

COVID-19

Virtual Press conference

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00:00:23

MH Hello, everybody. This is Margaret Harris at the WHO headquarters in Geneva. Welcome to our COVID-19 press briefing today, this Monday July 20th. As usual we'll be providing simultaneous translation in all six languages - all six UN languages - plus Portuguese and you may also listen in Hindi. Note owing to the way Zoom is set up you will have to go to the button marked Korean to access Arabic.

We have been having some connectivity problems today so we apologise if there are any problems. We will ensure that we keep it going on Zoom but there may be some problems with our social media connection. Now I will hand over to Dr Tedros. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Margaret. Good morning, good afternoon and good evening. Although people of all walks of life

are affected by COVID-19 the world's poorest and most vulnerable people are especially at risk. That's true of indigenous peoples all over the world in urban or remote areas. There are up to 500 million indigenous people worldwide in over 90 countries.

Indigenous peoples have unique cultures and languages and keep deep relationships with the environment. Like other vulnerable groups indigenous peoples face many challenges. These include a lack of political representation, economic marginalisation and lack of access to health, education and social services. Indigenous peoples often have a high burden of poverty, unemployment, malnutrition and both communicable and non-communicable diseases, making them more vulnerable to COVID-19 and its severe outcomes.

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Although COVID-19 is a risk for all indigenous peoples globally WHO is deeply concerned about the impact of the virus on indigenous peoples in the Americas, which remains the current epicentre of the pandemic. As of 6th July more than 70,000 cases had been reported among indigenous peoples in the Americas and more than 2,000 deaths. Most recently at least six cases have been reported among the Nahua people who live in Peruvian Amazon.

WHO's regional office for the Americas recently published recommendations for preventing and responding to COVID-19 among indigenous peoples. The WHO is also working with the co-ordinator of indigenous organisations of the Amazon river basin to step up the fight against COVID-19.

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One of the key tools for suppressing transmission in indigenous communities and all communities is contact tracing. No country can get control of its epidemic if it doesn't know where the virus is. As we have said many times, so-called lock-down measures can help to reduce transmission but they cannot completely stop it. Contact tracing is essential for finding and isolating cases and identifying and quarantining their contacts.

Mobile applications can support contact tracing but nothing replaces boots on the ground, trained workers going door-to-door to find cases and contacts and break the chains of transmission. Contact tracing is essential for every country in every situation. It can prevent individual cases from becoming clusters and clusters turning into community transmission.

Even countries with community transmission can make progress by breaking down their epidemics into manageable parts. This is all the more critical as countries are opening up. Reacting rapidly to new cases and clusters will allow countries to continue on the road to economic recovery while keeping the virus at bay.

Of course contact tracing is not the only tool. It must be part of a comprehensive package but it's one of the most important. Contact tracing has long been the bedrock of outbreak response from smallpox to polio to Ebola and COVID-19.

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One of the lessons from the recent Ebola outbreak in the eastern Democratic Republic of the Congo which was declared over last month is that contact tracing can be done even in the most difficult circumstances with security problems. When Ebola was discovered in the city of Butembo last year experts wondered whether it would be possible to bring the outbreak under control.

But against all odds the outbreak was stopped in large part because the Government, WHO and partners invested heavily in contact tracing, isolating suspected cases and treating those that became sick. Over and over again trained contact tracers working closely with local leaders and communities tracked the virus, sometimes over hundreds of miles in very difficult terrain.

Ebola and COVID-19 are different viruses but the principle is the same. No matter how bad the situation there is always hope. With strong leadership, community engagement and a comprehensive strategy to suppress transmission and save lives COVID-19 can be stopped. We do not have to wait for a vaccine.

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We have to save lives now. Make no mistake; we must continue to accelerate vaccine research while doing more with the tools we have at hand. To talk more about the importance of contact tracing both in the context of COVID-19 and Ebola I'm delighted to welcome Dr Socé Fall, WHO's Assistant Director-General for Emergency Response, and Dr More Keita, who is the Incident Manager co-ordinating WHO's fieldwork in the Democratic Republic of the Congo for the current Ebola outbreak in the west of the country.

Dr Fall and Dr Keita, welcome and, Margaret, back to you. Thank you.

MH Thank you, Dr Tedros. As Dr Tedros has underlined so powerfully, good contact tracing is key to stopping even a huge

outbreak like this. But what is not so well understood is how it is done and why it matters so much so Dr Fall is now going to engage in a dialogue with me to explain exactly why. I'm going to ask the questions in English because I don't want the interpreters to have to put up with my terrible French but Dr Fall is kindly going to answer in French.

The first question is, why does it really matter, why does contact tracing matter so much?

00:08:39

ISF Thank you, Margaret. Thank you, DG. I'm going to speak slowly in French to allow the interpreter to be able to follow me.

TR I think it's a very important question because from the point of view of this pandemic we are highlighting the importance of contact tracing. The aim of contact tracing is to be able to detect very rapidly the secondary cases so those who have been contaminated or infected by others.

So looking for and following up the contacts; we have to first of all follow them and find them. This helps us to break the chain of transmission because that prevents the contacts from having time to transmit it further in the community so it helps us to reduce the impact of the disease COVID-19 and by reducing the impact we reduce the propagation of the cases.

If we do it in this way we increase the chances of survival by contacting people early. Thank you.

Second question.

MH Can you tell us exactly how it works and what makes it successful and what are the things that make contact tracing fail? Many countries are struggling so much. What is it they need to really know how to do and what to look out for?

00:10:20

TR We need to understand that contact tracing isn't an isolated practice; it's part of the best practice for epidemiology but if a country doesn't make the effort and the necessary investment to have the epidemiological research then that will cause problems.

So it's part of the full-quality research if we look at the contacts and then the contacts of the contacts and that helps us to reduce the risks of infection. It's helpful to map the contacts so we can see how much effort needs to be made to visit all the contacts and to be able to plan the operational element.

But on a daily basis we need to ensure that we really spot the appearance of the illness and that helps us with isolation and screening and checking. This is something that's been known for a long time and, as Dr Tedros mentioned smallpox, that was one of the ways in which we were able to eradicate smallpox.

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But if we look at viruses, even viruses that are much more fatal than COVID, we were able to manage and master these epidemics by having regular following and high-level efficiency. If we looked at Madagascar at the end of 2019, the pulmonary pest which is transmitted much more rapidly than COVID-19, the incubation time is sometimes 24 hours so we have to be very rapid and it was very risky.

If you didn't act rapidly enough it had a fatality rate of between 30 and 50% but if we looked more recently at Ebola in North Kivu, where we have a situation of conflict and when we arrived there to places such as Butembo the transmission was happening almost everywhere. But with community engagement and being efficient in the decentralisation of the operations we were able to have totally decentralised operations and that meant that we were able to manage the epidemic.

So ideally contact tracing needs good preparation because you don't want to wait until the crisis hits to start planning but we saw unfortunately that many countries weren't very well-prepared for the contact tracing.

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Most countries, in particular the most developed countries, have surveillance systems centred on hospitals but by the time the patients arrive it's too late; they've already contaminated others in the community. So we need to have a good community basis so that each individual and each community and each member of the community protects themselves and then in that way they protect others.

So you need good communication of the risks, you need to build the capacities in the community so that we can have a performance at that level. It also needs good supervision with more specialist stakeholders who work with the communities. So we have to have the community base and we have to link that to the hospital surveillance so that we can have a full coverage of contact tracing.

MH But if it gets [inaudible]... When it becomes such a huge outbreak over such a large area and so many cases doesn't there become a point where it's impossible?

TR When it comes to controlling epidemics what's at stake is human lives and we can't give up, we can't abdicate our responsibilities. No matter how extremely difficult the conditions are we have to go on and in North Kivu in Congo, yes, we had huge problems. We had security issues, we had hundreds of thousands of people we had to try to cover.

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We worked with partners and we stuck to contact tracing and indeed many eminent experts were saying to us, look, you can't break this transmission, it's so difficult here you just aren't going to be able to break the chain of transmission. But with the commitment of the communities we were able to do that. We were able to contain the epidemic there, even in these extremely difficult conditions.

You always have to take account of the context but if you have sustained community commitment it is possible to do this. You need to look at the geography of different regions. There may be some areas where it's very difficult to contact people; others where it's easier. There may be different times of the year when it's more difficult and if there are difficult times then you have to combine contact tracing and actively going out to identify cases and if you do those two things together you can win.

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MH One more question. There's new technology now. We've got apps many countries are using. Surely those can replace the people that you use for contact tracing.

TR It's very important of course to make the best possible use of new technologies because that means that you can get information in real time. For instance it was at the end of the epidemic in Benin that we were able to use a Go Data app and that was very useful to us because we got information in 24 hours about exactly where we were so every evening we could look at the data and we could have a very, very accurate snapshot of the situation on that day.

So it can be very, very valuable but no tool, no instrument can ever replace people. People are the most important weapon that we have to fight epidemics; people in communities, knowing other people, going door-to-door, visiting people, identifying

contacts. That's the most valuable thing we have in our fight against epidemics.

Yes, it's good to have SMS, WhatsApp messages to get in touch with contacts; it can be useful. Yes, I'm not saying that's not valuable but if you want to have proper analysis of information you need people, you need human resources, well-trained, well-skilled and you need them to be a proper interface between what we're doing and the communities.

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MH In the absence of a vaccine, a specific therapeutic is it really possible to stop an outbreak like this just with public health tools, interventions?

TR Thank you very much. Vaccines, drugs, medicines are also, I think, public health tools but, as Dr Tedros said in his introduction, we just can't wait around until a vaccine turns up to save lives. We need to start saving lives right now with the tools that we have and that's what we're doing and what we're going to continue to do.

Of course research into treatment, therapies and vaccines is very important but there are things we can do and we have many examples of dangerous pathogens that have been brought under control even before a vaccine appeared for them. If you think about Ebola, we started off there with contact tracing, with many other public health interventions and thanks to that we were able to bring the epidemic under control.

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We have others. We have for instance SARS, we have West Nile Fever; many other examples I could give you of public health emergencies where public health interventions were effective and where testing, isolating cases, contact tracing, hygiene barrier measures did save lives.

MH Thanks, Dr Fall. Dr More Keita is trying to join as well but we haven't been able to get him yet but we will go to him with any questions if he can join. Can he join? No, okay. We'll go to questions now. We will now start with Nina from AFP. Nina, please unmute yourself and go ahead.

NI Sorry. Can you hear me?

MH Very well.

NI Can you hear me?

MH Yes. Go ahead.

NI Okay. Thank you very much for taking my question. The Lancet published two studies today indicating that there are two vaccine candidates that have been proven safe for humans and also produce strong immune reactions in patients. What is the significance of these findings, do you think? Thank you very much.

00:19:21

MR Great, thanks. I think it is good news. Effectively we have 23 COVID-19 candidate vaccines in clinical development and as of today we have one candidate vaccine for which phase one clinical data is available in peer-review journals, plus we have one other, the BioNTech Pfizer product for which the data is available on prepublication so it's great first of all to see the data coming through into peer-review journals.

I think the data is very new. We do welcome the study and congratulate our colleagues at the Oxford University's Jenner Institute and the Oxford Vaccine Group and obviously our colleagues at Astrazeneca for getting this data out there.

Again this vaccine was given to 1,000 healthy adults between the ages of 18 and 55 and certainly did not appear to have any serious adverse events other than the expected; in some cases chills, muscle aches, headaches. The vaccine did generate neutralising antibody, I think, in all participants and in a very small number of participants that were given a booster dose those responses were even greater.

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So in generating T-cell-mediated responses and generating neutralising antibody this is a positive result but again there is a long way to go. These are phase one studies. We now need to move into larger-scale, real-world trials but it is good to see more data and more products moving into this very important phase of vaccine discovery and we congratulate our colleagues for the progress they have made.

MH Thank you, Dr Ryan. The next question's from Gabriela from El Progreso. Gabriela, can you unmute yourself and please go ahead.

TR Yes. It's for process. We are hearing that there are some 70,000 cases in the Americas and in Peru and I'd like to know what other zones in Latin America are of concern. Also I've understood that no country in Latin America is carrying out

effective tracing and that there isn't an exact figure; I think the figures are estimated.

What can be done in this region to protect indigenous peoples between now and being able to carry out contact tracing?

MH Thank you, Gabriela. That was three questions. I'll remind journalists to try to stick to one but fortunately we have the expertise here.

00:23:04

MR We hope so. The situation across Latin America in general still remains that pretty much all countries have some level or other of community transmission. The numbers are stable in a number of countries but continue to rise in others. We've had difficult situations in Bolivia and in Colombia and in many other countries where numbers have increased over the last couple of weeks.

So I would say overall the situation in Latin America is one of continued threat, continued community transmission of disease but many countries are fighting back, many countries are really trying to deal with that at national and subnational level, are putting in place targeted lock-down, targeted public health measures and many are still trying very hard to do contact tracing and cluster-based investigations.

I think this is a challenge for many countries; when you're in the phase of full-blown community transmission and there are literally hundreds, thousands of cases a day it is very difficult, as Socé said, to keep doing case finding and contact tracing and testing the right people and investigating clusters.

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Very often in those situations the measures that work are really community-based measures and creating social distance between people, in some places targeted lock-downs. The trick is very often maintaining your contact tracing so that when the numbers do drop you're ready then when the numbers are under some kind of control, that your system is ready then when the numbers are lower to react to new cases, to react to new clusters.

You can't just not do contact tracing and then do it perfectly. It takes muscle memory, it takes the system being able to act and build its confidence and build its efficiency. Socé will remember many, many outbreaks where it's taken time to build the efficiency of the surveillance system and of contact tracing.

It's not just something you switch on and switch off because it requires a partnership between the community, the public health service. It's very often happening over a large geographic area and you're trying to detect signals of transmission and respond and for countries coming out of lock-downs with low numbers of cases the real way of avoiding going back into lock-down is sustained community commitment to physical distancing, hygiene and mask wearing and the other local measures that are in place matched with a very strong government-led programme of public health surveillance, case finding, contact tracing, testing, quarantine.

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It's a system, as Socé said. It's not just one activity. It requires a complex partnership between different services in order to make that happen and it is hugely important that we continue to invest in surveillance and contact trading and particularly in the Americas right now we need to build that capacity.

Again Latin America was the first region in the world to eliminated measles; it was the first region in the world to eliminate polio. The public health service infectious disease epidemiology is very strong in Latin America and has proven in the past to be very strong but it requires - and we all, all over the world, need to make a new commitment to public health surveillance and to building that capacity.

I've used the analogy for some countries with lower levels of COVID-19; a new cluster of cases of COVID-19 is like a major incident. If you had a major incident or you had a bad accident on a motorway it doesn't take three days to mount a response. The response is immediate and I think we need to really up our game collectively around the world and our reaction to cases and clusters of disease.

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But it is understandable in situations that countries find themselves in when there's a very high force of infection, maintaining contact tracing for every single case can prove hugely challenging but we should never give up on that.

In terms of indigenous populations, I don't know, Maria, if you want to add in on that.

MK Yes, just to specifically mention on the indigenous populations, PAHO has recently issued guidance on 15th July specifically on prevention and control measures for indigenous

peoples and in there discusses the need for and importance of complete engagement of community leaders of indigenous peoples and engagement of all of the population for information sharing - information exchange, I should say, so listening both ways, making sure language is appropriate, making sure culture is taken into account, to ensure that surveillance is taking place, to ensure that contact tracing is taking place and that it's done in an appropriate way.

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So in situations if communities are isolated or are remote and testing is not available rapidly and you can't have confirmation done very quickly then suspect cases should be considered as probable and the process of contact tracing should take place and that anyone who is a contact who is placed in quarantine should be supported through that quarantine, ensuring - and this is true for all people who are in quarantine - that people are given proper information, that they have contact with their loved ones, physically distant from their loved ones but still remaining socially connected, that they have food, that they have security, that they're cared for in a safe manner.

But there's a whole guidance that has been issued by PAHO on 15th which goes through all of the different measures from surveillance through laboratory measures through contact tracing through support and care of indigenous peoples.

MH Thank you very much. Dr Socé [inaudible].

ISF Thank you, Margaret. Just to highlight that any time during the response you can have some tactical and operational adjustment that will [?] mean that you have reached community transmission, that you cannot do contact tracing any more because giving up on contact tracing means giving up on investigation and if you give up on investigation it means you don't know which direction you are heading in and you might find yourself in a very difficult situation. Thanks.

00:29:49

MH Thank you so much. The next question is from Kai Kupferschmidt. Kai, could you unmute yourself and go ahead.

KA Yes, thanks a lot, Margaret, for taking my question. I wanted to ask a little bit about where we're at in terms of ensuring there's equitable distribution of vaccines. Given the positive news about vaccine candidates - and we all know that a lot of the decisions that are made now are going to be pivotal to

see whether this vaccine actually reaches those poorest and most vulnerable people that you've talked about - could you give me an idea of what exactly needs to be done at the moment to ensure that?

MR Thanks, Kai. As you know, it is a complex challenge. Obviously first of all we've got to get the candidate vaccines through the system and what WHO has been doing is working with partners to ensure that we have the maximum number of candidate vaccines and trying to level that playing field so that all potential candidates can be moved through the phase one and phase two cycles of trials.

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That is to remove barriers to that in terms of access to testing, access to assays and ultimately potentially even access to vaccine trial platforms and that's what we've obviously tried to do with the Solidarity trials for therapeutics.

So WHO is working to try and ensure that we have the maximum number of candidates coming through the system and obviously working with our colleagues in SEPI and GAVI and people within the other organisations contributing to the Access to COVID Tools Accelerator.

The second part of that is really getting to a point where we can have scaled-up production of any candidate vaccine which shows clinical efficacy or even scaling up production in advance. You've seen a number of examples of support to companies and researchers to begin even very, very soon the production of vaccine at risk [?] to ensure that there would be adequate or at least initial supplies of vaccine available should a signal of clinical efficacy emerge.

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The challenge is going to be, when vaccines do prove clinically efficacious, ensuring that there's enough production to be able to supply the need around the world and that is in itself the big question. There are a number of different consortia that have been created in the UK, within the European Union and in the US that are trying to ensure supplies for those populations.

But more importantly we have the COVAX initiative which is again an initiative of the ACT Accelerator which seeks to bring together a whole series of countries, both countries who will be traditionally clients of GAVI but countries well beyond that, to try and create an alliance of, in a sense, a consortium that comes

together to pre-purchase and advance purchase vaccines within a system allowing for fair and equitable distribution amongst those countries.

That mechanism as it presently stands is not going to be able to supply a vaccine for everybody on the planet. We are going to have to prioritise who gets what vaccine at the beginning depending on which vaccine becomes available and we're going to have to have some policy and priorities around the best use of those vaccines.

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Our colleagues within the ACT Accelerator, the different institutions and our colleagues within WHO are working very, very hard on the appropriate allocation mechanisms to ensure that those vaccines are distributed in the most equitable way possible but there are significant challenges and headwinds in order to ensure scaled-up production and ensuring that that scaled-up production results in as many people as possible around the world having access to the vaccine.

Part of that does depend on more countries joining in that COVAX initiative and the more countries that join in that initiative and that share the risk and the benefits that that poses the more likely it is that vaccine can be made available to more people around the world.

We would encourage our member states as much as possible to examine and look at the COVAX platform as a potential way for them both to contribute to the global good of vaccines and also benefit from that global good, notwithstanding the other initiatives and, I think, the COVAX platform, the COVAX facility is working very closely with those other initiatives and we thank those countries who've already indicated that they would be working to make their vaccine available on a global basis as well as part of national protection. I don't know if the DG wants to add.

00:34:55

TAG Yes, thank you. That's a very important question. You have covered it extensively. I would just like to stress some of the areas. As you know, Kai, when we launched - the WHO and partners - the ACT Accelerator it was with two objectives. One is accelerating developing of products, be they vaccine or therapeutics or diagnostics.

The second objective was fair distribution; access to those who may not afford to have the vaccine, which is actually your question. To that end together with the steering group WHO, GAVI, SEPI, Global Fund, World Bank and other partners we have developed the allocation framework, which is being finalised.

But for the fair distribution and especially access to the poor and those who cannot afford it the most important element will be political commitment, especially by our leaders. With political commitment of course that's the only way you get fair distribution.

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But one of the worrying patterns we see is some countries moving in the other direction. Of course more and more countries are joining in the benefits, the advantages of making the vaccine a global public good. But we see, if not many, some countries going in the reverse direction and when there is no consensus in having this vaccine as a global public good it could actually be owned by those who have money and those who cannot afford it may not have access to the vaccines.

As you know, Kai, many countries are now calling, many leaders... There was a recent article, I remember, an op-ed; some leaders already have called for and stressed the importance of making, when available, a vaccine or therapeutics a global public good.

We want a groundswell of political leaders believing in making a vaccine or therapeutics a global public good and this should not be considered as a charity to those who cannot afford it. The advantage of giving fairness or access also to poor countries is the world can really be lifted up and lift itself out of this pandemic together, which can speed up the economic recovery.

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The world, unless it's opened up in its major part and unless the whole world is opened up in this globalised world it will delay the economic recovery and that means more damage from lack of fast economic recovery which can again impact not only on containing [?] the pandemic but also its impact on other health problems and not only health but continued damage to the livelihoods of citizens.

So the most important element here is global political commitment and a consensus on this by all leaders to really,

truly commit to using vaccines or any product as a global public good. Thank you.

MH Thank you, Dr Tedros. The next question is from Natalie from China Global television network. Natalie, can you unmute yourself and please go ahead.

NA Hi, there. Can you hear me?

MH Very well. Please go ahead.

NA Great. Thank you so much for taking my question. I'm just curious if there're any updates from the WHO team in China and as well if there's any reaction from the WHO over different countries shifting their countries on wearing face masks; some countries requiring it, others not so much, what the WHO's response to that is. Thank you very much.

00:39:58

MH That's two questions but I'll tell you there's no update on the China mission so we can go to the second question. I think Maria's ready to answer that.

MK Thanks for the question. WHO has always supported the use of masks as part of a comprehensive strategy for COVID-19, first and foremost focusing on health workers, ensuring that they have proper PPE including face masks, eye protection, gloves, gowns, etc, when caring for patients and of course the use of respirators when dealing with aerosol-generating procedures.

With regard to the use of masks for the general community we've always recommended the use of medical masks for people who are ill and for individuals who are caring for them.

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Then there has been a shift in looking at the potential use of masks for other people in populations including people who cannot do physical distancing to wear a fabric masks, where we have put out guidance on what a fabric mask will look like in terms of the different layers.

What we are hearing now are changes in policies from many governments who are applying the use of masks as part of a comprehensive strategy, particularly in areas where you have active transmission and particularly in areas where you cannot do physical distancing.

So what we're hearing quite a lot about is the use of masks in shops, the use of masks in public transportation and things like

that so again we support the use of masks as one of the tools that can be put in place.

However it's not a substitute for other public health measures that also must be in place. You cannot substitute the use of a mask for hand hygiene, for cleaning your hands; you cannot substitute the use of a mask for physical distancing. You cannot substitute the use of a mask for testing, finding cases, for contact tracing, for quarantining cases.

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So all of this has to be done together as part of a comprehensive approach but again we do support leaders in taking those decisions and using this as part of the approach to tackling COVID-19.

MH Thank you very much, Dr Van Kerkhove. The next question is from Simon Ateba from Africa Today. Simon, could you please unmute yourself and go ahead.

SI Can you hear me?

MH Very well, Simon. Please go ahead.

SI Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. More than 720,000 people have contracted COVID-19 in Africa and 15,000 of them have died so far. South Africa, one of the richest countries in Africa, with more than 364,000 cases and 5,000 deaths, now accounts for more than half of all the cases in Africa and over 30% of all the fatalities.

In fact there are now more than 500 new cases in South Africa every hour or more than 12,000 every day yet South Africa was amongst the first countries in Africa to impose the WHO-recommended lock-down, shut-down, wearing of face masks, hand hygiene, contact tracing and treatment.

00:43:18

I was wondering, what else can South Africa do right now and what is South Africa missing? Thank you.

MK I can perhaps start and, Mike, you might want to supplement. Simon, that's a very good question and it's a complex one and if we look at all of the measures that South Africa and many countries have put in place it is about being consistent and persistent in applying all these measures.

We do know in South Africa a lot of the outbreak began in some urban centres and now the virus has moved into more rural areas, affecting different populations. We know that when a virus enters a country it doesn't enter uniformly across the entire country. It tends to start somewhere and take root and all of these measures do need to be applied in different aspects of it.

I think what South Africa is doing - and they have a very strong, robust response. The leadership in taking a comprehensive approach, engaging communities, looking at a data-driven approach... We engage quite closely with South Africa through our regional office, through our international networks to be able to apply what they are learning to be able to feed back into the response that they have themselves.

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It is about continuing to apply all of these measures. They will bring this under control as all countries will in applying all of these measures and stay vigilant, stay strong, continue to engage with communities, all levels of the community. Listen to the community, feed back into your response and adapt, be agile and adapt. Mike.

MR Yes, I know Dr Tedros has been in touch directly with very senior colleagues in South Africa and we are working with our regional office and providing surge support, further high-level technical assistance to support South Africa in its response.

I think we also need to remember that South Africa got its first cases quite early and it's in a later stage of development of this pandemic and the disease when it came into South Africa first tended to come in at the beginning into wealthier areas and now has become very much established in poorer areas, in townships, in rural areas so therefore South Africa's experiencing that acceleration.

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But it's not accelerating any faster than many other countries in eastern or southern Africa - all over Africa in fact. The South Africa numbers may be large but they've only increased about 30% in the last week but if you look around the region in the same time, although the numbers are smaller, Kenya's increased 31%; Ethiopia 26%; Madagascar 50%; Zambia 57%; Eswatini 32%; Zimbabwe 51%; Namibia 69%; and Botswana 66%.

Even though the numbers in those other countries are smaller I think what we're starting to see is a continued acceleration of

transmission in a number of countries in sub-Saharan Africa and I think that has to be taken very, very seriously.

South Africa may unfortunately be a precursor; it may be a warning for what will happen in the rest of Africa so I think this isn't just a wake-up call for South Africa. Really we need to take what is happening in Africa very, very seriously. Many of those countries exist in the midst of fragility and conflict. Many of them need external health and support but what they need is much more support for community-based interventions and much more support for improving clinical pathways so people who are sick get adequate care.

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And, as Socé has said previously, much more support to public health surveillance and being able to put in place the necessary early warnings. So while South Africa is experiencing a very, very severe event I think it is really a marker of what the continent could face if urgent action is not taken to provide further support and we've seen this in other regions.

Sometimes this disease can take off very quickly and sometimes in other situations it takes off more slowly and then accelerates and it's difficult to understand fully why that is the case. But I am very concerned right now that we're beginning to see an acceleration of disease in Africa and we all need to take that very seriously and show solidarity and support to those countries who may now be experiencing increasing numbers of cases and deaths.

MH Thank you, Dr Ryan. The next question - and it might have to be the last because we're coming towards the end of the time allotted - is from Helen Branswell. Helen, can you unmute yourself and go ahead.

00:48:32

HE Hi. Thanks very much for taking my question. I apologise; I missed the beginning of the briefing so you may have covered this but since Dr Fall is there I would like to ask if he could give us any kind of a sense of how things are going on the ground in Equateur province with the new Ebola outbreak.

Numbers are available from the Ministry of Health in DRC but we're not really getting much in the way of detail on how well or not well the containment effort is going. Thank you.

ISF Thank you, Helen. Good to meet you again; we have been interacting so many times around Ebola in North Kivu. As you

rightly said, this new outbreak is happening in Equateur, which is a different context with very limited resources and difficulties to move from one area to another. You have to move by boat, by helicopter to make sure that you can implement the right interventions.

So in terms of operations, we have now seven health zones affected although only six are active right now. It means decentralising operations to all those health zones, making sure that we have all the necessary capacity in terms of investigation, in terms of isolation, treatment, contact tracing and vaccination.

00:50:09

So we have a good team on the ground composed of Congolese WHO staff we already had in Congo, some from North Kivu, others from Kinshasa and a number of partners like MSF, UNICEF, IFRC working around various pillars.

So we still have some challenges in terms of alerts [?], mainly alerts related to dead bodies because it's very important to make sure that our surveillance picks up all the alerts not only from the health facilities on alerts related to the community but also dead bodies.

So we are scaling up. We still have important gaps in terms of operations because of the difficulties to move around the area so we continue monitoring the situation now. I'm having a daily briefing from the ground and making sure that all partners scale up in their areas of responsibility.

So it's challenging in the context of COVID because in the capital city, in Kinshasa many people are focusing on COVID-19 so making sure that they don't downplay Ebola is extremely important. We need also from the national side to scale up operations in all areas. Thanks.

00:51:27

MR If I might add some of the numbers, we had three new cases over the weekend; we now have 60 Ebola virus cases and 56 of those confirmed, four probable including 24 deaths. As Socé alluded to, the worrying aspects of this response are that there've been cases in 21 health areas across seven health zones so while the numbers are very low the disease is quite dispersed and five of those seven health zones have had cases in the last four days, which means the disease is active, it's not old.

So what we have is active disease in five health zones across a wide geographic area. Again worrying is that there are still nine

cases who are still in the community and there are really challenges in terms of community engagement and convincing people to come for care in Ebola treatment centres and of the overall period in terms of exposures.

Again this may go back to the whole issue of case finding and contact tracing and getting the information you need to know where and what the transmission factors are. It is interesting to me that in this case, in the most extreme situation of logistics probably in the world the data that comes in daily from surveillance teams tells us that for the people who've been exposed over the last 21 days for example over one in three people have been exposed at a funeral event.

00:53:03

Just over 10% - 11% - have been exposed through nosocomial or in the healthcare system and a further number of people have been exposed in the family context. So the information you glean from case investigation and contact tracing tells you who's at risk. We're able to say for a very remote part of Congo that a big risk factor in these particular clusters of cases is funeral practice and we're working very closely with communities then to really work with them on the funeral process and on engaging with them on how to make that practice safer.

It is very hard to engage in generalities. When you work with communities you must be able to engage on specifics. Getting good data from case and cluster investigation gives you the specific data that allows you to identify the risk factors and then engage positively with communities on how to reduce those risk factors.

00:53:56

This is epidemiology and public health in action. If we can do this in a remote part of Congo, if we can do this in the middle of a war zone in North Kivu we can do this for COVID-19. It is not impossible. Many countries have demonstrated that all over the world so I think even though we don't have perfect data from the field - and Socé can speak to some of the challenges we've faced logistically and operationally - the fact that we have these data; we know where our problems are in the field, we know where our hot-spots are, we know what's driving transmission in those communities.

That allows us and gives us the basis to intervene and to make a difference so while the situation in Congo remains of concern what reassures me at the moment is that we're improving in

community engagement, there are many partners on the ground and again we'd like to thank our partners, particularly in the Red Cross movement and others, who once again are working with local teams in terms of safe and dignified burial; our colleagues in UNICEF who are working on communications; our colleagues in the UN system working on co-ordination; the World Food Programme working on logistics and support to base camps.

00:55:08

But most of all the front-line health workers of Congo; the Congolese doctors, nurses, hygienists, community engagement specialists who make up the vast majority of the front line in this response and again our thanks to the government, the Ministry of Health and the Institut Nationale de Recherche Biologique, INRB, for their leadership in this response.

MH Thank you, Helen, for your question which really ties together much of what we have been trying to get across today. Now I'll hand it over to Dr Tedros for final words.

TAG Yes, thank you. Thank you to all who have joined today and look forward to seeing you... I think the next will be on Thursday. Thank you.

00:56:10