Hello, everybody. I am Fadela Chaib, speaking to you from WHO headquarters in Geneva and welcoming you to our global COVID-19 press conference today, Friday 30th October. Present in the room as usual is the WHO Director-General, Dr Tedros.
Joining him is Dr Mike Ryan, Director, Health Emergencies, Dr Maria Van Kerkhove, Technical Lead for COVID-19, Dr Janet Diaz, Team Lead, Clinical Care for COVID-19. We will also be joined by Dr Jaouad Mahjour, Assistant Director-General, Emergency Preparedness.

Dr Soumya Swaminathan, Chief Scientist, will join us shortly. We have in the room also Dr Mariangela Simao, Assistant Director-General, Access to Medicines and Health Products, and Dr Bruce Aylward, Senior Advisor to the DG, who leads the ACT Accelerator. Welcome all.

We are also joined remotely by Professor Didier Houssin, who will respond to your questions on the emergency committee on COVID-19. Welcome, Professor Houssin. We have simultaneous interpretation in six official languages plus Portuguese and Hindi. Now without further ado I will hand over to Dr Tedros for his opening remarks and Dr Tedros will also introduce our guest. Dr Tedros, you have the floor.

00:02:15

TAG   Thank you. Thank you, Fadela. Good morning, good afternoon and good evening. I want to start by noting that WHO is closely following the unfolding situation in Greece and Turkey after the earthquake today. We will work with the two countries to ensure that emergency medical care is provided for those in need. Our thoughts are with all those affected.

Over the past few months I have heard first-hand from people who face mid to long-term effects of COVID-19 infection. What's really concerning is the vast spectrum of symptoms that fluctuate over time, often overlap and can affect any system in the body; from fatigue, a cough and shortness of breath to inflammation and injury of major organs including the lungs and heart and even neurological and psychological effects.

Although we're still learning about the virus what's clear is that this is not just a virus that kills people. To a significant number of people this virus poses a range of serious long-term effects. While people do recover it can be slow, sometimes weeks or months and it's not always a linear route to recovery.

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Though exact numbers of people experiencing the long-term effects are not yet clearly defined post-COVID-19 symptoms and complications have been reported in both non-hospitalised and
hospitalised patients. There have been cases in women and men, both young and old and even in children.

WHO continue to do more research to establish best standards of care to accelerate recovery and prevent such complications. It's imperative that governments recognise the long-term effects of COVID-19 and also ensure access to health services to all of these patients.

This includes primary healthcare and, when needed, speciality care and rehabilitation. I would now like to hand over the floor to three patients who are still combating the long-term effects of COVID-19 so that we can hear their stories. First, Professor Paul Garner from Liverpool School of Tropical Medicine, who has himself been recovering from COVID-19 since March. Paul, the floor is yours.

PG Thank you, sir. It's a great honour to join you. I respect your leadership and your organisation's pivotal role in this pandemic. I am an infectious disease epidemiologist. I helped set up COCRAN [?] and I work with you in guidelines in infectious diseases.

00:05:17

I became unwell in March. I was fit and well and I assumed that this COVID illness would be - I'd be able to brush it off my shoulder. For four months I went through cyclical bouts of dreadful fatigue, sweats, headaches, unable to move, mood swings and that went on for four months and then I had another three months, completely exhausted.

When I overdid things the illness would echo back, it would come back and it was completely unpredictable and for the last two weeks things have been improving and I'm beginning to get my sense of humour back and am beginning to take gentle exercise.

I never thought I would have seven months of my life wiped out by this virus. It's just gone, evaporated. As you have said, sir, long COVID is a huge array of symptoms. I have one particular form. Others have damage to the heart, persistent breathlessness, problems thinking and other evidence of organ damage.

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But we must remember, post-viral syndromes are not new but what we have here is just a huge scale of people that are suddenly severely disabled, a wide variety of people that have
never experienced long illness but with a level of disability that hasn't been seen this century.

Last century it was seen with the world wars only and it affects everybody; drivers, people working at restaurants, building sites, hospital porters, doctors, everybody everywhere is getting this. So I would just like to say that I respect that WHO recognise this; this is very important.

Health professionals, families and patients need to know it exists, that it has many faces and it isn't in your head. Employers and society need to accommodate this and we need, as you say, sir, sensible, supportive primary health services to help people convalesce and get better. Thank you for asking me to join you today.

TAG Thank you. Thank you so much, Professor Garner, for sharing your experience. Now to Martha Sibanda, a nurse who is joining us from Johannesburg, South Africa. Martha, the floor is yours.

00:08:10

MS Good evening. My name is Martha Sibanda. I'm a nursing sister at the Charlotte Maxeke Johannesburg Academic Hospital. I started getting symptoms in the last week of June, one of them being shortness of breath and fatigue most of the time and coughing, a little bit of a productive cough.

So by the end of June I was so sick I got admitted at the same hospital that I work at. I was on oxygen because I couldn't breathe because of the shortness of breath and then three days later...

I was tested and then my results came back positive. Three days later I was taken to ICU because I was very hypoxic. I was put on high-flow oxygen. I stayed in ICU for eight days, eight solid days. I did very well. They weaned me off daily on oxygen and then on the eighth day I was taken back to the ward, still on oxygen, on 3l per minute on nasal cannula.

But the problem was that it wasn't easy to be weaned off the oxygen. I stayed on oxygen until the day I was discharged, which was 26 days later. At the moment I'm still struggling with shortness of breath even though this is my fourth month. Initially when I got sick it was June; now we are in October.
So four months; I still struggle with shortness of breath. I will be back to work. I'm still at home but I'm looking forward to going back to work some time end of November, hoping that slowly I'll manage to breath by myself without oxygen.

I also would like to emphasise the care that I got from my hospital. The ICU staff were very excellent, they were hands-on and the nurses, the staff in the ward were also excellent. I think I survived because of the teamwork of both ICU and the ward. Thank you very much for inviting me to your conference today.

TAG Thank you. Thank you, Martha, for taking the time to share your experience with us. I would now like to hear from Lyth Hishmeh from the United Kingdom. Lyth is a member of the Long COVID SOS patient advocacy group in the United Kingdom. You have the floor, sir.

LH Hello again, Dr Tedros. My name is Lyth Hishmeh. I am 26 and I'm from the UK. I am a member of Long COVID SOS, a group set up to advocate for patients with Long COVID here in the UK. I caught COVID on 13th March. I was at work and it started with just normal flu-like symptoms; a sore throat, a cough.

At the time I wasn't even sure it was COVID. I went home and over the next two weeks symptoms started to develop slowly. I developed a fever, slight cough, shortness of breath and just your typical flu-like symptoms and then that started to get worse until it developed into full-on delirium at some point.

But after that I was fine for about a week and I decided to leave and go and get groceries as I thought I'd recovered and so I could go and end my period of self-isolation at the time. When I got to the shop I developed shortness of breath, my heart started racing and I went through something I'd never gone through before.

Being 26 and feeling well before that I'd never gone through anything like that and I was terrified. I ran out to the street, I flagged down a police car and an ambulance was called. They arrived. I could not get up at the time so they checked my vitals and they loaded me into the ambulance and took me straight to A&E.

At the time in the UK COVID testing wasn't widespread so they did a long ultrasound on me because I was suspected of having COVID and it showed the end stages of pneumonia and the doctor diagnosed COVID-19 at the time but he said I should be
fine because it was the end of it, he didn't see anything concerning at the time.

Unfortunately he was very wrong and it's been almost eight months now and I'm still suffering from fatigue, brain fog, chest pain, heart palpitations, digestive issues, short-term memory loss. There is no system in my body that hasn't been affected and if you'd asked me eight months ago if I thought that this would happen, I'd catch COVID, I'd have said no, not at all.

I looked at the statistics and I thought, I'm probably going to be fine, it'll be flu-like, it'll be mild, two weeks and I'll be fine. But that has not been the case; I've been off work for the last few months, I went back to work on reduced hours but I couldn't even cope with that because of the brain fog.

I used to be a software engineer; now I just can't do that. I also used to do research into artificial intelligence and now I can't do that either. I just want my mental abilities back, that's all. Thank you.

TAG Thank you. Thank you, Lyth. Listening to Paul, Martha and Lyth share their experiences and array of symptoms it really reinforces what a dangerous virus COVID-19 is. Your stories underscore that those facing the long-term effects of the virus must be given the long time and care they need to recover fully.

It also reinforces to me just how morally unconscionable and unfeasible the so-called natural herd immunity strategy is. Not only would it lead to millions more unnecessary deaths, it would lead to a significant number of people facing a long road to full recovery.

Herd immunity is only possible with safe and effective vaccines that are distributed equitably around the world and until we have a vaccine governments and people must do all that they can to suppress transmission, which is the best way to prevent these post-COVID long-term consequences.

In that vein the emergency committee on COVID-19 has just concluded a two-day meeting where they discussed the way forward. With global cases continuing to rise and some countries going in the wrong direction the group has made a series of recommendations for WHO and member states to act on.
The take-home message is that it's important for governments and citizens to keep focused on breaking the chains of transmission. Governments should focus on tackling the virus and avoid politicisation. No matter where they are in terms of the outbreak they should keep investing in the health system and workforce and improving testing, tracing and treatment of all cases.

There is light at the end of the tunnel. As well as rapid tests and dexamethasone several vaccines are now in phase three trials. If proven safe and effective they will be rolled out through the ACT Accelerator's vaccine arm, the COVAX facility, which is now supported by 186 countries.

I thank Lebanon and Botswana for joining recently. The committee recommended that to prepare for new COVID-19 vaccines WHO and governments must work closely to develop roll-out strategies, train health workers and ensure clear communications with the general public about vaccination.

Just as we look forward with hope WHO continue to work to establish the origins of the virus to prevent future outbreaks. Today a group of international experts had their first virtual meeting with their Chinese counterparts. I join to thank them and offer any and all support to ensure the success of their ongoing research.

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From the long-term effects of COVID-19 to breaking the chains of transmission to establishing the origins of the virus WHO will continue to work in partnership across the world to drive science, solutions and solidarity. I thank you.

FC Thank you, Dr Tedros. We will now open the floor to questions from journalists. I remind you that you need to use the raise your hand icon in order to get in the queue to ask your questions. Let's start with Christophe Vogt from Agence France Press. Christophe, can you hear me?

CR Yes, hi. I can hear you very well. Thank you for taking my question. It was about the new measures that have been announced in France on kids wearing masks. France asks now that masks are worn starting at age six. The thing is that it seems that all over the world there are different rules, different people saying different things about what time and what age kids should wear masks.

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So I was wondering if you could give us an assessment and if there's any hard science or new hard science about how infectious kids can be and are they the super-spreaders that has been recently raised, I think, in a New York Times article.

FC    Thank you, Christophe. I would like to invite Dr Van Kerkhove to take this question. Thank you.

MK    Thank you, Christophe, for the question. I'll start with the second part of your question and then go to the first part of that. With regard to COVID-19 in children we are tracking mainly three things among many others; looking first at the severity and the disease that's caused in children and luckily for the most part children who are affected with the SARS-CoV2 virus, the virus that causes COVID-19, tend to have more mild disease and many are asymptomatic.

This is not universal though. There are some children who have developed severe disease and there are some children who have died from infection.

We are also looking at the extent of infection in children because in many parts of the world children are not tested and so it's very difficult to understand how many children are infected through current surveillance systems, which is looking for using PCR testing to find acute infection, infection right now.

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There are seroprevalence studies that are conducted, which look at the antibody response among individuals who are sampled and when we look at children there are a few studies that have been done and more that are underway and there are differences in the rates of infection among the youngest children versus adolescents and there tends to be less evidence of infection measured by antibodies in the youngest children compared to adolescents, teens and as compared to adults.

The third thing we look at is transmission and the rates of transmission either between children or from adults to children and children to adults. There are many studies that have been underway. Most of these are looking at household transmission, which tend to start with an infected, symptomatic adult and then looking at if transmission has occurred to children or the other way around.

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We know that children can transmit the virus. Again there does seem to be some difference by age group with the youngest
children transmitting less than adolescents and that makes sense if you think of the type of interactions that children have.

So to summarise, we know that children can be infected. Most of them have mild disease, many have asymptomatic but they can be infected and they can transmit. We use that information to help us better understand the extent of what is happening within children as schools open up of course because we all recognise the incredible importance of having children in school not just for educational benefit but for many other benefits.

WHO has issued guidance on the use of masks in children recently, a few months ago I think and what we do is we break down our recommendations by age. First of all masks must be part of a comprehensive strategy. For all age groups masks cannot be used alone, they have to be used with physical distancing, they have to be used with hand hygiene, they have to be worn appropriately, put on and taken off appropriately with the right hand hygiene.

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They need to be used with all of the other measures that are in place but for children what we recommend is under six years old - so five and under - we don't recommend the use of masks for many reasons; because of the way the children are developing, the adherence to wearing them; many reasons.

Between six and 11 years old we recommend taking a risk-based approach depending on where the children are, the type of activities the children are in, if they can be monitored because of course if you're wearing a mask there are some risks associated with wearing a mask so they need to be worn safely.

Then 12 and over; we recommend the same recommendations as adults so we have outlined that. We do have some guidance around the considerations when taking those decisions for the use of masks in children but again masks must be used as part of a comprehensive strategy.

FC Thank you. I would like now to invite Simon Ateba from Today News Africa to ask the next question. I would like also to remind journalists that our guests and Professor Didier Oussa are online if you want to ask them any questions. Simon, you have the floor.

00:23:44

SI Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. The US has now
surpassed nine million cases overall and we know the report recently cited President Trump as one of the biggest sources of misinformation on COVID-19. He's pushed miracle-cure hydroxychloroquine and all the rest.

I was wondering, does the WHO have a gameplan to stop this information from someone as powerful as the American president? Also the second part of the question has to do with the US elections. We've seen how people are being able to vote safely with almost 90 million people who have voted so far. Is that the way to go, do you recommend the Government have early voting in all the states to avoid all the people trooping into a polling unit at the same time? Thank you.

FC  Thank you, Simon. Dr Ryan.

MR  Yes, there're two parts to your question, Simon. With regard to voting we've been working with many authorities around the world in providing risk management advice for when they have decided to carry out elections and how to manage face-to-face or in-person voting in the safest way possible.

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Clearly many governments have made different decisions; some have postponed, some have created a mixture of in-person versus remote voting or absentee voting and some have gone for in-person voting exclusively.

This to a great extent has depended upon logistics, on technologies available, on the background incidence of disease in that country and again, as with travel, as with schools these are all contextually driven decisions based on how much disease there is, what the available resources are to deal with that and how much the activity is needed against how much can be invested to make them safer.

This is no matter what endeavour we undertake in our society now; each and every time we have any moment when people come together in large groups we have to decide on whether or not such events will go ahead and then if they need to go ahead how they can be derisked or whether we can do risk management measures to reduce the risk to the absolute minimum.

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You mentioned the US early voting at the moment and certainly we are not there but from what we observe the early voting process seems to have been undertaken with great care with a
lot of planning in terms of physical distance, wearing of masks and special training of the people working in those centres.

We have no data other than our own observations but certainly it would appear that that process is being managed very, very well. The first part of your question relating to information, misinformation and disinformation; WHO works very, very hard and in fact in this pandemic have never worked harder with external partners both in terms of community-level partners, governments, the tech industry to really deal with issues around misinformation and disinformation.

We focus on trying to get the best information out there, getting verified, truthful, good information to people as quickly as we can. That has been the focus but we are aware that misinformation can lead people to be confused and not to fully understand and be able to implement.

It's very important if our populations are to take action, information and knowledge don't automatically drive action. Conflicting information and conflicting stories will definitely not lead to the proper action.

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It is difficult enough with good information to generate the appropriate behaviours without having conflicting information so we've called - the DG has spoken about this many times - we've called for open, consistent, clear communications at all levels.

Everyone is responsible for this, from presidents to people on the street. We are all part of the information society. It is our responsibility to ensure that we pass on good information to others. We're all entitled to our opinions, everybody's entitled to their opinion but you must pass on good information to other people, not disinformation or misinformation.

FC Thank you. I would like now to invite Naomi Ollery from the Irish Times to ask the next question. Naomi, can you hear me?

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NA Yes, I can hear you. Thank you very much for taking my question. I appreciate it. I'd appreciate an answer from any of your experts really. My question is, a number of countries, particularly in Europe, are seeing a very serious surge in the virus. What are the new things that we have learned about the virus that we know now that we didn't know during the really bad
surge in the spring that will help us this time to contain it?

Thanks.

FC     Thank you, Naomi. I think Dr Van Kerkhove will answer this question.

MK     I could start. I would imagine many people would want to contribute to this because there's so much more that we know now than we did even in the spring, mainly around what works to prevent transmission, what works to reduce morbidity and mortality and reduce the ability for someone who is infected to develop severe disease and reduce the number of people who die from infection.

So one of the things that we continue to learn - and it may sound a little bit like a broken record but the fundamental steps of being able to know where the virus is circulating, know who is infected with the virus, making sure that they receive very quick test results so that they can enter this clinical pathway and know and be assessed quickly to determine what type of care they need.

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Individuals who enter clinical care pathways sooner can receive the life-saving care that they need and those that have severe disease, those that have critical disease can receive oxygen. We know oxygen saves lives.

Those individuals who develop severe and critical disease can receive dexamethasone and we know dexamethasone for severe and critical patients saves lives. Dr Janet Diaz is here with me, who can comment on this further.

But what we also know are ways in which we can prevent transmission from happening in the first place. We know that there are many ways that we could prevent amplification events from happening.

One of the ways is for us to avoid these closed, enclosed, crowded spaces, close-talking-type settings, especially where we're indoors and there's poor ventilation. Opening up a window can help bring in fresh air from outside and improve the circulation of the air.

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We know individuals who are in close contact with one another need to stay apart. Physical distancing works. Hand hygiene works. The wearing of masks works but again we cannot be over-
reliant on any one intervention and this is something that has been worrying for us.

In some situations we do see an over-reliance on one particular aspect, one particular intervention. Even if you are wearing masks you still need to maintain your distance, you still need to practice hand hygiene and make sure that your hands are clean when you touch the outside of your mask, you put on the mask appropriately, you take the mask off, you wear the mask over your nose and mouth.

There are certain ways that these interventions need to be used so that they can protect you and protect your family so there're a lot of aspects that we know around this. We know that cluster investigations help us bring outbreaks that seem overwhelming under control and break chains of transmission.

That workforce that is being built across the world needs to continue to be built, not just health workers and front-line workers who are absolutely critical and essential to be trained and protected to care for patients.

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We need a workforce that can test individuals, that can collect samples, that can run the labs, that can carry out contact tracing, that can make phone calls to make sure that those who are in isolation at home are followed up on, that those who are in quarantine are staying at home and receiving some follow-up and advice that they need.

So those are the things that we know work and that puts us in a very different situation than we were in in the Spring. Janet, I don't know if you want to comment on the life-saving work.

JD Thank you and thanks for the opportunity for this question. I just want to echo, what we know now and we didn't know then was really this COVID care pathway. We now know that early recognition of patients is necessary in order to apply the right isolation to stop transmission but also to apply rapid diagnostic testing and rapid care for patients.

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We know the symptoms now, not just the typical symptoms but we also know atypical symptoms of patients so we can recognise them even when they come in with atypical symptoms. Per severity of disease; we knew about pneumonia, we knew about ARDS and patients requiring invasive ventilation but now we also know about the other complications such as stroke, cardiac
disease and other causes of thrombosis so we can apply treatments for those conditions.

Now, as Maria had already mentioned, we do have one life-saving treatment and this is for patients with severe or critical COVID so the use of corticosteroids which reduces mortality.

Finally I just want to acknowledge what we heard from our guests that were here before, those patients that have had COVID. I just want to say thank you for joining us. It is so important to hear from them and to understand from them because what we're trying here is to save lives and to also reduce complications and hopefully reduce those post-COVID complications.

I think the best way to do that is to prevent transmission of disease and to prevent those hospitals from getting full. What we've learned from the first peak was when the hospitals got full the care got complicated. It is hard to care for that many sick patients in an ICU and so I think we have to remember that lesson and to stop transmission, stop patients from getting sick or getting very sick so that the health system can stay functioning and care for all patients so thank you.

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FC Dr Ryan.

MR I'd just add two points. I think certainly what we learnt, I learnt in this last ten months is the absolute power of communities and societies to do things when they put their mind to it, when they come together; the incredible capacities of individuals to look to the care of others when they have the knowledge of how to do that, the tremendous courage of our health workers and others in doing that.

But what I have also seen is a huge gap between rhetoric and reality, a huge gap between promises and practice and at times a lack of follow-through, a sense of magical thinking - enough, we've done enough now, this is going away, enough already, we need to go back to our normal lives - and not following through and doubling down on the public health investment that's needed to put this virus to the sword.

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While we now again once more face the prospect of putting our society and our economies to the sword we have got to learn from that, we have got to learn to follow through on this virus collectively, all of us because we do have the tools and it's not just vaccines coming down the line.
I would love Bruce to comment on this with his experiences in supporting Spain and Italy and beyond but also an understanding that when vaccines do come they will be a huge addition to our existing armoury. We are not using the tools we already have in our toolkit as effectively as we could.

Will we therefore misuse and not use vaccines as well as we could? So I think we have a few months now to really, really focus on what works. We have seen again and again across countries, within countries that certain activities work; bringing together a series of activities, both in healthcare resilience and public health practice and in community empowerment with government leadership.

It's not rocket science; it works but it requires commitment, it requires sustained commitment, hard work. It requires bringing people together and not tearing them apart. It requires humility, not hubris.

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I wish the answers were simple and there was a magic solution but like everything in our lives that's complicated it takes hard work and commitment to work our way out of it as an individual or as a society. Bruce.

BA I think we've had a comprehensive and fantastic response from Maria, Janet and Mike but I think one other point to Mike's suggestion that we've learned is we've learned what we're not doing right and one of the most striking things we've seen in some of the most heavily affected areas is we're paying a lot of attention to the serious disease, we're paying a lot of attention or increasing attention to the contacts.

But there's that bulk of the disease which is in the mild cases, in the moderate cases that are at home and we were hearing, to the point Mike was making, striking data from surveys of these people that a substantial proportion and in some places the majority; they say, we do not remain isolated, we have to go out to get food, we have to go out to get medicines.

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These are some of the most striking and important things that we're learning, just the challenge - to what Mike said - of maintaining effective isolation of people with very little symptoms if any because that is the key, that's where most of the virus is, that is the key.
If we're not managing that part of the virus we're not managing this crisis and the effective isolation of mild, moderate and now sometimes asymptomatic cases is just so fundamentally important to being successful. I think the other points have been highlighted.

FC Thank you so much. I would like now to invite Michael Busiorkiv from CNN Opinion to ask the next question. Michael, can you hear me?

MI I can hear you loud and clear. Good to be back on. I've missed you all. My question leads on from the last one of what we know now but we didn't know back then and that comes to the question of quarantine. Many jurisdictions are really grappling with recalibrating quarantines.

For example one jurisdiction here in Canada wants to lower quarantine for returning Canadians to two days providing they take a rapid test on arrival and one two days later. Canada has some of the most severe quarantines in the world, two weeks, up to $1 million fines and jail time so there's pressure on the Government to lower it.

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My question is this; can quarantine be safely lowered to, say, five days or a week and are rapid tests like the ones I've described reliable to slash those quarantine times? Thank you.

MR I'll begin; maybe Maria and Jaouad would like to add. Just to be clear, let us separate because we use this word quarantine in relation to two things. There's the quarantine of people who are contacts of confirmed cases and in that case individuals should be in a quarantine situation in their own home or in another place for that 14 days and WHO's advice on that is quite clear.

You speak specifically about the travel process and that is in a sense the quarantine of travellers who arrive in another country or the restricted movement of travellers or special arrangements, whatever countries call them; different things.

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That is aimed at trying to prevent disease, number one, being imported but more importantly aimed at ensuring that an imported case doesn't generate further transmission, secondary transmission or start a cluster.
The ignition of a cluster in a country very much depends on how much disease is already in that country. A cluster in a country with no cases is a disaster; in a country with hundreds of thousands of cases it may not be such a disaster in that context.

So I think everything here is looking at risk and when countries decide on this quarantine of travellers, testing of travellers they need to consider that there's no zero risk, there's no absolute test that will tell you that the person is going to be negative tomorrow or the next day or the next day, there's no completely foolproof follow-up plan that allows you to follow up those people for whatever number of days you choose to do that.

Therefore it is a trade-off that countries have to make; the risk of a traveller arriving and potentially starting another chain of transmission against the obvious benefit of allowing travel from a social and an economic point of view.

You can add testing and different measures into that. We are looking at that right now and Maria and I and others were reviewing new guidance today and I think we will be trying to create a little bit more specific and quantified guidance for countries on how to manage this.

It is a difficult issue. What I will say is that the process of travel itself has been significantly derisked. The travel industry, airlines, airports authorities deserve huge credit. Travelling now is actually relatively safe. Your chance of being exposed during the travel process is actually relatively low because of all the measures that have been taken.

That is not the problem we face right now. The problem we face is what we do with arriving travellers in another country and how that risk is managed by authorities and that's a decision, that's an active decision each country needs to make; how much risk are we willing to absorb and how can we manage that risk.

You do not know how to make that decision unless you understand what's happening in the country the person is coming from and you will not be able to make that determination unless you know how strong your own response mechanism is.

If you've got excellent public health surveillance, if you've got a really strong health system, you're able to monitor all the disease in your country then travellers are going to be part of that system. If someone is coming from a country where you don't
understand disease transmission and they're arriving in your country where you've got a very weak system then the risks are much different for you and for that traveller.

So it is a difficult issue, we are working with industry on it. I do believe the European Union and others are looking very hard themselves at how they can manage travel within the European Union and other places, other economic integration areas and we will be coming out very soon with more advice for countries in terms of the risk management process.

But there shall be no answers to this, there are no absolutes, this has to be made on a case-by-case, country-by-country basis and based both on countries' capacity to manage risk and their appetite for that risk, their willingness to accept that you cannot have a zero-risk situation pertaining to international travel going forward.

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FC Thank you.

MK Yes, thank you. I would like to comment more on the use of quarantine for contacts of confirmed cases so this is not about the use of the word quarantine for travellers so let me be clear. When we talk about - you hear us talk a lot about isolation of cases, contact tracing and quarantine of contacts.

One of the things that's really important and maybe it shouldn't be assumed but contacts who are identified - these are individuals who had contact with a confirmed case from two days before that case developed symptoms up to the point in which they were isolated themselves; those individuals, those people need to be identified so that they can go into what we call quarantine.

This means 14 days of being separated from other people but quarantine needs to be supported and so I think we take for granted that when we say quarantine it assumes that people are supported through that period.

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The really critical aspect of quarantine of contacts is you've been exposed to the virus which means that you have the possibility of having been infected and if you are put in quarantine for that 14 days we effectively reduce the possibility of you transmitting that virus to somebody else.
Whether you have mild infection, whether you have asymptomatic infection you break that chain of transmission so what is really important is if you are a case yourself we have some of these videos out which describe how to do contact tracing and what it means to break the chains of transmission.

If you are a case yourself make a list of the people that you were in contact with in the 14 days before you got sick, make a list of all of those people, all the places that you went and pick up the phone and make some phone calls. You should be contacted by a health authority in the area where you live but if you're not make a list of the people you came in contact with and make a phone call, send a text message and say, I've been infected with the virus, I think you were a contact of mine, I think you might need to quarantine.

All of us have a role that we can play to support all of these public health actions but if you are a contact of a confirmed case and you are in quarantine that does mean that you need to be separated from people for the 14 days and it means not going to work and it means not going to the grocery store so you need to be supported as you are in quarantine, whether people are helping to bring you food, making sure that you can telework.

00:46:44

That's what we mean by supportive. It's easy for me to say, be in quarantine for 14 days. But we know that means that you need to be supported through that and we need governance to be able to support people through quarantine.

The critical factors of breaking chains of transmission remain isolation of all case, whether you have severe disease, whether you have mild infection, whether you are asymptomatic, and the supported quarantine of contacts.

FC Thank you. I would like to invite Dr Jaouad Mahjour to take the floor.

JM Thank you, Fadela, and thank you for this very important question. Just to add on what Mike said already, we are working now on new travel advice that we will share with countries to guide them on how to take additional travel measures to protect their countries and also to make travel safe.

00:47:37

This new travel advice is based of course on the latest evidence that we collected but also based on the IHR emergency committee that met yesterday, which advised us to continue
using a risk-based approach in dealing with travellers and derisking travel. Thank you.

FC Thank you, Dr Mahjour. I would like now to give the floor to Peter Kinney from Anadolu News Agency. Peter, can you hear me?

PE Yes, I can hear you. We've heard advice about how we should tackle this and one of your mantras from the very beginning has been solidarity, testing. In the two hot-spot areas, North America and Europe, is there enough testing going on and is it the right testing? Could you comment on that, please?

MR Yes, and Maria will come with some more specific data. I think the second part of your question is actually quite telling and you can ask this question about every country in the world; is it the right testing - that is the key - and are we using testing as strategically as we possibly can?

I've seen countries with relatively low levels of availability of testing using that testing in a very strategic way; investigating clusters, trying to find out how disease is transmitting in the country.

00:49:21

Then I've seen other countries use their testing, lots of testing but not necessarily in a strategic fashion. So it's not about necessarily the amount of testing but if you're in a situation in any country where you can't keep up with your symptomatic cases, where people who are symptomatic with COVID are not being tested and you're systematically underestimating the size of the epidemic then it's very hard to beat the epidemic in a situation like that because you just don't know the size of the problem.

So I would say, yes, testing is very important but when - and Dr Tedros has been quoted many times saying how important testing was but if you cast your mind back to very early in February and other times he was also speaking about case finding, contact tracing, testing, quarantine, strengthening the health system, building community empowerment, depoliticising the situation, working in a bipartisan and an all-of-government fashion.

00:50:22

I think that has been proven true time and time again in this response. No country has done it perfectly but countries that have engaged in an honest and transparent attempt to develop
and support and sustain - and I use that word, sustain, carefully -
sustain the effort over time; learn, investigate clusters, find out
what's driving transmission in their own country.

They've done well, they've done relatively well and it doesn't
mean those that have done well before will do well again but
they're doing relatively well in the response. Some countries
were caught behind the curve. Some countries got disease early
without the knowledge we have now.

So we should not judge individual countries. In that sense the
real judgments don't come in the first wave of any epidemic
because nobody has all the information. The question is right
now; we have seen this wave pass over the Earth; we have seen
approaching 50 million people infected, confirmed. We're seeing
over a million deaths.

The question is, are we willing to apply the learning? Many
people have paid a heavy price. Have we learnt? Yes, we have.
That's not the problem or the challenge. The question is, can we
apply the learning and can we do that now as numbers rise again
in the northern hemisphere? I believe we can.

So in terms of testing, yes, testing is important, bringing in
antigen-based testing and other tests right now is important and
Maria will speak to that and that's what the ACT Accelerator and
others in the diagnostic consortium that we participate in are
trying to do.

But please, testing by itself is not the answer, it is testing plus
everything else. Maria.

MK  Thanks, Mike. Yes, I wholeheartedly support this strategic
testing. We've seen so many different types of testing strategies
all over the world and it needs to be strategic because there are
different types of tests that are on the market.

The early tests that were rapidly developed early in January are
still the mainstay; the PCR, molecular-based testing. The ability
for all countries in the world to test for SARS-CoV2 infection is
incredible, it has expanded and grown at exponential rates
across the world, not only using public health labs but using
private labs, using academic labs and in some countries using
veterinary labs.

00:52:55

There's been a mobilisation of the capacity to increase for testing
but it needs to be strategic and we have always recommended
the testing of the suspected cases, people who are believed to
have been exposed to the virus, who are at a higher risk of having that virus and start there.

Then through your cluster investigations you can expand that to those who are in that facility or in that environment where that outbreak is occurring.

So the PCR test; there are many on the market, there are so many countries that are doing these and that has really advanced our ability to find the virus and who is infected.

There are also these antigen-based rapid diagnostic tests which get results back quicker, they get back in 15, 20, 30 minutes. They're a little bit easier to use, they're cheaper and there are many of these on the market.

We have recently qualified two of these and are in the process of procuring them to supply to countries all over the world but the antigen-based tests don't perform as well as the PCR but they work very well in several situations.

First of all they work best when there's a lot of virus around. If the virus is circulating in the community they're able to capture the proteins in individuals to capture somebody's infection. They work best when someone is most infectious so when they have the most virus in their body and this from the viral shedding data that we have, from the research that's being published is about two days before symptom onset up to five, seven days after they develop illness; in that time period.

They also are good for screening of health workers for example, health workers who are highly exposed, who are more at risk of getting infected with this virus because they're caring for COVID patients and any situation where there's widespread community transmission.

So these rapid antigen-based tests which are cheaper, which are easier to use, which are becoming available more and more every day can really help countries detect where this virus is and do these cluster investigations as well as continuing to do the PCR tests.

But again, as Mike has said, as we have been saying it's not one measure alone, it can't just be testing alone, it can't just be contact tracing alone, it can't just be masks alone, it can't just be
hand hygiene alone. We will continue to say that over and over again.

But tests are a very important part of breaking the chains of transmission and bringing this pandemic under control.

FC  Thank you. I would like now to give the floor to Stephanie Nebahe from Reuters. Stephanie, can you hear me?

ST  Yes, thank you very much, Fadela. A question please specifically for Professor Didier Oussa as Chair of the emergency committee if he's still available. Since we're a little bit in the dark about what the recommendations were - I haven't seen it yet tonight - I wondered if you could perhaps comment a bit on what specifically the emergency committee has recommended in terms of precautions for travellers or measures governments should be taking in terms of facilitating and screening and so forth, if you had any new recommendations on that issue of travel or anything else that has changed since your assessment three months ago. Thank you.

00:56:30

FC  Thank you, Stephanie. Professor...

DH  Thank you very much. Nine months after the beginning of the pandemic and after the declaration of a Public Health Emergency of International Concern, as was said by the WHO speakers, it's clear that we have learned a lot so the recommendations made by the emergency committee have evolved over the time.

If you consider the differences between the recommendations we made at the end of July and these at the end of October I think it's important to differentiate the recommendations which are directed towards the WHO secretariat, which has of course a leading role in the management of this pandemic, and the recommendations which are made towards member states as temporary recommendations according to the International Health Regulations.

00:57:29

So these are defined into 13 recommendations on one side and 12 on the other and I will not go into the detail because it would take too long but I think I can focus on two or three main recommendations.

I think the question of international travel is a very difficult question and Mike Ryan explained very well the balance between
the risk of travelling, not travelling and the role that member states have to play in this.

I think it's very important that WHO produce updated guidance with regard to safe international air travel. Clearly the use of the tests is certainly now supposed to have a much larger place compared to quarantine for example, which would certainly facilitate things considering all the efforts which have been made by airlines and by airports, but of course considering what the country can do on the side of the traveller which is, I would say, from the starting point to the arrival point.

With regard to member states, I think one very important point; because the pandemic is now of nine months' duration it is extremely important to avoid politicisation. Of course it's a bit of a naive vision because clearly, unfortunately the pandemic is used in some cases as a political tool for an opposition or for keeping power or reaching power.

00:59:06
But it was our real responsibility to emphasise the fact that it's important not to use the pandemic as a tool and that national unity should certainly be a major asset in the management of this pandemic.

These are two points which I can mention but in this statement you will see more detail about the other recommendations which have been formulated by the emergency committee and I use this moment to thank members of the committee for their very useful contribution and also the Secretariat for its excellent preparation of this emergency committee meeting. Thank you.

FC Thank you, Professor Didier Houssin. I would like now to invite Imogen Foulkes from the BBC to ask the next question. Imogen, can you hear me?

IM Thank you. It's about China and the team because you said that they had the first meeting, which is great but it's virtual. I thought they were actually going to go to China. Do you have any update on that?

01:00:34
MR Hey, Imogen. How are you? Yes, that is definitely part of the plan but it was certainly always part of the plan that the teams would meet virtually first. There's a lot of work already being done in terms of international and studies that have been carried out already in China.
I think it's really important that the teams have opportunities to come together as a group, to look and review together what has been achieved so far so that the trip, the mission ultimately will address the issues which are the gaps in knowledge as opposed to going into the field and ending up repeating or not filling those gaps.

So part of the process here is, number one, for the international team to become familiar with their colleagues in China, to exchange information on everything that has been done so far, to understand the outcomes of those studies and then to plan the further studies that are needed and we fully expect the team to deploy on the ground.

Again reminding everybody, it sometimes takes a very long time to get these missions in place. I cast my mind back to MERS, to SARS and to other diseases in which it's taken months and sometimes years to establish animal origins and sometimes years to get fully-fledged investigations carried out on the ground.

What we don't want is to end up creating some semblance that the studies are happening and everybody just moves on and we create this idea. We want a full-scale, prolonged, sustained, comprehensive set of scientific investigations in China, in other countries.

We've seen the issues with mink and with other animals potentially outside China with the potential for us to infect animals who can then infect us back. It's a complex, complex issue and we need to get the right answers so I believe this is the method by which we will get the best answers and that's what we need, the best answers, not just any answer that satisfies political needs of speed and the political need of investigation.

We are scientists, we want the best possible scientific outcome generating the best possible evidence for the origin of this disease because it's important. It's important that we know but it's important that we know the truth, not just...

It's important that we do an investigation and it's important that we build confidence between scientists, between governments that this type of thing will happen again in the future and we have got to build trust and the mechanisms that allow us to do this together.
It is difficult to do this work in a politically intoxicated environment. It is hard for scientists to do what they have to do and want to do in situations like this. We are trying our best to ensure the best science in the face of one of the most devastating epidemics we've had to face together as a planet. We want to get the best, the right answers so we can take the best possible risk management measures into the future.

We thank those international scientists, eminent individuals for taking on that task to work on behalf of all science. We thank our Chinese colleagues, the scientists who've taken on that task on their side. We trust that this will be an example of how scientists, how health workers and others can come together despite the divides that we see more and more in this world to seek answers for the populations that we serve.

01:04:13

FC  Thank you, Dr Ryan. Just to let journalists know, the emergency committee statement has been posted. It's on our website and we will be sending it very shortly to our media list. Thank you. I would like now to invite Catrine Fioncombolonga to ask the next question. Catrine, can you hear me?

CA  Yes. Thank you, Fadela, for giving me the floor. Today we had a very interesting press conference from Dr Emma Hotcroft, who works for University of Basel and she spoke about the fact that researchers from Basel and Spain have identified a novel SARS-CoV2 variant.

She explained to us that it was very important that countries share sequencing and that that was not the case. Could you please elaborate a little bit on that and explain to us the importance of sequencing and also if there is a common platform, at least a European platform to share that? Thank you.

FC  I think that Dr Swaminathan would like to take the floor.

SS  Thank you for that question and I think Maria will add to the interoperation also of the results that we're seeing but I think it's a very important issue about sharing of genetic sequences, particularly from pathogens which cause epidemics and pandemics and pathogens which have the potential to cause these and to have a global mechanism for rapid sharing of the genetic sequence data is critical.

01:06:05

Early on in January we did have the Chinese scientists sharing the first full genome sequences of the SARS-CoV2, which of
course enabled labs around the world to start working on diagnostics as well as on vaccines.

So there are global platforms that are public databases where scientists can deposit the whole genome sequences and as well scientists can access and scientists around the world can collaborate on many different aspects.

This helps us for many reasons, not just for diagnostics and vaccine development but for tracking the epidemic because as viruses reproduce, multiply they mutate and so there are genetic signatures that get created as a virus over a period of time.

This then allows also countries to use the data to see how many importations they might have had, how the first viruses came, from where they could have potentially come, how clusters happen and also to track what's happening within countries also.

01:07:21

There are many applications now and this is something that technology has really allowed us to do during this pandemic, probably which we have not seen in the past. We have several databases including the GISAID database, which currently has over 170,000 whole genome sequences.

There's also Genbank and there is a European genomic data archive as well but Maria might want to add because there have been some recent analyses also about the latest variant that's circulating in Europe.

MK Thank you so much. Yes, as Soumya has said, there are many countries that are sharing their full genome sequences publicly so that they can be analysed and we need that to continue. We need researchers and scientists to continue to share those full genome sequences because as we analyse them, as Soumya has pointed out, there're many things that we're looking for.

01:08:28

These viruses change, they have mutations and I keep saying mutations sounds like a very scary word but these are natural changes in these viruses and what is important is that we monitor those changes to see if any of those changes mean the virus behaves differently; does it transmit more efficiently, does it cause more severe disease, do our diagnostics still work, will the vaccine that is in development still work or has the virus changed too much?
What we're seeing is that this virus is relatively stable; it mutates on the more slow end of the spectrum compared to some other viruses for example. WHO since January in my team under an incredible doctor named Mark Perkins with global scientists and virologists all over the world have come together to look at the viruses, look at the full genome sequences to determine which changes are important and why.

We will continue to see mutations and there are more and more papers that are coming out that suggest a new mutation here, a new mutation there and that is to be expected. But what is important for us is to make sure that we have a group in order that can help us evaluate which ones are the most important and what are the types of studies that will help us determine if this virus behaves differently.

01:09:47

So we not only work with the virologists, we work with phylogenetic experts that are looking at the differences in tracing these viruses in people to help us understand transmission. We work with mathematical modellers to help us look at changes in epidemiology so it's a multidisciplinary approach.

But your question is a very good one and if I can emphasise again, to continue to share these full genome sequences we are in this for the long haul so it is really important that we continue to monitor any of those changes.

While we do have more than 170,000 full genome sequences available we need more and we need more from different countries. The databases that we have are really predominantly supplied by a handful of countries and mainly high-income countries and we have seen an explosion of effort to do full genome sequences in low and middle-income countries.

01:10:41

There's incredible work that's happening in Africa with Africa CDC, the WHO in Africa and other partners to build full genome sequence platforms in the African continent. We see that happening across the Eastern Mediterranean region as well but we still need for that to continue.

So thanks for that question and, for the scientists that are watching us, please continue to share those sequences.

FC Thank you. We are up to the hour; time to close this press conference. I would like to invite Dr Tedros to give his final words. DG, you have the floor.
Thank you, Fadela. I again would like to thank Paul, Martha and Lyth for sharing your experiences and also for joining us today and look forward to working with you closely in order to understand more about long COVID and address the issues related to that.

I would also like to use this opportunity to thank our emergency committee chair, Professor Didier Houssin. Thank you so much for joining and for your continued support and help and through you to all members of the emergency committee.

With that thank you again to all those who have joined online and look forward to seeing you next week. Have a nice weekend.

Thank you, DG. Just to remind journalists, you will be receiving the audio file of this press conference along with the DG’s speech right after this press conference. The full transcript will be available tomorrow morning.

I would like to apologise journalists I wasn't able to take questions from but as usual don't hesitate to contact the WHO media team who will be happy to help you. Thank you and have a nice weekend.

01:13:02