



World Health Organization

COVID-19 virtual press conference - 13 April, 2020

Speaker key:

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JA Jamil
MR Dr Michael Ryan
AK Ankit
RA Ray
NI Nina
MK Dr Maria Van Kerkhove
MI Michael
KI Kimberly
BE Ben
MO Mohammed
SA Sara
GR Gracia
ST Stephanie
JA Jamie

TJ Hello, everyone, from Geneva, WHO headquarters. Welcome to this regular COVID-19 press conference. Today with us we have Dr Tedros, WHO Director-General, Dr Mike Ryan and Dr Maria Van Kerkhove. Before giving the floor to Dr Tedros, just to remind you, we are sending you a number of press releases from the headquarters but also from our regional and country offices so you get to know what WHO is doing around the world. As always we will have an audio file available immediately after this press briefing and a transcript probably tomorrow. I will give the floor to Dr Tedros for his opening remarks.

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TAG Thank you, Tarik. Good morning, good afternoon and good evening. Some countries and communities have now endured several weeks of social and economic restrictions. Some countries are considering when they can lift these restrictions. Others are considering whether and when to introduce them. In both cases these decisions must be based first and foremost on protecting human health and guided by what we know about the virus and how it behaves. Since the beginning this has been an area of intense focus for WHO.

As we have said many times before, this is a new virus and the first pandemic caused by a coronavirus. We're all learning all the time and adjusting our strategy based on the latest available evidence. We can only say what we know and we can only act on what we know. Evidence from several countries is giving us a clearer picture about this virus, how it behaves, how to stop it and how to treat it.

We know that COVID-19 spreads fast and we know that it's deadly, ten times deadlier than the 2009 flu pandemic. We know that the virus can spread more easily in crowded environments like nursing homes. We know that early case finding, testing, isolating, caring for every case and tracing every contact is essential for stopping transmission.

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We know that in some countries cases are doubling every three to four days. However while COVID-19 accelerates very fast it decelerates much more slowly. In other words the way down is much slower than the way up. That means control measures must be lifted slowly and with control. It cannot happen all at once. Control measures can only be lifted if the right public health measures are in place including significant capacity for contact tracing.

But while some countries are considering how to ease restrictions others are considering whether to introduce them, especially many low and middle-income countries in Africa, Asia and Latin America. In countries with large poor populations the stay-at-home orders and other restrictions used in some high-income countries may not be practical. Many poor people, migrants and refugees are already living in overcrowded conditions with few resources and little access to healthcare.

How do you survive a lock-down when you depend on your daily labour to eat? News reports from around the world describe how many people are in danger of being left without access to food. Meanwhile schools have closed for an estimated 1.4 billion children. This has halted their education, opened some to increased risk of abuse and deprived many children of their primary source of food.

As I have said many times, physical distancing restrictions are only part of the equation and there are many other basic public health measures that need to be put in place. We also call on all countries to ensure that where stay-at-home measures are used they must not be at the expense of human rights. Each government must assess their situation while protecting all their citizens and especially the most vulnerable.

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To support countries in making these decisions WHO will tomorrow be publishing its updated strategic advice. The new strategy summarises what we have learned and charts the way forward. It includes six criteria for countries as they consider lifting restrictions; first, that transmission is controlled; second, that health system capacities are in place to detect, test, isolate 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; and sixth, that communities are fully educated, engaged and empowered to adjust to the new norm.

Every country should be implementing a comprehensive set of measures to slow down transmission and save lives with the aim of reaching a steady state of low-level or no transmission. Countries must balance between measures that address the mortality caused by COVID-19 and from other diseases due to overwhelmed health systems as well as the socio-economic impacts.

As the pandemic has spread its public health and socio-economic impacts have been profound and have disproportionately affected the vulnerable. Many populations have already experienced a lack of access to routine essential health services. Our global connectedness means the risk of reintroduction and resurgence of the diseases will continue. Ultimately the development and delivery of a safe and effective vaccine will be needed to fully interrupt transmission.

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Finally I would like to thank the United Kingdom for its generous contribution of £200,000 to the global response to COVID-19 and I appreciate also the Prime Minister for his leadership and generosity. We greatly appreciate this demonstration of global solidarity. In an editorial last week Development Ministers from the UK, Denmark, Iceland, Finland, Germany, Norway and Sweden called on all countries to join this common endeavour.

They said that tackling this disease together is our only option. I couldn't agree more. The way forward is solidarity, the rule of the game is solidarity; solidarity at the national level and solidarity at the global level. I thank you.

TJ Thank you very much, Dr Tedros, for these opening remarks. We will open the floor to questions. We will ask journalists to be short and ask only one question so we can try to get as many as possible. We will start, if possible, with Jamil. Jamil, can you hear us now?

JA Yes, can you hear me?

TJ Yes, now it's okay. Jamil, please go ahead.

JA Thank you, sir. This is Jamil [Unclear] from URL, Brazil. Dr Tedros, what is your position and especially in this new strategy from WHO regarding chloroquine? What is the evaluation of the WHO on this medicament? Is it supposed to be used, is it not supposed to be used, do you recommend it, do you not recommend it, where are we on this issue? Thank you so much.

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TAG Yes, thank you so much. Before I pass this to Mike I would like to say a few words. First of all, a correction; the generous support from the United Kingdom is £200 million and I am glad also that the Prime Minister has recovered and is back home and we wish him well. I would like to appreciate him and his Government and the people of the United Kingdom for their generosity. Thank you. Mike.

MR Thank you, Tedros. The question was regarding chloroquine. Sorry about that. The issue with chloroquine is chloroquine and hydroxychloroquine are licensed medications all

over the world for a large number of indications and in many cases are life-saving and many patients with very difficult and chronic conditions are managed and have good lives by taking that drug.

Some initial indications that the drug may have some use in the treatment of coronavirus infections and specifically COVID-19 and in fact those drugs have been introduced to WHO's collaborations on trials under the Solidarity trials and also under the Discovery trials and other trials all over the world. So the medical and research community are really taking the potential of hydrochloroquine and chloroquine seriously and it's currently, as I said, involved in a number of different trials.

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Some countries have issued guidance to clinicians that allows a clinician treating a patient to use hydrochloroquine or chloroquine in an off-label mechanism. That means they may under the current licensing of the vaccine choose to use that in the care of a patient with COVID-19. There is no empirical evidence, there is no evidence from randomised control trials that it works and clinicians have also been cautious to look out for side-effects of the drug to ensure that first we do no harm. We eagerly await the outcome of the trials that are underway and Maria may have more details on that.

TJ Okay, thank you very much. We will go to India Today; it's Aneet Kumar, if I'm not mistaken. Ankit Kumar.

AK Hi, my name is Ankit Kumar. I represent India Today. My question is, an Indian province had placed an order for 500,000 rapid antibody test kits from China for the purpose of mass community testing. Now Indian local authorities are testing us that only days before delivery they have been told that those kits meant for community testing in India have been diverted to the United States, a country which is already testing more people per million than any other country on the planet.

Have you received any communication from the Indian Government regarding such issues? As the global body where do you stand on such issues? What can WHO possibly do in such a scenario? Thank you.

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MR To my knowledge we've received no such communication on this incident but there is in general around the world a lot of pressure on supplies of diagnostics, a lot of pressure on supplies of protective equipment and other essential supplies and it is really important that everyone remains disciplined in this process and that we don't allow a market that's already failing to fail entirely.

In that regard WHO - and the Director-General announced it on Friday - has been working over the last months with other agencies inside the United Nations and other multilateral organisations to create a global supply chain process, a task force that tries to bring together procurement allocation and supplies around a set of essential products like diagnostics, protective gear, oxygen supplies and ventilators and other important support equipment.

We have produced a global catalogue for that equipment and are endeavouring to work with our partner agencies and donors to do bulk purchasing of that material in order to distribute that in a more equitable way around the world but that doesn't fix the market problem. That could allow us to ensure that all countries get a minimum supply of essential goods or essential supplies but it in no way can fix what is a global failure in markets.

Competition between countries, whatever those countries are - or competition within countries for that matter - for materials only drives prices up and leaves a situation where people who need stuff may be without it. But I'm not aware of the particular incident that you refer to.

TAG I would just like to add to what Mike said, there is overall a shortage of supplies globally, be it test kits or PPE, and that's why we're trying to do what Mike said, which may not address the shortage, and at the same time we're working with the private sector and with the International Chamber of Commerce around three areas.

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One is to increase production; the second is to address the cross-border trade problems; and third, equitable distribution so we'll continue working to address the root causes of the supply problems.

TJ Thank you very much, Dr Ryan and Dr Tedros. We will now go to Ray Wilson from The Hill. Ray, can you hear us?

RA I can, thank you for taking my question. There are reports that President Trump may cut off funding for WHO this week. What would that do to the agency's budget, how would it impact the response to COVID-19 and can you talk more broadly about the relationship between WHO and the United States?

TAG As you know, the United States is actually the largest contributor to the WHO and I have met President Trump a number of times before, starting from 2017 and recently we had a call, conversation two weeks ago. What I know is that he's supportive and I hope the funding to WHO will continue and the relationship we have is very good and we hope that this will continue.

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TJ Thank you very much. Let's go to Agence France Press. Nina Larson, can you hear us?

NI Hi, thank you for taking my question. A lot of people who get sick from COVID-19 appear to show symptoms in waves where they appear to get better only to get sick again. Can you say whether or not it's been determined whether having COVID-19 actually provides immunity or if people can get sick with the disease more than once and what impact that would have on lifting confinement and physical distancing measures? Thanks a lot.

MR I can begin and Maria can supplement. Certainly during the course of any individual illness patients' clinical status may change. The initial response to the virus can generate very high fevers as the person fights the presence of the virus in the body and sometimes they can

appear to get better and people might say their fever breaks. But in other situations that process is set up in the lungs and people can then develop a pneumonia which then results in a further deterioration.

Other patients may have other organ failures that cause them to further deteriorate. Underlying conditions may come into play so a patient's clinical status during the course of an illness can change right the way through the illness depending on what is dominating their symptoms at that time; the virus, the immune response to the virus, the situation of the lungs and then other underlying conditions that may make things worse so seeing variations during infection is not unusual.

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With regard to recovery and then reinfection, I believe we do not have the answers to that. That is an unknown. One would expect that a person who generates a full-blown immune response with detectable antibodies should have protection for a period of time. We just don't know what that period of time is. We would expect that to be a reasonable period of protection but it is very difficult to say that with a new virus and we can only extrapolate from other coronaviruses and even there the data is quite limited. Maria.

MK Yes, to add to that, there is a limited amount of information that's coming out about the antibody response in people who have been infected and what we really need to understand is what does that response look like for somebody who had a mild infection, who had severe disease, who had critical disease, who recovered.

There's a study that's recently come out from Shanghai - it's a pre-print so it's not peer-reviewed - that has looked at plasma in 175 recovered patients and that found some individuals had a strong antibody response. Whether that antibody response actually means immunity is a separate question. That's something that we really need to understand, what does that antibody response look like in terms of immunity.

In that same study they found some patients who had no detectable antibody response and they found some individuals who had a very high response so right now the information is mixed. We need much more information from recovered patients. There're more than 300,000 people globally who've recovered and we really need to better understand what that antibody response is.

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There are a number of studies that are underway that are looking at the antibody response using different serologic tests that are currently available. Some of these are screening assays and some of these require high-BSL labs that can look at a neutralisation assay. So as soon as we have that information we will share that with you but right now we don't have a full picture of what immunity looks like and until we do we can't give a complete answer.

TJ Thank you very much, Dr Van Kerkhove and Dr Ryan. Next question comes from Michael Borsutkiv, a contributor to CNN. Michael, please.

MI Thank you. Can you hear me?

TJ Yes, please go ahead.

MI Okay, thanks for the question and the correct pronunciation of my name. Dr Tedros, greetings to you. Again I go back to the criticisms from the White House last week, especially in regard to the early actions by WHO. President Trump - among others, by the way - has said that WHO was late to the game, so to speak, especially on the declaration of human-to-human transmission.

I'm wondering if you could address that criticism and very quickly if you could also, what would be the financial gut punch if funding from the biggest donor were withdrawn? I think the world needs to know how badly this would affect the Organization at this crucial time. Thank you very much.

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MK Thank you for that question. I will start and perhaps Dr Tedros and Mike want to supplement with this. With regard to the human-to-human transmission question, right from the start, from the first notification that we received on 31st December, given that this was a cluster of pneumonia - I'm a MERS specialist so my background is in coronaviruses and influenza so I immediately thought, given that it's a respiratory pathogen, that of course there may be human-to-human transmission.

So initially when we started to put together our technical guidance for our member states we put guidance that focused on how this virus could be transmitted and what we focused on was droplet and contact transmission, which is how respiratory pathogens are spread. Also within our infection prevention and control guidance we put out a special provision for healthcare workers who are focused on conducting aerosol-generating procedures in which we put in place recommendations for airborne transmission. That guidance is still in effect.

The guidance that we put up was on 10th and 11th of January because there were five or six technical guidance materials that were put up on the web which were open to everyone. We also shared this guidance package which included surveillance guidance on how to find cases, laboratory guidance on how to detect cases, infection prevention and control, how to prevent infections, particularly in healthcare settings because, given our past experience with MERS and with SARS, we immediately thought that you could have transmission. In healthcare facilities, you could have amplification events in healthcare facilities and potential super-spreading events.

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I did a press briefing on January 14th where I mentioned this and in fact that got quite a few headlines because I think saying that we may have super-spreading events is something that we worry about as an Organization and we want to do everything that we can to prevent that from happening.

We also put out a readiness checklist at the time for countries to say, how are we prepared to deal with a respiratory pathogen and what systems do we need to put in place? We lastly put out a disease commodity package which listed all of the materials that one may need to detect cases, to care for cases given that we didn't have treatments - we still don't yet - but to put up how we can symptomatically treat individuals.

So very early on we suspected that there would be human-to-human transmission because it's a respiratory pathogen and so that's why our guidance on 10th and 11th January included information on how to protect people from getting infected, focusing on respiratory and droplet transmission.

MR If I may just add, in terms of official information to our member states on January 5th, WHO published an alert to all our member states on the epidemic platform that we have and on the same day published public information on that, on January 5th and very prudently on January 7th CDC established its incident management system in response to that and subsequently put out a health advisory, I think, to all front-line public health and health staff in the US which again, as Maria said, detailed the procedures for investigating cases including droplet spread precautions and the mechanisms for investigating and asking all physicians and front-line public health workers to report any cases meeting the preliminary case definition.

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So from that perspective the information was shared and very appropriate actions were taken in the United States in response to that alert.

TJ Thank you very much. I hope this answers the question. We go now to Kimberly from Time. Kimberly, can you hear us? We will try one more time; Kimberly from Time.

KI I'm here. Thank you for taking my call. Apologies for my inept action with Zoom. I wanted to ask whether China has yet given the WHO the DNA samples from the original outbreak, as well as explained on what date it concluded that there was indeed human-to-human transmission. And also has it done enough in terms of virus sharing as of today and what assurances has it given you that it will share in the future?

MK I can start. I believe - I'd have to go back to the timeline but I believe there were some suggestions of human-to-human transmission in mid January. With regard to virus sharing, I know your question was about China but in terms of the development of diagnostics, the development of therapeutics and vaccines it's really imperative that viruses are shared by all countries that have access to these samples.

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Given the fact that it has transmitted to a number of countries we advocate - we support the sharing of these samples to other labs so that those diagnostics, those vaccines, those therapeutics can be developed.

The sequence itself; the virus was shared on 12th, if I remember correctly, and because that happened we had PCR assays that were rapidly developed and shared globally. I believe we posted the first PCR assay on our website on 14th January and so because of that a lot of labs were able to develop PCR assays and so detection globally could happen very, very quickly.

TJ Thank you very much. Next question is Ben Qui, People's Daily. Ben, can you hear us?

BE Yes, can you hear me?

TJ Yes, please go ahead.

BE Thank you for taking my question. There is a positive signal about a lot of the things the DG said last week so how do you assess the current situation in Europe. Do you expect the turning point to come in one or two weeks for most European countries?

MR Obviously we all dearly hope that that is the case and we've certainly seen a stabilisation in a number of countries in the direction of travel of the epidemic curve and the intensity of increase has stabilised and some countries have actually begun to see a pretty consistent drop first in the number of hospital admissions but then we should start to see that follow through.

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Deaths take a little bit longer to drop because many people are in hospital already and some unfortunately may die so we look at the number of confirmed cases and we look at the number of hospitalisations as the first indicator that things may be stabilising and we're certainly seeing that.

It's of great credit to people all over the world and particularly from badly-affected European countries that they've stuck with the task of physical distancing and stay-at-home orders and that that's taken the pressure out of the epidemic but by no means does that mean that it's over. Now is the time for vigilance, now is the time to double down, now is the time to be very, very careful.

That does not mean that countries cannot begin to create an exit strategy, it doesn't mean that countries shouldn't be actively planning to do that but, as the Director-General said, in that sense there are things that need to be done. You can't replace lock-down with nothing. You must replace lock-down with a very deeply educated, committed, empowered and engaged community. We are going to have to change our behaviours for the foreseeable future and we've seen a huge embracement of that by people.

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In the vast majority of cases that has not needed to be enforced. The vast majority of citizens are doing what they can for themselves and to protect others but we are going to have to have those adapted behaviours in terms of personal hygiene, physical distancing, being careful for a long time.

So the base of moving out of lock-down is communities on the alert, communities aware of the risks and communities taking action and continuing to take action to protect themselves and others. That needs to be backed up with a way of finding the virus. At the moment everybody is suffering because everyone has to be separated. That's because countries don't know exactly where the virus is.

The only way to get out of this is to find the virus. The only way we find the virus is to identify those people who may be infected and test and isolate, find contacts and quarantine contacts. That is in a sense - community empowerment, community involvement and public

health intervention through the use of case finding, isolation, contact and quarantine is the alternative to having lock-down - and having a health system that's capable of absorbing any increase in cases.

We need to continue that strength in the health system. It's incredible how health systems have adapted and how hospitals have expanded, how they've done amazing things, absolutely incredible things over the last number of months and they have saved many, many lives but we're going to have to sustain that capacity and health workers are going to have to continue to have protective equipment and we're going to have to continue to have intensive care beds on stand-by because as we come out of these locked-down situations we may see a jump back up in cases and we don't want to lurch from lock-down to nothing to lock-down to nothing.

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We need to have a much more stable exit strategy that allows us to move carefully and persistently away from lock-down and the only way to do that is to have fully empowered communities and a fully activated public health architecture and a strengthened health system.

MK A small addition to that to say, it's really important that the lifting of these measures doesn't happen all at once all over Europe and we completely understand - we're in the same situation - the desire to want to release those and get people back to work and kids back to school and all that.

But it's really important that it's not done all at once because if the systems are not in place - as has just been outlined - the systems to identify where the virus is, to isolate cases, to find the contacts, to treat the cases, to have the beds free to actually care for patients - then you're going to be overwhelmed again.

So what could happen is if they're lifted in certain strategic areas maybe where there's lower incidence and if that can happen slowly then the system can divert where it needs to go to be able to quickly identify those cases while other parts of the country may still have those restrictive measures in place.

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But it does have to happen slowly, it does have to happen in a very controlled manner and it is important that the community understands this because it may be a little bit longer that you have to remain at home or you have to work from home or schools may need to be closed but again this is temporary. I know it seems like a long time now but it is temporary so not lifting all at once is very critical so that we can get people back to work, get these economies going back again as quickly as possible.

TJ Thank you very much. Now we will go to Morocco; Mr Mohammed Ashari from Morocco Media News. Mr Mohammed, can you hear us? We will try to establish the line with Mohammed from Morocco. Can you hear us?

MO Yes, I do.

TJ Please go ahead.

MO Can you hear me? Yes.

TJ Yes, we can hear you very well. Please go ahead.

MO Okay, thank you very much. Thank you very much for giving me a chance to ask my questions. I'm talking especially about Morocco. Please could you tell us how fast we're going towards this pandemic and are we slow or fast in this country, and also to stop and slow the cases. I'm talking about Morocco as an example. Thank you very much.

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TJ Thank you very much, Mohammed. The line was not the best but we understood that the question is about the situation in Morocco so I will see if Dr Ryan could say something about it.

MR I think Morocco has approximately 1,600 cases at the moment and I think the numbers are increasing of the order of 70 to 90 per day so the doubling time in Morocco is actually quite long and in that sense Morocco has the opportunity to keep it that way. There have been 76 deaths unfortunately so mortality is reasonably low. The epidemic curve is relatively flat but that can change at any time.

We've seen this in country after country; countries go along with a small number of cases and then it reaches a certain point and that curve takes off so it's really important and many countries in the eastern Mediterranean and North Africa have done a good job in doing that. But it does require to have extensive testing and broaden testing out, actively looking for cases and dealing with all of the other strategic issues that other countries do.

But in principle Morocco is in a strong place to continue control measures and also be in a strong place to be able to lift any restrictive measures as long as - as Maria has said - that's done gradually, as long as that's done with great care and as long as the other public health and community measures are in place. But I'm sorry, I don't have a detailed set of data for Morocco in my head but if my memory serves me that is where Morocco is epidemiologically at the moment.

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TJ Thank you very much. I hope this answers the question from Morocco. The next question is from Devex, from Sara Gerving.

SA Thank you. I'm wondering what is the appropriate time frame for someone to isolate if they think they might have been exposed. There seems to be this belief that 14 days is appropriate but since the incubation period can be up to 14 days then if someone is not showing symptoms after 14 days but does have the virus and doesn't have access to a test how long after that can a person have the illness and be contagious?

Then in terms of the reactivation in people, based on your previous response, is it possible for the virus to be latent in someone or are we talking about reinfection?

MK Thank you for these questions. Yes, what we recommend for somebody who is exposed to an infected person is that they be followed, that they be quarantined for 14 days. Most people who are infected with COVID-19 will develop symptoms within five days; that's the median time; five to six days but it goes up to 14 days so 14 days is a good marker.

For individuals who are infected - your question was how long can they be contagious and that's the right question because when we actually test people who are infected with COVID-19 - they have this molecular test, the PCR test and they can be PCR-positive for weeks but that doesn't actually mean that they're contagious for weeks. What the PCR does is it measures fragments of the virus, parts of DNA of the COVID-19 virus that are detectable through this molecular test but it doesn't actually mean that you're contagious for that long.

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What we've seen from some preliminary studies - I'm referring to a study from Germany - is among some mild patients - I believe it was eight or nine mild patients - that they could find live virus for eight or nine days after symptom onset. What we need is much more data from countries to actually be able to say, how long is someone contagious. Right now what we have are these PCR tests which suggest that people with mild disease can be PCR-positive for two to three weeks.

What we need to understand is, out two to three weeks, are those people still contagious. Again this is another example where we don't have the full picture but there're a lot of studies that are underway to give us those answers and so we hope to be able to get back to you with more details on that as soon as those are available.

MK On the issue of reactivation and latent infection, there are many situations in viral infection where someone doesn't clear the virus entirely from their system. It can happen in the case of immunocompromised people who are sick for other reasons and then the virus can come back and attack the person again and that's seen as reactivation. It's usually that the virus was never properly cleared.

There are other cases where someone clears the virus but develops a secondary bacterial infection. Often in influenza for example it's not the influenza that causes the problem; it's very often the secondary bacterial pneumonia. The damage to the lungs and the inflammation creates unfortunately an opportunity for bacteria that are normally non-pathogenic - they're all over the place - but can actually exploit the fact that the lungs are weakened.

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You end up then with a very high fever and very sick but you're actually not sick with the virus; now you're sick with the bacterial infection. So there are many reasons why we might see reactivation of infection, either with the same infection or with another infectious agent. The issue of long-term transmission, I think, has been dealt with by Maria.

There will always, always, always in health be exceptions. There will always be individuals who may transmit for longer. There may be individuals whose incubation period may be for longer; it may happen. There are outliers in every walk of life. We all know people who are given a year to live because of a cancer diagnosis and they live for ten years. That doesn't

mean that everyone with that diagnosis lives for ten years. It means one person has lived for very much longer but on average this is how long people survive.

I think we need to look at that; these are averages and then we look at the range around the average and we try to explain that this is likely where the longest or the shortest incubation periods are in reality but there will always be a chance of an outlier and I always say, we need to study the outliers, we need to study those who transmit for longer, we need to study those who don't clear the infection properly because these are very significant events.

But we also have to be able to make good public health policy and we have to try and make the best possible estimate of what is a reasonable incubation period that incorporates the vast majority of people and reasonable transmission periods that incorporate the vast majority of people and at the same time look at outliers, examine them, why they're occurring.

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That is the work of science and in the end you've got to translate science into policy, you've got to translate all of that data into a rational policy that can be implemented for public good.

MK If I could say what our policy actually is it may be helpful and this is based on the science that we have. What the WHO recommendations are are for someone who tests positive for COVID-19 with a PCR test, what we recommend is for them to be released from either hospital or home isolation is that their symptoms resolve and they have two negative PCR tests 24 hours apart.

We realise that that may be difficult in many situations where lab testing may be challenged for one reason or another so in situations where tests are not available if you have someone at home that's a suspect case, a probable case and couldn't get tested what we recommend right now is that those individuals are in home isolation if they can't be isolated in a medical facility until their symptoms resolve plus an additional 14 days.

What we're trying to do right now is look at that 14-day extra period to see if that's something that can be reduced based on available data.

TJ Thank you very much. We have time for maybe another one or two questions so let's go to Guatemala now, to Gracia [Unclear] from [Unclear]. Gracia, can you hear us?

00:44:19

GR Yes. This is a question for Dr Tedros. Many countries made the use of masks mandatory, including Guatemala, but what are the measures most that must accompany their use and what are the measures that you as the WHO consider vital or important?

MR WHO obviously advises the use of medical and N-95 respirator masks in a healthcare environment and I think our guidance is quite clear on that and we want to see that type of material reserved for use in that environment. However there has been a very healthy global debate around the use of masks or face coverings more broadly at societal level and WHO has been clear that there is no specific evidence to suggest that a mask may protect you from infection and equally a mask may provide protection for others. If you happen to be symptomatic and coughing it might stop you contaminating somebody else.

There are a number of issues around the broader use of masks; one, in that it may divert mask use from the healthcare setting and that's something that just cannot happen. There are issues around wearing those face coverings and disinfecting those face coverings and disposing of those face coverings or masks and the fact that putting on or off those masks often involves people touching their faces as well and therefore it cannot be done outside the context of very clean hands and proper personal hygiene.

Also masks are not an alternative to lock-down and we've said this publicly again and again. WHO will support countries who wish to implement a more broad-based strategy of mask-wearing or face-covering-wearing on a broader basis as long as it's part of a comprehensive strategy, as long as it's linked to the things we said before; community education, personal hygiene, a strategy to find, test and isolate cases.

00:46:32

If mask use is added to that then I think WHO can see the value but if mask use is used as an alternative to those public health strategies, if it's used as a reason not to do those other things then we believe that is the kind of policy that's counterproductive. So we see mask use in the broader context of a comprehensive strategy and in that sense will support member states who wish to introduce that as long as it does not take masks out of the healthcare environment and people know how to wear them, know how to dispose of them and are doing all of the other things that they need to do. Maria.

MK Just to add, with the comprehensive strategy that Mike just mentioned, it includes also physical distancing, it includes hand hygiene, it includes respiratory etiquette, it includes staying home if you're unwell, it includes confirmed cases being isolated, it includes contacts being in quarantine and it includes following the directives of the national governments if there are stay-at-home orders in place and of course overall having an empowered community to know what they can do to protect themselves and their families.

So, as Mike has said, it's part of a comprehensive approach; it cannot be used alone but we support governments in making these decisions and in our recent updated guidance we've put some considerations that they may take into account when making these decisions; for example if physical distancing is not possible in certain communities or certain populations perhaps the use of a face covering or a non-medical mask may be useful there.

00:48:12

So, as Mike says, we support these decisions being made but as part of a comprehensive approach.

MR If I could just supplement, one of the consequences we really don't want to see happen as lock-downs are eased; there is huge pressure on people to go back to work, to go back to school, to participate in daily life. I don't want to be the person at home with a fever and with a job to go to where I can make a calculation that instead of picking up the phone and phoning my health provider or phoning up the public health authorities and asking for a test and a diagnosis, that I think that putting a mask on is an adequate response to that situation.

That is something we really have to be careful about. You may be inadvertently sick, you may not know but it's something we have to think about very, very carefully and that's why everything we do in public health or in health or in policy affects something else so the pressures on people to go back to work are going to be very strong and very appropriate but we don't want people having to make difficult choices and in some way think that putting a mask on is the same as staying at home and reporting the fact that you're sick to authorities.

TJ Thank you. We'll see if we can take one more question; Stephanie from Reuters. Stephanie, can you hear us?

00:49:44

ST Yes.

TJ Please go ahead, Stephanie.

ST Yes. Thank you. Can you hear me?

TJ Yes, please go ahead.

ST Thank you. Regarding Yemen, please, I wonder what kind of data you're getting from Yemen. There was a case reported on Friday in Hadhramaut in the south. I wondered what you're getting in terms of information on contact tracing. It appears that the neighbouring provinces have closed the borders so I wondered if you'd had any suspect cases anywhere else in the cities of Yemen; I don't know, Sana'a or Sa'dah and what sort of capacity does Yemen have or not have in terms of hospital beds, medical professionals, etc'?

MR Stephanie, we'll have to get back to you on that. We actually had a conference call with our country representative there and I just don't have that data with me. There's been a huge amount of work going on to prepare isolation facilities, train contact tracing teams and establish the lab facilities and, as you indicated, the lab there confirmed the first case. What I don't have is the number of suspect cases that have been detected. We only have the confirmed number here at global level but I will certainly get that.

00:51:07

Your concern though is correct. The situation in Yemen; Yemen has a collapsed health system and a very fractured health system and a hugely vulnerable population and the UN system is working with all sides to try and ensure that the surveillance systems that we have in place for polio, that we have in place for cholera, that we have in place for other diseases are now being fully activated to detect any suspect cases of COVID-19.

Clinical care; many, many health facilities are destroyed in Yemen and WHO with partners has been delivering healthcare through adapted clinical pathways over the last number of years and we will be able to deliver supportive care to patients with suspect COVID-19 and potentially medical oxygen.

Ventilation is going to be a huge challenge, a major, major challenge and not just the ventilators but more the technicians to run those ventilators so we're also looking at how we can provide critical care to people. We do this in trauma care in Yemen and in Syria and in

Iraq and WHO with partners runs major clinical pathways for very high-impact trauma in many, many countries and we will attempt to do the same in Yemen but it's not easy, as you say.

It's a very large country; it's a very, very fractured health system and one in which we will all struggle to provide adequate levels of supportive care to people should the disease take off in this community.

TJ Thank you very much. If we all agree, can we have one more question, DG, before we wrap up? Let's go with our friend Jamie Keaton from Associated Press. Jamie, can you hear us?

00:52:59

JA Wow. Yes, Tarik, thank you very much. Let me just scroll back to my question here. Thank you very much. We're trying to... My question is really about travel and about why we're seeing this outbreak in urban centres more than we are in rural areas. I just want to see if you've got any new metrics on this front. How much does the fact that people travel so freely in places like Europe and North America, with high-speed trains and cheap flights and whatnot, explain why this has spread so fast to some countries?

Conversely might it be a saving grace that some parts of Africa and elsewhere are so remote, which would explain why they don't have such high rates? Thank you.

MR A very good point, Jamie, and this morning our teams were actually talking to ICAO and IATA around that same issue, around examining travel flows and how they've influenced the epidemic. I think what it reflects is regardless of the country all urban centres are connected around the world so we have a global network of urban centres and at any given moment you're no more than probably one or two flight connections from any other place on the planet but that is very much centred on high-density urban environments around the world.

00:54:38

It's amazing to see that and you're right; disease then penetrating from a national, urban, highly populated centre out into the periphery is a factor of the number of people who go and come; it's a factor of how much distance and social contact there is between people in those environments. But it's also a factor of can you see that disease because very often rural areas may have less sensitive surveillance systems, they may have less health services and that's a factor as well.

So is it that it's not there or is it that we're not detecting the disease when it is there? That's something we need to think carefully about but there's no question that the global urban hubs that are connected by so many connections allow disease to move. How it then amplifies in those urban settings is a factor of population density. It's no surprise that the disease exploded in places like New York City or first London became the epicentre in the UK before anywhere else.

In Italy it was slightly different but it did centre on urban centres in northern Italy. I think it was the same in Spain and in other places so yes, you are correct and it does mean for the

future that we really do need to look at urban health and public health in urban areas and surveillance and containment in urban areas. Again I've been positively surprised in many ways in that it's been incredible to see how urban populations have actually complied with and bought in to measures that you would not imagine people in urban settings would normally buy into.

The idea that people in some of the most cosmopolitan cities in the world have really stayed at home to me is a credit because you would have imagined that that would have been much more difficult and in that sense I see hope for the future but your point is well made. Maria, I don't know if you have any specific points on this.

00:56:56

MK Yes, just to add that even though we have seen some explosive outbreaks in urban areas just by the sheer fact that people are living in much closer quarters to one another and this is a respiratory pathogen that spreads by droplets from people who are in close contact with one another and also through contaminated surfaces.

So if you have people who are closer together you have the possibility to spread it but it doesn't have to be that way so we have seen some very large urban centres that haven't had explosive outbreaks and the difference is back to this fundamental approach that we've been talking about; if you know where the virus is and if you are able to test those individuals you can actually isolate them and you can find their contacts, quarantine their contacts and the virus doesn't spread.

So just because it's an urban environment and just because a virus shows up in a very densely populated city it doesn't mean it has to have an explosive outbreak so there is the possibility that this virus can be controlled. This is the first pandemic in history that we are able to do this and so it is really critical that even those initial cases that come in anywhere in the world - and there're a number of cities right now, there're a number of countries that are still seeing low levels of cases.

You still have the possibility to control this and so the quicker that that can be done, the more aggressive action that can be done as soon as possible the better the chances that you will not see that exponential growth and that outbreak taking off.

00:58:29

TJ Thank you very much. We will conclude with this and we will see you again on Wednesday. We will have an audio file sent to you, as we always do, in the next hour or so with other news from other WHO offices and then hopefully the transcript from this press briefing will be posted some time tomorrow. Thank you.

TAG Okay, thank you. Thank you, Tarik, and thank you, all who have participated and see you at our next presser.

01:00:18