

COVID-19

Virtual Press conference

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JO	John

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MH Hello, everybody. This is Margaret Harris in Geneva on this Thursday, August 13th welcoming you to today's World Health Organization press briefing on COVID-19. We have with us as always the WHO Director-General, Dr Tedros, along with Dr Mike Ryan, Executive Director of our Emergencies Programme, Dr Maria Van Kerkhove, Technical Lead for COVID-19 and a big panel of experts today so please ask a good, broad range of questions.

Our experts include Dr Bruce Aylward, Dr Mariangela Simao, Dr Soumya Swaminathan, who's joining remotely, and quite a few others. As usual we're translating this simultaneously into the six

official UN languages plus Portuguese and Hindi. Remember that under the Zoom system you need to go to the Korean button to use Arabic.

Now without further delay I'll hand over to Dr Tedros. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Margaret. Good morning, good afternoon and good evening. We're half a year on from WHO sounding its highest alarm by declaring the COVID-19 outbreak a Public Health Emergency of International Concern. At the time on 30th January there were just 100 cases outside of China and no deaths.

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Since then there has been an exponential rise in cases and every country in the world has been impacted and with major disruptions to essential health services the ripple effects of this pandemic are having a major impact politically, economically and in how people live their day-to-day lives.

Everyone is asking, so how do we go back to normal? Today I want to talk about not how we're going to go back but how we're going to go forward and that to move forward the best bet is to do it together.

In early January at the beginning of the outbreak WHO activated our global technical networks to gather all available information about this virus. Within the first two weeks of January the virus genome of COVID-19 was mapped in China, shared globally and the first PCR test protocol was shared on the WHO website.

This enabled the first diagnostics to be developed, vaccine research to start and soon after millions of tests, PPE and supplies were shipped around the world. In February we held the WHO's research and development blueprint meeting where scientists and researchers from across the world came together to identify research priorities.

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A roadmap was created for the development and fair distribution of diagnostics, therapeutics and vaccines. Also in February and March numerous countries showed that it's never too late to suppress COVID-19 using a comprehensive approach. This includes active case finding and isolation, contact tracing and quarantine, adequate testing and appropriate clinical care.

With these tools it was clearly possible to break the chains of transmission by a combination of traditional public health techniques. As the pandemic evolved countries clearly needed to come together in an unprecedented way to develop new vaccines, diagnostics and therapeutics and to set the stage for ensuring that they reach all people everywhere.

In April WHO convened world leaders and launched the Access to COVID-19 Tools - ACT - Accelerator. In just three months the accelerator has already shown results. As of today nine vaccine candidates are already in the COVAX portfolio and going through phase two or three trials and this portfolio, already the broadest in the world, is constantly expanding.

Through the COVAX global vaccines facility countries that represent nearly 70% of the global population have signed up or expressed an interest to be part of the new initiative.

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On therapeutics the first proven therapy for severe COVID-19, dexamethasone, was announced in June with support from the therapeutic accelerator arm and is currently in scale-up. On diagnostics more than 50 tests are currently in evaluation and new evidence has been generated around rapid antigen detection tests that could be game-changing.

The ACT Accelerator is the only global framework for ensuring the fair and equitable allocation of COVID-19 tools but it must be financed to be successful. IMF estimates the pandemic costs the global economy US\$375 billion a month and predicts a cumulative loss to the global economy over two years of over US\$12 trillion.

The world has already spend trillions dealing with the short-term consequences of the pandemic. G20 countries alone have mobilised more than US\$10 trillion in fiscal stimulus to treat and mitigate the consequences of the pandemic. That's already more than 3.5 times as much as the world spent in the entire response to the global financial crisis.

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It's easy to think of the ACT Accelerator as a research and development effort but in reality it's the best economic stimulus the world can invest. Funding the ACT Accelerator will cost a tiny fraction in comparison to the alternative where economies retreat further and require continued fiscal stimulus packages.

Before spending another US\$10 trillion on the consequence of the next wave we estimate that the world will need to spend at least US\$100 billion on new tools, especially any new vaccines that are developed.

The first and most immediate need is US\$31.3 billion for the ACT Accelerator. The ACT Accelerator is the only up-and-running global initiative that brings together all the global research and development, manufacturing, regulatory, purchasing and procurement needed for all the tools required to end the pandemic.

Picking individual winners is an expensive, risky gambit. The ACT Accelerator enables governments to spread the risk and share the reward. In particular the development of vaccines is long, complex, risky and expensive. The vast majority of vaccines in early development fail. The world needs multiple vaccine candidates of different types to maximise the chances of finding a winning solution.

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When a successful new vaccine is found there will be greater demand than there is supply. Excess demand and competition for supply is already creating vaccine nationalism and risk of price gouging. This is the kind of market failure that only global solidarity, public sector investment and engagement can solve but the ACT Accelerator funding gap can't be covered by traditional development assistance alone.

The best solution for everyone is a blend of development assistance and additional financing from stimulus packages to fund this effort and this blend of financing is the best solution right now because it's the fastest way to end the pandemic and ensure a swift global recovery.

We live in a globalised economy and countries are dependent on each other for goods and services, transportation and supply. If we don't get rid of the virus everywhere we can't rebuild economies anywhere.

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The real beauty of the ACT Accelerator and its work is that stimulus investments and globally co-ordinated roll-out of new vaccines, tests and therapeutics would have a major multiplier effect on our economies. The sooner we stop the pandemic the sooner we can ensure internationally interlinked sectors like travel, trade and tourism can truly recover.

There is hope. If we all deeply the tools currently at our disposal today and if we collectively invest in new tools through the ACT Accelerator we have a route out of this pandemic. Together, together, together with solidarity.

Over the past two years working with the Government of the Democratic Republic of the Congo, communities, health workers and local and international partners we collectively defeated one of the most difficult Ebola outbreaks the world has ever faced. However at the time of COVID-19 the outbreak in Equateur province is a worrying development.

So far there have been 86 Ebola cases across the province. The country, government and partners face significant logistical challenges in being able to rapidly investigate and establish response capacities in extremely remote and difficult-to-access areas.

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The geographic spread of the outbreak is vast with cases in some areas separated by more than 250km and many areas are only accessible by helicopter or boat. Right now WHO has approximately 100 staff on the ground working with the Ministry of Health, UN agencies, NGOs and communities.

We immediately released US\$2.5 million from the Contingency Fund for Emergencies and our regional emergency response fund to support the immediate response. To bring the outbreak under control and end it WHO and partners require additional funding. We're currently working with surrounding provinces and neighbouring countries to enhance preparedness as we did with the previous Ebola outbreak in eastern DRC.

As we know from past experience, this is not just a matter for a country's health security; it is a matter of global health security. Whether it's COVID-19, Ebola or other high-impact epidemics we must be prepared, we need to be on high alert and we need to respond quickly.

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Our best chance to be successful is to always do it together. I thank you.

MH Thank you very much, Dr Tedros. I'll now open the floor to questions from journalists but before that I'd like to remind you that if you want to ask a question you must use the raise your hand icon even if you've submitted the question beforehand.

I'll also apologise now to those who miss out. We've got a lot of people online so please restrict your questions to one. I know it's a really complex subject but please try to just ask the one question. We've got a lot of very strong science and health journalists on the line and we'll start with Helen Branswell from Stat News. Helen, could you unmute yourself and ask your question.

HE Hi, all. Thank you very much for taking my question. I've asked it before and I'm going to ask it again. One of these times the answer might be different. Is there any evidence yet of confirmed reinfection of cases, of people who have earlier had infection and have had a second, subsequent infection? Thank you.

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MK Hi, Helen. Thanks for the question; it's a timely one. I think this is on the minds of many individuals. There are some examples of countries that have suggested that an individual may have been reinfected. It's still not confirmed. What we need to be able to do is to look at a few things. One is the testing that's been done in an individual and how long that individual tests positive because some people can have PCR positivity for many weeks, not just days but many weeks and it doesn't necessarily mean that they are infectious for that long. In fact we know that they're not infectious for that long.

There are some examples of individuals who have tested PCR-positive and then after several days, several weeks after testing negative have tested positive again. We had some examples in Korea and that was not an example of reinfection.

What we are trying to do in the instances where there may be an individual that tests positive again; we need to look at a few things. One is how the tests were collected, what samples were collected, the tests that were used to see if there are any issues of false positivity or false negativity. What we ideally would like is to look at sequencing; if the virus can be isolated, if sequencing can be done so we can look and see if somebody has been reinfected.

The third thing that we're looking at is the immune response that an individual has after infection. You've heard us talk about this quite a lot. There's a lot that we're still learning. We expect that individuals who are infected with the SARS COVID-2 virus develop an immune response. We don't know for how long that immune response lasts, we don't know how strong it is or how long it lasts

and that is something that is currently actively under development. Of course somebody will have protection from reinfection while they have those antibodies.

It's a long-winded answer to say we don't know yet but we are actively following up any examples where this may be suggested.

MH Thanks very much, Dr Van Kerkhove. The next question comes from Antonio Roto from the Spanish news wire EFE. Antonio, could you unmute yourself and ask your question.

TR Good afternoon. I wanted to ask about the Russian vaccine. The World Health Organization in recent days has reacted with a little caution to the announcement from President Putin and I want to know if in recent days you've managed to get more information on the vaccine and if you think it will be reliable and if it can be extended to other countries, and if it's amongst the nine vaccines that Dr Tedros mentioned in his opening statement. Thank you.

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MH The question was about the Russian vaccine.

BA Thank you very much. This is Bruce Aylward, who's heading up the hub for the ACT Accelerator. As everyone on the call is aware, we have now dozens and dozens, indeed well over 170 vaccine candidates that are under evaluation around the world at different stages.

26 of those have been in clinical trial, one of which, as people on this call will be aware, was the Russian vaccine. It was not one of the vaccines that are in the COVAX portfolio. I think there was a specific question about the nine that are in the portfolio. It does not include that vaccine or those vaccines.

I think there was a specific question about whether or not we would see, the WHO, expanded use for that. We don't have sufficient information at this point to make a judgment on that and we're currently in conversation with Russia to get additional information, understand the status of that product, the trials that have been undertaken and then what the next steps might be.

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MH Add anything. Sorry. Dr Swaminathan on the line, do you want to add anything? No. Dr... No. Nobody.

SS I think that's fine, Margaret. I don't want to add anything.

MH Thank you so much. The next question goes to Kai Kupferschmidt from Science. Kai, could you unmute yourself and go ahead.

KA Thanks for taking my question. A very, very big-picture question; I'm curious. Following the WHO numbers on COVID-19 you can see that globally the numbers are levelling off. I'm aware that as a pandemic this is a lot of different outbreaks all going on at the same time, each with its own dynamic.

I'm just curious whether you can speak a little bit to the global picture at the moment. How do you see it, do you expect the numbers globally to stay at this spot or even go down, what's the dynamic if you take the very-big-picture view at the moment? Thanks.

MR I think I can start but Maria, Bruce and others may wish to weigh in. Kai, yes, you are right; the numbers vary from week to week, from month to month, from geography to geography.

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But I think what we have to keep in mind is a very small proportion of the world's population have actually been exposed to this virus and have developed an infection and have developed an immunologic memory to the virus so this virus has a long way to burn if we allow it.

It may move in certain populations more efficiently depending on behaviour; it may move in certain populations depending on whether people are spending more time inside or outside; it may return in colder periods; it may do many things.

But the one thing I think we have to remember is most people, the vast majority of people remain susceptible to this infection. Countries, I think, in terms of the overall global picture; there are still a number of countries that are very much dealing with extensive, uncontrolled community transmission with all of the consequences that go with that, with pressure on the health system, preventable deaths and all of the socio-economic damage that goes with that, having to take very, very strong measures to try and control the disease.

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There're a number of other countries at the other end of the spectrum who have previously brought the disease under control but are now experiencing spikes in the numbers of cases, mainly related to clusters of infection around particular events, around particular context, around crowds, around gatherings and other

things. They're struggling obviously to bring those clusters under control in order to prevent community transmission reigniting and I think that's probably the key issue here.

Once you get community transmission under control and you get back to clusters or sporadic cases you have to try and keep it there because if you take pressure off this virus it will slip back towards community transmission and once community transmission takes off, establishes itself and becomes intense then you have all the consequences of the health system under pressure, death rates rising, hospitalisation rates rising.

So the key objective for us all is to try and suppress infection to a point where we have control at community level and then risk-manage our way through this and we have to make some difficult trade-offs; opening schools versus crowded gathering places. We need to make choices and some of those choices are not easy; they are hard.

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I think that's going to be the struggle over the coming months; making good choices, governments making good choices, communities making good choices and individuals making good choices and that requires good information, that requires good data, that requires knowledge and being able to act.

The DG said it in his speech; he said, we have the tools. We have a number of tools that we know work. We need to continue to apply them and we need to - as he has alluded to and Bruce as well - accelerate the development of the vaccines and we need to be able to pay for a massive expansion in our capacity to deliver vaccines to everyone that needs them.

But I would characterise the global situation now; yes, we've seen a plateauing of numbers, Kai, and I know you track that every day. But this is like the cascades of a waterfall; you can go down one level and you think you're in calm water and you go over the next level and you're in a waterfall again.

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So I do think we need to be very, very careful; calm waters do not mean the storm is over. We may just be in the eye of the storm and we don't know it so I think absolute vigilance now and those countries that have made progress; please retain that progress. You will lose that progress if you relent, if you become complacent.

Those countries that are in community transmission - the DG keeps saying it - there is always time to turn it around. Some of the countries now that have the best numbers are countries that had terrible numbers only a few months ago. Look at Italy. Look what Italy has achieved in terms of its ability to control this disease.

It is never too late to put this virus under pressure so those countries that are making, have made progress give us hope but those countries who have made progress need to remain vigilant.

MK If I could add, we've said it many times but the trajectory of this pandemic in every country is in our hands, it remains in our hands and I think that we need to say that as much as we possibly can because there is hope of countries that have been in terrible situations, as Mike has just said, that have turned it around.

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The trajectory is in our hands and it depends on the actions of countries, it depends on the actions of governments, of communities, of individuals. There are many situations where we have choices, where we can reduce our risk of exposure and it is really, really critical that as societies open up we minimise the infections, the number of people who get infected even among people who are at a lower risk of developing severe disease because they may also pass the virus to somebody else who may be of a vulnerable category who could develop a severe disease, need hospitalisation and die.

I think that's really, really important and I think what we're learning seven months in is that the actions that need to be taken at the different levels to suppress transmission, to reduce mortality now with the tools we have now are fairly clear. It's the implementation that is incredibly difficult and the consistency and the vigilance and the focus to do this; having clear plans but localised, adapted implementation is really, really difficult and to have this done at the scale it's necessary depending on the intensity.

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What we're seeing for countries that are opening up that are seeing these clusters; really quick action to stamp out and put out those individual fires where those outbreaks are happening is proving successful.

So as an individual avoid the crowded places, wear a mask where appropriate, listen to your governments, if you're asked to stay home please do so because there are many front-line workers, essential workers who are out there who are doing incredibly hard work, who are keeping people alive.

Everybody has a role to play and we will say this over and over and over again; that we have control, we have power, that we can play a role in this and really do everything we can to prevent ourselves getting infected and prevent ourselves from passing it to someone else.

MH Thank you very much Dr Ryan and Dr Van Kerkhove. I'd also remind you, as I said, we've got a wealth of expertise in this room and on the line. I mentioned Dr Soumya Swaminathan. We also have Dr Hanan Belki who can talk about the therapeutics arm of the ACT Accelerator among many other topics. We also have Dr Edward Kelly, who can talk about the health systems arm of the ACT Accelerator so you've got a great opportunity here today.

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The next question goes to Simon Ateba from Today News Africa. Simon, please unmute yourself and go ahead.

SI Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. It's been six months since the first confirmed case of COVID-19 was recorded in Africa. Between then and now more than a million cases have been recorded and over 24,000 people have died.

However these cases are mainly concentrated within five countries in Africa; South Africa, Egypt, Nigeria, Ghana and Algeria. I was wondering, do you know exactly why some countries are affected more than others and what are other countries going right that these five countries are not doing? Thank you.

MR Thanks, Simon. There're a number of factors at play here. I think, if I remember correctly, you said South Africa, Nigeria, Ghana, Egypt and what was the other one? Ghana [sic]. Those are very highly populous... I think Egypt and Nigeria and South Africa are probably the most populous countries in Africa so yes, you would expect the most cases to be in those countries because that's where we have the most people.

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Some other factors; South Africa would have imported disease much earlier than other countries, quite early in the course of this pandemic. The pandemic has had longer to generate its epidemic curve in that situation; equally Nigeria as well.

Some of these countries are highly connected if you look at these countries, they're very connected through direct airline routes and others to Europe and they may have imported disease earlier. They also have a lot of family and other links with other countries so there may be elements of how and when the disease was introduced into those countries.

Also I would argue that paradoxically these five countries actually have relatively strong public health systems, they have good surveillance systems, they have good national labs and they may actually be detecting more cases than some other countries.

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The absence of evidence is not evidence of absence and in this case I think countries with stronger public health laboratory systems tend to find cases more quickly.

Equally though on the other side there are risk factors associated with these countries and that is large, dense, urban populations in Nigeria, in South Africa, in Egypt and therefore on the other side of it there are pockets of poverty and large pockets of urban poverty in which this disease can spread much more easily.

So I'd say there are factors in two directions; Simon; these countries are more at risk, these countries have larger populations, these countries have strong surveillance capacity to detect.

But also there are real reasons why these countries are at higher risk given their population distribution and their dense periurban and urban populations. Maria, anything to add?

MK Yes, just to briefly add to say in addition to what Mike has said, I think one of the things we need to accept is that in all countries there are unrecognised cases that are not being picked up by current surveillance strategies, that are not being picked up by current testing strategies.

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While Africa has done an incredible job of building and increasing and expanding testing capacity to be able to detect COVID-19 cases it isn't evenly distributed throughout the entire continent and so I think there may be unrecognised cases that way.

There're also demographic differences where you have younger populations, media age of a population is younger than some countries perhaps in Europe, in North America and you have different prevalences of underlying conditions, which put people who are infected with the SARS-CoV virus at a higher risk of developing severe disease and therefore possibly being detected by the health system.

So I think there're a number of factors there and I think at the beginning of this pandemic we were asked this question a lot; why are we seeing so many cases in this country or that country? It's a combination of factors.

I think one of the things that I find quite interesting are the results from the early serioepidemiologic studies. There's a variety of them, a large number of them that are happening across the globe, more than 100 at present.

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Some of the early results in Africa are suggesting that there are people who have detected antibodies, meaning they have been infected but they were unrecognised, they weren't picked up by the current system.

So I think we also need to look at that data as well and perhaps they didn't develop a severe disease or they didn't develop a disease and therefore weren't picked up. So, as Mike has said, it's a number of factors that are largely contributing to why we see differences in testing and differences in detection across countries.

MH Thank you very much, Dr Ryan and Dr Van Kerkhove. The next question is from Bianca Rotier from Globo Brasil. Bianca, can you unmute yourself and ask your question?

BI Thanks a lot, Margaret, for taking my question. Yes, Bianca; I'm correspondent in Switzerland for Globo News and Globo, the largest TV network in Brazil. My question is about China, which announced today that chicken wings imported from Brazil tested positive for COVID-19.

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What should be done in a situation like this; can we be impacted by the virus from food including frozen food, what are the risks, what are the recommendations for consumers, people who work in transportation of food and also in production and packaging and of course to companies and governments as well? Thanks a lot.

MK Thanks for the question. I can start and maybe, Mike, you would like to supplement. Yes, we are aware of the reports of these tests. What we understand is that China is testing on packaging, they're looking for the virus on packaging and they tested a few hundred thousand samples looking on packaging and have found very, very few, fewer than ten positive in doing that.

We have issued guidance with FAO on food handlers and working with food, working with frozen food, working with live foods to keep people safe in their working environments. We know that the virus can remain on surfaces for some time but the virus can be inactivated on our hands if you wash your hands or use alcohol-based rub and if the virus is actually in food - and we have no examples where this virus has been transmitted as food-borne, where someone has consumed a food product - the viruses can be killed. Other viruses as well can be killed if the meat is cooked.

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So we have issued guidance on how to ensure that people who are handling these products can work safely.

MR May I just add, I think people are already scared enough and fearful enough in the COVID pandemic. It's important that we track findings like this and it's important that we don't discount scientific evidence where we find it but it's also important that people can go about their daily lives without fear.

People should not fear food or food packaging or the processing or delivery of food. Food is very important and I would hate to think that we would create an impression that there's a problem with our food or there's a problem with our food chains. They're under enough pressure as it is already.

We will continue to track findings like this but, as Maria said, there is no evidence that food or the food chain is participating in transmission of this virus and people should feel comfortable and feel safe.

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There are many other reasons why we need to protect and we need to cook our food properly and there are many other contaminants of food that occur but I think we should not be placing COVID as a risk in this area.

I just think it's important that we don't conflate observations like this into a major concern around food. Our food from a COVID

perspective is safe but there are many other reasons that we need to keep our food chain safe and many, many people work very, very hard across the world to ensure that our food is safe and of the highest quality.

MH [Inaudible] and Dr Van Kerkhove. The next question goes to Michael from CNN. Michael, can you unmute yourself and ask your question.

MI Good afternoon from Ottawa. This is Michael Bosaker; I'm a contributor to CNN Opinion. Thanks for taking my question. There's been a lot of talk about the expected demand for the new vaccine but, as you know, anti-vaxxers have taken to social media in a big way. In fact I'd say there's almost a virus disinformation out there about the future of vaccine.

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According to a CNN poll in May - and this is quite shocking - about one-third of Americans said they would not get vaccinated against coronavirus even if it were widely available and low-cost.

Then just quickly, I interviewed just now the head of Rotary International, [Unclear], and he said one of the endgames of COVID crisis will be vaccinations and that there will be resistance, however there's a lot to learn from polio in terms of how to overcome the resistance.

So my question is, what needs to be done, have governments underestimated the degree of resistance and is it too late to counter that effectively? Thank you.

MS Thank you for the question because it's absolutely important that there's work on both sides on the vaccine acceptance and also on the vaccine hesitancy and WHO takes this extremely seriously because, as you mentioned, there are already problems with routine vaccination.

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We have seen that the problems are related either to mistrust of institutions or scientific information, but also because of the very rapid access to incorrect information that happens through social media and so on. So WHO has been working in the past years and it's intensifying its work with the social media platforms to ensure that there's early detection of incorrect information and then also that people looking for information have access to the right sites that provide solid and scientific-based information on vaccine [?].

But this is absolutely a workstream that WHO is taking very seriously, thinking that we will need to have a rapid uptake in many countries as vaccines become available. Thank you.

MK If I could just add, some of the things we're doing right now about this issue in addition to what Mariangela just said are that we're engaging with a lot of different groups right now to discuss vaccine understanding; what a vaccine is, what a vaccine does, what it's meant to do, what it can't do, how these are being developed to be a safe and effective vaccine, even though it's a rapid development, that steps are not being skipped in terms of safety and in terms of efficacy, and also to understand acceptance and demand.

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So we're working with different groups to work on communication packages, listening and so this could be worked on now as the vaccine itself is being developed. But what we understand from most countries that are communicating with us, most groups that are working with us, civil society, individuals is that most people want access to a safe and effective vaccine.

So there are a lot of different avenues that we are pursuing but really trying to increase vaccine understanding, acceptance and demand is something we take very, very seriously and we're listening and we're learning and we're developing those communication packages.

MR Maybe also speaking to the costs of doing all of this, we need to invest now in a dialogue with people, with communities, in creating the conditions in which this vaccine - these vaccines, we hope - can be introduced in the most successful way. There are reasons for vaccine hesitancy, there are reasons for lack of acceptance of vaccines and they range from specific fears about the vaccine to distrust of government; there are many different reasons.

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Bruce has vast years of experience in polio overcoming issues and misunderstandings and misinformation; I've had many years at it myself. If you think about eastern Congo in the last year-and-a-half, we were using an investigational-use vaccine, brand-new vaccine in a population in the middle of a highly-conflictual situation with a very disrupted society.

Through the work that we, UNICEF, the Government and others did with communities we had 97% acceptance of vaccine

amongst eligible people for that vaccine. That's incredible. That's a great testament to the people of Congo, to their understanding, to their acceptance but it's also a two-way street. There must be a dialogue.

People need to be allowed to have a conversation about vaccine and have proper conversation. It's not a one-way street, it's not about shoving things down people's throats, it's about having a proper discussions, good information, a good discussion no this and people will make up their own minds.

I think science and government have a job to do and that is to make the case. I think communities and people have a job to do which is to listen to that case and hopefully the result of that will be a widely accepted, successful vaccine that could bring this pandemic to an end. Bruce.

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BA Hi, thanks, Mike, and, Michael, thank you for the point. I don't want to belabour it because others have covered the big pints but first no-one's underestimating this and one of the ways and thinks we're doing to address it also is to make sure that we're putting together an integrated package of tools and that's what the ACT Accelerator is all about.

We all want a silver bullet but we want to make sure we have multiple ones. We need better, faster diagnostics, we need therapeutics, we need vaccines. Not everyone may use the vaccine, it may not work in everyone is we may need the right tool.

As Mike has been emphasising, we need those tools now, especially the diagnostics to be able to get the massive step-change in terms of the coverage of folks who, number one, know their status, whether or not they have the disease and, number two, whether or not they're still shedding and they're isolated properly.

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That's the reason and again one more of the arguments; as we do all these pieces, we work now to be prepared for optimum uptake that we also have the other tools.

Maria made the point but it's another thing to emphasise; one of the key things we're trying to do with the accelerator is to move in parallel things that we would normally do in sequence. Normally we do the research and development, then we do the

manufacturing and then a pre-qualification, then we work on the delivery issues.

But in this - again, Maria, I think you referred to it - we're trying to do all of those almost in parallel. That's why we need the money up-front; that's how we're going to be successful. If we do all the work on the R&D we don't have the resources to do this community preparedness work, exactly as you're speaking to, we won't be as successful as we want to be, we won't get the coverage that we need and we won't stop this as quickly as we could with the new tools that are coming online.

MH Thank you very much, Dr Aylward, Dr Simao, Dr Van Kerkhove and Dr Ryan for all those fantastic answers. The next question goes to Ye Yi of Xinhua. Ye, please unmute yourself and go ahead.

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YE Thank you for taking my question. My question is still about the vaccine. WHO has always been promoting the equal distribution of vaccines so now I want to ask, how many countries now have publicly declared if they have an effective vaccine against COVID-19 being developed and they will treat it as a public good for the world and what are the positions of the major countries that now have most developments in the vaccine research? Thank you,

MH I think this is a question for Dr Mariangela again.

MS Thank you for the question. It's a very hot discussion at the moment because we're talking about a safe and effective vaccine being a public health good and we are talking about ensuring that there is equitable access to the technologies that are developed and that they reach all countries, they benefit populations in all countries, not only high-income countries.

We're going through a moment where we see that some countries are doing bilateral agreements with companies but at the same time we have a global moment. We're working together in the international organisations; WHO with the vaccine alliance, with GAVI.

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We're working together, we're discussing with member states the organisation of a global facility and this global facility will be a [unclear] to procure, invest in vaccine candidates and ensure that countries who are participating; it's open to all countries.

We will have access to the vaccines once they prove to be safe and effective. So far we have 167 countries already engaged in this process so I think it's very reassuring that we have such a global commitment towards ensuring that - once a technology is available there would be a commitment to ensure equitable access in a timely fashion, that all countries are reached by the vaccines. Thank you.

MH Thank you very much, Dr Mariangela Simao. We'll now move to the next question. We've only got time for a couple more questions because we've got a hard stop at 6:30. The next question goes to John Miller from Reuters.

JO Hi, thanks very much. As we look around the world we see a lot of unilateral deals between companies and countries for vaccines and we heard earlier this week Dr Tedros talking about there only being about 10% of the way towards the AC Accelerator goal including the COVAX component of that.

I'm wondering; do you have concerns that these unilateral deals - whether it's between Switzerland and a company or US or Europe - that they are competing with efforts on a multilateral level to address this problem perhaps in a more comprehensive way. Thanks.

BA Thanks so much for the question. It relates a little bit to the question that we just heard. It's an interesting situation we're in. When we first started talking about vaccines of course against this disease everybody was quick to say, it's so important that we have enough of these products and we equitably distributes these products.

But then of course we've seen a lot- as you've just mentioned - of countries now moving forward on bilateral deals, we call them, or multilateral deals to try and secure access for their populations and the motivations behind that at a certain level of course; they can be understood.

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What's interesting now - and it's a little bit to the point that Mariangela just spoke to - is over the last couple of months there's been an increasing recognition among countries that it is not enough to vaccinate their own populations and they're also recognising that they don't need to vaccinate their whole populations immediately to get the biggest bang potentially from these vaccines.

What we're seeing more and more is that - in fact just over the last few days, even weeks we're seeing countries that have set bilateral and multilateral deals coming to us and saying, look, how do we work with you to make sure that we're part of a solution that this ensures that this rolls out simultaneously to the world.

So as the Director-General said, there's self-interest in this as well as the moral case for it because there's a recognition; we cannot get the global economies moving again, we cannot get the travel, trade, transportation. The world is just too interlinked and what we've got to do is get pressure off the health systems because that's been what the real drag on economies has been.

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In the course of doing that we'll save lives and we can do that, again, as Mariangela mentioned, by vaccinating a proportion of the global population together much more effectively than if we were to try to do pockets of it completely, one at a time.

It's been encouraging and just striking how many countries are doing deals. On the other hand, remember, as countries are making deals with the rest they're sending very loud messages that they want these vaccines and manufacturers have a whole new confidence that they need to expand their capacities, they need to produce more of these products, produce more of it at risk.

So the key thing at this point is, how do we harness all of those investments into a global solution and that's what the Director-General was speaking about. It's the time now that we've got hard evidence that the best solution is to roll this out simultaneously globally.

Every economy is interlinked today. It just will not work otherwise and as we move toward that now it's trying to work out the nuts and bolts; if you've bought a lot of vaccine over there how do we work with you to make sure that that can be part of a global solution. That's really where we are.

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Remember, we have some time to sort this out. We hear a lot of panic about buying and deals, etc, but we have a couple of months to work together as a global community to find a solution to this so we roll these out in the way that's going to be most effective.

So a global solution where we're all pooling our risks, pooling our procurement would be the ideal. If we do separate deals then it is how do we co-ordinate these so that we don't prejudice any part of the world in a way that's ultimately going to be detrimental to everyone, even those who work to try and vaccinate their own populations completely first.

Perhaps I'll leave it at that but, Mariangela, you've been a big piece of this work. Anything to add?

MS I think the fact that if you are betting on one or two candidates - we have about 200 vaccine candidates at the moment so what's your best bet? We don't have any of the vaccine candidates which has finished the clinical trials yet so we don't know which one will actually prove to be safe and effective.

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So we are encouraging countries to join a global facility because we will have access to more candidates and you have a better chance to actually have concrete access to be able to produce one of the successful candidates. I think this is the main issue.

BA Sorry. I'm just going to come back on it for one second because again the Director-General in his comments mentioned some numbers that are so staggering; \$10 trillion in global fiscal stimulus financing to deal with the consequences of this disease, not even the causes and the kind of numbers that we're talking about to try to roll out a global solution are a fraction of that.

So again coming to the points that we were discussing earlier, countries are recognising that. They're recognising that if we don't get a global solution there're going to be waves of fiscal stimulus financing needed to try and get out of this crisis, similar to what happened with the global financial crisis and that's a situation that nobody wants to be in.

So I think all of these factors are coming together. I'm sorry, I can't remember the name of who asked the question; I apologise but it's a fantastic question. We have an opportunity, we have a window and so now it's aligning all of these deals so that they roll out with the right timing.

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It's not who bought the vaccine almost; it's how they use that vaccine in a globally co-ordinated manner for a global solution to a global crisis.

MH Thank you so much, Dr Aylward and Dr Simao for those fantastic answers. We're really running out of time. For the last question we go to North Africa, to Morocco. The question is from Ulhassan Abdela from Moroccan news. Ulhassan, please unmute yourself and ask your question.

TR Thank you for giving me the floor. I'd like to ask about the number of cases in Morocco., where more than 1,400 cases are registered every day or even more since the implementation of policies in the country. How can you explain these numbers in Morocco? Thank you.

MH Thank you. Shukran. I think this question will be for Dr Ryan. Yes. Your question was about the number of cases and what the country should be doing about it.

MR Yes, we're just trying to get the exact numbers - sorry, forgive me - from Morocco. Maria, you can start.

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MK According to our data as of yesterday 35,195 cases; almost 8,000 new cases in the last week.

TAG The number of deaths, I think, is 556. I think if our see the situation, it's not the number of case but the trend is on the increase, both in the number of cases and of deaths so I think Morocco should do more especially to reverse the increasing trend that we're seeing.

Compared to many countries actually if you see the number of deaths it's low but with an increasing trend. If it continues to increase it may get serious so our advice is with the increasing trend to be more aggressive in the interventions that they take, tailored of course to the COVID situation at subnational levels and below.

Tailored action can be taken in areas where there is more contribution of cases because we don't think that the situation is very even throughout the country so they can focus where the concentration of cases is and where especially the new cases are coming from.

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But the week of August 3rd is the highest since the outbreak started in terms of number of cases, which is almost close to 7,000 in a week which is the highest number of cases reported.

MR If we can supplement as well, while the numbers for example across the Eastern Mediterranean, North Africa and the

Middle East, numbers in places like Saudi Arabia, Pakistan and others are falling and in the Gulf countries.

We've certainly seen rapid increases in Morocco; in Lebanon now unfortunately and that's a big concern in the aftermath of the explosion there, the rising number of cases in Lebanon and the stress that the health system is under.

But similarly in Syria and Iraq and of note in the last 24 hours Iraq has the most new cases reported from the Eastern Mediterranean region. I believe that's the first time Iraq has had the top number of cases for that region so I think we're seeing a very dynamic situation in the region.

Morocco's also had some previous issues of clusters of infections in prisons and other places and again it shows the difficulty. When you get clusters established in certain areas and certain groups you may end up with those clusters extending into full-blown community transmission.

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Morocco's not alone in North Africa or in the Eastern Mediterranean with an increasing trend of cases and, as the DG says, every country now needs to double down, examine what it's doing, where it's doing it at national and subnational level and effectively use the tools that we do have.

If you go back over the last number of months actually Morocco had a very, very low level of disease right the way through the really parts of this pandemic so there's no question that Morocco has the capacity to do that. Every country has had to contend with flare-ups, every country has had to contend with this disease bouncing back.

The question is not does the disease bounce back. The disease bounces back, it happens. It's a virus, it exploits weaknesses and gaps in our system. The real test is how do we react, how do we respond as a government, as a society and as individuals to that reality.

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I think that's what we would ask each country to do; don't lose hope when the disease bounces back, don't blame others, take action. If everyone takes action together in response to a jump in disease then the disease will go away, it'll be pushed away.

I think in too many countries we tend to look for scapegoats; whose fault is it that the disease is back, who made a mistake? In

an emergency response there's no time for that. It's a time for action. When the emergency is over you sit down and then you say, okay, who did what, who was slow, who was fast?

During an emergency we need everyone to act together and act quickly and I think Morocco has demonstrated right the way through this pandemic its capacity to keep disease at a low level. Morocco needs to get back there again, with many other countries who are in a very similar situation.

BA Thanks. Just to Mike's point, this really comes back to what Kai asked earlier about this levelling of virus that we're seeing globally. What we're actually seeing - and as Mike talks about all the time - is two factors. The first is the scale of the susceptibility in the world.

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The vast majority of the population in the world is susceptible to this disease.

The second thing that we're seeing is the stringency of application of control measure is dropping. People are coming closer together, as Maria's been talking about; masks aren't being used always the way that they should, etc.

So any levelling of the disease that we're looking at is just lulling you into a sense of false security because this disease, as Mike's been emphasising, has lots of space to still cause trouble. When it does level, Kai, we have to take advantage of that opportunity to really get the testing in place, get the isolation capacity in place, get the contact tracing and quarantining working.

Because the vaccines are not going to be here tomorrow but the virus is here today which means we've got to use the tools we have today or we're going to see these flares just as our caller from Morocco emphasised. But there's so much to be done long before we have a vaccine.

MH Thank you so much. On that important note of hope and action I will close the press conference. Remember we will post the audio files and we will also post a copy of the Director-General's speech. Now I will hand very to the DG, Dr Tedros, for final words.

TAG Thank you so much. Thank you to those who have joined today and see you on Monday for our next presser. Thank you.

01:01:09