COVID-19

Virtual Press conference

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00:01:10

MH Hello, everybody. This is Margareta Harris in Geneva on this Tuesday, August 18th, welcoming you to today's World Health Organization press briefing on COVID-19. We have with us as always in the room the WHO Director-General, Dr Tedros, along with Dr Mariangela Simao, our Assistant Director-General for access to medicines and health products, Dr Maria Van Kerkhove, Technical Lead for COVID-19, Dr Bruce Aylward, Senior Advisor to the Director-General, who's leading the work to accelerate access to tools to beat COVID, the ACT Accelerator, and also Mr Paul

Molinaro, our Logistician-in-Chief or officially Chief, Operations, Support and Logistics. Joining us remotely will also be Dr Mike Ryan, Executive Director of our Emergencies Programme.

As usual we are translating this simultaneously into the six official UN languages plus Portuguese and Hindi and remember that under the Zoom system you need to go to the Korean button to use Arabic. Now without further delay I will hand over to Dr Tedros. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Margareta. Good morning, good afternoon and good evening. I want to start by paying tribute to Professor Peter Byass, who passed away suddenly on Sunday. Peter was the former Director of the Centre for Global Health Research at Umeå University in Sweden and the Chief Editor of Global Health Action. He was a committed and talented servant of global health who helped many people shine around the world.

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He was also my dear friend and mentor. I have worked with him, learned from him and laughed with him. He will be much missed. My thoughts are with his family and loved ones at this time.

Our last media briefing focused on the world's progress in developing new diagnostic tests, therapeutics and vaccines. Today I'm going to outline some of the key logistical hurdles we have faced in the last eight months shipping life-saving medical equipment around the world.

The lessons learned from the distribution of these supplies will be important as we look to ensure that our supply chains and systems are honed for future breakthroughs from the ACT Accelerator.

Learning from past experience and challenges is key to improving the current pandemic response to this and future outbreaks. Every new disease outbreak presents new challenges but from a logistics perspective COVID-19 has been one of the toughest challenges we have ever faced because this respiratory disease passes relatively easily between people.

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When this outbreak started there was an urgent need to get advice, information, training and equipment to front-line workers. On 5th January, days after a cluster of unknown pneumonia was identified in Wuhan, China, WHO shared detailed information on the cases with the world and advised all countries and

emergency contact points to take precautions to reduce the risk of severe acute respiratory infections.

Between 10th and 12th January WHO published a package of guidance documents for countries. This covered topics related to the management of an outbreak of a new disease including finding and testing for the disease, caring for patients and infection prevention and control measures to protect healthcare workers.

By the second week of January China had mapped the genome and shared it with WHO and with the wider world. We rapidly published a how-to on building a PCR test for COVID-19 from our partner lab in Germany.

In the third week WHO identified and began contracting for validated production of these tests. By the first week of February we began shipping tests to over 150 labs around the world, which enabled the countries to quickly identify, track and trace the virus.

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As this was happening and outbreaks started to spread in other countries there was a huge surge in demand for personal protective equipment such as medical masks, gowns, gloves and face protection. Manufacturers in several key countries were under so-called lock-down and there was a collapse in air transport, which is imperative for sending supplies around the world.

Some countries put in place export restrictions and there were several instances of requisitioning key medical supplies for national use. Supply nationalism exacerbated the problem and contributed to the total failure of the global supply chain.

For a period of time some countries were without key supplies such as key items for health workers who were dealing with surging cases of COVID-19 and many countries still do not have enough.

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To boost manufacturing and ensure that supply chains began to function early on in the outbreak WHO convened regular meetings with key companies and industry groups. WHO worked closely with the World Food Programme and quickly utilised nine new and existing logistics hubs to establish a solid supply chain to deliver life-saving PPE and medical supplies around the world.

WHO worked with partners like UNICEF, the Bill and Melinda Gates Foundation, Jack Ma Foundation and Alibaba Foundation to purchase and deliver hundreds of millions of pieces of protective equipment for health workers.

The partners' platform created at the end of January has become a critical tool to help countries highlight financial, supply and personal needs and deliver the necessary public health response. WHO worked to unblock bottlenecks by working with public and private partners to increase supplies within the market.

So what are the lessons? While there is a wish amongst leaders to protect their own people first the response to this pandemic has to be collective. This is not charity. We have learned the hard way that the fastest way to end this pandemic and to reopen economies is to start by protecting the highest-risk populations everywhere rather than the entire populations of just some countries.

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Sharing finite supplies strategically and globally is actually in each country's national interest. No-one is safe until everyone is safe. No one country has access to research and development, manufacturing and all the supply chain for all essential medicines and materials and if we can work together we can ensure that all essential workers are protected and proven treatments like dexamethasone are available to those who need them.

With PPE and tests a collaboration between the public and private sectors meant supply was increased in order to support fair and equitable use of scarce products.

As new diagnostics, medicines and vaccines come through the pipeline it's critical that countries don't repeat the same mistakes. We need to prevent vaccine nationalism and for this reason WHO is working with governments and the private sector to both accelerate the science through the ACT accelerator and ensure that new innovations are available to everyone everywhere, starting with those at highest risk.

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Since May WHO has been in extensive consultations to develop a new framework to guide fair and equitable access to diagnostics, therapeutics and vaccines for COVID-19 across all countries. These cross-cutting principles are key to the promotion of equitable access and fair allocation of these essential health products for the greatest impact globally.

For example once a successful vaccine has been identified WHO's strategic advisory group will provide recommendations for their [sic] appropriate and fair use. The allocation of vaccines is proposed to be rolled out in two phases. In phase one dose will be allocated proportionally to all participating countries simultaneously to reduce overall risk.

In phase two consideration will be given to countries in relation to threat and vulnerability. Front-line workers in health and social care settings are prioritised as they are essential to treat and protect the population and come in close contact with high-mortality-risk groups.

Initial data has shown that adults over 65 years old and those with certain comorbidities are at the highest risk of dying from COVID-19. For most countries a phase-one allocation that builds up to 20% of the population would cover most of the at-risk groups.

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If we don't protect these highest-risk people from the virus everywhere and at the same time we can't stabilise health systems and rebuild the global economy... This is what the first crucial phase of the vaccine allocation mechanism aims to do.

We are all so interconnected. As a small example vaccine developed in one country may need to be filled in vials with stoppers that are produced in another using materials for the high-grade glass that are only available from yet another country.

We will need to quickly manufacture billions of doses to reach all those who need the vaccine, which means hundreds of millions of glass vials and ways to transport them effectively. All this means elite planning at the highest level is needed right now to prepare to vaccinate and treat the world as new technologies come down the pipeline.

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As we accelerate the science solidarity is needed to provide a joint solution to the pandemic. The COVAX global vaccines facility is the critical mechanism for joint procurement and pooling risk across multiple vaccines, which is why today I sent a letter to every member state encouraging them to join the COVAX facility.

Like an orchestra we need all instruments to be played in harmony to create music that everyone enjoys. One or two

instruments playing by themselves just wouldn't suffice when the world is waiting and listening intently.

We will work to bring the band together, to promote science, solutions and solidarity because we believe to our core that we do it best when we do it together. I thank you.

MH Thank you, Dr Tedros. I will now open the floor to questions from the press online but I'd remind you first that if you wish to ask a question you need to raise your hand. I'll also ask you to keep your questions to one. You may ask your question in any of the six UN languages plus Portuguese because we have simultaneous translation. We are restricting this briefing to under an hour as usual so, as I said before, please restrict yourself to one question.

00:15:53

For the first question because we've got this press conference earlier we've got people joining us from really all around the world. We have a question from Australia so I'll ask Jason Gayle of Bloomberg to please unmute yourself and ask your question, Jason.

Jason, can you hear us?

JA I just unmuted myself. Can you hear me now?

MH Very well. Please go ahead and ask your question.

JA As the northern hemisphere enters autumn what can we predict might happen with influenza and other respiratory infections this winter based on what was observed in the southern hemisphere?

What do we know about SARS-CoV2 coinfection? Is it a worse prognosis?

MK thank you, Jason, for the question. I'll begin. It's a good question that you have about the circulation of influenza virus in the southern hemisphere and what we may expect from the northern hemisphere.

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As I'm sure you know, we have what is called the global influenza surveillance and response system which is GISRS, which is a system which has been in place for more than 70 years which utilises laboratories and respiratory disease surveillance systems across the globe to collect samples from people who have

influenza-like illness or severe acute respiratory illness to test for viruses like flu.

That system was used for COVID-19 which is really quite incredible, which really facilitated the world to be able to quickly test for COVID-19. What we know is that countries are using the GISRS system right now for influenza and for COVID-19 and there are many countries that are continuing to test for influenza.

In the last two-week period where we have the reporting period from July 20th to 2nd August almost 300,000 specimens for influenza were tested and only 37 were positive for influenza. This comes across a large number of countries that are looking for influenza and so it seems flu circulation is low.

There may be a number of reasons for this, particularly in the southern hemisphere where they're having their winter flu season. Many of the physical distancing and public health and social measures that have been put in place which keep people apart may have played a role in reducing circulation of influenza.

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I think we need to be careful about making an assessment of what may happen in the northern hemisphere for a number of reasons. First of all we need to continue to test for influenza all across the globe so the systems that are in place that are testing for COVID must continue to test for flu. That's first and foremost.

Secondly we do have a vaccine for influenza and so it's important that people get vaccinated against influenza when that vaccine becomes available. That's really important because it will be quite difficult if somebody is infected with either COVID or flu and they have either a flu-like illness or cold-like symptoms; we won't be able to distinguish immediately between whether somebody has flu or has COVID. We will need testing to be able to do that.

So it could complicate the clinical picture but there are tools that are in place for influenza and so it is really, really important that when the vaccine becomes available for flu people do take that vaccine.

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MH Please go ahead, Dr Aylward.

BA Thanks, Margaret. Jason, just to reinforce the importance of the issue that you raise with respect to flu and COVID, last year, as Maria mentioned, COVID hit the northern hemisphere in most places as we were coming out of the flu season.

This is extremely important because as you look at the massive expansion that had to happen in critical care capacities in the northern hemisphere in particular, in a lot of the countries and areas that we were working with when you asked a hospital, how did you expand from 30 beds to 45 or 30 to 50 or whatever the answer often was, because we had that additional surge capacity for flu.

So a lot of the surge capacity that we relied on to be able to manage the critically sick patients last year, certainly initially, came from that surge capacity and that highlights the reason that it's so important to get the flu vaccination rates up this year even relative to previous years, as Maria emphasised, because we need that capacity potentially to manage COVID also this year, again as we spoke about in our last presser.

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We have a huge susceptibility gap still against this disease, COVID. We're going into a high season for transmission of respiratory illnesses and hence our concern that we have all possible capacities optimised to be able to manage that. Part of this is going to be managing flu and ensuring optimal flu vaccination, as Maria mentioned.

MH Thank you very much, Drs Van Kerkhove and Aylward. The next question comes from closer to home. It's from Nina from Agence France Press. Nina, please unmute yourself and go ahead.

NI Thank you. Can you hear me?

MH Very well. Please go ahead.

NI Thanks a lot. I was wondering; I saw that there were some reports out earlier this week that suggested that so-called herd immunity against COVID-19 could become effective with just around 50% of people immune, as opposed to 70 or 80% as thought previously.

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Is this something that you're looking at and do you have a better idea of whether contracting the disease could provide the wanted immunity or if it would mean that 50% of the world's population would have to receive a vaccine to reach that? Thank you.

MK Thanks for this question. I will begin. Normally when we talk about herd immunity we talk about the use of a vaccine and how many people need to be vaccinated to be able to reach the

right proportion so the virus will not have an opportunity to circulate between people.

What we are learning about immunity, what we're learning about antibodies comes from seroepidemiology studies. There are a large number of seroepidemiology studies specifically for SARS-CoV2 that are occurring right now globally, more than 100 right now.

We are working with at least 50 countries right now to carry out studies on seroepidemiology so that we use a standardised approach across these different countries. Most of the studies that have been conducted so far; they've used a variety of methods, they've used a variety of antibody tests so there are limitations in terms of...

I don't want to over-generalise but what we've learned from the studies available to date is that less than 10% of the population has evidence of antibodies against SARS-CoV2 virus.

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So what we really want to know is if people have these neutralising antibodies which are collected using a specific type of antibody test. Not all studies are actually looking for neutralising antibodies.

There are some higher seroprevalence rates among some front-line workers of higher risk groups so for example healthcare workers or some front-line workers who have been directly exposed to the virus; some areas with intense transmission and those seropositivity rates go around 20%, 25%.

But again that means that a large proportion of the population remains susceptible. There are some suggestions of what that level of herd immunity needs to reach. A lot of these are done through modelling projections.

That is quite helpful but what we are looking at right now are the results of the seroepidemiology studies that are being conducted and these tell us consistently across all regions that a large proportion of the population remains susceptible to infection and that means the virus has an opportunity to spread.

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This is why we emphasise so much that we have a responsibility ourselves to prevent ourselves from getting infected and if we are infected to prevent that virus from passing to others, which is

why we focus on the case finding, the contact tracing, isolating of cases, quarantining of contacts.

Having said that, just lastly to say, when somebody is infected with this virus we expect that they develop an immune response. What we are learning right now is how strong that response is and for how long that response will last. We do not have a complete picture of this yet but we do expect that if people are infected - and there may be some differences if they have a mild disease or even if they're asymptomatic versus if they have a severe disease - they do mount an immune response.

What we don't know is how strong that is and for how long that will last but those studies are currently underway.

IV I've got two interventions; Dr Mike Ryan remotely and then Dr Bruce Aylward. Dr Mike Ryan, please go ahead.

00:25:19

MR Hi, Margaret. Can you hear me?

MH Very well. We can see you too.

MR Great. Just to follow up on Maria, I think the issue here is that transmission and susceptibility are very different in very different countries; different people transmitting, different people susceptible.

The fact is that we don't know where this much-mooted herd immunity lies; the level of immunity in the population that by itself suppresses transmission because there aren't enough people susceptible available.

The question is - there is no question in my mind; we're a long way from that and will remain a long way from that in the absence of an effective vaccine. It may be lower than was previously suggested at 60, 70, 80%. We don't know how much lower, we don't know what role cell-based immunity and other things play in the disease and we certainly don't know how long protection lasts.

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So yes, there's a lot up in the air, there's a lot to be discussed, there's a lot to be worked out between the scientists but I think what we can say with certainty is right now as a planet, as a global population we are nowhere close to the levels of immunity required to stop this disease transmitting.

We need to focus on what we can actually do now to suppress transmission and not live in hope of herd immunity being our salvation. Right now that is not a solution and it's not a solution we should be looking to for our salvation.

MH Thank you, Dr Ryan. Now Dr Aylward has got some more to add.

BA Yes, sorry, Margaret. I think Mike already captured it because there are two parts of this question, as we're alluding to; what level of herd immunity? We're dealing with a respiratory-borne pathogen which is relentlessly seeking out the susceptible. That's what we're seeing, which means you want very high herd immunity.

We're also human so when we hear a range of 50% to 80% we think, gosh, I hope it's 50%. But in a situation like this where we locked down half the world's population, where the economies ground to a halt in so many places you have to plan for very high levels of herd immunity because we don't want to take chances, we don't want to be wrong.

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So as we're planning vaccination, as we're planning the roll-out you want to plan to get high coverage and not get lulled into a dangerously seductive suggestion that it could be low.

The other part of that question was about if we get 50% vaccination coverage are we there. No, this is another point we need to be very clear on; we can't confuse vaccination coverage with the proportion of the population that's immune because vaccine may work in 80% of people, 50, 60% of people so you have to multiply your coverage times the efficacy to figure out what proportion is going to be actually protected.

So if we only get 50% coverage the number that are actually protected will be even lower, which means we're nowhere near what it would take to protect populations in general.

The last point I'd make was the one we discussed last week and Mike keeps hammering it; you need the full package. There aren't silver bullets. You're dealing with a nefarious enemy here. You want to have your diagnostics, your testing, your quarantining; you want to have your therapeutics as well as your vaccine.

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That's why the Director-General launched and was talking about the ACT Accelerator so much. It's about getting all of these tools to scale so that we can actually tackle this thing properly and get back to the new normal we need to keep our societies functioning and our economies open and our health systems safe.

MH Thank you very much for all those answers, Drs Van Kerkhove, Ryan and Aylward. We're now moving to Azerbaijan for our next question which is coming from Kamran Kasimov of Real TV, Azerbaijan. Kamran, can you unmute yourself and ask your question.

KA Can you hear me?

MH Yes, we can. Please go ahead.

KA Okay. Greetings from Azerbaijan, from Real TV. I have a question about the education system because some countries - also Azerbaijan - are discussing the new school season of course. There have been many points about the reduction of lesson hours and we need an official position from WHO. Maybe you have new rules or suggestions about the new school season because, I repeat, many countries - also Azerbaijan - are preparing for the school season. Please.

00:30:09

MK Thank you so much for this really important question. It's a question we get quite often around the opening and closing of schools. WHO has issued guidance around the considerations of opening schools, closing schools, full closure, partial closure in the context of this pandemic.

What is really, really important is that we understand that schools understand in communities, schools are not in isolation so if the virus is circulating in communities, if the virus is circulating around that school, where the children live, where the people who work at that school live there's a possibility that the virus can enter the school system.

So what we have done is we have outlined a number of considerations for schools to take into account for the safe reopening of schools. Everybody recognises globally the importance of schools for children, not only for education but for security, for food, for social interaction, for protection so it's really important that we open schools safely but it needs to be done in the context of the wider circulation of the virus.

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So what we've done is we've outlined a number of considerations for the decision-makers to take which outlines what is the circulation of the virus around that school, what is the setting like of the school itself.

Not all schools operate the same way. There are different physical structures of the buildings themselves, there're different age groups that are part of the buildings where the children go. What are the policies, the resources, the infrastructure that is in place to ensure that you can continue to do physical distancing and that children have access to running water, they have the ability to wash their hands or use an alcohol-based rub and ensure that school can continue safely?

We have a number of... guidance that's out there that looks at hygiene and environmental cleaning within schools, that looks at screening within the school itself. So is there a system in place to rapidly detect a case in that school if it occurs in a child or among the staff themselves and then what is the plan?

In addition to that to outline considerations around communication so not only talking to the people who work at that school; talking to the children themselves, listening to the children themselves about how they can go back to school safely and the parents of those children, to weigh the concerns of the parents.

There are a number of considerations that need to be taken into account but again just to reiterate that these schools do not operate in isolation, that they are part of the communities so if the virus is circulating in the communities there's a possibility of that virus entering the school itself.

MH Thank you very much, Dr Maria Van Kerkhove. For the next question we're going to Spain, to Oriol from El Pais. Oriol, can you unmute yourself and ask your question.

TR Good afternoon. Can you hear me? I have a question from Spain. And in the European Union generally countries have responded with restrictions on the movement of people, with quarantines and with instructions not to travel. I'd like to know what your reaction is to those measures.

MH I think this one's one for Maria to start with.

00:33:50

MK Yes. Thanks again for the question about... We are seeing a large number of countries opening up their societies and part of

opening up their society includes travel, includes the ability for people to travel.

We have recently issued guidance similar to what I've just mentioned about the schools. These are about considerations for travel and how this can be done safely. It's not just the act of travel itself. It starts from when you leave home and if you are feeling unwell you shouldn't be travelling; if you are a case you should be in isolation; if you are a contact of a case you should be in quarantine and therefore not travelling.

But when travel is able to open up what are the considerations countries need to take? Some of this has to do with looking at the risk of circulation where you're travelling from to where you're travelling to.

Some countries have adopted measures of looking at these safe corridors of travelling between this country and that country, meaning that the risk of exposure or the risk of transmission is the same in each of these countries.

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But again it's more about considerations. There's no one-size-fits-all here. Because the virus is circulating at different intensity across different countries as an organisation it's very difficult for us to be very prescriptive.

So what we've done is we've outlined these considerations for the decision-makers to take when they're looking at travel; who should travel, how this should be done. It is important that if travel is taking place that essential workers need to get where they need to get, that supplies need to go across the country.

The Director-General has highlighted many, many times challenges in getting supplies across the globe because flights have not been able to take off and we're still seeing issues with this. We're still seeing issues with getting supplies to the countries where they need to go.

So again it's more about the considerations as opposed to being very prescriptive about, if this happens then you can do this.

MH Got something to add.

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BA Maybe just to add a point on that area where you ask our position as the World Health Organization on this. Our position is, you need to know who is infected with this disease, you need to

ensure those people are isolated and you need to ensure their contacts are identified and quarantined.

The reason countries are putting travel restrictions, etc, in place is because they don't know that and they're not able to manage the risks and they're not able to understand the risks. When we get to the position where we can really test at the levels we have to, know who's infected, those people are really being isolated so they can't infect others and their contacts; if those people aren't travelling then the virus isn't going to travel.

This all comes back again to extraordinary measures that are being implemented in the absence often of our ability to do the basic public health measures that are so fundamental to getting this thing under control.

So when you have a flare is that the first thing you need to do? The first thing you need to do; test, isolate, trace the contacts, make sure those folk aren't moving. That's why we quarantine and that's why we isolate them and then virus transmission stops.

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So again everything comes back to the fundamentals of managing this disease.

MH Thank you very much, Dr Aylward and Dr Van Kerkhove. The next question we have comes from Pakistan - we're really moving around the globe today - and it's from Niha. Niha, can you unmute yourself and ask your question.

NH Hi. Recently South Korea detected a genetically mutated COVID-19 virus in cases imported from Pakistan and Uzbekistan. What can you tell us about the mutation and is there any evidence that these mutations are the reason behind low mortality rates in both these countries? Thank you.

MK Thanks for this question. I'll begin. You highlight one article that's looking at mutations in this SARS-CoV2 virus. I want to give you a more general answer to this because there are a lot of people globally who are looking at sequences of this virus and looking at changes in the virus or mutations.

More than 75,000 full genome sequences are available publicly and globally, coming from countries all over the world who are sharing these viruses so that's wonderful and we need that to continue to happen.

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What we have done as an organisation is we have utilised and harnessed the expertise of laboratorians and virologists and people who study specifically coronaviruses and specifically study mutations and changes and what that means to work with us to help us disentangle what all of this means.

An article saying that there's a new mutation can sound quite scary but these changes in these viruses happen all the time. There is a change in this D614G mutation that is something that has been circulating since February, it was first identified in February and this is the predominant strain that is circulating in Europe and in North America and it's come back into Asia again.

What is important is that we're tracking these viruses and that these viruses are being shared. What we're doing with a special working group that has recently been formed - we had been discussing this in January but we specifically formed a research group to look at each of these changes, each of these mutations to say which one is important, which one means that the virus could potentially behave differently and then how do we study that.

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So it isn't just identifying that there is a change; it's actually looking to see, does this mean that the virus is behaving differently. Those are very important studies that need to be done.

In terms of mortality, in terms of the differences that we've seen in mortality across countries I think we've answered this question or we've had this question many times. There are many different reasons why we see differences in mortality across countries. It's quite dangerous to compare the crude case fatality rate across countries.

Some of this has to do with the people that are infected in the country and in South Korea, particularly in the beginning, many of the people who were infected were quite young and therefore didn't have as many underlying conditions or progress to severe disease or death.

So there're a number of reasons why we are seeing differences in mortality across the globe.

MH Thank you very much, Dr Van Kerkhove. The next question comes from Stephanie, the Reuters correspondent, Stephanie Nebahe. Please unmute yourself and ask your question, Stephanie.

00:40:43

ST Hi, thank you very much. I wondered if perhaps Dr Tedros could comment on this photo that has been circulating today on social media and so forth from Wuhan, China, of people partying in very close proximity in a pool and what concerns you may have about that, particularly ahead of the upcoming WHO mission to China, which may include a visit to Wuhan. Thank you very much.

MK Stephanie, thanks for the question. I will begin. I did see the picture that you are referring to but I would like to point out that I have seen almost exactly that same picture in probably every country globally right now.

So I think the point is that we need to ensure that everybody knows the... We want everybody to take a risk-based approach for themselves, to understand what is the risk themselves. We shouldn't be blaming people or putting people at fault for wanting to live their lives. We all want to be living our lives, we all want to get back to what - quote, unquote - normal used to be.

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But I think we just need to make sure that the messages that are getting out, particularly to young people, particularly to children and young adults that you are not invincible to this virus... That's not meant to scare people but it's meant to say that you can get infected and we are seeing people, even young people, who are ending up with severe disease.

We are seeing young people who are ending up in ICU and we are seeing young people who are dying from this virus. So it's very important that you not only protect yourself from getting infected and you prevent yourself from dying.

The decisions that you are making, everyone on this planet; the decisions that you are making are protecting yourself. Your life depends on this and not only that; even if you do get infected and you don't have a severe disease you could pass that virus to somebody else who's part of a vulnerable population.

Many of us live with older people, many of us live with people who have underlying conditions and if we pass that virus to somebody else who has an underlying condition they could develop severe disease and they can die.

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So it's possible for us to keep circulating that virus so I think what is really important is that everybody understands what their risk is and if it's possible to avoid these crowded places please do so. There are good messages out there. We need to make sure that they reach the right people without scolding people but make people feel empowered.

How do I still remain social, how do I still see my friends but still protect myself? It's a responsibility and accountability that all of us have as this pandemic continues.

MH Thank you very much, Dr Van Kerkhove. We now have a question from Ilgin from BBC Turkish service. Ilgin, please unmute yourself and ask your question.

IL Hello, thank you. My question is about Turkey. Turkey has initially applied a mixed approach, locking down certain age groups like over-55s and under-20s or locking down on the weekends but opening up during the week.

When you view the situation from Geneva how do Turkey's scorecard and its strategy look? I'm talking about the strategy for governments to provide treatment if somebody gets infected or offer a vaccination when it becomes available, but to say that if you're infected it's on you; in other words leaving the responsibility to protect oneself completely on the individual. Is this a viable strategy? Thank you.

00:44:29

MK Thanks. I will begin. I can't specifically speak to Turkey although I'm looking at the numbers and it appears as though transmission has been reduced to quite a low level so that is good.

I think one of the things I just want to mention is, you mentioned the individual responsibility, as I just mentioned in my previous answers. Individuals have a responsibility, absolutely; families have a responsibility, communities have a responsibility, governments have a responsibility.

It isn't just at the individual level, although the individual level's incredibly important because the decisions we make - and if we could reduce our exposure, if we can reduce the possibility of us getting infected that's the start.

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But governments also have a responsibility to put in place responsible, constructive, cohesive, clear national plans that look

at this all-of-government, all-of-society approach, which focuses on the fundamentals; active case finding, isolating cases, caring for cases, making sure that they have appropriate care in medical facilities or if they can be managed at home make sure that they're managed at home safely so that they don't pass the virus to others.

Making sure contact tracing is being conducted consistently and comprehensively and that contacts are quarantined so that they don't have the possibility to pass it to someone else if they are infected themselves.

To make sure that there's clinical care, appropriate care for individuals depending on the severity of their symptoms and this includes symptomatic treatment, it includes oxygen and respiratory support; dexamethasone if they develop critical or severe disease, for the most severe patients.

Making sure that our health workers are trained and protected and so that when they care for patients that they're not unduly exposing themselves to infection; and a number of other things.

So what Turkey has done and what other countries have done, taking this approach, tailoring it to the needs of the country, the capacities of the country and being consistent in this application of these measures is really what is critical.

00:46:38

As the pandemic evolves there may be situations where the virus could resurge and so the system that has been put in place for COVID, that is build on existing systems, needs to really act quickly so that any of these clusters can be brought under control.

MH We lost connection with Dr Ryan. Dr Aylward, did you want to add nothing [sic]? We lost connection with Dr Ryan but he's back now. Dr Ryan, would you like to add to that?

MR Hi, Margaret. No. I think, as I missed a good piece of the interaction, I'll reserve speaking at this time.

MH Thank you very much. The next question; we'll be going down south, down to South Africa to Tamar, Business Day, South Africa. Tamar, can you unmute yourself and ask your question.

00:47:33

TA Hi. I think this is a question to the Director-General, Dr Tedros. Could you please give us a sense of how many member

states have already signed up to COVAX and whether South Africa is among them?

Linked to that could you perhaps comment on what might be deterring or holding up the sign-up of more countries?

BA Thank you very much, Tamar, especially for raising the issue of the importance of COVAX. For the others on the line who may not be familiar, of course that's shorthand for what is the actase [?] coronavirus - or COVID, pardon me - globally vaccines facility.

This is a global solution that has been developed to try and ensure as many countries as possible can pool the risks of development of COVID vaccines. As everyone on this call knows, there're many, many vaccine candidates. Many of them are in trials built on many different platforms in different parts of the world. We simply don't know yet which ones are truly going to protect people against the disease.

So a key goal of this platform or this facility is to have as many countries as possible co-operate together to be able to pool the development risks, working with manufacturers and others, to pool the investments and then to pool the procurement and allocation of that product.

00:49:05

Because, as Dr Tedros said in his opening comments, one of the things we've learned a very hard way in this crisis is that we can't get out of it alone in terms of the protection of our health systems, our economies, our societies. We have got to get the highest-risk parts of the world vaccinated at the same time, roll that out from the highest-risk populations globally. That's going to be the most effective way to do that.

You can only do that or most effectively when you have a global solution, a global facility like the COVAX facility so this global vaccines facility; there are two groups of countries in it. There're 92 countries which are a combination of the usual countries that work with GAVI, the global vaccines alliance, and other countries that may need assistance so there're 92 of those.

Then there are a group of what we call fully-self-financing countries and there're 80 countries that have expressed an interest so we have a huge number of countries that are engaged right now in discussions about the global COVAX facility.

00:50:12

The total, as I said, now is over 170 and that represents about 70% of the world's population. You asked how many have actually signed up specifically. Right now we're still in the process of design. What we call the agreement terms which a country would sign to join the facility are just being finalised.

We are looking for a firm indication from countries by 31st August so that'll be the time frame when we'll be able, Tamar, to give you a better indication of who has expressed an interest versus who has actually signed on.

In addition to those 170 countries one of the questions we've had since last week is what about all the other countries. As people know, the European Union is working toward a solution for the European countries and some other countries are as well.

One of the other substantive developments over the past week has been a much closer working relationship with these to try and make sure we can all join forces together to ensure the most collaboration possible in the roll-out of vaccines.

Because again, as the Director-General said, the key is not ensuring all people in some countries get vaccinated; that's not the solution. The solution is some countries - some populations, the highest-risk populations in all countries. That is the fastest way to bring severe disease down, save lives, get health systems safe and robust again and then get our societies fully functioning and our economies working.

00:51:51

It's the self-interest of everyone to co-operate together and the facility is a key piece of that.

MH Thank you, Dr Aylward. The next question comes from Sarah Wheaten from Politico. Sarah, can you unmute yourself and ask your question.

SA Yes, thank you. I apologise for the construction noise that may be in the background coming from me. Also following up on COVAX, I would request an answer to my colleague's question about what resistance you may be hearing from countries that have not expressed interest yet and also any more details from what Dr Aylward just mentioned on collaboration with efforts such as that of the European Commission and if you are starting to see some collaboration, if not full-fledged joining, from the United States and China. Thank you.

00:52:57

BA Thank you very much. As I think Mike, Maria and Dr Tedros have said, we're all a little sleep-deprived and don't always hear the full question so apologies if we miss a piece and please do come back like that.

In terms of the challenges to joining the COVAX facility this is brand-new and a lot of it is still under design. The question was asked about resistance to joining. We're not twisting arms for people to join the facility. This is in the interests of countries, to pool their risk, to reduce the risk of an individual country and then be able to get the best possible prices and guarantee the receipt of this.

For many countries though, remember, this requires legislation in some countries to be able to work with a facility like this. In other countries they have to figure out, what are the actual costs going to be and what part of our balance sheet do we use and how do we do that.

Other countries have pursued bilateral deals, again as you're aware and you referred to those and so they want to know, how would we handle those within the facility. A number of these details are still being worked out.

00:54:07

I think the fantastic news is that no matter what the challenge there are potential solutions to all of them. What we've found - and credit here to the Director-General, who's led a lot of these conversations.

When we hit the big challenges such as, of course - and I think you referred to it - the EU and some other countries setting up some bilateral deals, the big issue is, how do we make sure that those deals work in collaboration with the global COVAX facility so that we can roll this out to the entire world at the same time to cover the highest-risk populations.

So the key word here is how you join forces on that collaboration and that's what I was referring to in the last intervention. We've had more and more discussions with a broader and broader group of players and tried to work through what might be the barriers to collaborating, whether those are issues around price, issues around timing, issues around national expectations, etc, but this does take some time.

00:55:16

As much as we all want to have a vaccine tomorrow we won't. It's going to take a little bit of time and the key for us now is this is

just one more of those windows of opportunity that we have to use extremely well to be able to optimise the use of the vaccines in scarce supply as they become available.

That speaks to the last point that was mentioned in Dr Tedros' intervention about the global allocation framework. Again this is a really important piece of work being led by WHO, working across all member states and other entities to try to agree together what our public health imperative is, what populations need to be vaccinated in which order to be able to achieve those objectives and then how do we translate that into a concrete mechanism to be able to collaborate together on that roll-out.

It's the right thing to do, it's the fair thing to do and I think again, as the Director-General said - DG, you should speak to this; I keep quoting you - the evidence over the past and recent weeks is economically this is in everyone's self-interest as well.

Mariangela's been leading a lot of this work and may wish to intervene as well.

MS Thank you, Bruce, and thank you for the question. I think this is an extremely important topic as we're talking about new technologies coming into the market. The experience has been historically that new technologies arrive at different speeds in different parts of the world.

00:56:51

So a lot of the work that's being done now on the COVAX and the COVAX facility and the WHO allocation framework is to give the best chances for a global solution to a problem that cannot be solved country-by-country.

We have close to 200 vaccine candidates right now and maybe 26 or 28 - because every day these numbers change - are already in clinical trials. As of Friday we have five that were in phase-three clinical trials.

Then when you're asking about resistance or specific countries that have bilateral deals or not, we, WHO is putting very clearly in discussion with member states that there is a limit to what one country can do in terms of committing itself to one or two or three or five candidates. But which one will be the candidate that will be successful we don't know yet.

So there's a lot of understanding and a lot of convergency globally, including with the one regional initiative that we have, which is the European Commission initiative; a lot of understanding that a global solution is needed.

00:58:05

We have countries that have already expressed interest in the COVAX facility that have bilateral deals themselves so by joining the facility and at the same time doing your bilateral deals you're betting on a larger number of vaccine candidates.

So I think what we see, especially in the past two weeks, is an increasing convergence around the need to find a global solution, in the commitment to ensure that once we have a vaccine that's both safe and efficacious there is equitable access to all countries at the end of the day. Thank you.

BA There's one nuance to this. Again I'm sorry, folks, to come back but just so that everyone's clear; when you hear about these multilateral and bilateral deals as Mariangela mentioned, often a country may be in a position to make a deal with one company because these are expensive.

The challenge is, they don't know if that vaccine is going to work or if it's going to work in the populations they need it to work in and multiple other factors. Again what the COVAX facility does is it tries to pool that so right now we have nine vaccines, just over nine, across three different major technology platforms in multiple countries to try and spread that risk.

00:59:39

If there's a winner in vaccines we'll have one; there's absolutely no question. The key now is we're looking to even expand beyond that to make sure that we have an even broader portfolio. Again the goal is to make sure that vaccines will be found because part of this is about supporting obviously the development of those and the development at scale but then also to ensure that the ones that do work are equitably and appropriately used because that is the only way to get out of this together.

MH Thank you very much, Dr Aylward and Dr Simao. With that excellent question and those really great answers we're running over time so we've only got time for one more question. That will come from Jonathan from DP2 in Denmark. Jonathan, please unmute yourself and go ahead.

JO Thank you. Can you hear me?

MH Yes, very well.

JO Thank you. Can you hear me? Can you hear me?

MH Yes.

01:00:40

JO Can you hear me?

MH We can.

JO You have included traditional Chinese medicine in your new international diagnostic manual. Therefore I ask, can you imagine fighting COVID-19 with a secretion extracted from the gall bladder of a live bear and how many doctors do you estimate it would require to hold the bear down while doing so?

MH Thank you, Jonathan. That's not a real question. I think that marks the end of our press conference. We will now say thank you very much to everybody who joined and I'll hand over to Dr Tedros.

TAG Thank you very much. Sorry for not answering the last question but Denmark is my favourite country. Tak skaduhe [?] for your question. Thank you to all who have joined today. I look forward to having you again on Friday. Have a nice day. Bye.

01:01:53