

COVID-19

Virtual Press conference

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Speaker key:

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CS	Professor Cass Sunstein
IS	Isabel
MR	Dr Michael Ryan
Jl	Jim
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NI	Nina
BI	Bianca
SA	Sam

00:00:00

MH Hello, everybody. This is Margaret Harris - Margareta Harris in Geneva welcoming you to this WHO press briefing on this Thursday afternoon, July 30th. We have with us today as always the WHO Director-General, Dr Tedros, Dr Mike Ryan, Executive Director of our emergencies programme, and Dr Maria Van Kerkhove.

We also have some special guests joining online. As usual we are translating simultaneously in the six official UN languages plus Portuguese and Hindi. Remember that under the quirky Zoom system you need to go to the Korean button to use Arabic. Now without ado 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. I would like to start by wishing all Muslims Eid Mubarak, Eid al-Adha and I would like to congratulate the Kingdom of Saudi Arabia for the steps it has put in place to make the Hajj as safe as possible this year. This is a powerful demonstration of the kinds of measures that countries can and must take to adapt to the new normal. It's not easy but it can be done.

The pandemic does not mean life has to stop. We must all learn to live with the virus and to take the steps necessary to live our lives while protecting ourselves and others, especially those at the highest risk of COVID-19.

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As you know, one of those groups is older people, especially those living in long-term care facilities. In many countries more than 40% of COVID-19-related deaths have been linked to long-term care facilities and up to 80% in some high-income countries.

Recognising the critical nature of this issue WHO has released a policy brief on preventing and managing COVID-19 in long-term care facilities. The brief lists key actions that must be taken by policymakers and national and local authorities to protect older people. These range from integrating long-term care in the national response to mobilising adequate funding to ensuring strong infection prevention and control to providing support for family and voluntary caregivers and much more.

For each policy objective the document lists actions that long-term care facilities can take and gives real-world examples of actions countries have taken in each area. The brief also suggests ways to transform long-term care services so that older people can receive quality care that respects their rights, freedoms and dignities.

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I especially want to acknowledge those who work in the long-term care facilities all over the world who're doing heroic work to save lives and protect those in their care. I salute you.

Although older people are at a higher risk of severe disease younger people are at risk too. One of the challenges we face is convincing younger people of this risk. Evidence suggests that spikes of cases in some countries are being driven in part by younger people letting down their guard during the northern hemisphere summer.

We have said it before and we will say it again; young people are not invincible. Young people can be infected, young people can die and young people can transmit the virus to others. That's why young people must take the same precautions to protect themselves and protect others as everyone else. They can be leaders, they should be leaders and drivers of change.

All of us have a role to play in reducing our risk of exposure to COVID-19. Every day we all make decisions that affect our health and the health of those around us in many ways. Reliable information is extremely important in enabling people to make the right decisions for their health. We have all seen the harm done by misinformation but information alone is not enough. People make decisions based on a wide range of factors to do with their culture, beliefs, values, economic circumstances and more.

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They make decisions under unprecedented financial and social pressure, high levels of anxiety and with ill-equipped health systems. Countries have been asking their citizens to understand their risk, to adapt, to engage, to give up the things they value and define them. In the face of the COVID-19 pandemic countries are using a range of tools to influence behaviour.

Information campaigns are one tool but so are laws, regulations, guidelines and even fines. We're learning what works and what doesn't. That's why behavioural science is so important. It helps us to understand how people make decisions so we can support them to make the best decisions for their health.

Today I'm proud to announce that WHO has created a technical advisory group on behavioural insights and sciences for health. This broadens and deepens WHO's existing work on behavioural science and will support our role to offer health advice that's not only stronger but more effective.

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The technical advisory group consists of 22 outside experts from 16 countries with expertise in areas including psychology, anthropology, health promotion, neuroscience, behavioural economics, social marketing and more. This new group will advise WHO on how to increase and improve the use of behavioural and social sciences in a range of health areas including COVID-19.

I would like to take this opportunity to thank my colleague, Eleanor Altieri, who proposed this idea a year ago and has worked hard to make it happen. Today I'm delighted to be joined by the chair of the technical advisory group, Professor Cass Sunstein. Professor Sunstein is the Robert Walmsley Professor at Harvard University and the Founder and Director of the Programme on Behavioural Economics and Public Policy at Harvard Law School.

Professor Sunstein, welcome and you have the floor and I would also like to welcome members of this group. Thank you for your commitment and thank you for joining and thank you for this path-finding role that will help WHO. Thank you. The floor is yours, Professor.

00:08:51

CS Thank you so much, Dr Tedros, and it's a great honour to be able to represent a diverse and extraordinary group of people who are working on this advisory committee. People are coming, as noted, from all over the world, from multiple regions and also from multiple disciplines. All of us have some experience with human behaviour but the orienting themes in our work are greatly varied and I believe that will be productive.

Our starting point, as you noted, is that health involves behaviour and whether we're speaking of COVID-19 or sexual and reproductive health or smoking or other non-communicable diseases human behaviour is at the root of it. There's been an extraordinary outpouring of work over the last generations about human behaviour and public health and the theme is to try and be as empirical as we possibly can about what works and what doesn't, which leads to a kind of pluralism with respect to fields; anthropology, economics, psychology, public health and others.

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There are a few things we know that are quite important. We know that habits are persistent even if they aren't healthy and we know from a great deal of work that habits can be altered and that can save lives. We know that human beings often focus on today and tomorrow and not so much on the long term; it's sometimes referred to as present bias and that can lead to unhealthy behaviour. We know also that present bias can be overcome by behavioural strategies.

We know as well - and this is in many ways a good thing - that human beings tend to be, many of us, unrealistically optimistic. That can lead to all sorts of good outcomes including in the

domain of health but it can lead to a kind of reluctance to take precautions whether the issue involves COVID-19 or some other health risk.

We know the good news is that unrealistic optimism can be rendered something much better which is realistic optimism. We know that simple, clear communications are often highly effective and that complicated, unruly communications aren't. We know that it's essential to meet people where they are rather than to speak in terms that are unintelligible or that sound like they're coming from some sort of elite that isn't in touch with cultural values and norms.

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We know that there are a great number of ways to help people to find their way to what each of us has a right to which is good health. One of the most inspiring developments in the world in the last ten years, I'd say, is the aspiration to the triple billion pioneered by the Director-General with one billion people benefiting from universal health coverage, one billion people - in addition to the current - better protected from health emergencies and one billion people enjoying better health and well-being.

We're hopeful that we can contribute to some of these goals and the trick is to help people to make choices that are healthier by reference to the best available science. Every human being on the planet matters, every life counts and it's a great honour to give our best efforts to contribute to the efforts, to the WHO's ongoing enterprise of making that aspiration a lived reality.

TAG Thank you, Professor. I hope you will stay with us. Hopefully there will be some questions for you and Eleanor. So back to Margaret.

00:13:09

MH Thank you, Dr Tedros, and thank you very much, Professor Sunstein. As Dr Tedros said, Professor Sunstein will stay online so you can also address your questions to him. As usual to ask your questions please use the raise your hand icon to get in the queue. I'll apologise now; I can see there's a long list of people. We've got hundreds of people connecting. We will not be able to take all your questions and please only ask one question.

The first person in the queue is Isabel Sago from EFE. Isabel, please unmute yourself and go ahead.

IS Good afternoon. Thank you very much. I would like to have a comment on the situation in Colombia where the situation is aggravating with up to 10,000 cases per day and what the situation tells you about the situation overall in Latin America. Thank you.

MR Yes, the situation in Central and in South America, Latin America in general is, as you see from the figures, mixed. Many countries still have very, very intense community transmission. The number and rate of cases and deaths are still rising across large areas in Central and South America so from Mexico all the way down to Argentina we still see a very difficult and challenging situation for countries.

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The Government in Colombia has taken a very sound approach over quite a long time in dealing with this and has also provided much assistance to other populations, refugee populations who are present from Venezuela as well and Colombia has always shown great care and great support for others who've been in need in the region.

So from the perspective of WHO we still consider Central and South America to be an epicentre of transmission and much work is still to be done in terms of both suppressing transmission and reducing exposure at the community level.

This is a challenge in many situations where you're dealing with complex social settings, poverty, people living in periurban slums, a high proportion of indigenous communities who have sometimes difficulty accessing services and barriers to access to such services.

So the situation is complex and countries in Latin America still require great solidarity and support from other countries. Having said that, progress is being made but Latin America is still very much in a big fight to battle this disease.

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MH Thank you, Dr Ryan. We'll stay with the Americas. We have a question from Jim Rupe, Westwood One. Jim, please unmute yourself and ask your question.

Jl Thank you very much. As usual things have changed now with your guest so I'd like to ask Professor Sunstein, if he's still there; human behaviour and health is a very interesting combination and I get that there is a connection there. But it's been my observation recently that people don't necessarily view

freedom - or they view freedom really as the right to do what they want rather than an opportunity to do what's right.

So how can you mould behaviour, change behaviour or influence behaviour to match the public health measures that are necessary to prevent the spread, how you can get everybody on the same page? I'd like to know if there's a plan for that.

CS Thank you for that. It's a deep and large question. There was a great philosopher who once wrote a footnote that he never published saying, we post a signpost, no deep thinking here, things are bad enough already.

So I'd suggest that we try to be intensely pragmatic. Of course different cultures have different approaches. In some places the pandemic is less severe than in others and less intrusive approaches are highly appropriate to those places.

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In some places the pandemic is costing a lot in terms of lives and more intrusive measures have been found acceptable in some of those places at least. Freedom is an extremely important value and there are approaches to the pandemic that are completely compatible with freedom where people are doing voluntarily things that decrease health risk.

I think the path forward in terms of general orientation is one that recognises that one way that people exercise their freedom is to diminish risk to their own health and that's something people of course greatly value and we're witnessing it every day in these difficult days.

MH Thank you very much, Professor Sunstein. The next question - we'll now go to a question about Africa from Simon Ateba from Today News Africa. Simon, please unmute yourself and ask your question.

00:18:52

SI Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. According to the Africa CDC there are now 900,000 COVID-19 cases in Africa and close to 19,000 deaths. The pandemic is still accelerating and ravaging the African continent. Testing remains low and countries are reopening amid economic hardship.

But many African countries including those who receive billions of dollars in loans from the IMF, the World Bank and the African Development Bank, do not seem to invest in the race for a

vaccine. Dr Tedros, is it not a pipe dream to assume that the US, Europe and the rest of the world will send their vaccine free of charge to Africa? How does the WHO ensure that a vaccine, if successful, will reach the most vulnerable people in Africa? Thank you.

MH I think that's a very good question for Dr Soumya Swaminathan. Is she connected? No, I'm afraid we've not been able to connect Dr Soumya. Is she online? Okay. Simon, I think we'll move on to the next questioner. No, we've got Soumya.

SS Hello, can you hear me?

00:20:23

MH Very well. Nice to hear you.

SS Yes, thank you. Thank you for that very important question about how to get vaccines equitably distributed around the world to different countries, whether they're high-income, middle or low-income. This is why the ACT Accelerator was launched by the DG on April 24th along with several heads of state and Melinda Gates.

One of the pillars of the ACT Accelerator is the vaccine pillar that we call COVAX and WHO works with CEPI, the Coalition for Epidemic Preparedness Innovation and GAVI, which is a vaccine alliance, in order to make this a reality, what you just asked.

The idea is that by investing in both the research and development of as many vaccine candidates as possible - so to ensure that we have success... We know that not every vaccine that goes into clinical trials will be successful. Normal success rates are about 10% so the more candidates that go into clinical trials the more the chances of success and it would be good to have different candidates - different vaccines that might work in different settings, in different population groups, in different age groups and so on.

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But at the same time to ensure equitable access we've created what's been called the COVAX facility. The facility is basically doing two things. It's pooling risk for countries that want to invest so any country that wants to provide vaccines for their own citizens can do that by investing in the COVAX facility, which will then invest across a range of vaccine candidates, both in the R&D and in the manufacturing.

So any country that supports COVAX has a better chance of getting a successful vaccine candidate than going after a single one on their own. The other thing it does; so it pools the risk. It also pools the market because we're able to anticipate and tell companies how many millions of doses this facility will buy or billions of doses. So companies have an advance market commitment which incentivises them to manufacture more vaccines and you can also then negotiate pricing when you're doing pooled procurement.

The idea really is that high-income countries and upper-middle-income countries would pay for the vaccines for their own citizens and that ODA funds, overseas development funds would come into this facility to pay for vaccines for all the low and low-middle-income countries. It's about 80 to 90 countries, possibly 90 countries if we include some of the small islands, that GAVI would then provide the vaccine for.

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This of course requires that the COVAX pillar, the vaccine pillar of the accelerator be freely funded to the tune of about \$32 billion and also that many countries join this facility because the more countries that join this facility and contribute to this risk pooling mechanism the greater the chances of success and also the greater the speed at which we could move.

So this is the concept that WHO and partners are advancing, are hoping that we can convince as many countries as possible to join this. If it happens then as a sign of global solidarity it would also mean that perhaps for the first time we would have a situation where people, regardless of where they live, will get the vaccines as they become available at the same time rather than some countries having had to wait for others, as has happened many times in the past, including during the H1N1 pandemic.

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So we need to change the way we've operated in the past and have a different approach for this pandemic. Over, thank you.

MH Thank you very much, Dr Swaminathan. That was Dr Soumya Swaminathan, our Chief Scientist, for everybody who may not have heard Dr Swaminathan's title at the beginning. No further additions from the room. The next question goes to Hanayo Kuno from Mayinichi, the Japanese outlet. Hanayo, please unmute yourself and ask your question.

TR Good afternoon. I have two questions. First of all, wearing masks. I have heard that some hospitals are asking pregnant women to wear masks whilst they're giving birth. What do you think about this measure, do you think it's necessary, do you think it's reasonable? Thank you.

MK Thank you for the question. Yes. There are some situations in which the use of masks can be helpful as a measure of source control which means that if an individual is infected and they wear a medical mask it could prevent them from passing the virus on.

I'm not aware of the particular measure that you are referencing. We can look into that and find out the reason for the recommendation for that but it may be the case that the recommendation is that a woman giving birth would put on a medical mask for source control.

00:26:04

MH Thank you, Dr Van Kerkhove. The next question goes to Nina Larsson from AFP. Nina, unmute yourself and please ask your question.

NI Hello, can you hear me?

MH Very well. Please go ahead.

NI Thank you. Sorry. I wanted to ask; today it's been six months since the WHO declared this crisis a public health emergency of international concern. How would you characterise the responses since then? The situation appears to obviously be getting worse so, looking back, are there any recommendations that you regret or any actions you wish you'd taken earlier to have changed the course of this or do you think that you've done what needed to be done? Thanks.

MK Perhaps I will start and others may want to supplement. Yes, indeed we've just hit the six-month mark of the time where we declared this pandemic a public health emergency of international concern, which is the highest level of alert that we have under international law and it has been a pretty incredible six months that we have seen.

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I think we can characterise the response globally as mixed. I think we can very strongly show that countries that have acted fast, have acted aggressively, have acted comprehensively... and really it's due to many countries who have had direct experience

with something similar or a similar threat; countries that had experience with SARS-CoV1, the first SARS in 2003.

Countries that had direct experience with avian influenza, those that have had experience with MERS, those countries across Africa that have had experience with other infectious diseases that they deal with so often really saw the threat, really knew the threat of this.

We as an organisation acted immediately. We mobilised ourselves on the day we were alerted to this and mobilised all of our forces to act and to inform. Our first guidance materials were out on 10th, 11th and 12th January, which was the comprehensive package of how to find cases, care for cases, how to protect healthcare workers from infection, how to collect samples to be able to test and a checklist to get countries ready.

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So there was a lot that was put out early and we really saw countries that took an aggressive approach, countries that took an all-of-government, comprehensive approach really see some success in the beginning of trying to combat this.

I think that even countries that didn't, even countries that didn't act as fast; we are seeing them turn things around and we are seeing many countries who had very difficult outbreaks to go through and we've mentioned these countries over and over again. Even the Republic of Korea and Italy and Spain and Germany and many countries were able to turn this around and implement this comprehensive approach, these public health measures, all-of-government, all-of-society, engaging their public, informing their public.

So I think that what we are learning is that these tools work, these tools over and over again, if they are implemented they work. They can suppress transmission and they can save lives and I think what we need to do going forward is look at how we can be more efficient in our response, how can everyone be more efficient in the tools that we apply so that we don't have to go into large lock-down again or so-called lock-down measures, that we can tailor the approach to the geographic area and to the transmission area where it's needed.

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MK I'd maybe just add one point. I think traditionally WHO provides a global service in the area of global goods, global standards, global science and we do that on behalf of all nations.

But also traditionally we expect usually to be providing on-the-ground operational and technical assistance, usually in countries that are low or middle-income countries that have gaps or fragility or vulnerabilities in their systems.

In this case I think what has certainly surprised me is the way in which public health systems - the slowness in general of systems to react on things like contact tracing, cluster investigation, testing, being able to bring a comprehensive public health strategy to bear.

We did focus in the early days of this crisis on really driving our technical and operational assistance to countries that we would traditionally feel need that assistance. If I could go back and change anything I think we would have also been better served to be offering that operational and technical assistance to countries where I think we made some assumptions about capacities that existed in countries and skills and workforces that maybe should have existed or should have been expanded in some of those countries.

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I think we're all learning lessons; that there's been a deep underinvestment in the public health architecture, the capacity to do surveillance, the capacity to do contact tracing, the capacity to run an integrated response. I've said it here in the past; we end up doing that kind of fully integrated operation in extreme environments like in eastern Congo.

If many things around the world and many countries... Nobody gets through a crisis with a perfect score; it's just not possible. But I do think we need to look really, really hard at what we assume to be capacities for public health intervention in all countries and maybe we made some assumptions about the existence or performance of those systems in all countries that did not prove correct.

00:32:45

MH Thank you very much, Dr Ryan and Dr Van Kerkhove. The next question goes to Alejandro Aleman from Medicina Digital, Mexico.

TR Good afternoon. Thank you for taking my question. This is the 40th year of our alma mater [?] and we have in Mexico tried to ensure that we have universal access to healthcare but we have had poor results to ensure universal access to healthcare. We know that people need to change their habits but we also

need to change the social environment. So what is the WHO doing to take into consideration this variable?

MR I didn't quite get the full depth of your question but I think what you were really speaking about is - certainly in the case of something like COVID; a disease like this exploits all of the vulnerabilities and the underlying vulnerabilities that individuals, communities and health systems have and we've seen that.

We've seen how this disease impacts on people who are marginalised and have underlying health conditions. We've seen how this impacts on people who don't have access to basic healthcare services in terms of diagnostics and treatment.

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We've seen how this impacts on areas in which the health infrastructure is poorly invested in and we've seen hospital systems collapse, we've seen huge queues of people not able to access healthcare in many countries. It's not just an issue in Mexico; it's an issue across the world.

Dr Tedros has spoken about this many times; health is not a reward for development. Health is a primary investment in the security of communities, in the security of the state, in the security of the economy and I think what epidemics do very often - and unfortunately they're a massive stress test for the system; they stress governance, they stress co-ordination, they stress community cohesion, they stress the trust between people, between communities, between communities and government.

So what happens in a crisis or in an epidemic is in a very small period of time much of the system is placed under stress and its natural resilience, how resilient and how able that system is to absorb stress determines the damage that's done and we know that ourselves.

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We deal in many parts of the world with natural disasters. If you build your house well, if you build your house with a view that a storm might come then you build a house that can withstand the storm. If the storm comes and your house is not prepared then you may lose your house and I think that's what we're seeing.

We're seeing in these situations in many, many countries the absence of universal health coverage, the absence of primary healthcare, the absence of an affordable health system that people can access without financial hardship. Dr Tedros has been speaking about this for years now.

This is the whole core of our global programme of work. Epidemics in themselves cause a major impact but that impact is amplified over and over again by weaknesses in the underlying health infrastructure and we're paying a heavy price again for the lack of that investment.

MH Thank you, Dr Ryan. I'm going to now do something a little different. We've got a good question for Professor Sunstein but the questioner can't get through so I'll ask it on behalf of them. The question is, what are your recommendations for motivating protective behaviours and helping people maintain those behaviours in light of what looks like the long-term nature of this COVID pandemic?

00:37:13

CS It's a wonderful question and it's one of our largest questions. We have just started as of today and there are over 20 of us and we have a stock of data, some of it from the domain of psychology, some of it from the domain of anthropology, some of it from the domain of economics about what is motivating to people and that data is what we'll be consulting as we engage with the WHO.

I apologise for being abstract but it's good not to get ahead of your skis and this is definitely a form of skiing that we're doing here. There are data points and there is evidence that is highly responsive to your question but there are 22 people who are experts who are thinking very hard about exactly how to apply that evidence to the COVID-19 problem.

We do have wonderful precedents in the form of successfully met public health challenges where behaviour has changed rapidly often in a way that saves lives. We've compiled over the last six months as well as unfortunate, tragic circumstances some evidence of significant success and those bright spots are something that fit nicely with the evidence that we have of successful behaviour change efforts.

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MH Thank you very much, Professor Sunstein. The next question comes from Bianca of Globo. Bianca, can you unmute yourself and please go ahead.

BI Hi, Margaret. Can you hear me?

MH Very well. Please ask your question, Bianca.

BI Thanks a lot for your attention, for taking my question again. In his speech today Dr Tedros gave special attention to young people. He repeated that young people are not invincible so what exactly does the WHO know so far about the impact that COVID-19 can have on young people? Thanks a lot.

MK Thank you for this really great question. There still is quite a lot that we are learning about COVID-19 and the impacts on different age groups. What we know about young people is that young people can be infected, young people can transmit the virus to others.

The majority of young people who are infected tend to have more mild disease but that is not always consistent. We know that young people can develop severe disease. We know that young people can end up in ICU and we know that young people can die.

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So what we are learning more about are even people who have mild disease; some of them will go on to recover just fine but some of them also have longer-term effects and we're just starting to really learn about this.

There are a number of patient groups who have formed, who have come together to say that they have these long-term effects, whether it's extreme fatigue, whether it is shortness of breath, whether they are having difficulty in resuming normal activities; going to the gym, going back to work.

We're learning what that means and in fact we have actually reached out to some of these patient groups to ask them directly, what are the impacts on them so that we can hear from them directly so when we look at our rehab, rehabilitation, when we look at longer-term care we can hear directly from you, so that we can make that better.

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What this means is that we are asking for all people including young people to be your own risk manager, to really understand what is the risk for you in terms of your risk of getting infected, of catching this virus, what is your risk of developing severe disease and what is your risk of transmitting this virus to somebody else.

So maybe you are healthy and you are young but you may pass it on to somebody who you live with who may be more vulnerable, who may be in an older age group, who may have an

underlying condition and they are at a higher risk of developing severe disease.

So we need you to understand what your risk is in the area where you live; where is this virus, where is it circulating and what do I need to do to minimise my risk of exposure and of infection and there are many things that you can do.

You can avoid crowded places; you can wear a mask if you're being asked to wear a mask, especially if you cannot do physical distancing. You can practise hand hygiene; you can practise respiratory etiquette and physical distancing at all times. You can avoid those crowded places and those nightclubs.

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We are consistently seeing nightclubs as being amplifiers of transmission and this is very unfortunate because we know that young people want to resume normal activities but there are situations where the virus, if it's present, can take hold and it can transmit efficiently.

So know what you can do and know what role you have to play, part in this pandemic.

MR Maybe I can just add, certainly in younger people - it depends how you define a young person - it's quite clear... COVID-19 causes an inflammatory disease in the lungs but it's also been clearly demonstrated that the inflammatory process extends into the cardiovascular system, into the blood, into the heart potentially into other organs.

So in many cases this disease, while it may be mild or it may be moderate, it can affect any organ and we just don't know what the long-term impacts of those infections will be. If we just look maybe at - there's one recent scientific review of patients in Germany, in Frankfurt looking at patients who weren't admitted to hospital, who were considered to be relatively mild.

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Those patients who never had to be admitted to hospital were followed up and had MRIs, magnetic resonance imaging on their hearts done all the time and they were found to have prolonged changes; inflammatory changes in the linings of their heart and the cardiac muscles.

That may and will probably resolve itself in most of those patients but when you start to see inflammatory changes that are prolonged - and we all know inflammation is essentially the

body's reaction to the presence of a virus or something else but inflammatory responses can also in themselves do damage and they can do long-term damage.

Any inflammatory process in the cardiovascular system can lead to longer-term heart disease and can actually accelerate other chronic heart conditions that may develop much later in life but we could accelerate the development of what would be older-age cardiovascular disease by having lots and lots of younger people exposed to a disease that caused generalised inflammation and we just don't know.

Why take the chance, why take the risk? It's really important that we take those options that protect our health too and yes, we want people to be altruistic and reach out to protect others but it's also play safe, use your brain, use your mind, don't take a risk that you cannot quantify.

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These risks right now cannot be adequately quantified and when we say that the vast majority of people have a mild illness and recover that is true. But what we cannot say at the moment is what are the potential long-term impacts of having had that infection. We hope that everybody who recovers from COVID-19 will make a full and permanent recovery but there are enough people out there having difficulties with their exercise tolerance, having difficulties with their breathing and potentially having long-term impacts on their cardiovascular system that we want to try and avoid all COVID infections if possible, not just those COVID infections that lead to death.

We need to avoid all COVID-19 infections, both in terms of reducing transmission but also in reducing the long-term health impacts of this disease.

MH Thank you, Dr Ryan and thank you, Dr Van Kerkhove. The next question comes from Morocco, from Sam Chagee from the Moroccan Voice. Sam, could you unmute yourself and then please ask your question.

00:46:12

SA Yes, good morning, everybody, and thank you, WHO, for all you do to keep us informed about COVID-19. My question is, what is the fate and the status of Sahari detained by the Policario in Tinduf [?]. Do you have any statistics on the number of people affected by the pandemic? Thank you.

MH Were you referring to detainees, did you say, people who are in some kind of prison? Was that what you were saying?

SA No, they are in what we call refugee camps in Tinduf.

MH Refugee camps; okay, thank you. Whereabouts, throughout the Sahel, did you say, or Sahara?

SA The Sahara; they are in Tinduf in Algeria.

MR We'll have to get you obviously specific information on that and we will get the data for you. What we can obviously say is that the people who live in refugee camps, in detention centres and other situations have particular risks. There are particular risks of the rapid spread of disease anywhere you put people close together in positions where they can't physically distance, where they haven't access to adequate hygiene; there is always a higher risk of transmission.

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Equally in other humanitarian situations as well you have people with high levels of vulnerability; malnourished children, people with underlying conditions and we see that more and more in refugee populations, particularly across North Africa and the Middle East because there are many people who would have chronic diseases as well in that situation.

We've been tracking the situation in refugees across many countries including the Sahel countries and again we at this point have not seen massive outbreaks. A huge amount has been done, led by our colleagues in UNHCR, in IOM, in IFRC and other agencies in both shielding and protecting populations in that situation and in also providing enhanced services in response to that.

It's not easy, it's difficult; the conditions are difficult and we have to remain ever-vigilant and continue to both reduce the chance that disease is introduced into those populations and decrease the impact should the disease be introduced there.

We've seen already infections in refugee camps in South Sudan; we've seen infections in refugee camps, in the Rohingya refugees and I'm probably more concerned about detention centres and prisons where there's even more overcrowding and it's really, really, really important that governments who are in control or in charge of those centres and detention centres, prisons and other centres where people are congregated; that there is a duty of care.

00:49:13

It is extremely important that governments take that duty of care seriously and do everything in their power with international organisations to ensure the security and safety and adequate care both in terms of prevention and treatment for those individuals who may be in that situation.

That's an extremely important message and we in WHO and partners in the UN and the non-governmental organisations around the world are working as hard as we can to support that but there is also a strong duty of care on host governments and on governments running centres to ensure the safety and well-being of people who live in those circumstances and situations.

But we will get some specific information. I just don't have the numbers here on that particular situation.

00:50:04

MH Sam, please contact media enquiries and send us your email so that we can get you that specific information. After that important question we've come up to the hour so I'm just going to hand over to Professor Sunstein for any final remarks or any comments on some of the very interesting questions we've had and then of course Dr Tedros will close the event.

CS I'm grateful for the questions which combined passion about public health with a real interest in what progress we can make on the behavioural challenges that the world faces. I'd emphasise that the world has met many challenges successfully over not just the last 20 years but over the last 100 years and this is in some ways particularly severe.

But there's an accumulation of knowledge from multiple fields about how to handle severe problems and one thing that those fields focus on is that individual choices have extremely large aggregate effects and if there's a single person or a single community that makes healthier choices tomorrow than it did yesterday then the likelihood is that we're going to see some sort of dent in the problem.

00:51:26

That kind of thing scales up from cities to nations and from nations to continents and of course to the world and our mission really, of this group is to help extraordinary people at the WHO who are working every day to combine the best scientific understanding with the best understanding of how human beings react to health risks.

MH Thank you, Professor Sunstein and over to you, Dr Tedros, for final remarks.

TAG Thank you so much. I think Professor Sunstein has already summed it up very, very well and I look forward to watching you and your colleagues. Thank you also to those who have joined us today and see you; all the best, until Monday. Thank you.

00:52:35