COVID-19

Virtual Press conference

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Speaker key:

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PS	Peter Sands
RM	Robert Matiru
JN	Dr John Nkengasong
LA	Lara
PR	Priti
EM	Emma
JA	Jamie
SO	Sophie
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GU	Gunila
MS	Dr Mariangela Simao
KI	Kil
MR	Dr Michael Ryan

00:00:00

FC Hello, everybody. I am Fadela Chaib, speaking to you from the Geneva WHO headquarters and welcoming you to our global COVID-19 press conference today, September 28th. Last week we briefed you about the COVAX facility, part of the COVAX, the

vaccines pillar of the Access to COVID-19 Tools and the ACT Accelerator investment case.

Today the press briefing... We are going to talk... how we can make sure that low and middle-income countries can have access to COVID-19 diagnostics tests. Before we go deep in developing this important aspect Dr Tedros, the Director-General of WHO, will address you first. Then we will hear from our guest speakers from FIND, Global Fund, Unitaid and CBC Africa.

Joining Dr Tedros are also, in the room, Dr Mike Ryan, Executive Director, Health Emergencies, and Maria Van Kerkhove, COVID-19 Technical Lead. Now I would like to hand over to Dr Tedros for his opening remarks. Over to you, DG.

TAG Thank you. Thank you, Fadela. Good morning, good afternoon and good evening. Since the beginning of the pandemic WHO has emphasised the vital importance of testing as part of a comprehensive strategy to control COVID-19 transmission.

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Within two weeks of WHO learning of the first case of the novel coronavirus China shared the genetic sequences with WHO and the wider world. Working with our partner lab in Germany, Charite University, we then published the first instructions on how to build a validated PCR test for COVID-19.

By the third week of January WHO had contracted the manufacture of PCR reagents for COVID-19 and by late January WHO began shipping PCR tests to over 150 labs around the world, enabling countries to identify and trace the virus.

At the same time we began working with partners to develop simpler, faster tests for use anywhere around the world to diagnose COVID-19. Last week we reached an important milestone in which WHO issued the first emergency use listing for a quality antigen-based rapid diagnostic test and we expect other rapid tests to follow.

Today I have good news. I am pleased to announce that thanks to an agreement between WHO and partners here today and others, a substantial proportion of these rapid tests, 120 million, will be made available to low and middle-income countries.

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These tests provide reliable results in approximately 15 to 30 minutes rather than hours or days at a lower price with less

sophisticated equipment. This will enable the expansion of testing, particularly in hard-to-reach areas that do not have lab facilities or enough trained health workers to carry out PCR tests.

This is a vital addition to their testing capacity and especially important in areas of high transmission. Volume guarantee agreements have been developed between two manufacturers and the Bill and Melinda Gates Foundation, which will make 120 million of these new highly portable and easy to use rapid diagnostic tests available over a period of six months.

Currently they're priced at a maximum of US$5 per unit. These are already substantially cheaper than PCR tests and we expect the price to come down. The quicker COVID-19 can be diagnosed the quicker action can be taken to treat and isolate those with the virus and trace their contacts.

We have an agreement, we have seed funding and now we need the full amount of funds to buy these tests. Over the weekend by friend, Boris Johnson, the Prime Minister of the United Kingdom, announced new funding for both WHO and COVAX, which is the vaccines arm of the ACT Accelerator.

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Together the world has to raise an additional $35 billion for the ACT Accelerator but this represents a great deal for countries in the context of the trillions of dollars they're currently spending on stimulus to keep economies afloat. If we are together we will win together.

To tell us more about today's breakthrough in diagnostics I will now hand over to my sister, Dr Catharina Boehme, who is the CEO of FIND. Catharina.

CB [Inaudible] as the CEO of FIND but also as the co-convener of the ACT Accelerator diagnostics pillar together with the global fund. As you've said, today is a major milestone not just for the ACT Accelerator but, we believe, for the global response to COVID-19. Testing is at the forefront of the response. It is our first line of defence, critical for countries to track, trace and isolate, to stop the spread of the virus and to ensure that we're not flying blind.

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The pandemic has exposed weaknesses in testing in health systems of all countries across the world. In low and middle-income countries however it's vital that testing levels are dramatically increased with great urgency.

There are over 30 partners in the ACT Accelerator diagnostic pillar and the package of interventions that we're sharing with you today is testament to the strength and breadth of the powers of our partnership.

As Tedros said, we are announcing a comprehensive package to make available 120 million affordable, high-quality COVID-19 tests, antigen rapid diagnostic tests in low/middle-income countries. Let me now walk you through the four main components of this package.

First of all innovative new tests; following the WHO policy guidance on antigen RDTs on 11th September we now have two high-quality tests which are the first in a series that are being developed and assessed by WHO for emergency use listing.

These tests provide reliable results in just 15 minutes rather than hours or days and will enable expansion of testing, particularly in countries that do not have extensive laboratory capacity or trained health workers to implement molecular or PCR-based tests.

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So these antigen rapid diagnostic tests are a critical complement to these molecular and lab-based tools. Second, volume guarantees; agreements have been signed between the Bill and Melinda Gates Foundation and two rapid diagnostic test producers, Abbot and ST Biosensor, to make 120 million tests available at US$5 for low/middle-income countries over a period of six months.

A US$50 million procurement fund is the third component of the package and that will enable to rapidly scale up these tests. The Global Fund has committed to an initial US$50 million from its COVID-19 response mechanism to enable countries to procure at least ten million tests. The first orders are expected already to be placed this week.

Last, not least, the fourth component on implementation, research and roll-out component [sic]; together with WHO we at FIND are working to understand how these tests will best be used in countries and how they optimally fit into a health system. We'll provide catalytic volumes of tests to enable countries to conduct implementation research.

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UNITAID and Africa CDC will be rolling out these tests in up to 20 countries in Africa starting in October. Their work is being

supported by organisations including CHAI, the Clinic and Health Access Initiative, the African Society for Laboratory Medicine, ASLM, and local organisations.

This complements the African Union's partnership to accelerate COVID-19 testing - PACT - initiative so this comprehensive end-to-end package of interventions has been put together with a speed that none of us here today have ever seen before and it's really a testament to the power of the partnership.

With this package and thanks to the financial support of several countries the ACT Accelerator partners have secured much-needed tools for low/middle-income countries to dramatically increase COVID-19 testing.

However, as Dr Tedros said and while we've made great progress, challenges of course remain. To reach all those who need testing and to bring test prices down we urgently need to fill substantial funding gaps that remain. Today the ACT Accelerator diagnostic partnership still needs 1.7 million billion before the end of the year to deliver what is needed to ensure that everyone who needs a test gets one. Thank you very much.

00:10:59

TAG Thank you. Thank you, Catharina, for those inspiring words. Now I hand over the floor to my brother, Peter Sands, CEO of Global Fund.

PS Thank you, Dr Tedros and I'm speaking her not just as the Executive Director of the Global Fund but as the other co-convenor of the ACT Accelerator diagnostics pillar alongside Catharina. Being able to deploy quality antigen RDTs - rapid diagnostic tests - will be a significant step forward in enabling countries to contain and combat COVID-19.

They're not a silver bullet but hugely valuable to complement the PCR tests since although they're a bit less accurate they're much faster, cheaper and don't require a lab. The significance of today's announcement is the entire package. Partners have come together to secure volume for low and middle-income countries, to provide funding and to provide technical support on the ground to expedite roll-out and ensure the most effective usage.

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This will enable low and middle-income countries to begin to close the dramatic gap in testing between rich and poor countries and is thus a big step towards more equitable

allocation of diagnostics. Right now high-income countries are conducting 292 tests per day per 100,000 people.

For upper/middle-income countries that number is 77, for lower/middle-income countries 61 and for low-income countries 14. There are still challenges. Fully utilising the volume guarantee for 120 million tests - and I'm sure you can do the maths - will require $600 million, which we don't yet have and even 120 million tests over six months, while a massive increase over what has been available so far, represents a fraction of what is really required.

If low and middle-income countries were testing at the rate high-income countries are testing right now 120 million tests would be enough for less than two weeks. Moreover with the emergence of these antigen RDTs we are likely to see testing rates increase significantly in countries at every income level.

The Global Fund anticipates using at least 50 million from our COVID-19 response mechanism to support countries in procuring these tests as well as continuing to support countries in procuring PCR tests.

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We anticipate initiating the first orders this week but our ability to continue to fund countries in purchasing these tests will be a function of the continued support we get from donors for our COVID-19 response.

But the volume guarantees are not tied to any particular purchasing mechanism or source of funds so we will be working with our partners in the diagnostics consortium to make access to these tests as easy as possible. For example we'll let countries use our procurement platform to buy these tests where they have funding from other sources.

It was Dr Tedros who said early on in the crisis, test, test, test. Experience since then has if anything reinforced the central importance of testing to fight COVID-19. With today's announcement we hope to give low and middle-income countries new testing tools that are an important step in enabling them to be even more effective in containing and combating the pandemic, saving lives, protecting communities and enabling economies to restart.

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TAG Thank you, Peter. I will now hand over to my brother, Robert Matiru, from UNITAID. Robert.

RM Thank you, Dr Tedros, thank you partners. As a development financing agency that brings innovation to the forefront of improving and preserving human life UNITAID is very pleased to be part of this global collaboration that's going to bring simpler, more effective and lower-priced point-of-care antigen tests to the global fight against COVID-19.

As you heard from Peter, the testing gap in low and middle-income countries compared to high-income countries is staggering; it's ten times less in low and middle-income countries. Of course having a test that can be simply used, that's high-performing and that's affordable can be a game-changer in accelerating the number of tests that can be performed and also closing this gap.

In support of the market and country preparedness workstreams of the ACT Accelerator Unitaid and the Africa CDC will combine resources to initiate the roll-out of these tests in up to 20 countries, as you heard from Catharina, starting in a couple of weeks.

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This multi-million-dollar intervention is designed to engage multiple partners active in the COVID-19 response on the continent such as the Clinton Health Access Initiative, the Africa Society for Laboratory Medicine and crucially local partners, those who are dedicated to building the capacity of community-based and front-line healthcare workers.

You've heard about the advantages of antigen RDTs so I won't belabour that point but what I will say is that this specific country-facing intervention will support activities such as accurate forecasting so we know how to determine how many tests should be ordered and deployed, registration of these tests, collaborating with regulatory authorities to ensure that they can be quickly improved for importation, developing innovative delivery models in all settings in these countries.

Training test administrators will be key, as is safety monitoring; developing data systems to capture test outcomes, planning for community mobilisation as well as methods to monitor product uptake.

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These tests, as you heard, can substantially reduce the transmission of COVID-19 which, as we know, will have a major public health impact in terms of morbidity and mortality but also

the significant economic benefits will be absolutely key, allowing countries to keep the epidemic curve flat and also to keep their economies open.

So we're very happy to be able to contribute to the objectives of the ACT diagnostics workstream, to collaborate with all the partners at this table and those that aren't to make this a reality. Thank you very much.

TAG Thank you. Thank you, Robert, and finally I will now hand the floor to my brother, John Nkengasong, who is the Director of the Africa CDC. John, you have the floor.

JN Thank you, Dr Tedros, and greetings from Addis Ababa. I see all the colleagues and friends that we've worked with over the years to strengthen health systems and expand diagnostics so it's truly a pleasure to join you.

For us representing Africa CDC today represents and symbolises the whole discussion around co-operation, co-ordination and collaboration in the spirit of solidarity as we fight this terrible pandemic.

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This is what we have been calling for as Africa; to support our efforts to scale up testing. We've always recognised that the pathway towards enabling us to achieve a testing goal is inevitably through a test that is affordable, is easy to use, is scalable and is reliable and I believe that the launch of this initiative around the antigen testing represents just that.

I would like to sincerely thank our partners we've worked with... are going to work on this initiative, FIND and Unitaid. As you are all aware, the continent as we speak has conducted just under 50 million tests and it's not because the continent doesn't know how to test. It is essentially because the current tools that we have do not enable us to fulfil those four criteria; that is, easy to use, affordable, scalable and reliable.

We have two initiatives that will immediately benefit from this announcement. First of all is the PACT initiative, as Catharina mentioned, the partnership to accelerate COVID testing, which is underpinned by the need to test, to trace and to treat.

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We've also just announced at the African Union level a campaign against COVID-19 whose goal is to expand testing to ensure that

we ease the lock-down of economies in a very systematic and safe manner.

So today's announcement, we believe, will be transformative in enabling us to reach these big initiatives that the continent is driving through the African Union. So I thank you for your partnership and co-operation and look forward to the implementation in the field.

TAG Thank you. Thank you so much, John. Hamase gnalo [?]. Now, Fadela, back to you for the Q&A.

FC Thank you, Dr Tedros, and to our speakers. We will now open the floor to questions from members of the media. I remind you that you need to raise your hand and use the raise your hand icon in order to get into the queue to ask your questions. I also remind you that this briefing is being translated into the six UN official languages plus Portuguese and Hindi.

00:21:15

Now I would like to give the floor to Lara Pinheiro from Globo, Brazil. Lara, can you hear me?

LA Yes. Can you hear me?

FC Yes, very well. Please ask your question. Go ahead.

LA I would like to ask Dr Nkengasong - I hope I pronounced that right - on his current view of the COVID-19 situation in Africa as a whole. What factors have contributed for example to the continent having fewer cases than others such as South America?

I wondered if you could maybe comment on specific regions or countries which are having the best or the worst responses to the pandemic. Thank you.

FC Thank you, Lara. Dr Nkengasong, you have the floor.

JN Thank you. I think I recognise the importance to continue to put out with clarity what the continent is doing. As we speak today the continent has recorded about 1.4 million cases of COVID-19 with about 35,000 deaths.

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I have always maintained that our pandemic was a delayed pandemic and because of that it gave us time as a continent to observe what was going on and take the bold measures that have really helped us.

It's very important to first of all recognise the leadership of the countries. The countries have done extremely well in terms of the sacrifices with regard to the lock-down of the economies and movement of people.

If you recall, as we speak so many countries in Africa are still under lock-down and the major economies - like South Africa is just beginning to - have announced that they will open up their frontiers just in the coming days. I think that represents a significant sacrifice that the continent has invested in trying to fight this pandemic.

The second thing we have to always recognise is that our demographic structure of the continent is very different from the demographic structure in the Western world and that has also to a large extent played in our favour.

Really the leadership role at the continental level, at the AU level led by President Ramaphosa is really a strong contributing factor. Very early on we recognised the need to co-operate, to co-ordinate our efforts and to collaborate as much as possible and establish mechanisms that are working for us.

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Having said that, we are very cautious and have been very clear that we are not yet out of the woods. We are seeing a tendency towards a decrease over the last couple of weeks but that doesn't represent victory. We need to scale up the tools that we are discussing here today. That is the testing, the public health measures that we all note in order to continue to battle this pandemic on the continent.

So there's absolutely no room for complacency on the continent. Thank you.

FC Thank you, Dr Nkengasong. I would like now to ask Priti Patnaik to ask her question. Priti, can you hear me? Geneva Health Files. Priti.

PR Yes, can you hear me?

FC Yes, go ahead, please. Priti, just make sure you unmute yourself.

00:25:10

PR Does this work?

FC Priti? Yes, go ahead, please.

PR Can you hear me now?

FC Yes, we can hear you.

PR Sorry for this. I just wanted to ask, it's understood that of the overall tests that are going to be commissioned through the diagnostics pillar only 20% will be available for low and middle-income countries. Can you confirm this and if it meant that the rest will be for high-income and upper/middle-income countries and will this help achieve equitable access? Thanks.

FC Dr Catharina Boehme maybe can take this question. Catharina, you have the floor.

CB Thank you. Just a very brief answer to this; indeed, this reflects 20% of the current manufacturing capacity of these two manufacturers. However they're rapidly scaling up capacity and so one of the important next steps is to make sure that we use these increased test numbers to ensure wider access for low/middle-income countries and of course also work on further price reduction.

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But indeed it's 20% that are covered through these volume guarantee agreements and then 80% remain available for procurement outside of these volume guarantee agreements.

FC Thank you. The next question is from Emma Farge, Reuters. Emma, can you hear me? Emma?

EM Yes, I can. Apologies. I was hoping to get a quick clarification, please, on the names of the producers of these diagnostic tests. Sorry, it was a bit quick for my ear; if you could repeat them slowly for us, thank you.

CB [Inaudible]. The two producers are SD Biosensor and Abbot. The Abbot test is called Panbio.

FC Thank you, Dr Boehme. Now I would like to give the floor to Jamie Keaton from Associated Press. Jamie, can you hear me?

JA Yes. Thank you for taking my question. I wanted to know, if we could, how much seed money have you received already and what do you expect to be the sources of the funding for the full programme?

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FC Mr Sands.

PS Thanks for the question. On the procurement side - and one of the aspects of this package is that it isn't just about the procurement but it is also about the support to countries in

deploying the tests in terms of technical assistance in the way that Rob described, that Unitaid and FIND and CHAI and others are doing.

But on the procurement side the Global Fund is making an additional $50 million available from our COVID-19 response mechanism. We anticipate that funding for procurement of the tests under the volume guarantees will come from a variety of sources including other partners in the diagnostic consortium such as UNICEF, UNDP, the World Bank, PAHO; from countries' domestic resources.

We ourselves at the Global Fund would anticipate being able to provide further financial support as well.

FC Thank you, Mr Sands. I would like now to give the floor to Sophie Mkwena from SABC, South Africa. Sophie, can you hear me?

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SO Yes, I can hear you. I just want to ask the head of the CDC Africa and of course the representatives of WHO; you spoke about the strides we have made and the achievement but clearly currently you also alluded to the fact that many countries are starting to open their economies and the air travel and tourism is currently happening.

But, two, you have many schools or many countries; learners are going back to school. Are you not worried about the fact we see countries in Europe and in different parts of the US there are problems, the numbers are going up?

Are you not worried and what is your advice to South Africa, a country where we have high numbers, we are an epicentre and again we see the numbers are slightly going up even though the death toll is a bit stable.

FC Thank you, Sophie. I would like to invite Dr Nkengasong maybe to take this question. You have the floor, sir.

00:30:52

JN Thank you. I think the question has two parts; the easing of the lock-down of the economy and the schools, which go hand-in-hand. As I indicated earlier we at the Africa CDC and the African Union Commission have launched an initiative called Africa Against COVID-19 which is underpinned by the need to save lives, save economies and save livelihoods.

There are three components of that; one is protecting travel and the borders; second is protecting economies and businesses and third is protecting schools. If you recall, we have been discussing this over our weekly press briefings all the time so I think what we are advising countries to do and partnering with countries... is that we have to unlock and ease the lock-downs safely and also make sure we work with countries to maintain that safety all along by doing the basic things we all know which are scaling up testing - this antigen platform presents a good opportunity for that - mask universally and in a sustained manner.

I'm very pleased, as I have indicated, when I go out on the streets of Addis Ababa. You can almost affirm that there's 100% masking, at least on the streets of the capital city. Maintain hand-washing all the time and then distance as much as possible; social distancing as much as possible.

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I think we don't have a magic bullet for this but these are the two weapons that have worked for us and worked for South Africa in bending the curve in the manner they have bent the curve all this while.

I think the pandemic in South Africa is the largest in Africa but it also represents a sign of hope that with determination and strong leadership you can bend the curve as South Africa has done. So I really want to give South Africa a shout-out of encouragement and praises for the remarkable work they've done in managing that large epidemic on the continent, which represents almost 50% of the pandemic in Africa.

With respect to the schools opening, the launch of this test, this ceremony we are here today... it has a lot of implications. One of those will be that we can apply that in school settings to enhance surveillance when schools open so that they open safely and they maintain that safety all along.

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So I think it has - as I said earlier - remarkable potential to be transformative in the way we conduct the fight against COVID-19 on the continent.

FC Thank you so much, Dr Nkengasong. I would like now to give the floor to Peter Schilling from European News Agency. Peter, can you hear me? Peter, can you unmute yourself, please?

PE Yes, now I've got the line. Can you hear me?

FC Yes, very well. Go ahead, please, Peter.

PE Okay, thank you. I was just wondering, for low and middle-income countries wouldn't it be better to focus on the LIMP visual diagnostic test rather than the rapid antibody detection test which is actually only indicating an antibody whilst the LMP test immediately indicates the virus?

FC Thank you, Peter. I would like to invite Dr Catharina Boehme to take this question, please.

CB Thank you. I think you're referring to the LAMP test. That is a molecular test so it's based on the amplification of RNA and indeed a lot has been talked about that in the press over the last weeks.

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However that test is not as simple to use and also not comparable in terms of pricing to the current RDTs that we're speaking here about today. I would like to clarify that we're not announcing here volume guarantees for antibody rapid diagnostic tests though but we're speaking about tests that detect COVID-19 antigen.

The tests are as simple to use as pregnancy tests and thus rather different from molecular tests. At the moment it relies still on the use of nasopharyngeal swabs but nasal swab testing is in the works and we expect to have that ready to go also within the next months, which means that the use right now is being limited to health professionals especially also due to the complicated sampling, taking the swab will become much easier going forward and that, I think, will really be a next important step.

I don't know, Maria, if you want to add anything.

FC Maria, if you have something to add...

MK Yes, thank you, Catharina. Just very briefly to say, because I think this can be confusing, that there are different types of tests that are used in the fight against COVID-19 and there are these molecular tests, these PCR-based tests which were rapidly developed very early on in the pandemic due to the fact that we had access to the full genome sequence within days of first being alerted to this cluster of unknown pneumonia in China.

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That has been the mainstay of testing across the world and we're very grateful to all of the national influenza centres and all of the

labs across the world who have rapidly increased their capacities to carry out PCR-based testing, which is available.

Results can be as quick as hours but most of the time it takes days to get those results back. There are the antigen-based tests that we're talking about today, these antigen-based RDT, rapid diagnostic tests, which detect the proteins of the SARS-CoV2 virus and these have been in development for many months but we have the good news today of having one with the EUL listing but there are more that are under evaluation and there will be more that will come online.

What is really beneficial about the antigen-based RDTs is that this will be very helpful in situations where there isn't ample access to PCR testing. WHO issued guidance recently to identify different areas and this is part of the package that was announced today.

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There are different settings in which these antigen-based RDTs can be very beneficial and there're four situations where we recommend them to be used where there's PCR that's not readily available.

First is to respond to suspect outbreaks in remote settings or institutions or semi-closed communities where we don't have the access to the PCR. Second is to support outbreak investigations where you have at least one case that you know is detected through PCR.

This really helps you do these cluster investigations, these outbreak investigations to bring them under control. You've heard us talk a lot about the fact that this virus operates in clusters. When it has an opportunity to find individuals in close proximity to one another, in closed settings like prisons or long-term living facilities or different types of settings where people are in close contact, these outbreak investigations rely on testing to understand the extent of infection in that outbreak.

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The third area is to monitor trends and incidents in specific communities, in higher-risk populations like front-line workers or essential workers and this will help to monitor if they are infected and these tests will give rapid results back.

The third is in areas where you have widespread community transmission, ie, you know that there's widespread community

transmission or you suspect that there is and again where you don't have access to that PCR testing.

So this will be really, really helpful for communities and countries to be able to know, where is the virus, who is infected with the virus and most importantly what do we do, what are those public health steps that are needed next once we know that the virus is circulating.

This is the case isolation, clinical care for cases, contact tracing of close contacts, etc, etc, so this is a really helpful tool that we have in our toolbox that will help us break chains of transmission.

FC Thank you, Dr Kerkhove. I would like to apologise because you may have noticed that the video signal from CDC Africa was cut for a short moment. The good news is we are back on video with CDC Africa. Sorry for that. I would like now to give the floor to Gabriela Sotomayor from El Proceso. Gabriela, you have the floor.

00:40:24

GA Hi, hola. Thank you for giving me the opportunity to ask. I want to know if Latin American countries are going to be favoured by this programme of testing because I see what you are mentioning with the African countries but I would like to know if in Latin America you are planning to... if countries have joined the programme or how the situation is with them and also if these tests can be bought from governments on the side like, for example, Mexico.

PCR in Mexico is very expensive and the Government prefers to save money so maybe this could help; I don't know if you can answer this question.

FC Thank you, Gabriela. I would like now to invite Mr Sands to respond to this question.

PS The volume guarantee covers 133 low and middle-income countries including many countries in Latin America. The way that it is structured also is to be purchaser or funder-agnostic so as long as the purchase is for use in one of the 133 countries it doesn't matter whether it comes through a multilateral, a government or another agency.

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FC Thank you, Mr Sands. I would like now to invite Simon Ateba to ask his question. Simon, you have the floor.

SI Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC and my question is to Dr John Nkengasong, the Director of the Africa CDC. Before I do I would like to congratulate Dr Tedros for being recognised last week by Time magazine as one of the most influential 100 people in 2020 for leading the fight against COVID-19 along with WHO experts around the world. Congratulations, Dr Tedros and the WHO team.

Now my question to Dr Nkengasong; last week Johnson & Johnson here in the US announced that they would be conducting some clinical trial in South Africa and we know that before then we had AstraZeneca and Oxford University clinical trials that were taking place in Africa.

Can you give us an update on those two clinical trials, Johnson & Johnson and AstraZeneca and Oxford University? Thank you.

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FC Thank you, Simon. Dr Nkengasong, do you want to take this question?

JN Thank you for that question. First of all I just want to share with you that as a continent we have now developed what we call the continental strategy for COVID vaccine development and access, which was presented to the Bureau of the Heads of States chaired by President Ramaphosa, the President of South Africa, on 20th August.

That was endorsed and there are three pillars to that. One is the need for us as a continent to engage in COVID-19 clinical trials and we have formed a consortium called the consortium for COVID vaccine clinical trials, which is co-led by Professor Sambaso from Mali and Professor Salim Karim from South Africa, which is going well.

Then the second pillar of that is vaccine procurement and financing and the third pillar is preparedness. I just wanted to put that in context. As part of that consortium we are working closely with all of the sites that are engaged in vaccine clinical trials and also preparing additional sites to engage with vaccine manufacturers to enable and facilitate clinical trials on the continent.

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We are also doing this very closely with WHO, Dr Soumya and her group at WHO. We've met several times to discuss that and

are actually in the process of finalising a framework of understanding how to work together.

So yes, we are tracking all these clinical trials on the continent and encouraging more because as a continent as part of our leadership and framework we really need to make sure that many countries are participating in these clinical trials and Africa is playing its rightful role in facilitating the clinical trials of COVID-19 on the continent.

So I think that the Oxford vaccine and the Johnson & Johnson; we are fully aware of that and we are following that very closely. Thank you.

FC Thank you, Dr Nkengasong. I would like now to give the floor to Ann Gilland from the Telegraph. Ann, can you hear me?

00:45:41

AN Hi, yes. Can you hear me?

FC Yes, please go ahead.

AN Great. Thanks very much. Thanks for taking my question. It was about the testing and I just wondered, would these rapid tests replace PCR testing and how do they work in conjunction? Is PCR testing more accurate than these new rapid tests or would PCR testing be more likely to stay in a more clinical setting like a hospital? Can you just give me a comparison of why you would use PCR over the rapid testing? Thank you.

FC Like to invite Dr Kerkhove to take this question.

MK Thank you for the question. I can start and maybe others would like to supplement. Again we have these PCR tests that are available all over the world and every country now has the ability to do PCR testing for COVID-19. Again we cannot overemphasise enough [sic] how incredible this is and this rapid increase in the ability of countries to, one, get access to this test and, two, have the facilities and the work staff to be able to do that so many countries are doing the PCR tests.

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The challenge with PCR testing in many countries right now is the turn-around time. There's a cost issue because the antigen-based tests are cheaper certainly and they're faster but for the PCR tests it does take some time in some countries to get those result back. They can be done in hours but oftentimes the results come back in days and that poses a challenge to control efforts and the actions that are necessary.

The antigen-based tests which are coming online - and more and more are becoming available and going through this validation and evaluation in this emergency use process - which is a very robust process to check how well they perform.

Our understanding of the antigen-based tests - and, Catharina, please come in on this because FIND has done a lot of this evaluation - is that they perform best when there's a lot of virus around in the community and when the person has the highest viral load and is the most infectious at the time during their infection.

This is about two days before symptom onset to within five to seven days after they develop symptoms, during their illness so they perform best in those types of situations. That's why WHO, when we put out our guidance, gave these four different situations and where they perform the best.

00:48:10

These can be used in conjunction with PCR testing. Having said that, there are many parts of the world that don't have access to rapid turn-around of PCR or where there are samples that need to be collected from an individual and those samples actually need to be brought to a centralised lab somewhere else that could take hours to days to get to, run the test and then it takes hours to days to get those results back to that individual.

Antigen-based tests can be very helpful in these types of situations because you could do them next to the patient, next to the individual and those results can come back quicker. None of these tests are perfect but many of them are working and the companies that are developing these and the labs that are validating these and evaluating these are working very hard to ensure that they perform optimally.

So what we do as WHO is to try to write guidance to show where and when they can be used as part of an algorithm but we're so grateful to all of our partners that are driving this development forward and really pushing the boundaries of what testing can do.

00:49:11

Catharina mentioned, right now we're using nasopharyngeal swabs but there's a lot of development of saliva-based tests and other types of test and these are coming online so we are grateful for the advancement of this and the acceleration of that but there are better places for the PCR test to be used and the

antigen-based tests and that's what the WHO guidance has outlined.

FC Thank you, Dr Kerkhove. I would like to invite Dr Catharina Boehme to add a few words. Thank you.

CB Thank you. As Maria said, this is a very rapidly evolving pipeline with much progress being made over the last months and we were almost surprised to see in our multi-centre evaluation studies that we work on with WHO the relatively high performance of these antigen RDTs.

With a sensitivity in the population that Maria mentioned with significant prevalence of COVID-19 we see a sensitivity of between 80 and over 90% and a specificity of 97 to 99%, which is a very decent accuracy. Just to restate, it is an important toolkit in our repertoire.

00:50:36

FC Thank you, Dr Boehme. I would like now to invite Gunila Van Hall. Gunila, are you online? Gunila? Can you please unmute yourself? Gunila, can you hear me?

GU Yes, can you hear me?

FC Yes, very well. Go ahead, please.

GU Sorry for that. Thanks for taking my question. My question concerns vaccines and development of vaccines. There have been some issues around phase-three trials of AstraZeneca and Oxford University, as you are probably aware. Two participants have developed adverse reactions, there's been a pause. Now the trial has been resumed in the UK, in South Africa, in Brazil but not in the United States and there's a lot of discussion around this in the US.

There seem to still be questions and a lack of clarify and I'd like to know how concerned you are that these adverse reactions and possibly a lack of information about cases in vaccine trials will lead to increased vaccine hesitancy, that people will actually not dare to take the vaccine once it's there. Thanks.

00:52:05

FC Thank you, Gunila. I would like to invite Dr Simao to take this question. Dr Simao, you have the floor.

MS Let me start and then maybe Maria can complement. I think it's very important in the stage we're in where we have ten

vaccine candidates at phase three, it's very important to highlight that there's no cutting corners at this stage.

When you go to phase three you need to finalise phase three and then you need to be assessed by a regulatory authority before the project comes onto the market. So it's just at these times we're living in now these results become publicly more easily because it's very common that trials are stopped for a while and any suspect adverse events are identified or are investigated properly.

So what we are seeing right now is the fact that there's a lot of scrutiny and there's a lot of responsibility from the companies in the case of AstraZeneca to act responsibly and stop the trial, do the necessary investigation and then the trial was assessed by the different national regulatory authorities in the countries where it's been because it's a multi-country study and it's gone back to finalise phase three.

00:53:35

I'm saying this because at the time we're in it's extremely important to say that we're not cutting corners either on efficacy or related to safety. I don't know if Maria [inaudible]...

MK Just to supplement on the part of the vaccine hesitancy, I think, as Mariangela has said, there's no cutting corners on safety. There is a very robust process that has been in place, that is in place for the development of a safe and effective vaccine.

WHO with our partners are working with communities, we are working with different groups to try to increase understanding of vaccines; what are vaccines - what do they do, what don't they do? - and really important right now about this process.

The consistency in the message about the development of these vaccines is really quite critical because there are so many that are in development and again the more vaccines that we have in development the more opportunities we have for success.

00:54:35

But that doesn't mean we cut corners on safety and efficacy and so it's really important that we reach out to different communities and understand what is the hesitancy even though we don't have a vaccine yet for COVID-19; how can we work together with communities to increase understanding, increase awareness, increase knowing why there may be some hesitancy already to try to work through that.

That is something that has been in development for the past several months already and we will continue to do that.

FC Thank you. I believe we will take the last question from Kil Yu [?] from Xinhua. Can you hear me?

KI Hello, can you hear me?

FC Yes, very well. Go ahead, please.

KI Thank you for taking the question. Good afternoon. My question is about the numbers. The global death toll of COVID-19 is exceeding one million, which without question reflects how serious this pandemic has been. We've also noticed that there may be some variance in the definition of death cases caused by COVID in different countries.

The US has topped the death case list but some cases of which the major cause may not have been COVID-19 but other underlying diseases or even accidents. Those deaths in the US may also have been tallied as victims of COVID which means that some countries may have had a much broader definition of COVID-19 deaths.

00:56:07

The question is, how is that fact going to affect the understanding of seriousness of the pandemic in some individual countries or does the WHO have a common or unified definition of COVID death cases when doing its own statistics? Thank you.

FC Thank you, Kil Yu. I would like to invite Dr Mike Ryan to take your question. Dr Ryan.

MR Thank you, yes. WHO receives data from all over the world on a daily basis from all our member states and we would like to first of all thank them for over nine months consistently sharing data with us. It's vitally important and it's a difficult task when you're under pressure yourself at national level to continue to feed the international team on this.

00:56:53

Secondly we collect information on confirmed cases of COVID-19. There are other ways then of looking at all-cause mortality or excess mortality. We don't count excess mortality in those numbers you see every day and in fact if anything the numbers that are currently reported probably represent an underestimate of those individuals who have either contracted COVID-19 or who have died as a result of it.

There are situations in countries where countries require a form of death certification and WHO has issued very detailed guidelines under ICD in order to assist countries with attributing cause of death to COVID when it comes to mortality statistics.

But I didn't quite get the thrust of your question but just to reassure you, there are not people who are suffering from accidents being counted as COVID cases. There are lots of different stories out there about things like that. I think you can probably find in any global surveillance system and in any national system exceptions and areas where things need to improve and that is the case.

When you count anything you never count it perfectly but I can assure you that the current numbers are likely an underestimate of the true toll of COVID rather than anything else.

00:58:15

Maybe just while I have the floor and before the end - I know John is on the line from Africa CDC - I think this is a wonderful stride forward, the partnership here and the partnership that's gone on for months and months, way back into January and scrabbling to get lab assays out with our colleagues in Find and Charite in Germany.

That collaboration has blossomed week on week into a diagnostic consortium, a procurement consortium and then morphed into the ACT Accelerator. I think it's got stronger and stronger under the leadership of the people who you see here today but it's also built on something and John mentioned this from an Africa perspective.

When we got tests out to all the countries in Africa it was actually based on having two strong WHO collaborating centres for influenza that we have spent years trying to fund. Those collaborating centres in Senegal and South Africa worked with us and with John at Africa CDC not only to distribute the first PCR tests but to actually train the lab workers from all of those labs so to ensure that when the tests arrived we had proper protocols for testing.

00:59:21

I think it demonstrates that just the small amount of money which needs to be invested in preparedness and building lab capacity can then be amplified during a crisis and we can then put the right software in a sense - the software being the tests -

with the hardware which is the labs and the people who run them.

I do think it's an illustration of the absolute value of investing in the human and the physical infrastructure for laboratory diagnostics and then how we can leverage that in a crisis with all of the wonderful work that the people and organisations represented here have carried out.

That was all done under the global influenza surveillance and response network, a 70-year-old network that's been tracking respiratory viruses for 70 years. What if we invested more in our ability to track respiratory viruses around the world, more in our lab capacity, more in our clinical capacity? Maybe we'd have done better in this response.

FC Thank you, Dr Ryan. I think we are up to the hour. Before I give the floor to Dr Tedros I'd like to invite our speakers, if they want to make final comments, maybe starting with Dr Nkengasong, CDC Africa. Do you want to make final comments?

01:00:43

JN Thank you. My final comment is really aligned with what Mike just said. I think the lab has always been that neglected component of a large system. The colleagues are noting [?] gaps and it has taught us that we cannot continue to not pay the maximum attention to it.

I think we should learn from the lessons we've acquired over the last nine months and really focus on strengthening our lab systems and diagnostics as a cornerstone for our preparedness and response. I think Africa is looking forward to that dialogue going forward.

FC Thank you, Doctor. Mr Sands, if you want to take the floor, thank you.

PS Just a couple of quick observations building on Mike Ryan's point and John Nkengasong's. I do think diagnostics is a good example where investing in health systems is critical. It wasn't just influenza but it was also the instruments put in place for TB diagnosis, for HE viral load testing and things that created the platform for [unclear] PCR test.

01:01:58

I hope that in the developments that we're seeing here today and the continued acceleration of testing capability across low and

middle-income countries we'll be creating an infrastructure and set of capabilities that will go far beyond fighting COVID-19.

The second point, very quickly, is I do think that what you're seeing here today is a demonstration of what the ACT Accelerator is all about, which is getting a diverse set of partners together to provide not just a product or a tool but to ensure that there is access to that tool and that it is delivered in a way with the appropriate guidance and appropriate technical support and so on that it can be used to maximum impact.

So it's quite a good demonstration of what I think the ACT Accelerator will be doing quite a lot of over the course of the next seven months. Thank you.

FC It's up to you, Dr Catharina Boehme, if you want to give us some final words.

CB Thank you. I think by now it's clear we will have to live with COVID-19 for a while and I hope that we use the diagnostic tests that we have available to live better with it and to unleash the power of diagnosis.

01:03:20

I also hope that we will build on the opportunities that arise from this crisis through building back better. Mike and Peter have said it; I think that entails and includes working on strengthening integrated and digitalised diagnostic and health systems that will enable us to respond better going forward. Thank you.

FC Thank you. Mr Matiru, you have the floor.

RM Thank you very much. What I'll say is, by way of closing, what is beautiful about this partnership and this initiative here that we're announcing is how end-to-end it is in terms of the solutions we're offering.

On the other hand it's addressing innovation so we need new test. We have a PCR backbone, we have an influenza backbone for surveillance but we're always iterating and innovating to get better solutions, better, cheaper, faster, easier to deploy and portable.

01:04:22

Availability is a critical component of what we're doing here as well. By ensuring that we secure capacity that will ensure low and middle-income countries are also covered with availability of these tests so the equity that I mentioned is really important as well.

Then when you look at demand and adoption it's not enough just to secure the supply side dimensions; lower pricing, actual production capacity. But then we have to work in countries with governments and their partners including those at the coalface, the communities, to ensure that there's actual demand for these tests and adoption of these tests.

So all the priming that has to be done in the coming weeks is really critical so that we can actually use the 120 million tests that have been secured, starting with these two companies and then more companies will be added down the line but you have to prime the countries and support them to do that and in a sustainable way.

Then lastly supply and delivery; we need to have procurement mechanisms in place. The diagnostic consortium for procurement here that is led by WHO in close collaboration with Global Fund and others is really key and we need to leverage that to ensure that supply is seriously delivered to countries, cleared rapidly at ports and then distributed throughout the countries.

01:05:27

So end-to-end solutions are really key; we have to avoid siloed solutions and this a really clear example of what we need to do in addition to obviously continuous improvement and never stopping to find better solutions. Thank you.

FC Thank you, Mr Matiru. We'd like now to ask Dr Tedros for his final comments. Over to you, DG.

TAG Thank you. Maybe I'll repeat what my colleague said, Peter Sands. When we launched as partners the ACT Accelerator together there were two objectives. One is to accelerate the development products like diagnostics, therapeutics, vaccines and also fair, equitable distribution of these products.

So today is a good example, as Peter said, of what we had in mind when we started the ACT Accelerator and we hope we will do the same with therapeutics and vaccines in the future and the partners from those you see today; we have FIND, Global Fund, Unitaid, GAVI, CEPI, the World Bank, Wellcome Trust, Gates Foundation. I don't know if I forgot anyone.

01:06:58

I think these are... Yes. We have been working very, very hard together and I would like to thank all the partners for their commitment and for their leadership.

At the same time I would like to appreciate those who have joined today; Peter Sands, Catharina Boehme and Robert Matiru and those colleagues who haven't joined but are members of the ACT Accelerator steering group. Thank you so much.

With co-operation and partnership anything is possible and that's what we're seeing. All agencies working on the ACT Accelerator are really motivated and hope to continue to work together to deliver better results for the people we serve.

With that I also thank the journalists who joined us today, the media, and others who have joined today and also my colleagues who have joined today, starting with my general, Mike. Thank you so much again. Thank you.

FC Thank you, Dr Tedros. I now close this briefing and remind you that you will receive the audio file and Dr Tedros' opening remarks just after this press conference. The full transcript will be posted most probably tomorrow morning.

As always, I apologise to journalists who were not able to get their questions answered. Thank you so much and see you very soon. Thank you.

01:09:02