COVID-19

Virtual Press conference

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BA	Professor Benedetta Allegranzi
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00:00:00

TJ Hello, everyone, from WHO headquarters here in Geneva. Today is June 5th 2020. My name is Tarik and we welcome you for this regular press conference on COVID-19. Today with us we have WHO Director-General, Dr Tedros, Dr Maria Van Kerkhove, Technical Lead for COVID-19, we have Dr Mike Ryan, Executive Director for Emergencies. We also have Professor Benedetta Allegranzi, who is the Technical Lead for Infection Prevention and Control, as well as her colleague, Dr April Baller, who works on infection prevention and control.

Before I give the floor to Dr Tedros I will just remind everyone who is watching us on a number of platforms that we will have an audio file available from this press conference immediately. For journalists who are watching us on Zoom, you can listen to us in six UN languages plus Portuguese and Hindi, which you will find in your settings. For those journalists who would like to ask a questions in six UN languages and Portuguese they can do so and I would thank our interpreters who are here with us and who make this simultaneous interpretation possible today. I will give the floor immediately to Dr Tedros.

TAG Thank you. Thank you, Tarik. Good morning, good afternoon and good evening. First of all I would like to thank all donors who stepped up yesterday to fully fund GAVI for its next five-year cycle. This is a vital investment in saving millions of lives from vaccine-preventable diseases. WHO looks forward to working with GAVI to realise the power of vaccines for everyone everywhere.

00:02:04

Today WHO is publishing updated guidance on the use of masks for control of COVID-19. This guidance is based on evolving evidence and provides updated advice on who should wear a mask, when it should be worn and what it should be made of. WHO has developed this guidance through a careful review of all available evidence and extensive consultation with international experts and civil society groups.

I wish to be very clear that the guidance we're publishing today is an update of what we have been saying for months; that masks should only ever be used as part of a comprehensive strategy in the fight against COVID. Masks on their own will not protect you from COVID-19.

Here is what has not changed. WHO continues to recommend that people who are sick with symptoms of COVID-19 should remain at home and should consult their healthcare provider. People confirmed to have COVID-19 should be isolated and cared for in a health facility and their contacts should be quarantined.

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If it's absolutely necessary for a sick person or a contact to leave the house they should wear a medical mask. WHO continues to advise that people caring for an infected person at home should wear a medical mask while they are in the same room as the sick person and WHO continues to advise that health workers use

medical masks and other protective equipment when dealing with suspected or confirmed COVID-19 patients.

Here is what's new. In areas with widespread transmission WHO advises medical masks for all people working in clinical areas of a health facility, not only workers dealing with patients with COVID-19. That means for example that when a doctor is doing a ward round on the cardiology or palliative care units where there are no confirmed COVID-19 patients they should still wear a medical mask.

Second, in areas with community transmission we advise that people aged 40 years or over or those with underlying conditions should wear a medical mask in situations where physical distancing is not possible. Third, WHO has also updated its guidance on the use of masks by the general public in areas with community transmission.

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In light of evolving evidence WHO advises that governments should encourage the general public to wear masks where there is widespread transmission and physical distancing is difficult such as on public transport, in shops or in other confined or crowded environments.

Our updated guidance contains new information on the composition of fabric masks based on academic research requested by WHO. Based on this new research WHO advises that fabric masks should consist of at least three layers of different material. Details of which materials we recommend for each layer are in the guidelines.

We also provide guidelines for how to wash and maintain a fabric mask. Our guidance also explains how to use a mask safely. People can potentially infect themselves if they use contaminated hands to adjust a mask or to repeatedly take it off and put it on without cleaning hands in between.

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Masks can also create a false sense of security, leading people to neglect measures such as hand hygiene and physical distancing. I cannot say this clearly enough; masks alone will not protect you from COVID-19. Masks are not a replacement for physical distancing, hand hygiene and other public health measures. Masks are only of benefit as part of a comprehensive approach in the fight against COVID-19.

The cornerstone of the response in every country must be to find, isolate, test and care for every case and to trace and quarantine every contact. That's what we know works. That's every country's best defence against COVID-19. WHO will continue to provide the world with advice based on the most up-to-date evidence as part of our commitment to serving the world with science, solutions and solidarity.

I think when I was reading the presser I said 40 years and above and it has to be corrected as 60 years and older. Sorry for that. I will read again that part of my statement.

In areas with community transmission we advise that people aged 60 years or over or those with underlying conditions should wear a medical mask in situations where physical distancing is not possible. Thanks again.

00:08:48

TJ Thank you very much, Dr Tedros, for these opening remarks. We will be sending the updated guidance on the use of masks to our global list as soon as it gets published as well as some accompanying material. Before we go to questions, just to remind journalists to be short, concise and one question per person so we can take as many as possible. Again you can ask questions in six UN languages plus Portuguese and our interpreters will make sure this is interpreted simultaneously.

We will start with Financial Times. Do we have Anna Gross online?

AN Hi, can you hear me?

TJ Yes. I can hear you.

AN Great. Hi, thanks for taking my question. Professor Hawby from Oxford University said earlier today in a press briefing that he spoke to WHO this morning to relay Recovery's negative headline data on hydrochloroquine. He said that WHO had said it would reconvene its committee to revisit its decision to resume the hydrochloroquine arm in light of that data. Is there anything else that you'd like to say about that?

00:10:05

SS Thank you for that question. Indeed we are aware of the release of a statement from the chief investigators of the Recovery trial in the UK, whose data safety committee has unblinded the data and looked at the hydroxychloroquine arm

versus the standard of care arm and they have large numbers in each of those groups so about 1,500 versus 3,000.

They have come to the conclusion that there is no benefit of hydroxychloroquine use on mortality in hospitalised COVID patients so as Solidarity and Recovery are two of the larger trials and moreover they have very, very similar study designs we have been in touch and we were encouraged by the rapid enrolment into the Recovery trial, which is what is needed really to answer the questions.

So Professor Hawby and ourselves had a conversation this morning. They informed us about the preliminary results, which they have gone to the press with. We wait to see the final data analysis and the publication that's going to come out of it and certainly our committee will be considering these results as we go on.

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However they're two distinct trials with their own protocols, their own oversight committees and therefore we will continue for now and our committee will consider the data as it becomes available. That's what data safety monitoring committees are supposed to do; look at the data within our trial but also consider evidence that's coming out of other randomised trials and we will continue to update you on the progress of the Solidarity trial. Thank you.

TJ Thank you very much. This was Dr Soumya Swaminathan, WHO Chief Scientist, who answered this question. Now we will go to South Africa broadcaster. We have Sophie Mkwena online. Sophie. Can you unmute yourself, please?

SO Hello, can you hear me?

TJ Yes.

SO I just want to find out from Dr Tedros; we know that scientists currently are racing to develop a COVID-19 vaccine and clinical trials have started in different parts of the world but the question is, how is WHO going to ensure that all its member countries have access to the vaccine should the trials be positive and a vaccine be introduced by those countries where currently they are conducting trials?

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Because when you look at the inequality around the globe, we may find a situation where poorer countries won't have access to this. How are you going to ensure access to all?

TAG Yes, thank you, Sophie. As you know, we launched an initiative called ACT Accelerator on April 24th and as you may know, there were two objectives to be achieved by the ACT Accelerator initiative. The first one is to accelerate the development of a product. It could be a vaccine, therapeutics or a diagnostic tool.

The second objective is of course to ensure access, equitable distribution to those who need it. Following the April 24th launch of the ACT Accelerator the European Commission did a pledging conference on May 4th which was successful, as you know, and raised about US$8 billion to finance the initiative.

In the meantime we are already working also on what kind of model we can have on allocation of the product, be it a vaccine or others, but more importantly it needs a political commitment also from leaders. As you know, during our World Health Assembly and during the pledging conferences and yesterday also during the GAVI replenishment, many leaders said that a vaccine should be a global public good and that political commitment and leadership will also be very important.

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But since we have already launched the ACT Accelerator and we're preparing to achieve the two objectives which I have said, we hope that when the product is available or when the product is ready, when vaccine is available we believe that it can be accessed by those who need it.

We will do everything with our partners to make that happen but I will repeat; political commitment by political leaders, by our leaders from the north and south will be very crucial and it will be at the centre to realise and make sure that any vaccine that will be available will be a global public good. Thank you.

MR Maybe I can just add to that more examples in other areas. I think WHO working with our member states, with UNICEF, with MSF, with IFRC, with GAVI have maintained crucial global stockpiles of vaccines for a number of diseases; yellow fever, meningitis and cholera.

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We both procure and distribute those vaccines on the basis of epidemiologic need in epidemic situations. The challenge here is obviously much greater but there are successful mechanisms for the fair allocation of products that are on the basis of need. They need to involve member states, they need to involve the

multilateral organisations and they need to involve nongovernmental organisations and civil society as well.

I believe we do have the basic architecture to achieve that but as the Director-General has said, ultimately this requires political consensus across the world around the global good and its fair and equitable distribution.

TJ Thank you very much, Dr Ryan and Dr Tedros. The next question comes from CNN; Jacqueline Howard. Jacqueline, can you hear us?

JA Yes, I can hear you. Thank you for taking my question. My question was, along with the new guidance that was just announced is there any guidance specifically for a nation's leadership personally? For instance here in the United States our leadership has not worn a mask and there was even a press conference earlier today at the White House where we didn't see many people wearing masks.

00:18:07

So is there any guidance for nations' leaders themselves to wear masks or any other guidance for administrations?

MR No. This guidance is given as guidance to our member states and it must be interpreted and adapted by national authorities accordingly and we have no specific advice for any specific grouping at country level other than certain occupational hazards and other areas like healthcare, where we believe there's a significant excess risk and in that situation we advise very specifically around the type of mask to be used.

TJ Thank you very much. We will go to Sarah Veeton from Politico. Sarah. Sarah, can you press unmute, please?

SA Yes. Thank you very much. Regarding hydroxychloroquine and the mixed messages that have been going on, one of my colleagues just mentioned the news out of the UK that they've ruled it out as a possible treatment but at the same time we saw this Lancet study being retracted. Do you have any requests to researchers, to journal editors about how they talk about their findings and what would you say to people who are tracking the news and are just feeling very confused and not feeling they can trust research that's coming out?

00:19:47

MR I can begin and Soumya could add. I think with regard to what you spoke about mixed messages, I don't believe there are

any mixed messages but obviously with a story of such huge public interest and with 24-hour coverage of those issues then the normal process of science can sometimes appear confusing; that's for sure.

But can I assure you that the actions that were taken in relation to the signal of potential higher mortality for hydroxychloroquine were taken in the best interests of the people who enrolled in that study and the patients enrolled in that study to ensure that any indication of a higher mortality from a peer-reviewed publication will be taken seriously and the hydroxychloroquine arm was suspended for that reason.

The action taken today by the Recovery trial organisers is a different action and it happens and both of these issues happen in trials. One, a trial can be suspended or paused in order to look at a safety issue. Secondly, the data safety monitoring boards, these independent boards that oversee trials can stop a trial when they feel either that some drug has really outperformed others and we need to stop because there's a clear signal of something really working as opposed to others so you don't want to deny patients the best drug.

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Secondly, if you find that you're using a drug that is not showing any benefit then ethically you have to stop the trial because you're now denying maybe that patient the benefit of another drug in the trial that may be more efficacious.

So these are two really well-managed processes and I know they sometimes seem confusing to the general public but let me assure you, these are very, very important processes to monitor the safety, the efficacy and to ensure that those decisions are made independently, not by the researchers themselves as such but made by these oversight committees and boards that ensure the interests of the public and the interests of patients.

Then when you speak specifically about the Lancet article and the retraction, again a responsible journal will publish peer-reviewed publications. There is a process of external peer review and for the vast, vast majority of cases in peer-reviewed journals those papers are not retracted. It's an incredible success rate in terms of papers that are published that are good, that are solid, that are adding to science.

Occasionally when a paper is published inadvertently and subsequently the data that supports that publication is found to be questionable or called into question then it is the responsible

thing to do for the journal to retract that paper on the basis that they need to check the data or they're not sure or there's a question or a doubt.

Again that is good science, that is doing the right thing. I know it sometimes can give the impression that the science community is confused or giving mixed messages and for that we all collectively apologise to all of you for that but we must follow science, we must follow evidence and we're absolutely dedicated to ensuring that people entering into clinical trials are entering into safe trials that are planned with their benefit in mind and that any signals related to lack of effectiveness of a drug or safety of a drug will be monitored carefully so that patients are protected in the process.

SS Maybe I can just add to exactly what Mike was saying; that this is the normal process in science so if you take any disease or any subject you have clinical trials, you have observational studies that take place, usually over years and then this evidence is reviewed and guidelines and recommendations on treatment are made and things don't happen at the speed at which we see them happening now.

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We also find that each movement, each step is reported widely in the media for natural reasons because everybody is keen to see which drug is going to be effective, when is the next vaccine coming out. But what that can do sometimes is to confuse the lay public who don't understand what a randomised clinical trial is and what the rules are that govern these trials.

The fact is that it is quite normal to have slightly different results coming out from different trials and that is why the scientific world normally wants more than one trial for any particular drug or vaccine to really confirm that what you're seeing is actually a true effect.

So it's very normal in practice to have many trials, to have slightly different results and then you put them together in what we call a meta-analysis or a systematic review to look at what the overall message is; what's the overall benefit or the overall harm.

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I think the issue with masks is very much the same; there's been a lot of debate and a lot of small studies and retrospective studies and observational studies, no randomised trials so you

have to put all of the data together to really make the best-informed decision.

It's the same with treatment. We will be looking continuously at the results of these different trials and updating our treatment guidelines but I think this is to be expected and it's our responsibility to explain to the public that every result doesn't mean that we're actually changing recommendations or contradicting because this is the way science progresses.

We encourage more research and we encourage people to also understand what randomised trials are and how they're governed. There's a process, there's a mechanism. It's not really any individual who decides whether to stop or start. They go by very clear guidelines and that's why there are data safety monitoring committees which are completely independent of the investigator who see the data so that investigators are not biased when they're actually doing the trial. Thanks.

00:26:14

MK If I could just add very briefly, I think many people who are watching us don't always know about how papers are actually published and Soumya and Mike were mentioning this. Normally what happens in any field, whether it's the clinical trials or the epi studies, as you mentioned; researchers conduct that research. They write up a paper, they write up a manuscript and they submit it to a journal and then the editors of that journal will send it out for what we call peer review.

It's a robust review, line-by-line, word-by-word, result-by-result, challenging and reviewing and critique the paper. Those reviews go back to the authors themselves and the authors have to address any concerns that come up and then resubmit that paper. It's a very robust process, an iterative process that goes back and forth and over sometimes weeks, most times many months those papers actually get published.

In a pandemic and in an emergency situation a lot of that is accelerated. It doesn't change the peer review but there is that robust back-and-forth.

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Once these papers are published what we do at WHO is we review all available evidence; as the Director-General mentioned in his speech today, masks is a good example; transmission is another; hydroxychloroquine, other treatments. All of this literature that is published is reviewed and is discussed and is

debated in constructive debate with our international networks that we convene during these events with guidelines development committee and we turn that into the guidance itself.

We don't rely on any one individual paper and we certainly can't relay on any press releases. Particularly in this pandemic because it's so fast, because everything is being published so fast a lot comes out early in a press release. I mentioned this when I mentioned the seroepidemiology study. A lot is results by press release so we wait for that paper and then we collectively look at all of the evidence together and that process takes time but that's something that's normal.

We've said many times before, science is not static, science evolves and as an organisation we evolve with it and we make sure that the guidance that we put out reflects the best evidence that's out there, all of the evidence that is out there so that we can advise our member states and all of you what measures to take.

00:28:33

TJ Thank you all for these answers. We will go now to the New York Times. We have Apora Mandavili online. Apora, can you hear us?

AP Yes. Can you hear me?

TJ Yes. Please go ahead.

AP I have a question about the lack of change in the recommendation to the N95 masks for healthcare workers. Some experts have said that even though the evidence is not conclusive quite yet that it's still wise to take the most precautions so can you address, what would be the harm in medical workers wearing N95 masks even if they're not engaged in aerosol-generating procedures?

BA Thank you for your question. As my colleague has just explained, our process of developing guidance is based on the consideration of the evidence broadly so all the existing evidence and then through a process of consultation of international experts from different countries and different disciplines.

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Of course this topic is dealt with mainly by infection prevention and control, infectious diseases and epidemiology specialists. Many of these people actually are health workers who take care

of COVID-19 patients so we consulted these experts and evaluated a variety of evidence; first of all the evidence about the modes of transmission of this virus, which so far have been demonstrated for droplet and contact.

The aerosol transmission so far is only related to settings where aerosol-generating procedures are in place so there is some evidence emerging about identification of the RNA of the virus in air samples in other settings but transmission is different and it has not been demonstrated apart from in those settings I mentioned.

The second element of the evidence is the evaluation of the effectiveness of the face protections and there are randomised control trials which are the best type of evidence we can wish that demonstrate no difference in effectiveness in preventing transmission of influenza or other respiratory viruses.

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Eventually there is also some emerging evidence from observational studies which unfortunately have a lower level of evidence but still these studies demonstrated altogether that face protections including respirators or medical masks result in a large reduction in transmission of coronaviruses such as COVID-19.

This evidence also of low quality shows that there might be a greater reduction in risk by respirators but this is still limited evidence with many limitations due to the fact that these are only observational and small studies.

The third element is the evaluation of harm so respirators may also have more side-effects than surgical masks such as skin lesions or difficulty breathing, etc, in some situations. So our experts evaluating this evidence altogether and also assessing recommendations for the global level so having to consider many different contexts in different countries where it's important to assess resource availability, supplies availability, feasibility of interventions in a widespread manner, also equity of access.

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So altogether these elements led our experts to consider that there is no strong reason for changing our recommendations, which still recommend the use of medical masks along with other personal protective equipment for care of COVID-19 patients when these patients are not in settings where aerosol-generating

procedures take place. Whereas of course respirators are needed for settings where these procedures take place.

TJ Thank you very much, Dr Allegranzi. I have been told that many people are asking questions on social media right now as we speak about more details on use of masks for the general population so maybe Dr Van Kerkhove, Dr Baller or yourself can give more information on that. Yes.

AB Thank you very much and thanks for the question. Really we have quite exciting updates of this guidance and really what we're looking at with respect to the general public in areas where there's widespread community transmission and containment measures or control measures such as testing, contact tracing or maintaining physical distance is a challenge for the general public.

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There is now the advice that they can use or should be encouraged in the use of non-medical masks. The non-medical masks is often called face coverings or a cloth mask and here we're using the terminology fabric mask from now on. These are basically things that either can be made at home or commercially purchased; we have some here we can show.

The idea is that the reason we're doing this is because many times in the community now there are concerns about not only not maintaining the distance but there're discussions now around how much transmission is happening through either presymptomatic or asymptomatic transmission.

So taking that into consideration - and as Benedetta was saying before - this was then taken back also to the guideline development group and looked at and now really the consensus coming out is that when people are in the public with these masks they can actually use them and they provide some source of control. What they do is they prevent a person who may have the disease from transmitting it to somebody else.

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MK If I might add to that, yes, we do have this new advice to encourage decision-makers to make the recommendation to wear a face covering and a fabric mask. What is really new in the guidance that is being published is the research that we requested to be done on this innovation and engineering and looking at which types of materials can be used in making these non-medical or fabric masks.

What we have in the guidance are details on which types of materials, the numbers of layers and we recommend three layers to build this fabric, the inner layer being an absorbent material like cotton, a middle layer of non-woven material such as polypropylene, which is the filter, and an outer layer which is of non-absorbent material such as polyester or a polyester blend.

In doing so the evidence we have through this research is that with those three layers and in that combination that fabric can actually provide a mechanistic barrier so that if someone were infected with COVID-19 it could prevent those droplets from going through and infecting someone else.

This is new, novel research that WHO commissioned that we didn't have a month ago and this started when we convened the world experts on a variety of topics in February to discuss what are the key, critical questions that must be answered in areas all the way from epidemiology to infection prevention and control, health workers all the way through clinical trials for vaccines and therapeutics.

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This is new and this should be encouraged even more. We need our partners to carry out studies to be able to help us make the best guidance going forward so if people are going to wear a non-medical mask or a fabric mask it can be done using materials that can actually provide that barrier.

In our guidance that we're releasing now it gives the outlines to do so and we're talking not about giving advice to companies to build them. You can do this at home. These are materials that can be sourced by individuals and put together in a certain way so that it could provide that barrier so that is something that is new.

This area of research will expand, it will grow and we will evolve our guidance as more information becomes available. We also encourage leaders and countries that can, that have the capacity to do so to carry out studies to show how these masks work, what kind of benefit they provide because we need this, we need to fill this space. It's an open question and we need the research to be conducted and we need your help in doing that.

00:39:07

MR Maybe I could also help to clarify that WHO's been saying for months now that we would support countries implementing broader mask use as part of a comprehensive strategy to contain

this disease and again we've emphasised previously and would like to emphasise again today that the primary use of masks at community level is as a process of source control; in other words, they're mainly aimed at preventing one person giving the disease to somebody else and managing the person as a source.

In that sense wearing a mask at a community level is more about protecting others if you happen to be infected rather than protecting yourself so it's an altruistic act in that sense and it is to be done where you cannot keep an appropriate distance from others so if I'm trying to protect others from any potential that I will infect them the first thing I will do is stay away physically from them.

But there are situations like public transport where that cannot be maintained and in that situation the wearing of a mask will assist in reducing the risk of you becoming a source of disease for others.

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But let me also emphasise that if you were sick with a fever, with a cough and are sneezing you should not be in public, you should be seeking the care of a medical professional and seeking a COVID-19 test and if that test is positive you need to be cared for appropriately in isolation and all of your contacts need to be traced and followed for 14 days.

This is where the Director-General has said in his speech, masks are part of a comprehensive solution and we need to be very, very careful that masks are not seen as an alternative to the other public health measures that are so desperately needed.

You'll see in the countries that have done well - and many people have said to me, masks are used broadly in country X or country Y and country X and country Y are doing well. That's great but in those countries case finding, cluster investigation, widespread testing, isolation of cases and quarantining of contacts is also done comprehensively.

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So where we see success in countries - and I think I said it at the last presser - is a well-educated, empowered community caring for their own personal hygiene and protection, caring for the rest of their community in terms of protection and being supported by a public health service that's capable of finding the virus, isolating cases, quarantining contacts; a health system that's

capable of treating people successfully and all of that in the context of good co-ordination, good governance.

When that is being implemented then the appropriate and targeted use of masks at community level in order to reduce transmission within the community in areas where physical distance cannot be maintained... I think we've been consistent on this and I think the work over the last number of weeks - and we'd like to thank our academic and science partners for this - was to come up with what is the best form of face covering, how we can make those face coverings most effective in achieving that objective. Thank you.

TJ Thank you very much. Now we will go to the United Arab Emirates news agency. We have with us Ahmed Haroon. Ahmed. Can you just press unmute, please, Ahmed?

AH Do you hear me now?

00:42:49

TJ Yes, now it's okay.

AH Very good. Thank you very much, Tarik. I would like to ask about the impact of chloroquine and hydroxychloroquine on the people having the familial Mediterranean fever.

TJ Ahmed, can you just repeat? We didn't fully get what sort of fever you were referring to.

AH The familial Mediterranean fever.

TJ Let's see if anyone can comment.

SS This is a genetic disorder and I think it should be a treating doctor; it needs an expert physician to guide the patients so this is probably not something that we could discuss just now.

TJ Now we have Ajeet from United News of India. Ajeet, can you hear us?

AJ Yes, can you hear me?

TJ Yes, it's okay.

00:44:30

AJ Thanks, Tarik. My question is related to India. In the last days cases have been increasing rapidly in India. Seeing the population density of India, is there any specific concern in WHO regarding the situation here? Thank you.

MR I'll begin while Soumya's doing musical chairs here. The number of cases in India has been going up by an average of 33-and-a-third per week so the doubling time of the epidemic in India is probably about three weeks at this stage so the direction of travel of the epidemic is not exponential but it is still growing and it has also very different impacts in different parts of India; very different between urban and rural settings.

In any setting - and we've seen this in Central and South America over the last couple of weeks and I would say that in Africa and particularly in South Asia, not just in India but in Bangladesh and other countries, Pakistan and other countries in South Asia with large, dense populations the disease has not exploded but there is always the risk of that happening.

As the disease generates and creates a foothold and gets a foothold in communities it can accelerate at any time and, as I said, we've seen that in a number of settings. The measures taken in India certainly had an impact in dampening transmission and as India and other large countries open up and people begin to move again there's always a risk of the disease bouncing back up.

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There are specific issues in India regarding the large amounts of migration, the dense populations in the periurban environment and the fact that many workers have no choice but to go to work every day and there's a lot of threat to livelihood from not being able to do so. But I'll pass the floor to Soumya, who's got a much closer perspective on the situation in India than I would.

SS I think, Mike, you covered the major points. Of course India with a population of over 1.3 billion; the numbers that we see now which are over 200,000; they look big but for a country of this size it's still modest. I think the important thing is to really keep track of the growth rate, the doubling time of the virus and make sure that that doesn't get worse.

Also because it's such a heterogeneous and huge country with very densely populated cities to rural areas where the density is much lower and also with the health systems being different in different states, all of these offer challenges to the control of COVID.

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I think what's been happening with the expansion of testing, tracking, making sure that contact tracing is done, making sure

that clusters are identified and dealt with, particularly in the overpopulated, very dense urban settlements in the low-income groups, making sure that mass gatherings do not happen because these are really the situations where the spread can happen and you can get these high-transmission events and also as the lock-down is lifted and as the restrictions are lifted, to ensure that in all aspects of life precautions are taken, that people understand.

I think we have been making this point repeatedly; that really if you want behaviour change at a large level people need to understand the rationale for asking them to do certain things. We're talking about the wearing of masks. I think in many urban areas in India it's impossible to maintain physical distancing and therefore it would be really very important that people wear appropriate face coverings when they're out and about.

Also in office settings where physical distancing cannot be maintained; in public transport; in educational institutions as some states are thinking about opening. I think every institution, organisation, industry and sector needs to think about what are the measures that need to be put in place before you can allow a functioning - and it may never be back to normal.

We say that wherever possible if people can work from home - there are certain professions where you can work from home - that could be encouraged but of course there are many professions where people have to go to work and we need to put in place measures which allow them to protect themselves, which make it easier for people to both protect themselves and protect others.

I think communication and behaviour change is a very large part of this whole exercise. I don't know if Maria will want to add more to that.

TAG By the way, one thing I would like to add is, of course COVID is very unfortunate and it's challenging many nations but we need to look for opportunities too. For instance for India this could be an opportunity to speed up Ayushman Bharat, especially with a focus on primary healthcare and I know there is a very strong commitment from the Government to speed up the implementation of Ayushman Bharat.

00:50:58

With primary healthcare and community engagement I think we can really turn the tide so using and speeding up what has started could actually help in India and that's what... WHO was

very appreciative, by the way, when Ayushman Bharat started and this could be a very good opportunity to test that and speed up and use it to really fight this pandemic.

TJ Thank you very much. Let's try to take one or two questions more and I would like to thank Dr Swaminathan, who was speaking from a different chair. We have lots of guests so we had to change places during this press briefing. Helen Branswell; Helen, please go ahead.

HE Hi, thanks very much for taking my question. I was wondering if Maria or some of the people from the Infection Control and Prevention team could answer this question for me, please. We've seen a lot of studies come out that talk about long-term shedding from the throat or nasal passages by PCR and people concluding from that that people remain infectious long after recovery.

00:52:31

But I think very few have actually done viral isolation. What do we know about how long people shed infectious virus after infection, please?

MK Thanks, Helen, for this very important and specific question that is so important for our understanding about transmission. As you say, there are a number of studies that have been published that look at how long people remain PCR-positive and these are the results of these PCR tests from individuals.

What we know is that mild patients, people with mild infection that don't require hospitalisation necessarily can be PCR-positive for two, three weeks or so from the time of symptom onset. We know that people who have severe disease, who end up in hospital can be PCR-positive for much longer, for weeks and weeks and I don't have the upper bound of that.

A few studies have now looked at trying to isolate virus from patients and the reason that that is important is because when you do a PCR test you're measuring the fragments of the RNA, fragments of the virus and that's important and there could be different viral loads but we don't know what that relates to in terms of infectiousness, if somebody could actually pass the virus and that research is ongoing.

00:53:58

There have been a few studies that have tried to isolate virus. There's one study that was published in Germany; there was a

study from the US - I don't know if that one's published yet - and a few others that have attempted to isolate virus.

What we know from that is that individuals who are on the more mild end of the spectrum; from the time of symptom onset virus can be isolated up to eight or nine days and then after the tenth day or so they are not able to isolate virus.

That gives us some clues about when a person my be more infectious, may be able to transmit to others. That doesn't necessarily mean we've been able to demonstrate that someone can pass the virus to another person but that's important.

We are aware of some unpublished data from another country from a high-quality lab that followed severely ill patients that were hospitalised and they attempted to isolate virus from severely ill patients and they found virus up to three weeks.

00:54:57

These patients are in hospital, they're already isolated but they're able to isolate virus up to three weeks so this is again another evolving field where we need more information. WHO has recently updated our discharge criteria for isolation and they were released in our clinical guidance published last week.

We have a scientific brief coming out with more detail on that hopefully today but probably over the weekend, which articulates the evidence around this and so our new criteria for discharge, for isolation is ten days from symptom onset for symptomatic patients plus an additional three days of symptom recovery, meaning that they don't have symptoms including fever and respiratory disease.

We also are aware that asymptomatic cases - so people that are PCR-positive - can also be PCR-positive for a week or so but again we need more data to be able to characterise that well. The discharge criteria for isolation of an asymptomatic case is ten days from the time of the positive case.

Helen, I'm sorry; it's a long answer because the data is still coming out but I think the point that you're making that someone that is PCR-positive especially after they have recovered, especially if they're weeks and weeks into their recovery; it's not likely that they are still infectious.

00:56:29

But we are working with many labs, we're working with many partners to better understand this area.

TJ Thank you very much, Dr Van Kerkhove. We'll go to the last question for tonight as we're approaching the one-hour mark. We have Anna Pinto with us from Folha de Sao Paolo de Brasil. Anna, unmute yourself, please.

AA Yes, can you hear me?

TJ Yes.

AA Okay, I have a question about chloroquine, not hydroxychloroquine but chloroquine. It was one of the drugs selected to be tested within the Solidarity trial but the trial was pursued only with hydroxychloroquine and last week chloroquine was removed from the list of potential drugs on the Solidarity trial website.

I'd like to know why chloroquine has not been tested and if it is excluded from the trial once and for all or if it may be tested. Thank you so much.

00:57:44

SS Thank you for that question. At the beginning when the committee was looking at what drugs to put into the Solidarity trial hydroxychloroquine and chloroquine were both considered but looking at both the efficacy and the safety profile of both the drugs and the potential to have more benefit hydroxychloroquine was selected.

I think the earlier versions of the protocol said hydroxychloroquine or chloroquine but as a matter of fact the protocol that was approved and started enrolling in many countries only had hydroxychloroquine and since they both have a similar mechanism of action you would expect similar efficacy and safety but hydroxychloroquine did seem to have an edge based on some of the laboratory studies and so the experts recommended that that be prioritised.

So the later versions of the protocol do not have that so no country actually started losing chloroquine; it was only hydroxychloroquine.

TJ Thank you very much. I understand before we finish that Dr Van Kerkhove wanted to clarify one point.

00:58:50

MK Yes, thank you. Sorry, I've received several texts to try to clarify our position on masks that's coming out in our guidance and you'll see the full guidance so just very briefly to reiterate what the Director-General has said in his speech - and I

encourage to to read the full speech and our guidance - we recommend that masks are used as part of a comprehensive package which includes a variety of things including that people who are sick are at home, suspect cases are tested and confirmed cases are isolated and cared for, contacts are identified and traced and quarantined.

In our guidance what we recommend for healthcare workers who are caring for patients who are suspect or confirmed COVID-19 is that they follow droplet and contact precautions which include the use of a medical mask in addition to other PPE such as gowns, eye protections and gloves.

We also recommend for healthcare workers whether they are performing aerosol-generating procedures or in the vicinity of where these aerosol-generating procedures are conducted to use airborne precautions and that includes the use of a respirator.

01:00:01

What is new in the guidance that we're putting out is in areas of community transmission, in areas of clinical care that the workers continuously wear a medical mask throughout their shift. That is something that is in addition to the advice that we have put out previously.

For the general public WHO has recommended that the general public - if you're sick of course you should be at come but if you are unwell you wear a medical mask and the people who are caring for you also wear a medical mask.

What is new in the guidance that's coming out today is that we provide specific examples of situations in community transmission, in particular where physical distancing cannot be achieved, cannot be maintained, that a non-medical mask, a fabric mask should be used.

What we have in the guidance is materials and how to compose that fabric mask and that comes from new research that we've requested from our partners to be able to say how many layers, what types of materials. There's a lot of detail in here about the filtration efficiency and whatnot but I want to reiterate that this is in areas where you have active transmission and in particular where you can't do physical distancing so pubic transportation or in some close settings and that's important.

But as Mike has said and as I have sand and as at DG has said, for many months now we have been supporting governments, supporting decision-makers in taking a risk-based approach on

where and how and what type of masks can be used because it is very context-specific. So we hope that the guidance that comes out clarifies some of these positions. We're always happy to take more questions if anything is unclear but I just wanted to add that so thanks, Tarik.

TJ Thanks. Obviously, as Maria said, if you have more questions on this important topic don't hesitate to contact the media team and we will put you in touch with one of or speakers who have been with us tonight.

With this I will conclude this press briefing. The audio file will be sent to you shortly and the transcript will be posted hopefully tomorrow. I wish everyone a very nice evening and a good weekend.

TAG Thank you. Thank you, Tarik. Thank you for joining us and have a nice weekend. I look forward to seeing you on Monday. Thank you.

01:02:37