

# 1

## WORLD HEALTH ORGANISATION

### The challenges of providing global leadership

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#### **Political context**

The World Health Organisation (WHO) is a subsidiary agency of the United Nations, established on April 7, 1948, with a remit to advocate for global universal healthcare and coordinate responses to health emergencies. The WHO's reputation rests on the success of projects on which it has provided leadership. It proudly advertises its leading role in eradicating smallpox and the development of a vaccine to combat the Ebola virus, which as a disease transferred from primates to humans and attacks the respiratory and digestive systems and has similarities to COVID-19.

The WHO's ability to oversee global public health relies on effective co-ordination of the World Health Assembly (WHA), a meeting of representatives of the 194 member states as well as securing funding. The WHO's budget, at around four billion dollars a year (\$4.8 billion 2020–21),<sup>1</sup> is made up of assessed contributions from member states, based on national GDP and population size, and voluntary contributions; the latter constitute 80% of its budget. The United States, as the most significant contributor, pays in around one hundred million dollars per year in assessed contributions and between one and four hundred million dollars in voluntary contributions, without which the WHO could see its budget contract to one billion dollars.

The ability of the WHO to provide leadership is constrained by an inability to force honest reporting or political compliance with its guidance. It is also hampered by having to balance competing demands, such as between religious teaching and the promotion of safe sex to combat HIV/AIDS. The WHO is also seen as cumbersome, decentralised and bureaucratic, all of which hinders achievement of specific goals on a global scale. The remit of Current Director-General Tedros Adhanom, former Health and Foreign Minister of Ethiopia, is to

improve the WHO's effectiveness in developing better technical and governance partnerships while retaining political independence. COVID-19 highlighted the challenges the WHO faces in providing early alerts, appropriate guidance as well as developing a communication strategy that could reach all nations, their leaders and citizens.

## Chronology

From the first case being reported in Wuhan, China on December 31, 2019, by August 28, 2020 there were 24,257,989 cases across all 251 countries recognised by the UN and 827,246 deaths resulting from COVID-19 (<https://covid19.who.int/>). See Table 1.1.

## Analysis

From January 1 to the end of August 2020, the WHO delivered almost a hundred press conferences and briefings. The first official statement on January 23, called on the global community to demonstrate solidarity and cooperation in identifying and tackling the spread, which was then described as only having the potential to be transmitted from human to human. While the WHO cannot create the environment for global solidarity, it had the position to lead the response to COVID-19. In order to do that it must: (1) provide clear, accurate and up-to-date information on the spread, i.e. information on numbers of active cases, human-to-human transmission and mortality rates; (2) identify effective countermeasures to prevent spread and (3) debunk false and misleading information. Our analysis centres on these three key communication areas.

## *Informing the world*

As the agency focusing on health emergencies, the WHO relies on information provided by national authorities. The first occurrence of any disease, number of active cases, infectivity, mortality or source of infection cannot be obtained without cooperation from countries experiencing an outbreak. A problem arises when that country eschews transparency and attempts to restrict information as this constrains the WHO's understanding and ability to develop effective guidance. Unfortunately, this was the case with China at the turn of 2019 and 2020. Information about the first cases of COVID-19 were leaked to the media by whistleblowers, not official communication channels. Moreover, multiple testimonies show China tried to withhold information about the novel coronavirus (Kuo, 2020). China's approach caused several weeks of delay in understanding the threat of COVID-19.

The novel coronavirus outbreak was identified in Wuhan, China, and reported to the WHO representation in China on December 31, 2019. The WHO published a statement informing about a 'pneumonia of unknown cause' on January

TABLE 1.1 WHO chronology

<i>Date</i>	<i>Global Diffusion of COVID-19</i>	<i>Key official actions</i>	<i>Key communication events</i>
December 31	First case being reported in Wuhan, China.		
January 1		WHO set up IMST (Incident Management Support Team).	Flags a potential threat posed by this new strain of coronavirus by putting the organisation on an emergency footing for dealing with the outbreak.
4	3 confirmed cases in China.		WHO posted to social media #China has reported to WHO a cluster of #pneumonia cases – with no deaths – in Wuhan, Hubei Province, China.
5		Disease Outbreak News includes a risk assessment and advice for public health.	No specific measures for travellers or travel and trade restrictions on China advised.
10	45 confirmed cases in China. First death reported.	Guidance released stating testing should only be given to those with symptoms.	Technical guidance issued focusing on detecting, testing for and managing potential cases, drawing on experience with SARS and MERS.
14	50 confirmed cases.		Press briefing and social media posts state no clear evidence of human-to-human transmission.
22	470 confirmed cases. 9 deaths reported.	Emergency Committee convened to assess whether the outbreak constituted a public health emergency of international concern, no consensus was reached.	Technical advice is issued calling for preparedness for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread.

(Continued)

TABLE 1.1 (Continued)

<i>Date</i>	<i>Global Diffusion of COVID-19</i>	<i>Key official actions</i>	<i>Key communication events</i>
30	7,912 confirmed cases. 170 deaths reported.	Emergency Committee re-convened, consensus reached that the outbreak constituted a Public Health Emergency of International Concern.	
February 3	17,478 confirmed cases. 362 deaths reported.	Strategic Preparedness and Response Plan released to help protect states with weaker health systems.	WHO opposes travel restrictions, even on citizens from Hubei province.
11	43,199 confirmed cases. 1,018 deaths reported; 108 in a single day.	Research and Innovation Forum convened to bring together entrepreneurs and funders to help with mitigating the crisis.	
March 11	124,209 confirmed cases. 4,641 deaths reported.	COVID-19 classified as a global pandemic.	
13	141,073 confirmed cases. 5,486 deaths reported.	COVID-19 Solidarity Response Fund launched to receive donations from private individuals, corporations and institutions.	
18	209,075 confirmed cases. 9,270 deaths reported; 1,083 in a single day.	WHO and partners launch the Solidarity Trial, an international clinical trial that aims to generate robust data from around the world to find the most effective treatments for COVID-19.	
20	262,298 confirmed cases. 12,017 deaths reported.	WHO Health Alert for coronavirus launches on WhatsApp.	Media briefing, Director-General (D-G) suggests social distancing measures.

23	339,301 confirmed cases. 16,634 deaths reported.	WHO and FIFA team up on campaign to kick out coronavirus.	
25	427,077 confirmed cases. 21,287 deaths reported.	UN launches COVID-19 Global Humanitarian Response Plan to #InvestInHumanity.	
26	483,727 confirmed cases. 24,147 deaths reported.	Extraordinary Virtual G20 Leaders' Summit on COVID-19.	
31	767,696 confirmed cases. 40,661 deaths reported.	Report of falsified medical products, including in vitro diagnostics, that claim to prevent, detect, treat or cure COVID-19.	Chatbot launched with Rakuten Viber to help users be informed, learn how to protect themselves, test their knowledge and bust myths.
April	1	842,704 confirmed cases. 44,846 deaths reported.	WHO in Africa holds first 'hackathon' for COVID-19 bringing together entrepreneurs to pioneer creative local solutions and address critical gaps.
	2	916,160 confirmed cases. 49,811 deaths reported.	COVID-19 Health System Response Monitor created jointly with the European Commission and the European Observatory on Health Systems and Policies to offer cross-country comparisons and track public health initiatives.
	6	1,228,566 confirmed cases. 72,084 deaths reported.	#BeActive launched campaign with FIFA. Advice issued on face masks: 'Masks alone cannot stop the #COVID19 pandemic. Countries must continue to find, test, isolate and treat every case and trace every contact.'

(Continued)

TABLE 1.1 (Continued)

Date	Global Diffusion of COVID-19	Key official actions	Key communication events
8	1,373,454 confirmed cases 84,303 deaths reported		D-G responds to criticism from US president Trump calling for solidarity and: 'please quarantine politicising COVID-19.'
13	1,787,323 confirmed cases. 116,865 deaths reported.	Expert group forms to collaborate on vaccine development.	
14	1,857,917 confirmed cases.	Major update to COVID-19 dashboard <a href="https://covid19.who.int/">https://covid19.who.int/</a>	
17	112,324 deaths reported. 12,453 deaths in a single day, the peak of deaths Jan-Aug.		
20	2,321,417 confirmed cases. 167,348 deaths reported.	Launch of text messaging service to provide alert information to those without Internet access.	
24	2,630,691 confirmed cases. 192,482 deaths reported.	Launch of COVID-19 Tools Accelerator: Global Collaboration to Accelerate the Development, Production and Equitable Access to New COVID-19 diagnostics, therapeutics and vaccines.	
30	3,104,568 confirmed cases. 224,724 deaths reported.	D-G convened the third International Health Regulations (IHR) Emergency Committee on COVID-19.	Statement that COVID-19 still represented a Public Health Emergency of International Concern (PHEIC).

May	4	3,446,082 confirmed cases. D-G addressed leaders from 40 countries from all over the world at a COVID-19 Global Response International Pledging Event, hosted by the European Commission.	
	5	3,528,251 confirmed cases. WHO launches the COVID-19 Supply Portal, a purpose-built tool to facilitate and consolidate submission of supply requests.	
	10	3,947,799 confirmed cases. WHO sets out considerations in adjusting public health and social measures for workplaces, schools and mass gatherings.	WHO issues interim guidance on contact tracing protocols.
	13	4,188,036 confirmed cases. WHO Academy App launched, designed to inform health care workers to help them care for COVID-19 patients and protect themselves.	
	15	4,359,238 confirmed cases. WHO released a Scientific Brief on multisystem inflammatory syndrome in children and adolescents.	
	18	4,647,626 confirmed cases. The 73rd World Health Assembly, the first ever to be held virtually, adopted a landmark resolution to bring the world together to fight the COVID-19 pandemic.	D-G 'Let our shared humanity be the antidote to our shared threat.'
	21	4,918,089 confirmed cases. WHO signed a new agreement with the UN Refugee Agency to support ongoing efforts to protect 70 million+ forcibly displaced people from COVID-19.	

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TABLE 1.1 (Continued)

<i>Date</i>	<i>Global Diffusion of COVID-19</i>	<i>Key official actions</i>	<i>Key communication events</i>
29	5,707,599 confirmed cases. 358,565 deaths reported.	Thirty countries and multiple international partners and institutions launched the COVID-19 Technology Access Pool (C-TAP), an initiative to make vaccines, tests, treatments and other health technologies to fight COVID-19 accessible to all.	
June	5 6,516,317 confirmed cases. 388,297 deaths reported.	WHO published updated guidance recommending the wearing of masks to help control the spread of COVID-19.	
13	7,531,572 confirmed cases. 424,627 deaths reported.		WHO reported that Chinese authorities had provided information on a cluster of COVID-19 cases in Beijing.
16	7,918,966 confirmed cases. 436,125 deaths reported.		WHO welcomed initial clinical trial results from the UK that showed dexamethasone, a corticosteroid, could be lifesaving for patients critically ill with COVID-19.
17	8,038,634 confirmed cases. 441,634 deaths reported.	WHO ended trials of hydroxychloroquine as an effective COVID-19 treatment due to poor results.	WHO reminds public to remain vigilant through Mr Bean's Essential COVID-19 Checklist.
26	9,454,484 confirmed cases. 484,313 deaths reported.	The ACT-Accelerator launched its investment case, calling for \$31.3 billion over next 12 months to fund diagnostics, therapeutics, vaccines and the health system connector.	



July	4	10,925,739 confirmed cases. 523,063 deaths reported.	WHO withdraw support for all hydroxychloroquine and lopinavir/ritonavir trials due to poor results.	
	6	11,332,503 confirmed cases. 532,381 deaths reported.		WHO shared survey findings, showing that 73 countries have warned that they are at risk of stock-outs of antiretroviral (ARV) medicines as a result of the COVID-19 pandemic.
	9	11,879,532 confirmed cases. 545,526 deaths reported.	D-G launches Independent Panel for Pandemic Preparedness and Response (IPPR) to evaluate the world's response to the COVID-19 pandemic.	
	13	12,774,911 confirmed cases. 566,681 deaths reported.	'State of Food Security and Nutrition in the World' is published, which forecasted that the COVID-19 pandemic could tip over 130 million more people into chronic hunger by 2021.	
	17	13,622,372 confirmed cases. 585,754 deaths reported.	D-G launches updated Global Humanitarian Response Plan for COVID-19 for \$10.3 billion to fight the virus in low-income and fragile countries.	
	22	14,772,512 confirmed cases. 612,075 deaths reported.	COVID-19 Law Lab launched to provide vital legal information and support for the global COVID-19 response.	
	31	17,114,704 confirmed cases. Peak of 293,128 new cases. 668,943 deaths reported	The fourth meeting of the Emergency Committee is held.	News release highlights need for long-term coordinated response.

5. The statement was the first of regular reports on the number of new cases and later, the numbers cured or of those who succumbed to the disease. For these figures, the WHO had to rely on national reports. The speed and credibility of information was thus negatively affected from the outset. The first cases appeared weeks earlier than officially claimed by China and evidence of human-to-human transmission was concealed. Despite having the expertise and capacity to produce its own analysis and recommendations, the WHO had limited access to data at the beginning of 2020. China's political regime kept control over the information and data provided. The WHO was unable to officially confirm human-to-human transmission until January 22, although some information from Chinese doctors indicated the likelihood during the first days of the outbreak and the WHO admitted it was likely on January 14. But it took the identification of cases in Thailand before a definitive statement was made.

Although this delay was due to receiving limited information from China, the WHO received criticism from other states and the media. It was accused of not having a proactive approach, uncritically adopting Chinese statements and providing information belatedly. Hence, during January and February information from the WHO had serious flaws. WHO advice on testing on January 10 stated only those who presented with symptoms should be tested, suggesting there were no asymptomatic carriers.<sup>2</sup> There was also initial uncertainty about person-to-person transmission and the failure at the first meeting of the Emergency Committee on January 22 to reach a consensus on the severity of the global threat made it appear to vacillate. Statements claiming the virus was similar to SARS and MERS, both of which were contained with minimal global disruption, and continued opposition to travel restrictions offer evidence the WHO facilitated the complacency that led to risks being downplayed by national leaders and their health experts. It was only on March 11 that a global pandemic was declared, and nine days later social distancing measures were recommended. By this point, nations had adopted independent approaches, drawing on their own medical experts, to put in place restrictions on travel and social activities. Responding to criticism, Adhanom stated that a global health emergency had been declared on January 30 and some health experts defended the delay in declaring a pandemic as this represented a change in language rather a change in the potential threat (Spinney, 2020). Declaring a pandemic, Adhanom argued in a statement on March 11, was a response to 'alarming levels of inaction' as it was deemed necessary to compel nations to 'detect, test, treat, isolate, trace, and mobilise their people in the response, those with a handful of cases can prevent those cases becoming clusters, and those clusters becoming community transmission.' Criticism thus became muted, and later, only to come from US President Trump who blamed the WHO on many (often contradictory) fronts, for exaggeration of active cases and fatality rates to the belated alerts and, therefore, its responsibility for the pandemic, specifically the situation in the United States (Stevens & Tan, 2020). In response, Trump announced the freezing of US payments to the WHO (Murray, 2020).

However, by that time, the WHO was not a subject of criticism in most other countries. Greater attention was paid to the organisation during the outbreak phase when countries were seeking clear guidance on preventative measures. After the spread of the virus to all continents, the central role of the WHO was to provide global statistics based on data gathered from national authorities and updates on the effectiveness of measures. Further initiatives were introduced but the WHO's focus shifted to the most vulnerable countries as well as refugees. The WHO also sponsored the development of a range of apps and tools to support health workers and people to identify symptoms. The shift in focus demonstrates the WHO sharing good practice, especially from northern hemisphere countries that experienced early outbreaks, but unable to take full leadership for combatting COVID-19 globally or being the sole arbiter of what constituted credible information.

### ***(In)effective measures***

Identifying the most effective measures such as travel restrictions and the wearing of face masks equally became challenging. The first advice the WHO offered on international travel came out on January 10, advising the avoidance of close human contact and promoting frequent hand washing. It explicitly stated no restrictions for international traffic were recommended. Updates on January 24–27, 2020 added recommendations for temperature screenings at airports in countries with and without transmission. Later travel advice, published on February 11, saw the WHO repeat it was not recommending any travel or trade restrictions arguing such measures would be effective in the short term only and just in selected cases and cannot be implemented long term. The measures countries should consider were repatriation and quarantine for their citizens residing in affected areas. The WHO continued to advise against travel restriction even when dozens of airline companies suspended or limited flights to China and several countries imposed travel restrictions which came into force from late January (Sang-Hun, 2020). According to the United Nations World Tourism Organisation (UNWTO), by April 6, 96% of all worldwide destinations had introduced travel restrictions and by April 27, 72% had completely closed their borders (UNWTO, 2020). When a responsible restart of international travel became a reality (40% of all countries had eased the restrictions by mid-July), the WHO published updated travel advice on July 30 keeping most of the previous recommendations and containing no recommendation on travel restrictions as retaining the position travel bans had no justification after a virus has spread worldwide. This countered some expert evidence. Chinazzi et al. (2020) showed the epidemic in mainland China would have been delayed by approximately two weeks in the case of 90% travel reductions. The research argued early international restrictions could have helped flatten the curve, mainly in the first affected countries such as Italy, the Republic of Korea and Iran.

Further confusion accompanied the question of whether the wearing of face masks reduced the risk of contagion. Face masks were recommended by many scientific, national and supranational authorities as a public and personal health control measure against the spread of disease. Yet face mask wearing was not promoted by the WHO recommendations. The original interim guidance on January 29 generated confusion when identifying medical masks as the one important protection to limit the spread of COVID-19 but in the same statement noting that use of masks alone is insufficient. The confusion and chaos in the initial recommendation have been criticised (not only) by scholars (Chan et al., 2020). An updated version, released on March 19 stated there was no evidence of the usefulness of face masks for protection; therefore, it was recommended that masks should only be worn by those with a cough, fever or people who have difficulty breathing. Further advice published on April 6 stated mask wearing by healthy people carries potential critical risks but reduced the potential exposure risk to healthy people from those infected but pre-symptomatic. The conflicting evidence has fuelled protest movements opposing mandatory face mask wearing on the grounds they are useless or even counter-productive although these movements are driven as well by political beliefs (Leung et al., 2020). Debates on face masks have continued unabated. Scientific articles have demonstrated any face masks can reduce exposure to respiratory infections, suggesting home-made masks do not provide the same level of protection as medical ones, but can be effective when worn by the majority of a population to protect them from infection by asymptomatic individuals who emit droplets containing the virus (Ma et al., 2020). The WHO stated it recommends an evidence-based approach; however, when providing the list of risks of mask usage, the evidence supporting claims provided by the WHO seems to be missing. The latest update, from June 7, states masks should be used as part of a comprehensive strategy of measures to suppress disease transmission and save lives. Hence with two key preventative measures, travel restrictions and face mask wearing, the WHO has lacked a definitive and clear position.

### ***Rebutting fake news***

At the same rate of spread of COVID-19, misinformation and disinformation has gone viral globally, mirroring the challenges society has in controlling what the WHO described as an infodemic (WHO, 2020). The first misleading information appeared in parallel with the initial outbreak of COVID-19. On January 30, the BBC reported on the growing number of conspiracy theories relating to the origin of the virus and misleading advice regarding prevention and cure (BBC, 2020). A frequently circulating story suggested COVID-19 was part of a Chinese (Gertz, 2020) or US (Kurlantzick, 2020) biological weapons programme. *Global Times*, China's state-affiliated tabloid newspaper, published a story claiming the virus was of US origin (Shumei & Lin, 2020) while Iran's supreme leader Ayatollah Ali Kamenei refused US help to fight coronavirus in

March 2020, citing the conspiracy theory that the virus could be US made (Hafezi, 2020).

In late January 2020, conspiracy theories that 5G caused, or helped spread, COVID-19 were shared in Facebook anti-5G groups (Cellan-Jones, 2020). Regardless of the fact that there is no evidence that 5G weakens immune systems or is harmful to humans (Rahman, 2020), that viruses cannot be transmitted by radio waves and COVID-19 has spread to countries without 5G networks, the story gained some credibility. The theory has been debunked by national health authorities, mobile data providers and health experts (Gallagher, 2020). However, a statement by the WHO was slow in being produced.

Another claim, widely shared, advised people to keep their throat moist, avoid spicy food and take vitamin C in order to prevent contagion (Lytvynenko, 2020). The WHO did provide a statement on February 5 stating no treatments, including certain antibiotics, alcohol or herbs, were known to have any palliative effect. The WHO also ended trials of hydroxychloroquine on June 17 due to poor results; however, this seemed belated as Jair Bolsonaro and Donald Trump, presidents of Brazil and the United States, respectively, had both extolled the virtues of the drug in preventing infections. On March 21, Trump declared he had completed a two-week course of Hydroxychloroquine and Azithromycin declaring them in a tweet to be 'the biggest game changers in the history of medicine' (Trump, 2020). The WHO launched a Chatbot to aid myth busting and obtain clear factual information; however, it was unable to emerge as the most credible source of information to many, particularly where facts became politicised and among groups who find conspiracy theories compelling (Van Prooijen & Jostmann, 2013).

## Conclusion

The WHO should be able to provide global leadership for health emergencies and pandemics. However, the reliance on member states' openness and transparency hinders their ability to be first and be right when identifying the threat posed by a new virus, an issue which is particularly highlighted in the case of COVID-19. The evidence shared by China led to vacillation on the threat posed and so, nations had to develop their own responses to the spread of the virus within their own territories. The declaration of a global health emergency seemed to have limited effect, with the threat downplayed by accompanying questions regarding person-to-person contagion, a failure of the Emergency Committee to reach a consensus on the threat and a refusal to recommend widescale travel restrictions. The failure to have the right information during the early stages meant the WHO had to catch up with state-level approaches and focus on supporting more vulnerable nations who were witnessing the spread of the virus later. Further conflicting advice on the use of face masks opened spaces for a coalition of libertarians and populists to undermine measures to combat contagion. While it is difficult to criticise the WHO for failing to combat the spread of fake news, the

lack of credibility due to early vacillation, conflicting recommendations and lack of clarity meant they were not in a strong position to be the primary definers of scientific evidence. These factors highlight not just the weaknesses at the heart of the WHO but weaknesses in the ability of the world to overcome differences and work together when facing a common threat.

## Notes

- 1 The data is obtained from <https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-the-world-health-organization/>
- 2 <https://apps.who.int/iris/bitstream/handle/10665/330374/WHO-2019-nCoV-laboratory-2020.1-eng.pdf>

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