World Health Organization

COVID-19

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00:00:22

TJ Hello to everyone watching us on WHO's social media platforms and welcome to all journalists who are joining us on Zoom. Welcome to this regular COVID-19 press conference. Today we have a number of guests. We have as usual WHO Director-General, Dr Tedros. We have Dr Maria Van Kerkhove and Dr Mike Ryan. With us is also Mr Steven Solomon, Principal Legal Officer in the legal office and we also have Dr Samira Asma, who is Assistant Director-General in our department for data analytics and delivery for impact. Dr Asma's team has been working on the world health statistics that we have shared this morning with our media list.

We will go to questions after the opening remarks from Dr Tedros. I give the floor to Dr Tedros now.

TAG Thank you. Thank you, Tarik. Good morning, good afternoon and good evening. Yesterday was International Nurses' Day and a moment to celebrate those critical front-line health workers saving the lives of people with COVID-19, Ebola and many other diseases. As the world celebrated nurses I was shocked and appalled to hear of the attack on an MSF hospital in Afghanistan which led to the deaths of nurses, mothers and babies.

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Civilians and health workers should never be a target and, as my colleague and dear friend, Mike Ryan, said last week, the weaponisation of health is not helping anyone. We need health and peace. We need peace for health and health for peace and we need it now.

In the time of a global pandemic I urge all stakeholders to put aside politics and prioritise peace, a global ceasefire and ending this pandemic together. Every day without a ceasefire more people are dying unnecessarily.

Out of solidarity and respect for those killed and injured as well as all those nurses and health professionals working right now in some of the most difficult environments in the world I would like to ask for a collective minute of silence to remember those that have been slain in their daily work to serve and save lives. Please join me.

[Minute's silence]

TAG Thank you. Today the 2020 World Health Statistics were published by WHO. There is good news that overall people around the world are living both longer and healthier lives. The biggest gains were reported in low-income countries, which saw life expectancy rise by more than a firth since the turn of the millennium.

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Better maternal and child healthcare has led to a halving of child mortality since the year 2000, an achievement for the world. Furthermore lower-income countries dramatically scaled up access to services to prevent and treat HIV, malaria, tuberculosis as well as a number of neglected tropical diseases such as guinea worm.

However the report reflects that the rate of progress is too slow to meet the sustainable development goals and will be further thrown off-track by COVID-19. The new statistics shine a light on one of the key drivers of this pandemic, inequality. How is it that in 2020 approximately one billion people are spending at least 10% of their household budgets on healthcare? How is it that in 2020 over 55% of countries have fewer than 40 nursing and midwifery personnel per 10,000 people?

How is it that in 2020 because of a failure to invest in preparedness we now risk backsliding on child immunisation, malaria, neglected tropical diseases

and HIV? The answer is that the world has not done enough to deliver on the promise of health for all.

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The COVID-19 pandemic is causing a significant loss of life, disrupting livelihoods and threatening to undo much of the progress we have made. While the coronavirus is an unprecedented shock to the world, through national unity and global solidarity we can save both lives and livelihoods and ensure that other health services for neglected disease, child vaccination, HIV, TB and malaria continue to both function and improve.

During the World Health Assembly next week we will discuss with health leaders from across the world not only how to defeat COVID-19 but also how we can build back stronger health systems everywhere.

We have a once-in-a-lifetime opportunity to prove that the world is more than just a collection of individual countries with colourful flags. We're one world that has more in common with each other than we would ever dare to believe. The pandemic has made it crystal-clear that we're one world that has more in common with each other than we would ever dare to believe.

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The best defence against disease outbreaks and other health threats is preparedness, which includes investing in building strong health systems and primary healthcare. Health systems and health security are two sides of the same coin. If we don't invest in both we will face not just health consequences but the social, economic and political fall-out that we are already experiencing in this pandemic.

Today I join leaders from the global health, human rights and development institutions to draw the attention of political leaders to the heightened vulnerability of prisoners during the COVID-19 pandemic. Along with WHO's own guidance on prisons I urge political leaders to enhance all prevention and control measures in respect to vulnerable populations in places of detention.

Overcrowding in prisons undermines hygiene, health, safety and human dignity. A health response to COVID-19 in closed settings alone is insufficient. We urge political leaders to ensure that COVID-19 preparedness and responses in closed settings are identified and implemented in line with fundamental human rights and are guided by WHO guidance and recommendations to protect human health.

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Furthermore today the WHO announced the launch of the WHO Academy application designed to support health workers and the WHO info app designed to inform the general public during COVID-19. The apps are available in all UN languages; Arabic, Chinese, English, French, Spanish and Russian.

With these new mobile apps the WHO is putting the power of learning and knowledge sharing directly into the hands of health workers and people everywhere.

The WHO Academy app provides health workers with mobile access to a wealth of COVID-19 resources developed by WHO that include up-to-the-minute guidance, tools, training and virtual workshops that will help them care for COVID-19 patients and protect themselves.

Furthermore in response to COVID-19 WHO has utilised our Open WHO platform and translated guidance into training, including 68 online courses to improve the response to health emergencies. It now has more than 2.5 million enrolments and hosts free training on ten different topics across 22 languages to support the coronavirus response, including our first course in Swahili this week.

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Every day we learn more and more about COVID-19 and new apps and courses for health workers and the general public allow us to disseminate information quickly and effectively. Sharing experience and best practices is critical for strengthening our response to the pandemic. Learning together is key to building national unity and global solidarity so that together we accelerate progress faster and build a better world for us all to live in. I thank you.

TJ Thank you very much, Dr Tedros. We have shared with journalists several press releases on topics that have just been mentioned now. We will start with questions as we have in previous weeks. You can ask questions and listen to this press conference in six UN languages plus Portuguese and Hindi. Our interpreters, who we would like to thank, are here to help with that.

If we are okay we will start with Jennifer Rigby from the Telegraph. Jennifer.

00:12:03

JE Hello, Jen here from the Telegraph. I wanted to ask please, have you been tracking attacks on healthcare workers that are linked to the pandemic and how concerned are you about those attacks?

MR Thanks for the question. We have a system for tracking attacks on healthcare which we've operated since 2017. As you can imagine, that system was very much focused in zones and countries of conflict around the world and has heavily focused in countries where we've seen horrific attacks on healthcare, like the most recent one in Afghanistan. Again my personal condolences to the people affected and to our great colleagues in MSF. They've always been brave, courageous and in the front line.

We are increasingly concerned about a whole range of attacks, not necessarily on healthcare facilities related to COVID, although there have been situations

where isolation facilities have been, in a sense, not attacked in the military sense of the word but where there's been public unrest around those facilities.

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Again we would like to separate here in our minds what is the direct targeting of healthcare facilities and the healthcare workers for the prosecution of war or conflict, which is the most abhorrent weaponisation of health you can possibly imagine; we need to separate that from what is in this case, in COVID-19 very often uninformed, very often overreactions from individuals or communities who don't fully understand.

They themselves are sometimes scared and in that sense I don't equate these two things together; it's very important. These are targeted, perpetrated, organised problems but it does nonetheless have a huge impact on individual health workers, particularly when we've seen assaults on health workers themselves because they're health workers dealing with COVID and are perceived to be bringing a risk back to their community.

We've seen some assaults on COVID patients themselves, equally seen as a potential risk in communities and just in April alone we've noted more than 35 incidents in over 11 countries that were quite serious events involving attacks on individuals or groups.

Some of this again we have to look at in terms of the way that COVID-19... a lot of other issues have arisen around human rights and on the profiling and targeting of ethnic groups or ethnic minorities.

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We've seen similar issues arise around blame from settled communities versus communities that might be migratory. So I think in a sense COVID-19 is bringing out the best in us but it's also bringing out some of the worst. It's bringing out reactionary groups, it's enhancing discrimination and in some way we're seeing the facilitation of extreme responses in which people feel empowered to take out their frustrations on individuals who are purely trying to help and help the communities.

So I think we have to be sensitive to the fact that sometimes this happens because of misunderstanding and lack of information and education and then other times this is senseless acts of violence and discrimination that must be resisted.

We also need to be sure that our words as leaders are condemning and not facilitating and enabling such behaviours. Thank you.

TJ Thank you very much, Dr Ryan. The next question is from Andrew Culbert from CBC News in Canada. Andrew. Andrew, do we have you? You need to unmute. Yes, please go ahead.

00:16:41

AN Thank you. On March 11th you rung the international bell that we had a pandemic so I'm curious, what conditions need to be in place for you to unring the bell, let's say, for there no longer to be a pandemic. Is that to do with the finding of an immunisation? If you could expand on what conditions and be specific, thank you.

MR I can begin. I don't know if you were using the alarm bell analogy or the boxing analogy but there's a long way to go before there're going to be any bells unrung in this response so I think we need to be clear about that. Countries, as you've seen, are trying to find a path out and a path towards a new normal, as many people have put it.

We're going to be on that pathway for a long, long time and, as we've seen in some countries, even a small recurrence of disease can cause the need for a serious response in terms of the public health response.

So I think we're going to have to remain on alert, stay the course and ensure that we're ready to respond. In terms of reducing the alert, I think one of the issues that arises is that WHO has been given a binary system by our member states. It's not the choice of the Secretariat; our member states decide that we either have a public health emergency or we do not.

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In that sense from an official perspective they are the choices we have. Obviously as time goes on in our risk assessment we can reduce the level of alert at national, regional and global levels through our systematic risk assessment process. At the moment we obviously consider the risks to still be high at all; national, regional and global levels.

But as time goes by we will seek to adjust those risk assessments and move them down but that is going to require us reaching a point of very significant control over the virus, very strong public health surveillance and stronger health systems in place to cope with any recurring cases.

But there is no formal system of de-escalating this other than for WHO to change its national, regional and global risk assessments and obviously, as I said, the IHR only allows WHO two choices; there is either a global public health emergency or there is not.

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TJ Thank you very much. The next question comes from Georgia, Konstantin.

TAG [Inaudible] to what Mike said; with regard to the alarm, the highest level of alarm for WHO was actually raised on January 30th and this is when, in the rest of the world, we had only 82 cases of COVID and zero deaths. Raising the alarm should be associated with the highest level based on the IHR, with January.

Of course many countries would like to get out of the different measures that are being taken by many countries and rightly so but our recommendation is still the alert in any country should be at the highest level possible and whatever measures we take should be very phased ones that reflect the country's situation while investing in the comprehensive package that we have been advocating for..

So while opening a country still the alarm in each country can stay as high as possible and we can do everything we can to control the epidemic so the two can go together.

TJ We will try Konstantin Yonathanishvili from Georgia. We tried to have you on Monday. I hope this time it will be better. Konstantin, can you hear us? We are trying to get in touch with Konstantin from Georgia.

00:22:03

KO Yes, I am not.

TJ Okay, we can hear you.

KO Okay. Thank you very much. I'm from news agency IFRSG from Georgia. Georgians as a nation have very tight social contacts that are motivated not only by tradition but also by economic necessity; to live in extended families without the possibility to distance or isolate. Our social behaviour and welfare situation are very different to those of Sweden or the Baltic countries.

My question is, in the future will you issue country-specific guidelines accommodating specific social and welfare contexts? How in this situation where distancing is not an easy option can we protect the most vulnerable groups? Thank you very much.

MR I can begin on Georgia and I think Maria will come in. I think you make a very, very good point in the second part of your question around how we can ensure that this global guidance is adapted into local contexts and it is important that they are.

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We have seen the impacts of lock-down measures in lower-income settings, which are having a deep impact on people's lives so we have to be very, very careful that we offer advice that can be adapted at national level and we have issues advice for adapting our global guidance to refugee camps, to low-income settings, to various other settings and Maria can speak to that guidance.

With specific respect to Georgia, I think Georgia's been on a very flat growth curve over the last couple of weeks and has obviously kept cases down to under 650 and has a doubling time of cases of weeks now so I think there's

only been a 6% increases in cases in the last week so I think Georgia itself is doing well.

We do understand the context in Georgia and I was proud to serve on epidemic response in Georgia many years ago and have travelled throughout Georgia and understand the special social and cultural context but I think Georgia also has a very strong and proud tradition in public health and science and I'm sure, given the way the data looks, that Georgia will pull through.

But I do respect the question that we must - and this is the job of national government. WHO can only create guidance at a global level aimed at giving governments the best possible scientific evidence and options.

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Very often you see with our documents, we call them considerations sometimes, we call them scientific technical advice because what we really are conscious of is that what science may say is a fact at a global level must be adapted in terms of policy to local situations.

The translation of scientific knowledge into policy and into action requires that this happen not only at national level but very often at subnational level and the context in some big countries is very different at subnational level. There are different groups, different ethnic groups, different populations and therefore the constant capacity to be able to adapt guidance to the specific context in which our peoples live is extremely important and something that's overlooked in the process.

We tend to focus on the generation of scientific evidence as the primary job. In my experience that's very important but the ability to adapt that evidence and make it practical and usable at more and more local levels, especially at community level is a great gift, I think, that's been under-recognised very often in this response and in many other public health endeavours in the past. Maria.

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MK Thanks. Just to supplement that to say, as Mike has just said, that we develop guidance at the global level. We work at the regional level through our regional offices where there are some adaptations that are made for the context of the region. We work through our country offices where the guidance is adapted further to the national context and we work with ministries of health and other partners in countries to make sure that the guidance is adapted even further.

So it takes into consideration the local situation, the capacity of the country, the economics of the country, the culture and, as Mike has said, that adaptation is what makes this guidance useful. Having something on paper at a global level is not the same as taking it and putting it into a national action plan, resourcing that, ensuring that you have the right capacities in terms of

people and products and testing and health workers and PPE to be able to implement that.

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That takes some work and that's really important because that adaptation makes it worth its weight. One thing to note though is that the goals don't change when you adapt to different contexts. We don't change the goal or minimise our efforts to save lives, to prevent infections. That goal remains the same regardless of where the guidance is implemented.

What we have to do is be practical and we have to find those adaptations that make it work. You mentioned the multi-generation homes where people are living in close contact to one another. That is common in many parts of the world and that needs to be taken into consideration, which is why it's so important that countries have the ability to rapidly detect cases and isolate those cases in healthcare facilities and if they can't be isolated in healthcare facilities they're isolated in facilities that take them away from the home and care for them depending on the severity of their symptoms.

That's important because then you remove the virus from that home and further to that, find the contacts, quarantine the contacts in safe situations. Just to highlight that we do acknowledge that what we put out at the global level may not be perfect for every situation and it certainly is not but it's using the evidence that we have and we are constantly looking at that evidence and we are constantly adapting that guidance and trying to make it the most useful for everyone across the world.

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TJ The next question comes from the Independent. We have Borzou Daraghi online. Do we have Borzou Daraghi from the Independent? If possible unmute, please.

BO Hi. I'm sorry about that. My question is regarding the reimposition of lock-down measures in Algeria, Lebanon, south-west Iran and a few other places in recent days as well as plans to reimpose the lock-down in Saudi Arabia later this month. Of course we had the situations in Seoul and Singapore earlier.

I'm sorry if this is a rather basic question that I'm sure you've rehashed over the recent weeks but do you see these as anticipated and normal? Given the trajectory of this and other pandemics do these reimpositions suggest policy failures in any way? Are they cautionary tales or just understandable trial and error?

MR I think you answered your own question, sir; I think they're all of the above. Some are cautionary tales and some represent the kind of things we expect.

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It's all about scale and it's all about how much you understand the problem. I think there is no question; the reason why countries have gone into different forms of severe public health and social measures and into lock-downs was to separate people so we could stop the virus jumping from person to person.

If the virus is still present and you bring people closer together you don't have to be an astrophysicist to work out that the disease will move more easily from person to person in that situation. So if you can get the day-to-day case number down to the lowest possible level and get as much virus out of the community as possible then when you open you will tend to have less transmission or much less risk.

If you reopen in the presence of a high degree of virus transmission then that transmission may accelerate. If that virus transmission accelerates and you don't have the systems to detect it it will be days or weeks before you know something's wrong and by the time that happens you're back into a situation where your only response is another lock-down.

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I think this is what we all fear, a vicious cycle of public health disaster followed by economic disaster followed by public health disaster followed by economic disaster. Sometimes there's a bit of a false equation here. I'm listening and involved in discussions all the time where people are asking me; so this is the economy or the health system.

It's not because I think very, very smart people are saying on the economic side that the worst thing that can happen is if we come out of a lock-down and then we don't do the health thing right and then we go back into a lock-down, that that has more danger for the economic system than it actually has for the health system in a sense.

Because you can imagine that if the health system gets time to recover then it can cope with another rise in cases and the health system can probably do that a few times. I'm not sure how many times the economic system can do that so I do think this isn't an either/or and it's really important that we learn those lessons now.

I think you see in cases like particularly in Korea, in China, in Germany where there's been a jump in cases, the governments there have been alert to that happening and have taken very immediate action to investigate and I think that's what we need to see.

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When we see that kind of rapid action then we're reassured and I think populations are reassured but if we don't have those public health surveillance systems in place and then we start to see the hospitals fill up

again as the indicator, if we have to wait until our hospitals are overflowing before we recognise there's a problem then I think you're not into trial-and-error.

Then you're into a cautionary tale and we should not be waiting to see if opening of lock-downs has worked by counting the cases in the ICUs or counting the bodies in the morgue. That is not the way to know something has gone wrong. The way to know that the disease is coming back is to have community-based surveillance, to be testing and to know the problem's coming back and then be able to adjust your public health measures accordingly.

Let us not go back to a situation where we don't know what's happening until our hospitals are overflowing. That is not a good way to do business.

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MK I just want to comment on the use of the phrase lock-down. I think there's this misconception that a lock-down is one thing. It's not. It's a set of measures that countries have taken. They include individual and community-level restrictions of movement or some of them are called stay-at-home orders.

They include closures of different types of facilities whether these are schools or workplaces, partial closure or full closure and we should say that not all countries did school closure; not all countries closed all their workplaces. They include closures of bars and nightclubs. They include restrictions to limiting of mass gatherings or sporting events and so this use of the word lock-down makes it sound as if an entire country has shut down overnight and it's just not the case.

So what we're seeing in a number of countries and where we're seeing more success in this... and we're constantly learning; we have to keep saying that. There is no one solution here that you must do this or you must do that. It must be a comprehensive approach and in some countries they've looked at the virus, they've looked at, where is the intensity of transmission, where do we need to impose some of these measures in terms of restricting people's movements and putting stay-at-home orders in and where do we need to lift them when the situation changes.

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I think we need to get into this mindset that it's going to take some time to come out of this pandemic, whatever that looks like, including the lifting of these measures in a slow - in a staggered way which will differ based on the country itself. You may see a lifting in some parts of the country where it's staying in place in others.

And as the virus is either controlled or it has found a place to take off and resurge those measures may need to be put in place again. I think that having the communities and having all of us understand that they may need to be

lifted, they may need to be implemented again; I think we need to be ready for that. It's important that countries have the systems in place to be able to rapidly detect cases and then take appropriate actions.

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So I just wanted to comment on the use of this word, lock-down, because it isn't an all-or-nothing and we need to find the new normal as we go forward in managing the risk of resurgence and protecting people's health while getting people back to living their daily lives.

TJ Thank you. A few of you were asking about a background noise. That was rain. It's just stopped now but it could come again so it's just the rain. The next question is for Shane Zhu from CCTV. Shane, can you hear us?

SH Hi, Tarik, thank you. Can you hear me?

TJ Yes.

SH Thank you, Tarik. Shane from China Central Television, CCTV. In most days [?] the United States at least one-third of COVID-19 deaths are from long-term care facilities. How could this happen; is it because of the idea of herd immunity that was discussed in a previous briefing or there is a lack of care for this vulnerable group? Thank you.

MR Yes, I think the issue of deaths from COVID-19 in long-term care facilities is a phenomenon that's unfortunately happened all over the world and many, many countries have been affected by this around the world and in that sense it is a tragedy. We've spoken about that many times.

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There are obviously many factors driving this; the population of people who live in long-term care settings are very often older and many, many have underlying conditions so they're a very vulnerable community from that perspective.

The long-term care sector is not like the hospital sector. People are living in very many different types of settings around the world; it's not a standardised setting and some long-term care facilities can have many, many residents who have been served by a relatively small number of staff who may or not have lots and lots of training in healthcare provision and infection prevention and control.

Those standards will very greatly from country to country but I think the one thing that most countries would accept is that we haven't managed to shield those centres from disease entering and when the disease has entered those long-term care facilities it has been extremely difficult to prevent the spread in those facilities and a lot of our wisest people have died in that.

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I think this is something that's going to have to be dealt with as countries now emerge from a high-incidence phase because not only is it a tragedy that this disease is occurring and killing so many people in those facilities. If that disease remains in those facilities it will come back out into communities through the workers who work there and families who visit.

The DG has said, no-one is safe until everyone is safe. So we do have a duty of care to care for and protect our most vulnerable, our wisest, our most cherished citizens and we also need to take this on because our communities will not be safe in many countries where over 50% of all the cases have been in long-term care facilities.

I can tell you that's a long list of countries, if you measure how many countries in this response have more than 50% of their cases in long-term care facilities. But we also have long-term issues to face in terms of how we are providing care for our older citizens and how that is delivered and how that is paid for and how safe and how appropriate that is.

That's a bigger discussion for another day but it's one that will have to happen but for now we need to shield those very vulnerable people and we need to be sure that we pick up these diseases.

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We were discussing earlier today with our colleagues who work in the NGO sector about refugee camps and we spoke about historically how one case of measles or one case of meningitis in a refugee camps is an emergency because the consequences of not reacting to that first case are so catastrophic.

We need to have that view when it comes to a respiratory disease in long-term care facilities and I think there may be a degree of complacency that if someone has a respiratory disease in a long-term care facility that person's just old or that may or may not be COVID.

I think we have to have a high index of suspicion and I think we need to be very reactive and I think we need to provide support too to those facilities. I've seen some very good examples of local hospitals twinning and providing direct support to long-term care facilities to support their infection prevention and control, to have more access to doctors and nurses to come and help them make diagnoses, to have more rapid testing available and prioritise for long-term care facilities.

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They're the things we can do immediately in order to address the immediate needs but I do think in the long term we will have to look at how we provide care and support for, as I said, our older and most cherished citizens.

MK Just quickly, we do have guidance out on long-term care facilities but the critical factor is to prevent the virus from entering into a system, into this closed setting as they're known, in the sense that people live in one building and facility.

The goal is to prevent the virus from entering in and to help these facilities to have a risk-assessment-based approach, to say, what is our risk of having this virus introduced and if it is what do we do, what is our plan to be able to protect the residents of these long-term facilities, how do we protect the workers who work there?

Part of that is looking at infection prevention and control within that facility, ensuring that the workers who are there are trained, that the residents are familiar with what COVID is and how they can protect themselves and ensuring that the right prevention and control measures are in place.

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As you've highlighted, this is a persistent problem in many countries and we really need to find ways to better support countries in this. But not only that; we need to also ensure that the people who are living in these facilities also have the right clinical care for their chronic conditions so that that is maintained, so that they have the right psychosocial support as they're going through this.

Some people who are living in long-term care facilities are at the end-of-life stage and we need to make sure that they still have access to their families and their loved ones as they're going through that so there's a balance that needs to be taken into account. But we must protect people who are living in long-term care facilities sand we must make sure that the guidance that we do have is used and find ways to adapt that to the different settings so that we protect people who are living in these facilities.

TJ The next question is from EFE news agency, Isabel Sacco. Isabel.

IS Yes, hello. Can you hear me?

00:43:31

TJ Yes. Please.

IS Thank you. Thank you, Tarik, for taking my question. There re some countries that did not wait to have too many cases of COVID to lock down and I can take two examples, very far away one from the other. Russia has had six weeks of lock-down and Peru eight weeks up to now but in both countries cases are still increasing and Russia is now the country with the second-most cases in the world.

My question to you is, why did lock-downs which were quite strict not work for them and how much of the outcomes depend on government or state responsibility and how much on individual responsibility?

MK I can start. I don't know the specifics about the implementation of public health and social measures in Russia and Peru off the top of my head but what we can say is the virus needs people to transmit between. If people are in close contact with one another and you have an infected person it will transmit to another person through these respiratory droplets and so everything that we can do to prevent that from happening where we know this virus is we need to, one, look for it so that we know where the measures need to be put in place.

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But if the virus is spreading when there are measures in place we need to assess that. This is why we mention looking at a comprehensive approach and taking a data-driven approach; look at the epidemiology in the geographic context of where it is, break that down to the lowest administrative level you can, look at which interventions are being used, how they are being implemented and see if there're any cracks there, if there're any ways in which that could be done better or that could be done differently and we need to learn from that.

I think that will help understand why the virus is taking off in certain situations, in certain contexts, in certain communities. I say that because we know what has worked in some areas and that includes finding cases, isolating those cases, finding the contacts, quarantining the contacts. By doing that you're actually breaking the chains of transmission, you're breaking the opportunity for an infected person to pass it to another person so the interventions that are put in place need to have that in mind.

MR May I just add, I did speak the other day about the rapid increase in the number of cases in the Russian Federation and obviously the situation there is developing. Equally with regard to Peru there's been nearly a 50% increase in cases in the last week and Peru, a relatively small country, is now up to, I think, 67 or 68,000 cases there and there've been quite a number of cases amongst health workers in Peru as well; I think around 1,600 health workers have been infected and a lot of infections amongst police officers and others.

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We've seen that in other countries, how the first responders and the front-line workers are very often the ones exposed to the virus. Some of the success of implementing stay-at-home orders and movement restrictions have related to how quickly it was done and when it was done and a difference of two weeks in those stay-at-home orders could make a big difference in the epidemiology.

It also depends to what extent countries had good surveillance in place and then added public health and social measures to that as opposed to having very little in place in terms of public health surveillance and then having to put the lock-downs in place to try and suppress the disease spread.

There is some magical thinking going on that lock-downs work perfectly and that unlocking lock-downs will go great. Both are fraught with dangers. Just putting in place swingeing lock-downs can do as much harm as good. If it's not done, as Maria said, carefully - you choose the measures you want to put in place, they're adapted to your social and societal needs, are adapted to stopping the virus most effectively. From what you understand as the transmission of virus in your community, what measures can you use that are adapted and acceptable and implementable and sustainable in communities in order to stop the virus?

00:48:19

Then whatever risk is left - and there will be risk left - you manage with surveillance and response. That is a risk management approach - we've said it since the beginning - a comprehensive strategy based on measures to mitigate the spread and suppress the spread of the virus and measures to pick up and respond to cases.

The two together with a well-empowered, involved and educated community; I think we've seen again and again in a large number of countries, they've made that work. Other countries haven't yet quite made that work. We all need to get on that journey but I do think that when we say lock-downs didn't work it may be a timing issue, it may be the fact that people were not on board with the processes; maybe the wrong measures were chosen or weren't adapted to the social context.

So I think it's hard to say that but I think we need to be very, very careful in also saying that if lock-downs didn't work then taking away lock-downs will work. They're not the same.

TJ The next question is Steven from BBC World, Steven Snider, if I'm not wrong. Steven, can you hear us?

00:49:34

ST Yes, I can. Can you hear me?

TJ Yes.

ST Very good. This is a question about the numbers of test kits in Yemen. On April 21st Reuters reported that the International Initiative on COVID-19 in Yemen was sending a shipment that contained tens of thousands of test kits. The article said that the IICY was working with the United Nations. This week I learned from a WHO staffer that there were 803 tests that have been conducted country-wide in Yemen so far so my question is, why have so few coronavirus tests been completed in Yemen?

MR I'll have to get back to you on the number of test kits that have been shipped to Yemen; I don't have that data with me. I do know as of 9th May we have 35 lab-confirmed cases and seven deaths in Yemen and we in the UN

are operating under the assumption that the virus is circulating widely and undetected in local communities.

Since 2nd May we've seen a fivefold increase and while increasing from seven to 35 cases may not seem like much we've seen that before; very, very slow, low-level incidence followed by a rapid escalation. Everyone starts at zero or one. It's where you go after that that matters and we do see worrying trends there.

00:51:13

We have not suspended any of our operations at the moment but we are greatly curtailed in our movements in the country for security reasons. We're also trying to increase our footprint but that also involves the rest of the UN decreasing footprint because there are limitations on the number of UN staff that can be in country.

So responding to COVID effectively means not responding to other things and we thank our colleagues in the UN and the leadership of Lisa Grande, the Humanitarian Coordinator there, for facilitating and co-ordinating a process by which we can have more boots on the ground.

We would like to see more testing but to do more testing you also have to have access to healthcare facilities, you have to have workers who can do that testing, you have to be able to train people to do that, you have to be able to do waste management. It is exceptionally difficult to deliver services in the context of Yemen; a fractured state with multiple different warring parties.

But as I say, I will come back to you on the number of tests shipped - I'm sorry, I don't have that information at hand - and with any further information on plans to scale up testing across the country.

TJ We'll take one or two more questions. Karl from ARD, Karl Maurer. Hello, Karl. Can you unmute yourself, please?

KA Hello. Can you hear me?

00:52:52

TJ Yes.

KA This is Karen Wilson speaking from World Health Alert Crisis. Good afternoon. I'd like to ask you, what are the risks, do you think, of the UK having eased lock-down with people going back to work, public transport quite crowded and shops starting to open before having implemented a full tracking and tracing system? Or do you think that they have already? Thank you.

TJ Thank you, Karen. We will try to go to Karl as the last question. Sorry, Karl, do you.

KA Okay, thank you. I'm happy [overtalking]...

TJ Karl, can we just respond to this question and then we will come back to you.

KA Okay, thank you. I'm waiting. Sorry.

TJ Okay. DG says, Karl, go ahead, ask your question so we will then have two in a row. Karl, please go ahead.

00:53:47

KA Okay. I wonder if we can talk about the discussions if closed borders have an effect in spreading the virus, especially since states like Germany, Switzerland and Austria now plan to reopen. I wanted to know, are there any recommendations, what should states keep in mind when reopening borders, when reactivating travel?

MR I think this is obviously a major consideration. I think there were two questions, one about the UK and one about borders. I think the borders one has more general relevance and we'll answer that one first and then come back to the specific UK one.

I think there are both land and air borders and obviously crossing a land border in itself doesn't present a tremendous amount of risk because the conveyancer is usually a car so it's a person moving from one zone to another. I think a lot of countries now are looking at risk and response equalisation; they're looking at other countries and saying, is the risk of disease in your country similar to mine and is your response comprehensive like mine so if we exchange citizens or tourists there's no real difference.

If a person from a country that's managing risk well and managing response well can move between countries then you're not adding any extra risk by moving your citizens between the countries and in that sense you see countries in the Baltic like Latvia and Lithuania looking at what they call bubble travel zones.

00:55:17

I think Australia and New Zealand are doing the same. I think countries in the ASEAN are doing the same and I think that's maybe how travel and trade will return. I'm not an economist and I'm not a futurist but I think you're going to see countries in the same subregions or regions, particularly those with land borders or strong, traditional trading or historical links are going to look for ways to equalise the risk, bring their responses into line so that they have the confidence of their communities that the risk in that country and the response in that country is very similar to what we have here and therefore we can move as citizens between.

That's going to take time but I sense that's the way it's going to happen. Air travel is a different challenge because air travel can bring people a very long way, around the world literally in half a day or a day and that's going to

introduce more complexity for countries as regards the rules they will have for arrivals from far away. That's going to involve much more sophisticated risk management and risk reduction measures both in terms of which countries can travel to which and then how the airline process or the travel process is managed.

00:56:32

I think a lot of airlines now - and we're working with IATA and we're working with IKO [?] on guidelines for how airlines can resume in a safe manner and that risk has to be managed right the way through the airport process, the travel process and then the immigration and arrival process so it's not just being on the plane, it's a long procedure.

So we're working to try and advise the travel industry how to do that as safely as possible but again this comes back to national policy and obviously nation states will decide who can travel to and from their countries and they will need to do that both at their land borders and their air borders. The arrangements made in those two situations may differ greatly and we may see the return of land border travel, certainly extensive cross-border travel before we see extensive air travel but that again remains to be seen. Maybe the UK question.

MK Sure, I'll take the first question. The question was specifically about the UK but I'm going to answer this question for all countries because this is consistent for every country across the world. There are six criteria that countries need to take into account when they are considering adjusting their public health and social measures or so-called lock-downs.

We've already discussed that lock-downs can mean a number of different measures. The first criterion - and the DG has said this several times in his speeches - is that transmission is controlled. That means that the incidence of cases, the number of new cases that are happening, is reducing and that is reducing over a period of time.

00:58:17

Second is that sufficient health systems and public health capacities are in place. That means that countries have the workforce and the ability to detect, to test, to isolate, to care for cases, making sure that the hospital facilities have enough beds to be able to care for patients depending on the severity of their symptoms, to have the right kinds of ICU facilities or advanced care facilities, respiratory support, having healthcare workers that are in place that can actually care for patients, to ensure that they have the ability to contact trace the contacts of known cases and they have the ability to quarantine those contacts in safe facilities.

The third is to make sure that the risks of outbreaks in highly vulnerable settings are minimised. We've spoken about some of these today; the DG mentioned prisons and detention centres in his speech today. We've talked

about long-term care facilities. It's very important that there are systems in place to protect vulnerable settings.

The fourth is that workplace preventive measures are established. We've also issued guidelines around workplace and the resumption of work in a safe way so that certain control and prevention measures are in place like physical distancing for example and that workplaces have plans to be able to rapidly identify cases and manage those cases.

00:59:43

Five, the risks of imported cases are managed. Mike just described how with borders opening and people being able to move - and it could even be within a country - that we are able to find the virus so that the risk of the virus moving from one geographic area to another can be traced, can be tracked and we can break those chains of transmission.

Lastly, that communities are fully engaged; these are informed, empowered, knowledgeable community members who understand how the lifting of these measures needs to take place in a controlled, slow was and so that they understand that we may be able to lift them, we may need to impose them again and that we are listening to our communities, we are working with our communities so that they know what role each individual has to play in controlling and suppressing this virus.

TJ We will go to the last question for today and that's Emma Farge from Reuters. Emma.

EM Hello, good afternoon; another question on the potential longevity of the virus, please. I understand that the Chief Scientist at the WHO spoke today to the FT about it taking four to five years before the virus is under control. That seems to me like a sea change in people's expectations because I think most people think, we'll muddle through until there's a vaccine and that will take 12 months.

01:01:20

Is this view of the Chief Scientist something held widely within the WHO? Thank you.

MR We'll have to see what Soumya's commentary was but I suspect it was an answer to probably a question of how long this could last as opposed to how long do you predict it will last. We have a new virus entering the human population for the first time and therefore it is very hard to predict when we will prevail over it.

What is clear and I think may be what Soumya may have been alluding to is that the current seroprevalence or the current number of people in our population who have been infected is actually relatively low and if you're a scientist and you project forward in the absence of a vaccine and you try and

calculate, how long is it going to take for enough people to become infected so that this disease settles into an endemic phase...

We may never and I think it's important to put this on the table; this virus may become just another endemic virus in our communities and this virus may never go away. HIV has not gone away but we've come to terms with the virus and we've found the therapies and we have found the prevention methods and people don't feel as scared as they did before and we're offering life - long healthy lives - to people with HIV.

01:02:56

I'm not comparing the two diseases but I think it is important that we be realistic and I don't think anyone can predict when or if this disease will disappear. We do have one great hope; if we do find a highly effective vaccine that we can distribute to everyone who needs it in the world we may have a shot at eliminating this virus but that vaccine will have to highly effective, it will have to be made available to everyone and we will have to use it.

Before we began responding to this event on 31st December we were heavily involved and had teams in the Western Pacific working on measles. At that time every single ventilator - and we've learnt about ventilators, all of us around the world, in the last... A lot of people talk about ventilators. I think there were 14 ventilators in Western Samoa at that time and all 14 were occupied by young children who had a devastating disease. It was called measles and they weren't vaccinated against that disease.

01:04:07

So forgive me if I'm cynical but we have some perfectly effective vaccines on this planet that we have not used effectively for diseases we could eliminate and eradicate and we haven't done it. We've lacked the will, we've lacked the determination to invest in health systems to deliver that. We've lacked the capacity to sustain primary healthcare at the front end.

Therefore science can come up with the vaccine but someone's got to make it and we've got to make enough of it that everyone can get a dose of it and we've go to be able to deliver that and people have got to want to take that vaccine. Every single one of those steps is fraught with challenges. It's a massive opportunity for the world.

The idea that a new disease could emerge, cause a pandemic and we could, with a massive moon-shot, find a vaccine and give it to everyone who needs it and stop this disease in its tracks will turn maybe what has been a tragic pandemic into a beacon of hope for the future of our planet and the way we care for our citizens and the way we work together to solve our problems through solidarity, through trust, through working together and through a multilateral system that can actually benefit mankind.

So I think there are no promises in this and there are no dates. This disease may settle into a long-term problem; it may not be. In some senses we have control over that future but it's going to take a massive effort to do it. The DG's been calling for it.

01:05:43

He's been speaking, bringing leaders together, trying to drive the issue so that we have access to COVID tools. We believe we have a coalition that can deliver on that but it's going to need the political, the financial, the operational, the technical and the community support to be a success.

MK I just wanted to add that I think many people are in a state of feeling quite some despair. They've been at home for quite some time and they're going through a very difficult situation; they've had loved ones who have been infected or who have died. But I just want to say that the trajectory of this pandemic, the trajectory of this outbreak is in our hands and we have seen in a number of countries without medical interventions - and as Mike has said, the global community has come together to work in solidarity to accelerate the development of a safe and effective vaccine and to come together to commit to have access to that safe and effective vaccine when it is available.

But we have seen countries bring this virus under control, we have seen countries use public health measures, the fundamentals of public health and epidemiology and clinical care to bring the virus under control and to suppress transmission to a low enough level where communities can get back to work and communities can open up again.

01:07:07

So we can't forget that. It will take some time before we have the information on these medical interventions and it's coming and people are working very hard on that but this is in our hand and we are seeing hope in a number of countries and I really don't want people to forget that.

TJ With these comments we will conclude today's press conference. Thanks to everyone who was watching us on WHO's social media platform; also to all journalists who were online. We will have an audio file available for you in the next hour or two and a transcript tomorrow. We wish everyone a very nice evening.

TAG Thank you. Thank you, Tarik and as Maria said, I think the trajectory's in our hands and this is everybody's business and we should all contribute to stopping this pandemic. Thank you for joining and see you on Friday.

01:08:30