

COVID-19

Virtual Press conference

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SS	Dr Soumya Swaminathan
SI	Simon
MR	Dr Michael Ryan
PE	Peter
KU	Kumar

00:01:43

FA WHO, Geneva. I welcome you to our press conference on COVID-19 today, Friday 4th September. We have with us as always in the room the WHO Director-General, Dr Tedros, along with Dr Maria Van Kerkhove, our Technical Lead for COVID-19. We have also Dr Bente Mikkelsen, Director of Noncommunicable Diseases. Joining us online will be Dr Mike Ryan, our Executive Director of the Emergencies Programme, and Dr Soumya Swaminathan, our Chief Scientist, who will join us in the room.

As usual we are translating this into the six official UN languages with Portuguese. We exceptionally do not have translation into Hindi today; sorry for that. We will be posting the Director-General's remarks and an audio file of this press conference will

be sent to you on the web as soon as possible. A full transcript will be available later but now without further delay I will hand over to Dr Tedros to give you his opening remarks. DG, the floor is yours.

TAG Shukram, Fadila. Good morning, good afternoon and good evening. Yesterday I had the honour of addressing foreign ministers from G20 countries. The focus of the discussion was on how together we can reopen societies, economies and borders. This is something the WHO supports wholeheartedly. Lock-downs are a blunt instrument that have taken a heavy toll in many countries. With the right mix of targeted and tailored measures further national lock-downs can be avoided.

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Several countries are using a data-driven approach to drive a targeted response. This is allowing them to open up carefully and safely while remaining ready to respond rapidly to any new clusters or amplifying events.

Once again I want to reiterate the four priorities we urge countries to focus on; prevent amplifying events, empower people to protect themselves and others, focus on the public health basics and protect the vulnerable including older people and those with underlying conditions.

COVID-19 has preyed on people with noncommunicable diseases such as cancer, cardiovascular disease, diabetes and respiratory disease. Globally NCDs are... their risk factors are increasing vulnerability to COVID-19 and the likelihood of worse outcomes including in younger people.

The odds of developing severe COVID-19 have been found to be as much as seven times higher in patients with obesity. Smokers have been found to have been 1.5 times more likely to have severe complications from COVID-19 and a systematic review has shown that people with diabetes are between two and four times more likely to have severe symptoms or die from COVID-19.

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The pandemic has underscored the urgency of addressing noncommunicable diseases and their risk factors. Next week is global week for action on noncommunicable diseases, which aims to increase accountability by governments, policymakers, industries, academia and civil society to reduce the NCD burden globally and increase health and equality.

Today I'm pleased to launch a set of publications that have been developed under the UN NCD inter-agency taskforce that call for urgent action on NCDs during and beyond the pandemic. First we call for the voices of people living with NCDs to be heard in all discussions about policies that directly affect them.

Second we call for global financing instruments to be extended to low-income countries that request support for noncommunicable diseases. Third we call for constructive dialogue or partnership with the private sector.

Because people with NCDs are at high risk of severe COVID-19 finding effective therapeutics for these patients is a high priority. Earlier this week WHO issued new guidance on the use of corticosteroids to treat patients with severe COVID-19.

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Evidence shows that corticosteroids can be life-saving for patients on oxygen and ventilators. However corticosteroids do not help patients with mild or moderate disease and can be harmful. WHO therefore recommends the use of corticosteroids only in patients who are severely or critically ill.

These guidelines combine the high scientific standards with the urgency needed to respond to this pandemic. Providing guidance on therapeutics, diagnostics and vaccines is one important part of WHO's work. Ensuring access to those products is another. In the coming months we all hope to have good news about a vaccine for COVID-19.

But if and when we have an effective vaccine we must also use it effectively. In time as production increases we want all people everywhere to have access to vaccines but initially when supply is limited priority must be given to vaccinating essential workers and those most at risk including older people and those with underlying conditions.

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In other words the first priority must be to vaccinate some people in all countries rather than all people in some countries. This is not just a moral imperative and a public health imperative; it's also an economic imperative. In our interconnected world if people in low and middle-income countries miss out on vaccines the virus will continue to kill and the economic recovery globally will be delayed.

So using vaccines as a global public good is in the national interest of each and every country. Vaccine nationalism will

prolong the pandemic, not shorten it. The COVAX facility is the agreed international mechanism for ensuring equitable global access to vaccines. It is solidarity in action.

COVAX guarantees access to the world's largest portfolio of vaccine candidates. Our partner, the Coalition for Epidemic Innovation and Preparedness, CEPI, is supporting nine candidate vaccines that will be made available to the facility if successful, seven of which are in clinical trials.

We're also in discussions for other promising vaccines. Another nine candidates that are in earlier stages of development are being evaluated for inclusion in the facility.

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We're delighted that 78 high and upper-middle-income countries and economies have now confirmed they will participate in the COVAX facility and the number is growing. I urge those who have not yet joined to do so by 18th September.

I would like to thank those countries and economies who have announced publicly they're joining COVAX this week; Germany, Japan, Norway and the European Commission. Vielen dank; Arigatou Gozaimasu; takk skal du ha. Of course many more countries have joined and we look forward to being able to share the full list in due course.

Although we still face many challenges WHO is encouraged by the progress we have made against this new virus in eight months. With national unity and global solidarity we can and will end this pandemic. I repeat; with national unity and global solidarity we can and will end this pandemic. I thank you.

00:11:24

FA Thank you, Dr Tedros. I will now open the floor to questions from the press but I would like to remind first that you need to raise your hand; use the raise your hand icon in order to get in the queue to ask questions. Also remember we have a large number of you in the queue so please stick to one question.

The first question is from Agnes Pedrero from Agence France Press. Agnes, please unmute yourself and ask your question. Agnes? Agnes, can you hear me? Agnes? We will come back to Agence France Press later on. Now we have Anna Pinto. Anna, can you hear me? Please don't forget to unmute yourself. Anna, can you hear me?

We have some technical problems but trying again; Anna or Agnes? Can you hear me? If we cannot have Agnes or Anna I will go to Gabriela Sotomayor, Mexican journalist. Gabriela, can you hear me? Really? Let's see how we can fix this problem; sorry for that. We are trying to fix the technical problem so let's try once again Agnes, AFP.

If you cannot hear me and speak please type your questions. We will receive them. Thank you for your patience.

We received a question from Gabriela Sotomayor from Mexico, journalist from Proceso. I would like to know if you agree with the comment by Amnesty on accountability and if you can say how the rights of health personnel can be protected.

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They are exhausted. The pandemic continues. It has not stopped. How to help them? Many work in terrible conditions and they are fired if they complain. Who will take this question? Dr Maria. Thank you.

MK Thank you very much for the question. Just checking if people can hear us. Thank you very much for this question, Gabriela. Healthcare workers are front-line workers and need to be cared for and respected and protected for the incredible work that they do on the front lines saving people's lives from COVID-19 and from many other infections so all healthcare workers are important. Even one healthcare worker infection is too many.

We have some information on healthcare worker infections by country and it's highly variable by country. From the data that we have that's received through our clinical platform for case report forms that come in by country it's anywhere between eight and 27% of the reported cases.

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From data from our regional offices this week our regional director of PAHO noted more than 570,000 health worker infections in North and South America and in the US and Mexico healthcare workers account for about 14% of infections.

Across our African region it's around 5% that are healthcare worker infections and if you look across the published studies again the data is highly variable and if you look at seropositivity which is evidence of infection through antibodies healthcare worker infection ranges from 1.6% to over 31% depending on the study. If we look at PCR testing by study it ranges from 0.4% to over 23%.

So what we understand about how health workers are getting infected; there are several studies that are looking at this and we have a living systematic review that we are conducting where we are constantly looking at the literature.

Some of the reasons why health workers are infected is because of a lack of PPE, not having adequate PPE to do their jobs and in some situations not having the training to wear the PPE appropriately. Early on in the pandemic when we had cases in come different wards such as geriatric wards or other wards that weren't prepared for droplet and contact precautions for infectious diseases they weren't trained to wear the right type of PPE but that has been changed and that has been improving.

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We also know that health workers are infected while on the job when they're in rest areas between each other so there's transmission that's happening between health workers and we know that there are conditions in which they're working where there are extended shifts, not adequate rest periods. That really needs to be supported.

But we also need to remember that health workers are people too and they live their lives and unfortunately many health workers are also infected outside of the healthcare facility. So I think there're a number of things that we are doing and that countries are doing to prevent health workers. This is a priority of WHO's beyond the pandemic but is a top priority of WHO's to protect health workers.

We have guidance that is out around infection prevention and control so how they can care for patients safely and the type of precautions that are needed depending on the type of care that's given.

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Our supply chain taskforce has worked very hard to ship PPE to 172 countries in all regions; millions of respirators and medical masks, face shields, gowns, gloves, goggles. We've issued training for infection prevention and control to make sure that all health workers know what this virus is, know how it is transmitted, know what are the proper infection prevention and control measures that they can take.

But we do need to ensure that health workers are equipped with the right PPE and I think, just lastly, we do need to do more to make sure that the right conditions are in place for health

workers, that they have adequate rest periods, that they have psychosocial support.

What health workers are going through is incredibly difficult and we owe so much to them. I think just lastly we owe the respect to them and there should be no stigma attached to the life-saving work that healthcare workers do.

FA Thank you very much, Dr Maria. We have also in the room Dr Bruce Aylward. He's the Senior Advisor to the Director-General. He leads the ACT Accelerator and he has something to add. Bruce.

00:19:53

BA Thank you, Fadila, and thank you especially, Gabriela, for raising this important issue of just he stress that the healthcare workers and care workers in long-term facilities continue to be under in this crisis because you cannot give it too much attention quite frankly.

I think Maria's done a wonderful job laying out all the things that we're trying to do collectively through the health sector, the health organisations to try and ensure they have the tools, the training, etc, to take care of themselves.

But I think what we have to remember, Gabriela - and you asked what else we can do - is going back to what the Director-General said in his opening comments, the single most important thing we can do is to collectively change our behaviours in the ways that are going to reduce the intensity of transmission and reduce the cases and reduce the pressure on the health system.

At the end of the day that I the most important thing we do. We will look to our political leaders, we look to our health leaders to help address these issues but we also have to look to us collectively, the general population; how we choose to live, how we socialise. These are the important things that drive transmission.

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We've got to ensure we maintain the distance between people, the masks and the other public health interventions because ultimately that's what's driving transmission, that's what's putting the pressure on the healthcare system.

But as you emphasised, most importantly behind that system of people it's the healthcare workers, it's the nurses, it's the cleaners in the facilities, it's the physicians and so many others

who work in these facilities who pay the ultimate price for the choices we make as individuals in terms of doing our part to reduce transmission. That is the most important thing we can do to help.

FA Thank you, Dr Bruce Aylward. We will go now to Agnes. I was told the technical problem is solved. Agnes, Agence France Press, can you hear me?

AG Yes, I can hear you. Do you hear me?

00:22:02

FA Welcome, Agnes. Just ask your question.

AG Okay, great. I will ask it in French.

TR According to the Swiss media figures have shown that there has been no excess mortality linked to COVID during the first three months of the year. The situation however would appear to be different in other countries in different parts of the world.

My question then is this; does WHO have statistics demonstrating excess mortality rates from the beginning of the pandemic or otherwise and are there regional variations?

FA Thank you, Agnes. Dr Maria.

MK I can begin and maybe others want to jump in. You highlight a very important aspect of a pandemic or any emerging pathogen as this pandemic evolves. There are deaths that are counted, that we know are associated with COVID-19 from infection and are tracked in real time as they occur.

There are ones that will be identified as we retrospectively go back in time and look at deaths and there are systems in place in several regions, in several countries that are looking at excess mortality.

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The one that I'm most familiar with - and there are others - is the one that's in Europe. That's the Euromomo project which is looking at excess mortality over time and as you point out, there are some variations in excess mortality by country.

I think it's too early to make conclusions about this because this is something that is ongoing but I think it is important to recognise that deaths from COVID are likely to be uncounted at the present time but countries are working very hard to better understand this.

We do also need to be looking at other causes of mortality that are occurring during the pandemic because people have not been able to access the care that they need so it is really critical that we get essential medical services and life-saving services back online so that people who need the care that they need can receive it and can receive it safely. That is something that all countries are working very hard on, we are working very hard on to support countries to be able to do.

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But I think we will see some differences in excess mortality and we are tracking the systems that are currently in place that are collecting that information.

FA Thank you, Dr Maria. Dr Bente Mikkelsen would like to add something. Please go ahead.

BM Thank you very much for the question. As Dr Tedros said, we have had several surveys which show that we have major disruptions in the case of noncommunicable diseases - cardiovascular diseases, cancer, diabetes and respiratory diseases.

So far we have comorbidity studies from single countries and we are working on this also on the global level so of course it will be very important to trace what you're actually assaying [?] because we really need to know if this will again dwindle the achievement of the SDG, namely to reduce the mortality from noncommunicable diseases.

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So we don't know this yet but from studies we know - and the good thing is that the majority of countries have actually now started to register comorbidities in their hospitals so we know for example that in Mexico diabetes was the most frequent comorbidity in the registered deaths from COVID and we see other figures; like in Italy among those dying in hospitals we see 67% of people living with hypertension and 31% living with diabetes.

This is of course very important both for the current situation but also to understand the picture and be able to close these gaps with the guidance that WHO can give. Thank you.

FA Dr Bruce.

BA Agnes, you raised a really important point about this excess mortality data and as Maria laid out, many countries do

track excess mortality, not all countries so we don't have data from all over the world and as Maria says, it's actually tracked differently in some countries so we don't have exactly comparable data.

But what we do know very, very clearly is that there has been more mortality during this period than the numbers from COVID-19 alone tell us and that's extremely important. Some of that excess mortality is probably COVID disease that was not recognised or reported but then it's also telling us that this incredible impact on the health system that Gabriela asked about earlier is having a real cost in terms of human lives.

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This all emphasises the importance of the measures that the Director-General has just emphasised day after day after day because there's a real cost in human lives that go beyond the numbers that we're seeing in the COVID numbers alone.

FA Thank you all for these answers. We will go now to India to ask Aziz Ahmad from Hello Mumbai. Aziz, can you hear me? Please unmute yourself and ask your question. Aziz. I was told he was no longer online. If not we will go to Anna Pinto. Anna, can you hear me?

AN Yes, I...

FA Hi, Anna. Just ask your question, thank you.

AN Earlier this week the President of Brazil, Jair Bolsonaro, was approached by a citizen who asked him not to deploy vaccines against COVID-19 in the country because according to him - and I quote - vaccines are dangerous. Bolsonaro replied to him that the Government will not force anyone to get vaccinated.

00:28:32

My question is, I'd like to know what is the WHO's message for people who believe that vaccines are dangerous and what can be done to counterbalance anti-vaxxers' movements and disinformation. Thank you.

FA Thank you, Anna. I believe this question is for Dr Soumya Swaminathan, our Chief Scientist. Soumya, you have the floor.

SS Thank you, Fadila, and thank you for that very important question. I think this is really a topic that everyone around the world is discussing today. I think the first thing to remind ourselves is that vaccines are life-saving interventions and if you think about diseases like smallpox, like polio, like measles that

used to kill hundreds of thousands and maim millions of people around the world it's thanks to vaccines that we don't see those diseases today.

So we've forgotten what smallpox is like, we've forgotten what polio's like, we've forgotten how measles used to kill millions of children, still does kill hundreds of thousands of children unfortunately around the world despite the fact we do have a very safe and effective vaccine for measles.

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So we have to put in perspective vaccines and what they've done for humanity when we start thinking about COVID vaccines. We're at an early stage of development. No doubt there's been an unprecedented speed of development of COVID vaccines; we've never seen anything like this before and that's because of advances in science and technology and also the fact that there are now platforms which have been developed because of investments in the last several years which make it possible for companies and academic groups to just take the new virus sequence and put it onto an existing platform which has already been tried and tested for other diseases.

This is part of the reason why you had a phase-one trial of one particular vaccine 66 days after the first genetic sequence of this new coronavirus was made public.

Having said that, vaccines still need to go through phases of testing, they need to go through lab testing followed by animal studies followed by human trials starting in very small numbers of people to test safety, moving on to what we call immunogenicity studies where we look for the development of protective antibodies and other immune responses which we think are signals.

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But eventually you need phase-three trials which actually look at reduction of disease in the group that's vaccinated compared to the group that's not given the vaccine, that was given a placebo. This happens in tens of thousands of people who are also followed for safety signals.

No vaccine is going to be mass-deployed before the regulators are confident and the governments are confident and WHO is confident that these vaccines have met the minimum standards of efficacy and safety.

We have a very elaborate and thorough process where we look at all the criteria, the qualities of the vaccine and whether they are being met before we make any kind of recommendations either on emergency use authorisation or on a general licensing or authorisation for use through pre-qualification programmes.

We have an independent group of experts, the SAGE, scientific advisory group of experts on immunisation that makes recommendations. Again it's a globally recognised independent group of experts that will look at the properties of an individual vaccine and the data from the trials. Therefore they'll make a policy recommendation.

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So I think we should reassure the public that vaccines that are recommended for use by WHO and by the national regulatory authorities would have passed the minimum standards needed. We've also heard very encouraging statements from a number of vaccine developers and the heads of those manufacturing companies that they will abide by the standard guidelines and rules for development of vaccines.

So there needs to be... I think the questions that people are posing mean that there is a need for more information-sharing, there's a need for more transparency, for more education of the public on vaccines in general and then on COVID vaccines in particular. Thanks.

FA Dr Tedros, please.

00:33:30

TAG Thank you, Fadila. I think Soumya has said it all. I just want to stress a bit. I would like to assure the public that WHO will not endorse a vaccine that's not effective and safe so that's one.

Second as she had said, vaccines have helped in eradicating smallpox. They're almost on the verge of eradicating polio but I would like to remind the world how we used vaccines to defeat Ebola in northern Kivu, eastern DRC where the Ebola outbreak situation as very much complicated due to security.

As you know, North Kivu is a place where more than 20 armed groups operate and it's with the help of vaccines that we were able to stop or end the Ebola epidemic in northern Kivu in eastern DRC.

So for people to understand the power of vaccines it's better to see the track record of many of the vaccines we used in the past several decades and even in the recent past, as I said, in eastern DRC.

Going forward, vaccines on COVID-19; we have a good number of promising ones. They will only be used when they're found to be effective and safe. That's what I would like to assure the world and, as Soumya said, this will be done by WHO and local authorities.

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As to the anti-vax movement, they can build narratives to fight against vaccines but the track record of vaccines tells its own story and people should not be confused by a movement, the anti-vax movement but they can have a look for themselves on how the world actually used vaccines to reduce under-five mortality, to save children and to have successful eradication of diseases like smallpox.

So just please go to the track record of vaccines and have a look for yourselves, especially parents; have a look for yourselves and see how vaccines actually change the world. That's why we have this famous saying; vaccines actually affect adults, our children will be healthy adults when we use vaccines.

For COVID we are hopeful that we will have one so that the world can get back to normal. Thank you.

FA Thank you, Dr Tedros. We will move now to Simon Ateba from Today News Africa. Simon, can you hear me? Simon?
Second attempt.

00:37:53

SI Yes, I can hear you.

FA Simon, we can hear you. Please go ahead.

SI I can hear you. Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. Yesterday WHO Africa said virtually all African countries, all 54 or 55 African countries have expressed interest in COVAX, the ground-breaking initiative to provide almost 220 doses of vaccine to Africa.

I would like WHO to give us an update on what the next step is and what would be the contribution of each African country to take part in COVAX; and also to ask WHO if 220 million doses of

vaccine for a continent that has 1.2 billion people is enough.
Thank you.

FA Thank you, Simon. We will start with Dr Bruce Aylward.
Bruce.

BA Thank you, Simon, and thank you for emphasising the importance of the landmarks that we passed this week in the battle against COVID and getting our ACT Accelerator up and operating.

00:39:11

As you highlighted, this week we passed the landmark. By 31st August we were asking countries to confirm their intention to participate in the COVAX facility and as the Director-General highlighted, we were delighted to hear that 78 high and upper-middle-income countries will be joining with the 92 countries of GAVI and that will receive support through what we call the advance market commitment for a total of now 170 countries that will be part of the ACT Accelerator.

The African continent has been a huge contributor to the work of COVAX and some people on the call will be aware, there have been a number of important partners that we work with in terms of trialling vaccines and studying vaccines, also in terms of planning how they would be rolled out and operationalised over time; also in the very design of the COVAX facility.

We've had a number of big conference calls that have involved many of the countries that are now signing up to COVAX, many, many countries from the continent who are providing their input as we worked out the details of the COVAX facility and designed it really together so a huge contribution and will continue to be as we go forward.

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In terms of vaccine numbers and doses, remember the way that we've been discussing the use of these products that will come out of the ACT Accelerator, especially the vaccines, our immediate goal is to reduce the burden of severe COVID disease around the world because if we can reduce the risk of severe COVID disease then we can very rapidly - as the Director-General emphasised - start getting back to more open societies, functional societies and rebooting our economies.

Because it is the severe COVID disease which is generating the fear and it's the severe COVID disease which is resulting in the

loss of confidence whether it's in terms of individuals, in terms of employers, etc, that underpin the economic challenges we face.

So what we look at is how much vaccine do we need to reduce the risk of severe disease and, as was described in the opening comments of the Director-General, we have a better and better understanding of who is most at risk of the disease and most at risk of severe COVID disease.

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So we don't need vaccines for absolutely everyone right at the very beginning. What we need to make sure is, as we've said before, all countries get some vaccine and that we use that vaccine to protect our healthcare workforce and care workers and then to protect our elderly and then to protect the others who are at highest risk.

That can be done initially with relatively small quantities of vaccine as they come out and then grow over time so the important thing is not what is the exact number but how much vaccine do you need at the beginning to be able to reduce the risk of severe disease because that's the key to removing the fear, rebuilding the confidence and getting our societies and economies working again.

The 200-plus million doses would definitely go a long way to achieving that but right now we're a very long way even from that 200 million doses. So that's the key, it's been an important week and we're certainly encouraged by what we're seeing again in terms of a tremendous solidarity to try and ensure we reduce that risk of the disease around the world and start getting back to a more normal way of functioning going forward. I think Soumya wanted to add.

00:43:00

SS Very briefly just to add - I think Bruce has explained it very well - that the African Union has taken real leadership in this and engaged in discussions with WHO but also with other partners on making sure that there's access to the best vaccines for the African people but also to be part of the research and development process.

So the strategy for the COVID vaccines for Africa really has three pillars, the first one being very much to be playing the leadership role in the research and development of these vaccines, ensuring that clinical trials take place in Africa so that these vaccines are tested in different ethnic groups, different racial groups, age

groups, etc, so that you have better estimates of how this vaccine works in different populations.

Also focusing on expanding manufacturing capacity in Africa, getting into technology transfer and so on. This is building capacity for the future and of course focusing on the policy, the implementation, how delivery of these vaccines will take place as we know that many countries face a lot of challenges in delivery even of routine vaccines to children and this is going to be a vaccine that's going to have to be given to other age groups.

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This is not a childhood vaccine so every country needs to start thinking about how these campaigns are going to be run and what is going to be needed in terms of human resources, supply chains, cold chain equipment, logistics, needle syringes, etc, training so that when the vaccine is available there's no delay in launching these immunisation programmes. Thanks.

FA Thank you, Dr Swaminathan, and thanks, Dr Bruce, for your answer. I believe Mike Ryan has something to add. Mike, can you hear me?

MR Yes, I'm just speaking with specific reference to Africa and to colleagues in Africa.

FA Sorry, Mike. You are very soft. Can you speak up, please? Thank you.

MR Can you hear me?

FA Yes. Try again, Mike.

MR Hello.

00:45:37

TAG Speak a bit louder or maybe increase your volume.

MR [Inaudible], DG. I can't speak any louder otherwise I'm shouting so can you hear me now?

FA You are great. Go ahead.

MR I just want to reflect on the contribution that African countries have made in general to vaccination and to congratulate Africa as a continent for the eradication of polio and certification of that eradication; a huge task carried out with many, many, many years of effort. Both Tedros in Ethiopia and our RD, Dr Moeti and Dr Bruce himself, who's sitting there, championed a lot of the work that led to that.

But also in the areas of cholera and meningitis and yellow fever and Ebola African countries have championed a lot of the techniques we use now for mass vaccination, for community engagement and for really going after infectious disease, particularly these epidemic diseases.

But Africa has a lot to also share with the world; it's not just a beneficiary in this process. Africa has learnt the techniques of introducing new vaccines, of introducing new vaccines quickly against epidemic diseases and innovating in terms of implementation, in terms of logistics and again Dr Tedros spoke to the situation of Ebola.

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It was African health workers, African scientists who worked to bring the Ebola vaccine into the field, a vaccine that had to be transported at -80 degrees into the deep field and given with very stringent oversight and data gathering and safety measures; again a huge triumph for African public health.

So in this I believe African countries and particularly African scientists and African doctors and nurses have a lot to tell the world about how we can introduce a vaccine against COVID in an effective way and at scale. Thank you.

FA Thank you, Dr Ryan. There is no other intervention in the room. I would like to give the floor now to Peter Schilling from the European News Agency. Peter, can you hear me?

PE Indeed, thank you. Can you hear me?

FA Yes, very well. Go ahead, please.

00:47:59

PE With all the schools opening up in most of the European countries now there's a very big debate what to do and how to handle children. I want to refer to a publication that was made by the Massachusetts General Hospital and the Child Hospital that provided critical data showing an alarming twist with children, that they likely play a much bigger role in spreading the coronavirus than we thought so far and also that they were having a very high viral load.

So the question is to what extent should we then go through lock-downs when a class is identified with having a COVID-19 infection, should we lock down or should we contain the children in class for the period, otherwise they go back home and be spreading it more than we thought? Thank you.

FA Thank you, Peter. Dr Maria.

MK Yes, thank you, Peter, for this really important question. You highlight a study that has been recently published and in fact there are a number of studies now that are looking at three major important aspects of COVID-19 in children. One is the severity of disease, the disease that is experienced by children and adolescents. Luckily most children have mild disease, many children have asymptomatic infection. It's not universal. We do have reports of children having severe disease and some children have died.

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The second thing we look at is the extent of infection among children. We've known from the beginning and we have said repeatedly that children can be infected with the SARS-CoV2 virus and of course they can; all people are susceptible to this virus.

What we didn't understand and what we are starting to learn is the extent of infection among children. This is captured mainly through the seroepidemiology studies and there are several studies now that have been published that look at age differences and seroprevalence.

What is important when we look at infection rates is we need to break the children down by age group because there seem to be different rates of infection as measured by these antibodies in the youngest children with lower levels of rates of infection or seroprevalence compared to adolescents so they can be infected.

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The third thing that we look at is transmission and are children capable of transmitting the virus and again from the beginning we knew that children could be capable of transmitting the virus. We learned this very early on from household transmission studies that were conducted in the early days in China and what we were really concerned about in the beginning was were children infecting adults, were adults infecting children.

We knew and we know that transmission can happen both ways although in the beginning it appeared it's more often transmitted from adults to children. What we're learning about now is that again it's very sensible and important to look at age differences in children because there are different contact patterns among children.

In terms of transmission the youngest children tend to transmit less and you just look at the type of contact patterns that they have and their ability to transmit.

But adolescents do transmit and they can transmit the virus and they seem to transmit at similar rates to adults so it's important when you consider what to do with children - and that was your question and you treat all people - we look at different age groupings.

00:51:36

When we think about schools and opening up schools, you've heard us say many, many times it is important that we don't look at schools in isolation. Schools are part of communities and if the virus is transmitting in communities it can transmit in that school.

But there is some importance to making conditions when schools are open for the youngest children compared to adolescents. We've outlined a series of considerations and guidance around how schools could open up safely. Everybody recognises the incredible importance of schools not only for education but for security, in some situations for their food and for their social and mental well-being.

So it's very important to consider the type of school, the age group that's there and the grades, their ability to comply and adhere to public health measures like physical distancing, the wearing of masks where appropriate, hand hygiene; all of the different factors that are part of opening up society safely and opening up schools is included in opening up society safely.

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So we're learning a lot but I do think it's important - we don't know everything as it relates to children but there are a lot of good studies that are out there and I think we all recognise the importance of keeping children safe but it starts with the community.

Bringing transmission under control in the communities is critical. All of the individual measures that you need to take to protect yourself, whatever age you are, from getting infected and passing to another are important; hand hygiene, respiratory etiquette, wearing a mask where appropriate, all of that in addition to active case finding, isolation of cases, contact tracing. All of this needs to be as part of our new normal as we go forward.

FA Thank you, Dr Maria. We have now a question from BN Kumar from India Biz News Connect. Kumar, can you hear me? Kumar?

KU Yes, can you hear me?

FA Yes, very well. Go ahead please.

00:53:46

KU My question comes from the experience in India. For a long time many leaders, politicians have been claiming that by the end or middle of next year we'll have a safe vaccine, etc. On the other hand there we have a group of doctors cautioning not to make false promises, not to create false aspirations among the people for the vaccine.

My question is, how realistic is it to assume that the vaccine will be available soon, in six months, eight months? What kind of period can we look at? Because it's creating a lot of confusion in the minds of the people.

FA Thank you, Kumar. I think this is a question for Dr Swaminathan. Soumya, please.

SS Thank you for that question. As you know, there are a large number of clinical trials going on worldwide. We have more than 30 candidates now in clinical trials. About nine of them are in phase three clinical trials. There are at least three clinical trials going on in India, phase-one and two trials so it's a very optimistic scenario because there's a huge field of candidates.

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We know that normally in vaccine development we expect about a 10% success rate and so to have more in the early stages of testing gives us hope that several of them would be able to prove themselves to be safe and efficacious.

As we said earlier, these need to go through the full phase-three clinical trials before we can answer that question. We expect results from some of the candidates which are already in phase-three trials to come by the end of the year or the beginning of next year, following which there will have to be scaling of manufacturing to produce the hundreds of millions of doses that are going to be needed.

In fact the world is going to need billions of doses and that's going to take time to manufacture so we have to be optimistic and realistic at the same time so realistically speaking probably the middle of 2021, maybe the second or third quarter of 2021 is

when we can start seeing doses actually flowing into countries so that they can start immunising their populations.

As Bruce was saying earlier, we're not going to have enough for the whole world right at the beginning. We're going to see first tens of millions of doses, then hundreds of millions of doses and subsequently hopefully that scale-up will happen.

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So eventually there will be enough for everyone but it will mean prioritisation; prioritisation of groups within countries who should receive that first tranche of vaccines. This is where the COVAX facility and the fair allocation framework that's been developed by WHO in consultation and agreement with our member states would play an important role in determining how those scarce doses of vaccines in the beginning will be distributed and used hopefully in a fair and equitable manner so that, as the DG was saying earlier, it is important to make sure that the people who need the vaccine get it regardless of which countries they're living in.

There's no point some countries vaccinating entire populations while others are waiting for a long time. That's what the COVAX initiative and the COVAX facility aims to achieve and if it comes sooner, the better but certainly by the middle of 2021 we should start seeing some vaccines moving into countries and into populations. Maybe Bruce wants to add.

MK If I may add one thing to supplement what Soumya was saying about the advancement of the vaccines, I just want to make it crystal-clear, there's so much that we can do now. While the vaccines are being accelerated and being developed - and it's been outlined very clearly that it's a safe and effective vaccine that so much of the world is working towards and that's really wonderful.

00:58:21

But there's so much that you can do now and I think we will hammer this as much as we possibly can because there are individual steps that you as an individual can take to protect yourself from getting infected, to minimise your exposure, to manage your risk.

This has to do with how you live your daily life and everybody wants to get back to a normal life and get back to what used to be but we need to make considered decisions about how we go

about doing that, how we go to work, if we need to wear a mask if we can't physical distance.

We need to practise hand hygiene and respiratory etiquette, avoid these three Cs; crowded spaces, enclosed settings, especially with poor ventilation. There are ways in which you can minimise your exposure.

To be informed so what is really important is that you know where the virus is in the areas where you live and in the areas where you work. This comes from the strong, governance-led responses that we are seeing in so many countries, the strong, clear response at a national level, implemented at the local level.

00:59:29

What we are seeing now is countries that - in the beginning many had to put in these national so-called lock-downs because they needed to buy themselves some time to take the heat out of the virus, out of the transmission and get some time to get their systems on track.

Many countries have a public health workforce now, they have testing capacity that has been greatly increased, they have contact tracers that are out there, they're preventive clusters from happening or when clusters do happen they're rapidly carrying out these outbreak investigations.

All of these things are really positive and I just want to highlight this because we are seeing many countries apply these public health measures and make great efforts to bring outbreaks under control and these are things that are happening now.

01:00:15

So we need strong government, strong government-led responses, we need very targeted, tailored local implementations so that we can avoid national lock-downs again. We are very hopeful and we are seeing in many countries they are applying targeted, time-bound, geographically bound measures to bring outbreaks under control and using all of the active case finding, contact tracing, training your workforce, protecting your workforce, improving clinical care, getting hospitals ready.

All of that is still happening in the background and countries that have been successful in suppressing transmission are ready. They're ready to identify cases very quickly, they're ready to identify clusters and carry out the necessary steps to prevent those clusters from becoming community transmission.

So I just want to emphasise that there's so much that all of you are doing now that is benefiting society and is helping this pandemic so please be hopeful and be empowered that there's a lot that you can do.

FA I think Dr Bruce has something to add. Bruce.

BA Yes, just to help Mr Kumar - that was an important question - I think it's hard for the general public when they're hearing these sometimes substantially different estimates of how long it will take us to actually have a successful vaccine if indeed these trials are successful.

Sometimes it's helpful to demystify these timelines a little bit but if you think about these trials - you keep hearing phase-three trials - remember these involve tens of thousands of people - usually, the large ones - we really need to see an effect of the vaccine on.

You have to give people one dose and then usually it's at least two weeks or three or four weeks before they get the second dose and then by the time you enrol that many people, get those two doses in that's often three months or longer. It can't be shorter than two obviously but it's usually a few months just to get that many enrolled in the trials.

Then you've got to observe them for a long enough period to understand who is protected and not protected. There you're a little bit at the mercy of the epidemic itself because it depends on how much disease is actually circulating in the community by that point.

01:02:31

Then when you finally have that, which will take a couple of months, a few months depending on the intensity of transmission, then you've got to analyse those data, you've got to get the product licensed.

There're some things we can do to speed things up. If we think it's a very promising vaccine we can produce it in parallel at risk - even if it fails we'd have to throw those doses away, as you've heard.

But there are other things you simply can't speed up and this goes back to the important question asked earlier - if I remember, it was by Anna, I believe - about the vaccine confidence. We can accelerate many parts of the process and we'll work very, very hard to do that. Scientists, manufacturers, everyone is doing their best.

But you cannot accelerate certain parts which are essential to ensuring the vaccines are safe and efficacious. That takes a certain amount of observational time that you simply can't rush and it would be in no-one's interest to rush that part of it because that is what would shatter the confidence and trust which is so important in this process to roll out these vaccines.

01:03:35

So when you stop and think a little bit, these phase-three trials; how big are they? They're going to give two doses up to a month apart and then they're going to have to follow those people for some time. You can understand why these timelines can be fairly long between now and when we have a definitive answer.

Also some of the factors are simply out of our control because it will depend on how intense transmission is in an area.

FA Thank you, Dr Aylward. I think we will wrap up the press conference now if there is no other intervention in the room. Maybe Dr Bente wants to add something.

BM Thank you very much and thank you for also focusing today on the chronic diseases. Of course the primary task just now is to defeat COVID-19 but at the same time I think we cannot ignore - as Dr Maria also says - that we have to work to really also continue to strengthen the health system. We have seen today during this pandemic almost an x-ray, that people living with cancer, diabetes, cardiovascular diseases; first of all they get more severely ill and they die from COVID.

01:04:55

The second is that because of course we need to try hard to defeat COVID-19 these are the patients also suffering. When we have reductions in heart attacks dropping in many countries, in the admission to hospitals, this is a clear call to action.

That's also why we have today four papers published this week. One is about disruption to treatment and we can see that cancer diagnoses really are suffering but also the Lancet article focusing on the universal health coverage tells us that we will not be able to reach this without also including noncommunicable diseases.

The publication today from the Lancet, Imperial College, WHO and NCD Alliance shows us that we need to work much harder. If I may add, I think we need to learn from this pandemic and build back better and we cannot continue the same way because a new pandemic will again also be a threat to the people with chronic diseases. Thank you.

FA Thank you, Dr Mikkelson. I think we will wrap up this press conference. Final words, Dr Tedros? Thank you.

TAG Thank you. Thank you, Fadila, thank you for moderating today. I would like to use this opportunity to thank Margareta for moderating for the past few months. Today's Friday so I wish you a nice weekend. In this room I have many colleagues here with me and I would like to introduce the countries they come from.

01:06:54

Maybe I'll start with the moderator, who's from Algeria. Then I have Australia, Canada, Poland, Serbia, India, the United States, Norway, the United Kingdom, Lebanon, Afghanistan, Netherlands, Ireland, France and of course myself from Ethiopia. That's the diversity we have in WHO and I'm really proud to be WHO. It's the whole world which is serving you.

Thank you all for joining us and please accept our happy weekend from all my colleagues, representing almost the whole world, as I have just read where they come from. We are the world and national unity and our solidarity is the antidote to this pandemic. Thank you so much again. Have a nice weekend. Bye and see you on Monday.

FA Thank you all. Bye.

01:08:13