people with underlying conditions. So as that picture becomes more and more clear we'll be able to have a more clear answer.

MR With regard to your specific question regarding this longer syndrome, certainly there have been some reported cases of putative relapse so people who've fallen sick again and a lot of work is going on to see whether people have been reinfected or whether it's just a chronic part of a condition.

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The people who leave hospital are free of the virus; they usually test negative before they depart hospital but I think what we have to remember is many people who've been hospitalised have experienced severe disease and while they may be free of the virus and no longer infectious many are experiencing longer-term issues with energy, they're literally been through the wars, many of them, in very difficult circumstances.

Some have had impacts on their respiratory system, their cardiovascular system, their liver, their kidney function and others so people could remain quite frail and without energy and struggle to get back to full health. We have to separate here what is a long struggle to get back to full health from what might be a continued COVID-19 syndrome where you have persistent virus.

Thus far there is very little evidence to suggest there are people who are persistently suffering from COVID-19 although when you see the data from the hospitals and the length of admission it is taking many people a very long time to recover in a hospital environment and we should expect that when people are discharged that recovery continues and people don't necessarily just bounce back to full health.

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Although when they are discharged from hospital it is safe for them to return for themselves and their families.

TJ The next question comes from Brazil; Anna Pinto from Folha de Sao Paulo. Anna. Anna, can you hear us?

AN Hi, can you hear me?

TJ Yes. Please.

AN Okay. I have a question to Dr Maria. Dr Maria, last week you mentioned epidemiologic studies with serologic tests in several countries. I'd like to know, how high is the prevalence found in those studies and as far as the percentage who have had contact with the virus is below the level of the so-called herd immunology [sic], if having a higher prevalence protects more than having a lower one given a certain population base.

For instance a country or a region with 30% of the population that already has been infected; is this population more protected to tackle a second wave than another with, let's say, just 5% of prevalence? Thank you very much.

00:44:41

MK Thank you for the question. There are a large number of countries that are conducting these seroepidemiologic studies. We are tracking them and there're more than 90 studies that are underway. Some of the results of

the early studies are now starting to be published. I say published; one of them has come out in a peer-review journal.

There are a few others that we've seen as pre-prints - that means they haven't undergone the full review - and a number have also released results as press releases. I say this because it's important because we aren't able to critically evaluate all of these studies yet.

What is interesting from the studies that are coming out is that many of them across a number of countries in Europe and the United States, in Asia have found that a very low proportion of the people that have been tested have evidence of antibodies as measured by these serologic tests.

The range is between one and 10%; it depends on the study; it depends on the assay that was used. There are a couple of studies - I haven't seen the full studies, I haven't evaluated them - that suggest it's a little bit higher, maybe 14, 15% but we haven't seen the full studies. Again I say that because we need to understand which populations were studied, which serologic assays were used so that we could really understand what the results mean.

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Having said that, there seems to be a consistent pattern so far that a low proportion of people have these antibodies and that is important, as you mentioned, because you mentioned this word, herd immunity, which is normally a phrase that's used when you think about vaccination, when you think, what amount of the population needs to have an immunity to be able to protect the rest of the population.

We don't know exactly what that level needs to be for COVID-19 but it certainly needs to be higher than what we're seeing in some of these seroprevalence studies. What these seroepidemiologic studies indicate to us is that there's a large proportion of the population that remains susceptible and that's important when you think about what may happen in subsequent waves or what may happen as a potential resurgence.

So we have a long way to go with this virus because the virus has more people that can be infected. Having said that, we have the tools in our tool box to be able to prevent this virus from taking off again and we know that that's about finding the virus, finding people with the virus, isolating them, caring for them appropriately depending on their symptoms, making sure that we find all contacts, we trace those contacts, quarantine them so that they don't have the opportunity to transmit further, making sure our population's fully engaged so that they know how they can protect themselves and how they can protect others.

So we do have tools at our disposal to be able to prevent transmission from happening further and seroepidemiology is one of the ways we are using to help us understand how we move forward through this pandemic.

MR Yes, and again just reiterating that herd immunity - again a term taken sometimes from veterinary epidemiology where people are concerned in animal husbandry with the overall health of the heard and an individual animal in that sense doesn't matter from the perspective of the brutal economics of those decisions.

Humans are not herds and as such the concept of herd immunity is generally reserved for calculating how many people would need to be vaccinated in a population in order to generate that same effect. So I think we need to be really careful when we use terms in this way around natural infections in humans because it can lead to a very brutal arithmetic which does not put people and live and suffering at the centre of that equation.

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What also does concern me in this narrative is that there was an assumption that this disease spread around the word, that we're really just seeing the severe cases and the difficult cases and when the seroepidemiology comes it will demonstrate that most of the people have been affected and this will all be over, we'll go back to normal business.

The preliminary results from the seroepidemiologic studies are showing the opposite. They're showing that the proportion of people with significant clinical illness is actually a higher proportion of all those who; been infected because the number of people infected in the total population is probably much lower than we expected.

As Maria said, that means we've a long way to go and it means, as the Director-General has been saying for months, this is a serious disease, this is public enemy number one. We have been saying it over and over and over again and we really do need to now step back and recalculate this as a mild illness and effectively make the same mistakes we made the first time around in terms of not taking this seriously and not putting in place the necessary measures.

00:50:04

We have a second chance now as a society to put in place the necessary public health interventions, put in place the necessary community support to support our vulnerable populations, be they in long-term care facilities or be they in refugee camps. No-one is safe until everyone is safe.

Again when we look at the epidemic around the world and we see that in some countries over half of the cases have occurred in long-term care facilities or are workers in those facilities we need to look at these hot-spots, at these really terrible situations in which we either haven't properly shielded people or protected them.

So I do think this idea that maybe countries who had lax measures and haven't done anything will all of a sudden magically reach some herd immunity

and so what if we lose a few old people along the way; this is a really dangerous calculation and not one I believe most member states are willing to make, that arithmetic.

00:51:12

Member states and responsible member states will look at all their population. They value every member of their society and they try to do everything possible to protect health while at the same time obviously protecting society, protecting economy and other things. We need to get our priorities right as we enter the next phase of this fight.

TJ Next question comes from Georgia; Ypres, Georgia. We have on the line Konstantin Lanatamishvili. Konstantin. You need to unmute yourself. Do we have Konstantin from Georgia? If you can just push the button to unmute yourself. Hello, can you hear us now? Okay, we will have to go to the next journalist. Really sorry we couldn't hear, Konstantin. We go to Emma Farge from Reuters. Emma.

EM Yes, good afternoon, thank you so much for taking my question. I just wanted to ask a little bit more about South Korea and Germany and other countries experiencing a resurgence in new infections.

The timing of this, I think, is interesting because it's happened just as they're beginning to ease lock-downs and like Ryan you used that lovely metaphor of looking through a telescope in space. In fact we should not see the impact of those measures for another two weeks.

00:52:56

So how can you explain the timing of this and what is your message to those countries experiencing a resurgence? Thank you.

MR Thanks. I think most people observing on in the world have also even that in advance of the lifting of measures social mobility has actually increased as well before in anticipation. It could well be that people were already beginning to move before the actual restrictions were lifted.

But I think the telling thing here - it's really important; countries like Germany and Korea shouldn't be criticised for looking, for finding, for being alert, for reacting quickly and engaging quickly to investigate, to isolate, to trace and to track because that's what we've been saying.

The virus is still here so even as you lift lock-downs, even in low-incidence situations, even in a place like Korea where the number of cases per day had dropped to a very low level they didn't let their guard down; they knew the virus is still here.

00:54:05

The virus is still here a lot more in other countries so the warning to everyone is, as restrictions are lifted people will make some more. That is undoubted and they will maintain physical distance and they will do other things but the risk of transmission will potentially go up.

The question is, can we reach a point where we have strong public health measures in place, where we can invent clusters of cases and suppress those clusters without going back to the intense transmission patterns of before.

That's what we're trying to avoid so we hope and we have faith that Germany, Korea and other countries will be able to suppress the clusters they're having and in some cases maybe at a subnational level they may have to impose some specific measures that are targeted at reducing particular types of transmission.

Again we've seen a situation where people come together in a crowded environment is probably the riskier situation that we face, especially if there is still disease present at country level.

00:55:13

So there's a lot of be one but it's really important that we hold up examples of countries who are willing to open their eyes an willing to keep their eyes one; shutting your eyes and trying to drive through this blind is about as silly an equation as I've seen.

I'm really concerned that certain countries are setting themselves up for some seriously blind driving over the next few months.

MK If I could just add something short to say that you said what can we say to these countries? It's just stay strong, stay vigilant, keep doing what you're doing, be open, be transparent, as you are. As Mike said, this isn't a punishment for reporting this. We shouldn't be punishing countries for reporting this.

We should be saying, this is what we need to be doing and we need to be learning from each other, Every country, every person has something to teach us about this virus and we need to learn from each other. We need to be humble that this virus is smart, that this virus finds those cracks, this virus has plenty of place to move and if we take a slow and a staggered and a data-driven approach to adjusting our measures, whether the investment is lifting the measures or intensifying them again, it's really important that it's a data-driven approach.

00:56:38

That's what we're seeing in these countries. They're looking at different measures, they're looking at different parameters like the reproduction number for example, at the percent positive that are coming back from their tests. They are humble in this and they're showing that they can find cases

again but they're taking that same aggressive approach that they did the first time and they will show us that they can bring us under control.

So keeping the public informed about what is happening as these measures get lifted and if they have to be intensified again is really critical because people are growing tired. We understand but we need people to stay with us, to really understand that this is going to take some time to work through.

We may not get this right exactly the first time. We may have to implement, we may have to lift, we may have to adjust but we will get through this so just stay vigilant, stay strong, be open, be transparent, be aggressive and you will get through this.

TJ Thanks. Maybe the last question that we can take for today; that will be from Simon Ateba for Today News Africa. Simon.

SI Yes, thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. I wanted Dr Tedros to comment a little bit more on the latest projection that up to £5000,000 additional HIV tests could be recorded in sub-Saharan Africa as a result of COVID-19 disruption. Is there any urgent thing that we need to do right now? Thank you.

MR I think again the DG did say in his speech that this is a worst-case scenario; what he's laying out for people is a future scenario if we don't fix the things that need to fixed and this is really about the supply chains for drugs and the basic primary healthcare and the basic services available for people living with HIV.

I think we've all seen the great success, the great partnership that has led to a dramatic fall in HIV positivity and AIDS-related deaths in Africa over the past number of years, a partnership's existed with countries with support from external countries.

The Director-General himself while in Ethiopia worked very closely with PEPFAR and the US Government and others to reduce the scourge of HIV and AIDS with so many other donors.

We don't want to lose those gains and I'm sure nobody wants to lose these gains and we need to work together to ensure that we have the drugs and we know the people are; we've got to connect people with therapy, we've got to reconnection people with services and we've got to ensure that people don't lose access to services.

00:59:40

The Director-General has been saying this for months; it's not just about COVID-19, it's that the whole health system must be preserved and we must now move to ensure that primary and essential health services are maintained.

There is nothing more essential than ensuring that someone with HIV has access to the appropriate therapy that we've all worked so hard for decades to put in place.

TJ Thank you. I think we can conclude this press briefing with this question from Simon Ateba. An audio file will be sent out shortly and the transcript will be available tomorrow. Just to mind you, two of our regional offices will have press briefings tomorrow; WHO regional office for the eastern Mediterranean, as well as WHO regional office for the Americas. Those advisories will be sent to you.

I wish everyone a very nice rest of the day or evening.

TAG Okay. Thank you also from my side and see you on Wednesday. Thank you, Tarik.

01:00:44