# COVID-19

## Virtual Press conference

## 2 November 2020

### Speaker key:

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|---|---|
| FC | Fadela Chaib |
| TAG | Dr Tedros Adhanom Ghebreyesus |
| MM | Mervyn Mer |
| YJK | Professor Yae Jean Kim |
| ML | Dr Marta Lado |
| IS | Isabel |
| MR | Dr Michael Ryan |
| CA | Carmen |
| MK | Dr Maria Van Kerkhove |
| JD | Dr Janet Diaz |
| EM | Emma |
| JO | Jordan |
| CN | Chen |
| CO | Corinne |

**00:00:00**

FC 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, November 2nd. The Director-General, Dr Tedros, will be joining us remotely. Present in the from are Dr Mike Ryan, Executive Director, Health Emergencies, Dr Maria Van Kerkhove, Technical Lead for COVID-19, Dr Soumya Swaminathan, our Chief Scientist, Dr Mariangela Simao, Assistant Director-General, Access to Medicines and Health Products.

Welcome all. As usual we have simultaneous interpretation in the six official UN languages; Arabic, Chinese, French, English, Spanish and Russian; plus Portuguese and Hindi. We will be

joined remotely by several gusts that Dr Tedros will introduce. Now without further ado I will hand over to Dr Tedros for his opening remarks and to introduce our guests. Dr Tedros, you have the floor.

TAG Good morning, good afternoon and good evening. I want to start by saying that WHO has been following closely the situation with Typhoon Ronnie in the Philippines. This is the strongest storm of 2020 and WHO will work with the Government to ensure emergency medical care is reaching those who need it. Our thoughts are with all those affected.

I have been identified as a contact of someone who has tested positive for COVID-19. I am well and without symptoms but will self-quarantine in the coming days in line with WHO protocols. At this time it's critically important that we all comply with health guidance. This is how we will break chains of transmission, suppress the virus and protect health systems.

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Over the weekend we saw that while many countries have brought COVID-19 under control cases in some countries in Europe and North America continue to spike. This is another critical moment for action, another critical moment for leaders to step up and another critical moment for people to come together for a common purpose. Seize the opportunity; it's not too late.

We all have a role to play in suppressing transmission and we have seen across the world that it's possible. We have release videos featuring multiple countries demonstrating their comprehensive response to COVID-19. This includes New Zealand, Rwanda, Thailand, the Republic of Korea, Italy and Spain and today a new video was released that highlighted Mongolia's success in responding to COVID-19.

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Mongolia has so far had no disease or local transmission and what Mongolia and all these stories show is that there are shared lessons that we can all learn from and we all have a role to play in suppressing transmission.

In some countries we're seeing cases go up exponentially and hospitals reach capacity, which poses a risk to patients and health workers alike. This is leaving health workers with difficult decisions to make on how to prioritise care for those that are sick.

To understand more about how hospitals can prepare and cope with COVID-19 I'm pleased to be joined by three distinguished health specialises. First I would like to introduce you to Professor Yae Jean Kim, who is joining us from the Republic of Korea, to reflect on their experience tackling COVID-19. Professor, you have the floor.

YJK Thank you very much for the kind introduction, Dr Tedros. I send you a warm wish that you stay health and get back to your office after and eventful quarantine. Good morning, good afternoon and good evening. It's my privilege to share our experience with the COVID-19 outbreak in Korea.

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Korea had the first patient around January 20th, similar to other countries and in February and March we had the second-highest number of COVID patients next to China in the world. But now we have a lower number of cases than many other countries.

The first thing that I would like to mention about Korea's response with COVID-19 is the rapid PCR testing and rapid isolation during the initial large outbreak in [Unclear] area and the following outbreaks later on.

Having experienced the worst COVID outbreak in 2015 we knew that setting up a PCR test and expanding the test capacity would be very important to investigate and also work on any outbreak situation. In fact the PCR testing was available in many clinical laboratories of hospitals including my hospital around during the first week of February.

In addition to speed up the test sample collection with the limited test rooms Korean physicians developed an idea of drive-through test facilities, which is already published in the literature and many other countries also use those ideas.

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We had a community treatment centre for milder cases and that was somewhat unique for Korean response to prevent any transmission in the community and also in the household. There are pros and cons in this community treatment centre and we are continuing our discussion for these matters.

Secondly the public hospitals; we have public hospitals and private hospitals and these public hospitals have been prepared for high-risk communicable diseases for the past couple of years, especially since before the March outbreak but also strengthened since the March outbreak.

This time these hospitals were utilised for COVID-19 patients. When the hospitals were filled with critical patients who could not be moved physicians from other hospitals in other cities volunteered to help the patient care and in addition when the hospitals were saturated the private hospitals also took care of the patients when the overflow occurred.

Another important aspect of this COVID-19 in Korea is the collective joint effort of the experts in the field with the health authorities, which we also exercised during the March outbreak as well.

**00:08:30**

But the patient care aside, we had a central clinical taskforce from the beginning to share the clinical knowledge and experience about the patient care. For the COVID-19 response side we had a coalition of the response team in the field of infectious diseases, infection control, laboratory medicine, clinical care, homenology [?], epidemiology, etc, and all worked together with the Korean CDC; now the Korean Disease Control and Prevention Agency; now it's an agency.

This health authority also shared the information with the public on any new patient numbers and outbreak situations openly and these updates with a daily press release. The Korean CDC, former Korean CDC continued the epidemiologic investigation when other countries discontinued further investigations when they have a large outbreak.

However we continued epidemiological investigations whenever there as an outbreak and whenever possible and now we came to learn many more situations that can be linked to further outbreaks so that was also a lesson we learned from the various investigations we performed.

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Finally most of all the participation, co-operation and compliance of the public, the community members of the nation was one of the most important aspects of COVID control in Korea. We encouraged the wearing of masks from the early phase of the pandemic and avoiding mass gatherings later on.

However we did not lock down the country or close the border but only perform the variable degrees of social distancing according to the epidemiological situation. Although we had a second wave in some metropolitan areas mid August and

September the outbreak was controlled with the various collective efforts.

Many Koreans remember the outbreak in 2015 and their mindsets are also changed since then and know that public co-operation and compliance is important for the safety of everybody and then you follow the guidance with positive acceptance.

Now we are preparing for the winter like any other countries and the health authorities; actually we're organising the social distancing levels from three levels previous to now to five levels in the future.

**00:11:06**

So we are trying to prepare ourselves with our best efforts. Thank you.

TAG Thank you. Thank you so much, Professor. I would now like to hand over to Professor Mervyn Mer of University of Wits, South Africa. Professor Mer is also Director of Intensive Care at Charlotte Maxeke in Johannesburg. Sir, you have the floor and thank you so much for joining again.

MM Gracious thanks, Dr Tedros, for the very kind invitation. It's been a real privilege and pleasure to participate in this press conference. I'd also like to take this opportunity just to extent and pay tribute and homage to the wonderful healthcare workers around the globe who've really done amazing and committed work.

From a South African perspective we are a low/middle-income-class country with a population of roundabout 60 million people and there are huge discrepancies between the haves and the have-nots. In fact 55% of South Africans live on under US$2 per day.

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We also have, as was alluded to in your earlier presentation, a public healthcare system as well as a private healthcare system but 84% of the country's 60-odd million people are dependent on state healthcare and in many areas these are extremely resource-limited.

So I'm going to focus on some of the elements in our own institution which served as the major referral hospital in Johannesburg in terms of what we did and how we in fact

prepared and most importantly many of the lessons that were learnt that I think have been exceptionally useful for all of us.

We first began to hear, as did the rest of the world, what was going on in China in early January and very shortly thereafter we in fact got together a group of role-players and had our first meeting. This was shortly after things were made public knowledge.

Within the context of the first meeting we'd already drawn up a protocol. That protocol; the ensuing months and weeks were subsequently refined and in fact widely rolled out and what we in fact realised at the time - and it was something that I felt quite strongly about - with a preparation and we had the benefit of several months versus individuals in China, the US, Europe and elsewhere before in fact our surge occurred.

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So we really tried to maximise, bearing in mind our resource limitation, everything that we feasibly could and one of the things that we felt and I certainly felt very strongly about was that there were plans to put a field hospital, as had happened elsewhere in the world.

I felt one of the most important things we could do was look at our own infrastructure, our own hospitals and expand capacity within those. To put into perspective, as someone speaking from the intensive care background, we have about 70 to 80 intensive care specialists in South Africa, half of whom don't practise intensive care.

So we have 40 or fewer intensive care specialists to look after 60-odd million people, a signifiant percentage and proportion of which may effectively have required intensive care; facilities and care.

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So within a short period of time we partnered with various social responsibility partners, addressed the issues of ventilators, oxygen in the country, getting sufficient masks, making sure that in fact we could expand our existing capacity and within no time our own ICU capacity in Johannesburg was more than doubled.

We also made sure we started a nursing up-skill course so that we could actually provide adequate care for the patients and we made sure that human resources were extended a little so that even though we didn't have the specialist care we could employ

people who could often be trained quite readily to deliver appropriate intensive care in our institution.

In fact what this effectively has done; we were able to do that within a few weeks and so we have more than doubled our capacity. As you may be aware South Africa now ranks number 12 in terms of the most commonly affected countries; we were number four or five at one stage.

In my own hospital at a point in time we had close to 400 patients and a packed ICU with this expanded facility. So we felt that in the context of things in fact every challenge brings opportunity and so we try to maximise the opportunity and this ICU that we've created and expanded will exist beyond COVID.

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In fact we were able to continue providing absolutely essential services for patients with non-COVID disease, being relevant in resource-limited settings like tuberculosis, HIV, ongoing surgical issues and we made sure that we could maximise those and have an expanded facility.

Additionally with the preparation and some of the work actually done in our own institution many years ago we took a leaf out of our own experience with varicella pneumonia and many individuals who may be in fact online currently would know that in fact from our institution many years ago, 1998, there was a seminal publication that described the benefit of corticosteroids in critically ill patients with varicella pneumonia, with massive reductions in mortality.

So very early on we in fact in our armamentarium of appropriate supportive care, oxygenal supportive care, appropriate fluids and so on we added corticosteroids long before the Recovery trial impact became well-known.

In fact when compared to other colleagues elsewhere in the country and elsewhere in fact our mortalities were dramatically different despite the fact that we were dealing with a very similar severity of illness.

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So we recognised that, as is often the terminology that's put out there, you can do more with less but what we did recognise and, I think, a very important lesson to learn is not to do less for more so don't expend and expand issues that are actually non-feasible.

So a huge amount was done by just a few for so very many. We also learnt most importantly so the first issue was preparation. The second was that communication is absolutely pivotal and at the outset based on what was happening elsewhere in the world there was massive fear, panic and anxiety.

We set up a daily really effective debrief in the morning and in the evening where everyone in fact had a voice, from every single healthcare worker that was from the security porters t the nursing staff to medical staff to everyone and has a role to play within the context of delivering care.

When we did this we were able to open all sorts of issues, take decisive decisions which were then very easily implementable and allow people to feel supported and in fact this made a massive difference.

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At the outset we had several healthcare workers who were affected. We initiated our own PPE training programmes and within no time people who initially veered away from wanting to be involved with volunteering, were doing more with less but not less for more.

So fabulous issues and everyone ultimately walked into this. We felt it was very relevant to maintain simplicity. In a country like South Africa we have to rely inherently on clinical acumen and excellent clinical acumen can make massive difference.

So in my opinion being poor doesn't mean poor care. In fact with creativity and initiative, in fact excellent can be achieve. There were some other lessons that we learned along the way; we learned to be flexible based on what was being shared abroad, had lots of interactions with colleagues abroad as well.

Ultimately in a nutshell I think those elements allowed us to actually provide care that was equitable in a resource-limited setting. With what is going on elsewhere in the world and in fact possibly have some outcomes that currently look as favourable if not better despite the resource limitations.

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So I think I want to remind everyone out there that it's an absolute privilege to in fact be within this profession and we should never forget that.

Another thing coming from Africa that I think we need to take up, we share is what we call the spirit of Ubuntu and Ubuntu is a

very, very special word that means never forget to be compassionate and humane both to patients and other healthcare workers. That went a massive way to making a huge, huge difference.

Then finally I had the fortune to grow up in a country where we were exposed to an individual of the magnitude of Nelson Mandela and he was someone who taught all of us around the globe that we can overcome difficult situations like the situation that we are dealing with and that it doesn't matter how turbulent the scenario is, how difficult and how many obstacles we face.

Something that stuck in my mind out of the many words of wisdom that he shared with all of us around the globe was a quotation that went something as follows; what counts in life is not the mere fact that we have lived; rather it is the difference that we have made to the lives of others that will determine the significance of the life that we lead.

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If we take that particular element of wisdom out we can all get through this. Nothing is impossible. In fact I often try and turn the terms around and use the terminology; impossible is nothing. So I'd like to share some of those elements with you, extend really gracious and humble thanks for this opportunity and really let everyone know out there that even in the most difficult scenarios we can get on with things in a simple way; simplicity's the ultimate sophistication.

A huge amount can be achieved and we in fact can change the lives of many individuals. Thank you so very much for this opportunity.

TAG Thank you. Thank you, professor Mer, for sharing your message from South Africa's COVID-19 response; Ubuntu. Finally I would like to introduce you to Dr Marta Lado from Spain. Dr Lado was the Chief Medical Officer for Partners in Health in Sierra Leone and the Senior Clinical Lead in the intensive care unit for COVID-19 at 34 military hospital in Freetown. Dr Lado, you have the floor.

**00:23:25**

ML Thank you very much. Thank you, Dr Tedros, for the introduction and for the invitation to be able to share some of the experiences that we have had in Sierra Leone in the last months with this pandemic of COVID.

We have had our first case in Sierra Leone on 30th March of 2020 and so far until today,y which is more than six months, we have 2,366 cases. Compared to other settings and other countries definitely it's quite a low number of cases. It's not really related with a low level of testing or because of not being able to acknowledge the infections that we have in the community. Probably there are a multifactorial system about young age, the weather, probably cross-immunity with other coronaviruses.

Also some specific measures that I would like to bring up with the audience in terms of being gable to analyse how much our context in a low-income country like Sierra Leone can affect the way that we respond to things when maybe other medium or high-income countries probably are struggling a little bit more.

I want to remind everyone that we had a very big outbreak of Ebola from 2014 until 16 and that it killed and affected many of our population here in Sierra Leone but also attacked deeply our healthcare system and made it even a little bit weaker than it was.

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So when all this COVID epidemic was going on all around the world and mainly Asia and moving into Europe and the US Sierra Leone was able to start putting into practice some of the lessons learned during the Ebola outbreak that we lived through in 2014-16.

One of them is we were one of the few African countries considered low-income countries that had five molecular labs functioning in the country so that was meaning that we were able to do PCR testing, like real-time PCR to most of the different regions of the country like the north, south, east and west. Two of them were located mainly in the capital where most of our cases of COVID happened.

Another thing is the contact tracing. We had already developed a very good system for contact tracing during Ebola whereby when one patient is affected being able to follow up all the relatives and all the close contacts, having a proper system of a 117, a free hotline where people can call whenever they feel sick and they want to be tested or just to report any kind of infection around their environment.

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That has also definitely made a big difference in the way that we were able to do contact tracing and surveillance in most of our

population. The third one was about the IPC; IPC training, PPE. Those were things that Sierra Leone was more than expert in.

I was here in Sierra Leone before Ebola so I have the privilege and also the experience of living here through the outbreak of Ebola and we spent a lot of time doing IPC training, how to wear the PPE, how to don and doff, etc, how to set up treatment centres, how to do isolation units, how to make sure that most of our staff are able to be protected when they are working so that we can reduce the hospital-acquired infections.

So these are things that we learnt from Ebola and we were aware that Ebola was not COVID but it definitely has made a ground where we were able to start working in a more easy way and probably faster than many other countries that we were seeing around.

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The other thing was about the lock-downs and the closure of the airport; they definitely have made a big difference and that has made many new cases not be able to come inside of the country so we were able to control our population.

The reality is that we don't have as much tourism as probably we see in other African countries so that means that most of our people that come inside of the country come for some kind of probably business or development work.

So with the closure of the airport and the lock-downs between different districts we were able to control the movement of people so we were able to identify cases in the capital and be able to follow them quite closely compared to probably other regions where they are not so used to being able to put these measures in place.

For all of us it's one of the most important lessons learned and this is what we are now trying to focus on more and more; how we were able to develop a critical care training for our healthcare staff.

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So before COVID we only had one ICU in the country with only one intensivist for a seven million population. That means that, as you all may imagine, the basic idea about monitoring patients, about vital signs, about being able to control patients that are coming in shock, different types of shock but also ventilation, oxygen.

Only two hospitals in the country have piped oxygen so most of the oxygen administered in any regional or district hospital is through oxygen concentrators and sometimes if you are lucky and you have an oxygen factory some canisters that we can fill in.

So as my colleague, Professor Mervyn, was saying before we try to do our best with the small but we end up reaching and getting many, many good outcomes and that's what has happened in the country; from 2,300 cases we only have 74 deaths so far and also this means that we have been able to develop systems.

We don't have a specialist in ICU to be able to do mass ventilation, at least mechanical ventilation but we have over-expanded the use of CPAP, the use of high-flow oxygen. We have been able to train a new generation of healthcare workers in how to manage physical cases, how to do a good monitoring and close care of patients with high-dependency units.

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In our case with 34 military [?] we have been able to set up from what was an Ebola treatment centre with 30 beds we are transforming, transitioning into 30 beds of ICU for COVID where we work with oxygen concentrators of 5l, 10l oxygen canisters that we refill in our oxygen factories.

But also we put CPAPs in our patients that are coming with more severe respiratory insufficiency and respiratory distress. So now trying to get ready for the second wave, right now in the last days we have not reported any case in the country, which should not give us so much confidence or complacency because we know that sometimes the waves come a little bit later.

But what we can definitely say in Sierra Leone is Ebola taught us a big lesson about how to manage infectious diseases as well as other vertical programmes like TB, HIV in terms of contact tracing, surveillance, etc, IPC and also PPE use.

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But now we need to get ready for the second wave, just being able to witness what is happening now in Europe, USA and Asia and trying to put our big improvement in the healthcare system and the capacity of the healthcare workers in managing critical care and trying to get us much operations and medical equipment available.

Now we have seen that with just oxygen, [unclear], steroids and good monitoring and a good high dependency unit with close

monitoring of the patients we are able to make most of our patients survive. Thank you very much.

TAG Thank you. Thank you, Dr Lado and we are pleased that you have recently joined WHO and we'll be using your experience from Sierra Leone to drive our work on clinical case management. Muchas gracias. That caps three amazing stories. There are many lessons from the Republic of Korea, South Africa and Sierra Leone that can help other countries suppress the virus, save lives and protect health workers and hospitals.

It really reinforces that while some countries are putting in place measures to ease the pressure on the health system there is also now an opportunity to build stronger systems, ensuring quality testing, tracing and treatment measures are implemented are all key and we need countries to again invest in the basics so that measures can be lifted safely and governments can hopefully avoid having to take these measures again.

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On a macro level this also reflects why a whole-of-government, whole-of-society approach to sustainable global preparedness is so important. Health systems and preparedness are not only an investment in the future. They're the foundation of our response today.

Public health is more than medicine and science and it's bigger than any individual and there is hope that if we invest in health systems, health workers and shared tools through the ACT Accelerator we can bring this virus under control and go forward together to tackle other challenges of our time.

We have to keep going and whether at home or in the office WHO will keep working to drive forward science, solutions and solidarity. I thank you. Fadela, back to you.

FC Thank you, Dr Tedros, and thank you to our guests. I will now open the floor to questions from journalists. I remind you that you will need to raise your hand under the raise your hand function in order to get in the queue to ask your question.

**00:34:30**

I would like now to invite Isabel Sacco from EFE, the Spanish news agency, to ask the first question. Isabel, can you hear me?

IS Yes, thank you, Fadela. Good evening. I would like to ask your comments on the protests in several, parts of Europe against the COVID restrictions decided by governments. Do you

see them as a sign that people did not yet understand the gravity of the situation that we are living in? Thank you.

MR Yes, we've seen many of the protests around the world in association with restrictions from time to time and clearly people are frustrated and they have every right to be frustrated and they're fatigued and they want, as we all do, to get back to our normal lives.

People have every right to question when authorities indicate certain measures need to be taken. We would prefer that to be seen as a dialogue between governments and communities so that we can reach consensus on what needs to be done.

It's really important that governments reach out to all levels of society to do that and to have dialogue. Sometimes government have to act quickly and in doing so it can cause a reaction at the community level. Communities have a right to protest. It's a very important part of modern society. Governments don't always get it right and also need, like ourselves, to be accountable for our activities.

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So protest is good as long as that protest is safe, that protest is managed in a way that it doesn't increase COVID risk and obviously we would hope that such protest would be civil, non-violent and respect the basic rule of law and that no other civilians and others are drawn in.

So yes, we support the idea of protest and the idea of speaking out and we understand people's frustrations but governments in Europe in particular at this time are facing a very, very difficult situation.

You can argue how we've got into this situation but you can't argue that the situation is serious. We need to push this virus down, we need to take the heat out of this epidemic right now in Europe and governments have limited options right now in how to do that. Their options are limited.

**00:37:07**

Their options may get easier if we get some success but right now governments face very limited options. We would ask you to challenge - yes - your government but please support those decisions your governments make that are really, I think, aimed at trying to protect populations, trying to help people and we hope that any measures that have been put in place are short-

lived, are based on the epidemiologic need and are the least disruptive possible.

FC Thank you, Dr Ryan. I would like now to invite Carmen Paun from Politico to ask the next question. Carmen, can you hear me? Carmen, can you please unmute yourself?

CA Yes, can you hear me well now?

FC Very well. Go ahead, Carmen.

CA Thank you so much for giving me the floor. I have a question for Professor Yae Jean about the flu season. There have been concerns in many parts of the northern hemisphere about a so-called twindemic with flu and coronavirus. I was wondering if you had any indication so far in South Korea about the numbers of flu cases and how they compare to this time last year or whether we're seeing a similar situation as in the southern hemisphere where there were very few cases of flu because of the precautionary measures taken against the coronavirus.

**00:38:42**

If I may, also a question for probably Dr Tedros about the US funding for the WHO. I was wondering if there's been any assessment so far on how the freezing of funds from the US side will impact the work of the WHO.

I also take this opportunity to wish Dr Tedros the best and hopefully he'll feel well and be able to get out of quarantine soon. Thank you.

FC Thank you, Carmen. I would like to invite Professor Kim. I know it's very late in her country but - you are still with us. Do you mind taking this question, please?

YJK Sure. At the moment we have not started the typical flu season yet although we are entering. We are vaccinating people for the preparation for winter. Typically we see the flu patient probably some time in November and we see an increasing number of patients in December and January, typically in Korea in the past.

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So we do not know whether we will have the similar situation as in the southern hemisphere; during the summer time they have a low number of cases. However we are trying to do our best to prepare our population with vaccination at the moment.

So at the moment we do not see any signs of a significant increase of influenza in the community.

FC Thank you, Professor Kim. Dr Maria Van Kerkhove would like to add something.

MK Yes, thank you, and hello, Dr Kim. It's really nice to see you on the screen and thank you for joining us today. Dr Kim and I have known each other for a few years now based on our experiences together with MERS coronavirus and I'm very grateful that Korea has really demonstrated lessons learnt from experience with MERS in 2015 so thank you, Dr Kim, and all of the speakers today.

Just to highlight the question around influenza and influenza season in the northern hemisphere, as we are beginning the season here in the northern hemisphere there are surveillance systems that are in place to be able to test to see which influenza viruses are circulating. Those systems are strong. We need to make sure that in countries in the northern hemisphere we are still testing for influenza as well as testing for COVID-19.

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The restrictions that are in place for COVID-19 will be beneficial for influenza but we don't know yet how the influenza season will unfold. The good news for influenza is that we can be prepared for this and we are preparing for this.

There is a vaccine that is rolling out for influenza and we strongly urge those in the at-risk groups to make sure that they get vaccinated this year. There's also substantial work underway around making sure that patients enter the right clinical care pathway as they enter the public health system and Dr Diaz is here, who can comment a little bit more on that.

Because it is important the type of care that individuals receive depending on if they have COVID-19 or if they have influenza. So it will be difficult to distinguish what an individual has in terms of their symptoms because the signs and symptoms are very similar.

**00:42:03**

So entering that clinical care pathway early and making sure that patients receive the care that they need will save lives. Janet.

JD Thank you. This is a very important question and also important to be prepared and ready. I think as you start to think about influenza coming into the community obviously the

surveillance is key, recognising when influenza starts to circulate or is circulating in the community so the clinicians have to put it on their differential diagnosis when evaluating someone with an acute respiratory infection.

We do know that the symptoms are common, that both diseases do have some common symptoms but we do know some common differences and one of the differences I think I wanted to highlight is that those who are at risk for influenza include... There are some overlapping risks for severe disease but then there are some that are more unique to influenza.

So young children are at increased risk for severe disease with influenza and one must remember that. The second one is pregnant women; pregnant women are at risk for severe disease with influenza and so you have to remember that, including up to post-partum two weeks.

**00:43:13**

So those are two groups that we are not seeing severe disease in COVID-19 so that is clear so when you're starting to see influenza circulating don't forget that so someone with an acute respiratory infection and you suspect influenza's in the differential and they're a young child or they're pregnant then that patient actually does need to be tested.

Why do we test for influenza? We test for influenza because we do have antivirals that work for influenza so right now the WHO is soon to publish our guidance on influenza but we do know that there are antivirals such as ocaltamivir that if you give to patients who are at risk or with severe disease it does reduce mortality.

So that is our recommendation so we have an antiviral that would be used for patients that are either at risk or with severe disease for influenza and that is different than what we know for COVID-19.

Again there's another difference perhaps; the use of corticosteroids so corticosteroids right now for the treatment of COVID-19 it reduces mortality in patients with severe and critical COVID-19.

**00:44:22**

But the risk of corticosteroids in influenza; there has been some concern that that could actually increase viral replication so the same data doesn't exist for that. So I think what's important now is to, one, understand when it starts to circulate in the

community; two, to put it on your differential diagnosis, know the differences in severity, know the differences in treatment pathways.

But then there're some other commonalties; if the patients with influenza or COVID-19 develop severe pneumonia, need oxygen therapy, need intensive care then the best practices are the best practices; good supportive care, good patient monitoring, safe practices in intensive care unit, appropriate application of IPC within the healthcare setting in order to prevent any nosocomial transmission so then there are those commonalties so thank you.

FC Thank you, Dr Diaz. I would like now to invite Emma Farge from Reuters to ask the next question. Emma, can you hear me?

EM I can hear you. Good afternoon. My question is for Dr Tedros, please. It's regarding the quarantine. Can you give any indication of whether the COVID-19-positive person you're in touch with is from within WHO and if so is there a question of transmission within the agency and how big is it?

**00:45:43**

More broadly can you comment on whether this encounter is affecting the operations at headquarters; will you be testing staff or potentially then closing headquarters, what is the plan? Thank you very much.

MR I'll take the first part. The DG may wish to comment but just to reassure you, our staff health and welfare programme under the leadership of Dr Caroline Cross and Raoul Thomas, the Head of Business Operations, has had a very extensive case detection and contact tracing system covering our staff since the very beginning of this epidemic.

We have had a number of cases through that time. Most cases have been acquired at community level; very few within the building here but we've been very vigilant in maintaining... number one, reducing the footprint of staff in the office, moving very much to teleworking; all of the things you've seen elsewhere; hand-washing stations, limitations on the number of people per office, limitations on meeting rooms, the wearing of masks in open spaces and many other initiatives that have been incrementally added in order to manage the risks to our staff both in the building and in the community.

**00:47:00**

Remember we're part of a community here at WHO too both on the Swiss side of the border and the French side of the border.

Our staff live in the community, their children go to local schools, we shop, we pray, we do all the other things that people want to do so we are part of that community and we're subject to the same risks that exist in those communities.

The staff have been very, very vigilant in implementing those measures. We have temperature checks on arrival in the building, self-declaration of health status every single day for all staff members and an immediate response mechanism should someone become ill at home or become ill at the office.

I'll pass to Maria maybe for some of the detail but just to assure you that we, like any building and any organisation both here, at our regional offices, in our country offices have in place strong and robust risk management mechanisms in order to reduce transmission within the building and to manage that transmission should it occur.

**00:47:57**

This is not a zero-risk situation; we've said it again and again. There is no environment right now in the world that is without risk. We believe we have put in place appropriate and robust risk management measures that balance the risks of the disease against our need to provide the services that we must provide to our member states and the world. Maria.

MK Only to add that we're an organisation, just like everyone else in the world, trying to work this out in how we keep our staff safe and how we have the systems in place within the building but also making sure that everybody takes the steps they need to take throughout the day.

We're all everyday people as well and we live in homes and apartments and we have to grocery shop and we have to take our kids to the doctors and all of that so everything that we have put in place, everything that we are recommending to the world we are putting in place here as well.

So, as Mike has said, we are tracking all of the cases that are happening amongst staff, doing contact tracing forward, doing contact tracing backward to make sure we understand how people were infected and making sure that transmission is not taking place.

**00:49:02**

We haven't had any transmission take place on the premises. We have no clusters on the premises but it is something we're monitoring every day so we are always looking at the systems

we have and the rooms we have and the spacing and the work staff and that is something that we will continue to do.

But I'm sure every business, every office is having similar discussions but make sure that you have a plan in place in your own place of business so that you know what it is that you need to do as a staff member but also as an employer to support your staff should someone be a case and require care and also to provide supported quarantine for those who are contacts of confirmed cases so that they can be supported through the 14-day quarantine period.

FC Thank you both. I would like now to invite Jordan Kelly-Linden from the Telegraph to ask the next question. Jordan, can you hear me?

JO Hi. Can you hear me?

**00:50:04**

FC Yes, very well. Go ahead, please.

JO Perfect. A petition has been widely circulating calling for global guidelines on indoor humidity to be drawn up amid concerns that dry weather air could provide a perfect storm for successful coronavirus transmission.

The petition calls for regulations on indoor air quality to include a humidity level of 40 to 60% relative humidity. Is the WHO aware of this petition, has the WHO considered this and what does the Organization think of the evidence suggesting SARS-CoV2 transmits more effectively in dry air?

MK Thank you for the question. Yes, we are aware of that petition that's been circulating for some time. There're different ways in which relative humidity affects the ability for the virus to spread. If you have low relative humidity that will favour survival of the virus on surfaces for example but if you have high relative humidity it could favour respiratory droplet circulation or suspension of droplets in the air.

**00:51:12**

We have been working with the global heat health information network which is a combination of researchers from WHO, the World Meteorological Organization and the US National Oceanic and Atmospheric Administration in the US and have set some guidance on ideal temperatures for rooms and also ideal relative humidity of between 50 and 60%.

So within our networks we discuss a number of factors that can reduce transmission indoors and outdoors and everywhere and we do know that there are situations in which transmission can be amplified, which is why you hear us speak a lot about trying to avoid enclosed spaces, indoor spaces and spaces with poor ventilation.

You hear us speak a lot about making sure that we improve ventilation as one of the measures that could be put in place to help reduce transmission of this virus so it is one of the factors that we are looking at and we will continue to look at.

FC Thank you. I would like now to invite Chen from China Daily to ask the next question. Chen, can you hear me?

CN Yes, very well. I have a question for Professor Kim and maybe the other two experts if you want to weigh in. I'm actually based in Brussels, under the new lock-down. Europe and the United States are again the new epicentres so if the European Union leaders and the US leaders come to seek your advice and you don't have to be too polite what would you tell them they have done wrong to cause the second wave?

**00:52:58**

If you've followed their measures recently to tackle the second wave do you think they are doing things right so maybe there won't be a third wave before Christmas? Thank you.

FC Thank you, Chen. Professor Kim, are you still online?

YJK Yes, I am online and it's a very challenging question and I am not sure whether I have wise answers for that question. As we all already experienced during this pandemic this virus in many ways was unexpected and we were actually learning more about this virus just following the track of the virus.

I am not sure at this point whether we can say who did wrong, who did what wrong and I feel at this point what we need to do is collect our wisdom and also pick up all the lessons that we learned so far and we are preparing for the future in a more collaborative way.

**00:54:14**

I think that will be the way to go for the future and also there is some hopeful news about the vaccine trials and treatment regimens, things like that so until we have really more good weapons we tried to slow down the epidemic. I think that's the way to go so I think when we share our wisdom and knowledge

we can overcome this virus eventually and slow down the virus and we will have more options in the future for the treatment and a better outcome. That's all I can say. Thank you.

MK Thanks, Dr Kim. It's a very good answer. I do want to take this opportunity to highlight a few things that we think countries can be doing right now, especially as it relates to the topic at hand today where we're talking about clinical care, we're talking about the use of medical facilities to be able to care for patients.

I think one of the challenges that we're seeing across North America and across Europe is that the increases in cases, the increases in hospitalisation, the increases in ICU are happening at the same time.

In the spring there was some staggering of this increase but it's happening in many countries at the same time where many systems are becoming overwhelmed at the same time so that poses challenges for countries that were able to move facilities and move workforce around to help manage the most intense areas.

**00:55:52**

WHO has outlined a number of tools and a number of guidance that I'm going to run through very quickly right now because I think these can be helpful in dealing with this peak that we're seeing right now across Europe and across North America.

We have a number of tools that have been established - and these have been revised over time - which are essentially calculators. These are calculators for tools to help plan for the workforce that is needed for clinical care, for the supplies that are needed including therapeutics and medicines, in terms of oxygen, in terms of beds and different types of beds that are needed for different levels of clinical care and in terms of personal protective equipment that is needed.

These calculators can be used again, looking at what is needed for this increase and for building this surge capacity. We also have a number of tools which are working on expanding your capacity that you have right now so even countries that have brought transmission under control - you've heard from our speakers today - they're still expanding capacity and many countries that are seeing intense transmission right now need to expand clinical care capacity, whether this is restructuring of current facilities that you have to manage patient flow, whether this is about repurposing facilities that exist in buildings that exist, that can either care for those who are on the more mild

end of the spectrum, taking off some pressure from your hospitals that need to provide more advanced care or whether this is building facilities.

**00:57:22**

We have guidance out that can help build SARI [?] treatment centres, severe/acute respiratory treatment centres and we have seen a number of countries that have actually built purpose-built facilities for COVID, which will be beneficial for infectious diseases in the long run.

We also have a number of training pathogens that are out that will protect the workforce so providing adequate training for infection prevention and control when caring for patients who are suspected to have COVID or who have COVID through the various levels of their illness, in particular if you need to do aerosol-generating procedures for example.

**00:58:02**

You've heard from one of our speakers that there's a new generation of health workers that are being trained. This needs to continue to happen because our workforce is overwhelmed, overburdened already and they're quite exhausted so to be able to provide that support.

We also have a new screening guidance that's out for screening identification and management of healthcare worker infections because of course health workers are most at risk of infection because they are directly dealing with patients who are infected with this virus.

So this is a mixture of infection prevention and control procedures as well as occupational health and safety. We also have a number of guidance out across the public health spectrum to help countries deal with community transmission so this is prioritised surveillance activities, this is prioritised testing strategies because in situations where you can't do the level of testing that you might want to do you may have to prioritise those resources.

**00:59:02**

I think the last thing is that we keep hearing from all of our speakers, from all of our member states that it's the flexibility of the system to be able to cope as you increase your need or decrease your need as needed and learning from the experience that you have because countries are not in the same position that they were in previously.

We know a lot more now about caring for patients and that is saving lives. We just need to ensure that the medical system doesn't get overwhelmed so that we can provide the adequate care that is necessary so we will be repackaging this guidance that already exists in a way so we can put it on our website so that countries can go directly to this and see what are the surge materials that are necessary.

But there's a lot of existing guidance that is there, you have a lot of experience yourself so really utilise your knowledge and your management from the spring into the current season now. But it is time to scale up and it is time to continue to scale up and be ready.

FC Thank you. We would like now to invite Bloomberg News, Corinne Gretler, to ask the last question. Corinne, can you hear me?

**01:00:16**

CO I can hear you. Thank you. It's a very short one for Dr Tedros. I just wanted to ask if you have been tested or if you're going to be tested or if you're waiting for symptoms if they do show up.

FC Thank you, Corinne.

MR The current protocols in WHO are that people who are determined to be contacts of a confirmed case are asked to quarantine for the period of time required. That is the standard protocol and that is the regime Dr Tedros is under right now.

His testing will depend on the arrival of symptoms or otherwise and he may be tested in the days to come but our current protocols don't require that he be tested. He is at home in quarantine and, as you can see, very well and working away and continuing to do his job in supporting the world.

We, the staff of WHO extend our congratulations to our chief for becoming a grandfather. It is wonderful to see new life in the world as we face so much death and gives us hope and we congratulate him and his family, his sons and daughters and daughters-in-law. It's just good news for us all.

**01:01:53**

But as I said, Dr Tedros will monitor his own condition, he will be monitored by our staff health and welfare team and he will be tested as necessary at the appropriate time.

FC Thank you, Dr Ryan. I think we passed the hour so it's time to close this press conference. Just to check if Dr Tedros is still online for his final words. We lost him.

MR I think Dr Tedros has been obviously cut off. We didn't have any questions for Dr Mariangela Simao or Dr Soumya Swaminathan today but I will remark on the fact that it is remarkable and a wonderful sign of the times to be surrounded by four absolutely outstanding female scientists and doctors.

It's also quite intimidating; now I know what Dr Tedros feels like sometimes so I'm sure we'll have more questions on the ACT Accelerator and the science and the R&D side in the days to come. Thank you all for your attention. Bye.

FC Thank you, Dr Ryan. Just reminding journalists that we will be sending the audio file and the DG's speech just after the press conference. The full transcript will be posted on the WHO website tomorrow morning. If you have any follow-up questions don't hesitate please to contact the media team. Dr Tedros, would you like to say a few words before we close formally the press conference? Dr Tedros, you have the floor.

TAG [Inaudible].

FC We can't hear you. Please unmute yourself.

TAG [Inaudible].

FC Dr Tedros, we cannot hear you. Thank you, Dr Tedros. We will see you very shortly. You are back.

TAG Yes, because I was unmuted, I think, from the centre. That's why. I just had a look there. Thank you so much. I would like to thank all who have joined us today; to Professor Yae Jean, to Professor Mer and also to Dr Lado, thank you so much for sharing your experience from South Korea, South Africa and Sierra Leone.

Thank you also to our colleagues, to all journalists who have joined today and see you in our next presser. Thank you also for your good wishes which you just expressed since yesterday and I'm very grateful for that. Thank you.

FC Thank you, DG.

**01:05:53**