COVID-19

Virtual Press conference

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Speaker key:

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SO	Sophie
MK	Dr Maria Van Kerkhove
MR	Dr Michael Ryan
BA	Bayram
RG	Dr Rogerio Gaspar
JA	Jason
SS	Dr Soumya Swaminathan
JE	Jenny
DO	Donato
AL	Alli
SI	Simon
HE	Helen

00:00:58

CL Hello, good day and welcome to today's global COVID-19 press conference. It's Wednesday, 2nd December and, as you can see, we're still working on some connection issues. Again welcome. We'll have simultaneous interpretation provided today in the six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus we'll have Portuguese and Hindi at your fingertips.

Now the participants we have today, starting here in the room, are the Director-General, Dr Tedros Adhanom Ghebreyesus and we have Dr Maria Van Kerkhove, Technical Lead on COVID-19. Online joining us are Dr Mike Ryan, Executive Director of WHO's

Health Emergencies Programme, Dr Soumya Swaminathan, our Chief Scientist, and Dr Rogerio Gaspar, Director for Regulation and Prequalification.

I'll remind you, if you want to raise your hand to get into the queue use the raise your hand icon and we'll get to your questions. With this, let me hand over to the Director-General.

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. The end of a year is always an opportunity to look back and to look forward. As we look back, 2021 gave us many reasons to hope. Science delivered that hope in the form of vaccines which have undoubtedly saved many lives this year.

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On the other hand there is no doubt that the inequitable sharing of those vaccines has cost many lives. 2021 was a year in which we lost 3.5 million people to COVID-19, more deaths than from HIV, malaria and tuberculosis combined in 2020.

And still COVID-19 continues to claim around 50,000 lives every week. As omicron becomes the dominant variant in many countries all of us need to take extra precautions. Today WHO is issuing updated guidance for health workers recommending the use of either a respirator or a medical mask in addition to other personal protective equipment when entering a room where there is a patient with suspected or confirmed COVID-19.

Respirators, which includes masks known as N95, FFP2 and others, should especially be worn in care settings where ventilation is known to be poor. However we're painfully aware that many health workers around the world are unable to access respirators.

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We therefore ask manufacturers and countries to scale up the production, procurement and distribution of both respirators and medical masks for use in health and care settings. It's essential that all health workers have all the tools they need to do their jobs, the training, the PPE, the safe work environment and the vaccines.

It's frankly difficult to understand how, a year since the first vaccines were administered, three in four health workers in Africa remain unvaccinated. While some countries are now rolling out blanket booster programmes only half of WHO's member states have been able to reach the target of vaccinating 40% of

their populations by the end of the year because of distortions in global supply.

Enough vaccines were administered globally this year that the 40% target could have been reached in every country by September if those vaccines had been distributed equitably through COVAX and AVAT.

We are encouraged that supply is improving. Today COVAX shipped its 800 millionth vaccine dose. Half of those doses have been shipped in the past three months. Our projections show that supply should be sufficient to vaccinate the entire global adult population and to give boosters to high-risk populations by the first quarter of 2022.

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However only later in 2022 will supply be sufficient for extensive use of boosters in all adults so I call once again on countries and manufacturers to prioritise COVAX and AVAT and to work together to support those who are furthest behind.

Today the WHO strategic advisory group of experts on immunisation or SAGE is issuing an interim statement on booster doses. SAGE concluded that the focus of immunisation must remain on decreasing death and severe disease and expressed concern that blanket booster programmes will exacerbate vaccine inequity.

About 20% of all vaccine doses administered every day are currently being given as boosters or additional doses. Blanket booster programmes are likely to prolong the pandemic rather than ending it by diverting supply to countries that already have high levels of vaccination coverage, giving the virus more opportunity to spread and mutate.

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It's important to remember that the vast majority of hospitalisations and deaths are in unvaccinated people, not unboosted people and we must be very clear that the vaccines we have remain effective against both the delta and omicron variants.

The global priority must be to support all countries to reach the 40% target as quickly as possible and the 70% target by the middle of this year. No country can boost its way out of the pandemic and boosters cannot be seen as a ticket to go ahead with the planned celebrations without the need for other precautions.

Even as we work to make the best use of the vaccines we have WHO is also working to identify the next generation of vaccines through the Solidarity trial vaccines. The Solidarity trial vaccines is co-sponsored by WHO and the Ministries of Health of Colombia, Mali and Philippines and aims to accelerate the evaluation of more COVID-19 vaccines to expand the portfolio and improve access.

It's also intended to uncover second-generation vaccines with greater protection against variants of concern with longer duration of protection or to assess vaccines that can be given without needles.

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The vaccines in the trial were selected by an independent advisory group of leading scientists and experts. Research teams in Colombia, Mali and Philippines began recruiting volunteers in late September and so far over 11,500 people are participating in the trial.

So far the trial includes two vaccines. Three others will be included shortly and more can be included. WHO invites all countries and research centres to participate in this trial.

2021 has been a painful year for many of us but we cannot allow it to be a wasted year. As we approach a new year we must all learn the painful lessons this year taught us. 2022 must be the end of the COVID-19 pandemic but it must also be the beginning of something else, a new era of solidarity.

We must leave 2021 behind with sorrow and look forward to 2022 in hope. On that note, I would like to wish all who celebrate it a very merry Christmas. Merry Christmas. Christian, back to you.

00:11:20

CL Thank you very much, Director-General. Let me now open the floor to questions from the journalists and again to remind you, although we have a very long list already, if you want to raise your hand to ask a question please use the raise your hand icon and when I call upon you please unmute yourself.

We'll start with Sophie Mokwena from South African Broadcasting. Sophie, please unmute yourself.

SO Thank you so much. My question is directed to the officials, Dr Tedros, Dr Van Kerkhove and Dr Ryan. I just want to find out, as the world is commemorating two years, next week on

31st December, since China reported the coronavirus, where are we as the world in terms of fighting the coronavirus and the variants?

Are we beginning to understand the behaviour of the variants and are we a step ahead or are we still struggling?

CL Sophia, thank you. We didn't get everything without the crying child, a sign for 2021. Maybe we'll start with Dr Maria Van Kerkhove.

00:12:56

MK Sophie, thanks very much for your really very good, insightful question. I think two years into this pandemic we are well-trained, we understand this invisible pathogen that is causing complete havoc in all of our lives, we have the upper hand in terms of what we need to do to be able to control it, we have tools that can bring it to its knees, that could save countless lives.

What is unclear to me as we enter into 2022 is how we use those tools to actually end this. I'm very hopeful into the third year of this pandemic that we could actually bring this virus under control. I think it is a formidable enemy but I think we have an entire global army. Forgive the military reference there but I think we have an entire globe of people who know what they need to do to end this.

I think we just really need to come together to do that. We have health workers who are exhausted but who have been tremendous over the last two years and even before that of course in terms of keeping people safe and caring for our loved ones.

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We have a public that knows what they need to do and in some respects they just need to take some difficult decisions to make sure that they limit their exposure to this virus. We have governments that know that they need a comprehensive approach to tackle COVID-19 so I'm very hopeful.

My concern remains whether or not we have the stamina to really put in the effort to end it and I think we can. So there's a lot more to do. I do believe we're still in the middle of this pandemic unfortunately but I completely believe that we have the power to end it in 2022.

So vaccine equity and getting the vaccines to those who need them most in all countries must be a priority for every single government, not just some. We need to also be able to use tools to drive transmission down because if we don't we will continue to see the virus change and the virus threaten us in ways that bring us closer to the beginning rather than closer to the end.

So I choose to use my energy and the energy of all of the experts that work with us around the world to bring us closer to the end in 2022 and I think all of us can do that.

CL Thank you, Dr Van Kerkhove. Maybe Dr Ryan wants to come into this. Sorry for putting you on the spot in case.

00:15:55

MR Christian, no, I was just listening to Maria there. I think we have real hopes of doing better next year, especially when we see governments like that of South Africa, Botswana and the huge transparency that they showed in dealing with the omicron variant.

The power of science, surveillance and public health in southern Africa has really given us real important lead time for the rest of the world to prepare for the spread of omicron. We will see further variants and what we really need is to have more sustainable strategies that are agile and flexible and adjustable and scalable and that we're not lurching from doing nothing to doing full lock-downs.

We seem to be in a cycle of hoping that it's over, putting our hands over our ears and then going from that ignoring the problem to shutting down society.

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So I do think and I hope that we have more sustainable, adjustable strategies and we've seen that in many Asian countries. Many Asian countries haven't fully locked down at any point during this pandemic. If I recall, Singapore at no point has closed its schools, kept universities and things open and made the priorities of the society what society needs to remain open - for example schools - and then trading off where public health and social measures need to be more intense.

So I do think we are not at the end of this pandemic, we're not even close. We have the tools, as Maria said, better tools than we've ever had before thanks to science. We have a much better understanding about how to deal with this virus but what we've lacked is that collective will across countries and between

countries to be really comprehensive and sustainable in the strategies.

I believe that populations and communities have become confused by all of the changing guidance and we've also had huge issues of trust, notwithstanding everything that Maria said about vaccine inequity, which is probably the most horrific injustice of 2021. I hope and I pray that that can be improved in 2022.

CL Thank you very much, Dr Ryan. Next question goes to Bayram Altuk from Anadolu News Agency. Bayram, please unmute ourself.

00:18:35

BA Thank you, Christian, for taking my question. My question is for Mr Tedros, if I may, please. Turkey's a domestically-developed COVID-19 vaccine named Turkovac has been approved for emergency use, Health Minister Faritakoju announced a couple of hours in Turkey today. He said, as of today Turkey has become one of the nine countries producing a COVID-19 vaccine in the world.

So how does the WHO respond to this announcement and when will the WHO approve the Turkovac produced by Turkey for emergency use? Thank you so much and wish you all the best in 2022. Thank you.

CL Thank you very much, Bayram. I'll hand this question to Dr Gaspar, Director, Regulation and Prequalification. Rogerio, please.

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RG Thank you. Until now. Until now we had no communication about that and no interaction with any applicant regarding Turkovac. What we can say is that from our side, as we always do, we welcome all initiatives to develop vaccines that could help during this current public health crisis, provided that a number of standards and requirements are met.

So as soon as we have any interaction from the applicant with WHO we will start to engage and to discuss the conditions that not only the applicant but also the regulatory authority of reference have to meet. They are published on the WHO website. They are public and transparent. Over to you, Christian.

CL Thank you very much, Dr Gaspar. I think that answers that one. Next question goes to Jason Bobian from NPR, National Public Radio. Jason, please unmute yourself.

JA Thanks a lot for taking my question. I really appreciate it. With the omicron variant now out how much concern do you have at the WHO about the effectiveness particularly of the non-MRNA vaccines against it?

There have been some early studies that showed very limited effectiveness of some of these vaccines against this variant. How much concern is there and do you have any more information about how well some of the existing vaccines are working against this variant?

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CL Thank you very much, Jason. This goes to Dr Soumya Swaminathan, our Chief Scientist.

SS Thank you, Tarik. I can start. This is a question obviously that we are very interested in and that SAGE, the strategic advisory group of experts on immunisation, is keeping a very, very close eye on.

As you know, they are the committee that advises WHO on the policy for vaccines and they've been making recommendations for each of the vaccines that we have provided an emergency use listing for.

As you know, the Novovax/Covovax vaccine was the tenth vaccine to receive emergency use listing and SAGE guidance. These are all widely used of course around the world and it is important...

As each new variant has come along one of the things WHO has done is to track vaccine effectiveness. A lot of data is coming out on omicron, as it did for delta and it is really important to have a holistic view of vaccine performance and not have to make decisions based only on early data, which is usually laboratory-based experiments looking at neutralisation assays showing...

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Almost consistently all of the lab assays have shown a reduction, a significant reduction in neutralisation of the omicron variant which means that what it's indicating is that the omicron variant needs much higher levels of antibodies in the blood in order to neutralise it.

At the same time there have been studies that have been looking at the other arm of the immune system which is the T-cell immunity or the cell-mediated immune response, indicating that there is protection that is likely to be retained because the T-cell responses are against a much wider range of antigens on the spike protein and many of those have not been mutated in omicron so chances are that there is still a good amount of T-cell immunity, which should reassure us that vaccines will still continue to protect against severe disease and hospitalisation, which is of course what we want vaccines to do.

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Is there going to be a reduction in vaccine effectiveness, is this going to be different? You mentioned MRNA versus some of the others like the viral vector vaccines. There are inactivated vaccines being used and now we have some new subunit protein vaccines which have still not been used very widely, they're just in a few countries so far.

So what we propose to do is to really track the clinical data. I think that's really important, that we have to go beyond the lab and really look at clinical data. WHO has also set up a technical advisory group to think about the potential for changes in the strain composition of vaccines.

We know that a number of manufacturers are already working on omicron-specific vaccines. It's good to be proactive because we don't know if we're going to need them or not but in the meantime WHO's TAG COVAC has been meeting regularly to develop the criteria for when a vaccine strain change may be needed and if so what should be that strain, what should be that consensus sequence.

Because even within omicron you have a number of different sequences of all of the thousands of sequences being uploaded so the committee has to select the consensus-specific sequence that manufacturers would need to use if there is indeed a need to switch vaccines and that would happen if the current lot of vaccines are not providing enough protection.

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Also today we have published interim guidance from SAGE on boosters and again there is now data and SAGE has provided a lot of flexibility in heterologous regimens both for the primary course as well as for the booster.

So countries that have used one particular type of vaccine, let's say a viral vector vaccine, could opt to use a different vaccine, an MRNA or a subunit protein vaccine for example, for a booster dose if they chose to do so.

So there is more and more data coming out on that as well but I think this is a time where the data is evolving, we're learning more and more. It's important that we do not conclude that vaccines are ineffective at this stage. We've said repeatedly, it's very unlikely that a vaccine will become completely ineffective clinically because that's not how vaccines usually act.

But obviously we have to be driven by the data and our recommendations will change accordingly based on the emerging evidence. Thank you, Tarik.

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CL Thank you very much, Dr Swaminathan. Next question is for Jenny Fink from Newsweek. Jenny, please unmute yourself.

JE Hi. Thank you so much for continuing to do these briefings and taking the time to answer my question. I'm just curious. Alpha, beta and gamma have been accounting for less than 1% of sequenced cases for a while now and so I'm curious. If omicron is as transmissible as early data suggests could it hinder those variants' ability to spread so much that they're no longer variants of concern?

And if omicron's overtaking the other variants of concern but largely causes mild cases could this be an example of what an endemic COVID would be like?

CL Thank you very much, Jenny. I'll go to Maria Van Kerkhove.

00:27:22

MK Thanks for the question. Indeed you're correct. Since October 20th less than 0.1% each of the sequences uploaded to platforms like GISAID have been alpha, beta and gamma. 96% of the sequences available are still delta and about 1.6% of sequences that have been shared in recent weeks are omicron.

We definitely see increasing growth rates of omicron where it's being detected and it's now been reported in more than 106 countries to date. There's a combination of factors that we think are leading to this increasing transmission.

First are the mutations that are identified in the omicron variant and we know something about these mutations because some of

these are present in other variants of concern. So for example in omicron there are mutations that allow the virus to adhere to the cell more easily and infect the cell more easily.

We also see immune escape where we see increasing rates of reinfection in several countries and then there's some preliminary data that's looking at the efficiency in replication of the omicron variant in the upper respiratory tract as opposed to the lower respiratory tract, in the lungs.

So this combination of factors is likely leading to why we're seeing increased growth rates in a number of countries.

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In terms of how we classify variants of concern and whether we change them, we have actually been having some discussions about whether we need to reclassify alpha, beta and gamma to change them from being called a variant of concern to maybe a variant of interest or they become variants of monitoring strictly because they're not circulating any more and because delta has outcompeted those variants.

The discussion that we've been having is how we reclassify them and once you have a variant of concern how do you reclassify it as something else when in fact the properties of that variant are really what allowed us to classify it as a variant of concern.

What we've done in our weekly epi reports is we've shifted the way that we present this information so that you look at maps around where's the recent detection of these variants because we want to be able to put a timestamp in terms of what is circulating where.

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But I think the virus is changing. You've been hearing us say that delta would not be the last variant of concern that we would speak about. Omicron is likely not going to be the last variant of concern that you hear us speak about as well because the virus continues to circulate.

I don't think there's any question of whether or not this virus will become endemic. It's certainly on its way to being so but endemic doesn't mean that it's not dangerous. Endemic typically means that it has a lower level of circulation and it's really geographically bound to certain areas and you'll see flare-ups where you see unprotected populations and I think we're on our way to that, I don't think anyone questions that.

But we're very much still in the middle of a pandemic and we can't go into an endemic situation in part of the world where the rest of the world is in a pandemic-type situation. So I think there will be a long transition into how this pandemic ends and to how we get into what SARS-CoV-2 will look like going forward.

It is a respiratory pathogen, as you know, so we expect to see some kind of seasonal variation just due to behavioural factors but we haven't seen that yet. This virus thrives wherever we allow it and we don't get that reprieve in those summer months or certain times of the year.

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So there's still a lot of uncertainty over how this virus will behave. We expect the virus to continue to evolve. We expect the virus to continue to evolve, we expect the virus to become potentially more fit. Whether it becomes more or less severe remains to be seen.

We expect to see populations that are vaccinated have significantly reduced morbidity and mortality, reduced amounts of hospitalisation, reduced amounts of death and we expect to see flare-ups. It will depend on how big those flare-ups and those outbreaks are as we go forward but they will occur in underprotected populations, people who don't have vaccine and people who don't yet have their full doses of vaccines.

So I think there is some understanding of where this virus is going but we remain humble to it because I think it still has quite a few tricks up its sleeve.

CL Thank you, Dr Van Kerkhove and Dr Gaspar, Director Regulation and Prequalification, to add on.

RG Just a small add to what Maria has said. WHO is monitoring through two technical advisory groups, TAG VE for virus evolution and TAG COVAC for vaccine composition and at the same time WHO is monitoring and preparing for any public health responses that are needed.

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Also behind the scenes the regulators and the manufacturers are discussing the scenarios that if one day needed to be upheld [?] will be then deployed. So just to say that most of the time the general public doesn't know about the work that is done behind the scenes because it's preparedness work looking at scenarios extensively.

But just for everybody to be aware of that, regulators worldwide through ICMRA, the International Coalition of Medicines Regulatory Authorities, together with WHO and specifically the regulator advisory group inside COVAX, which is co-led by CEPI and WHO, that meets regularly with a cohort of those regulators through ICMRA, we have been since the first day discussing a number of scenarios if needed to be implemented.

So the preparedness is there but we need to go through the data, as Maria referred, in a systematic manner, not taking decisions too soon and certainly not taking decisions too late and this is our concern as the data is coming every day. Thank you.

CL Thank you very much, Dr Gaspar. Next question goes to Donato Mancini from the FT. Donato, please unmute yourself.

00:33:41

DO Hi, everyone. Thank you so much for taking my question. Does omicron lend fresh support for the pooling of intellectual property and to the TRIPS waiver negotiations, which have been described as - quote, unquote - stuck?

Have you spoken to vaccine makers recently after the emergence of omicron about this and what have the conversations been like? Obviously we know that supply is easing and will continue to ease unless there are catastrophic scenarios in 2022 but are you concerned about omicron-targeted vaccines if it turns out that we need them? Thank you so much.

CL Donato, thank you very much. I'll hand over to our Chief Scientist, Dr Soumya Swaminathan.

SS Thank you for that question, Donato. I think the answer is yes, it's obvious. This is something that WHO, the Director-General has been calling for now for a year and if we had seen that sharing of technology, that sharing of know-how, let's say, through the CTAP, through the WHO's technology transfer programme then maybe we would have had enough vaccines today, even MRNA vaccines, to have at least vaccinated all of the healthcare workers in Africa.

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We know that three-fourths of them are still waiting for vaccines so clearly this should have happened a long time ago. We've said it in as many ways as possible. The DG has spoken with the CEOs, we have spoken with heads of state.

There's of course a parallel process going on at the WTO where I understand that there are still negotiations that are going on. Of course their in-person meeting was rescheduled.

But at this point in time we have a number of second-generation MRNA vaccines so that's the encouraging part, that there are a number of biotech companies around the world who have MRNA vaccine technology that they've developed which may even be advantageous to the ones we have currently being used today, that are willing to share the technology with us.

But they're all at an earlier stage of development, just completing phase one, some of them completing phase two and still need to go through a clinical development pathway before they're approved.

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So we're looking at several months down the line and then to do the technology transfer and to scale up manufacturing so of course what we need right now is technology transfer and we hope that we can still see that happen with existing platforms.

Certainly MRNA has the advantage of first of all of course generating a very strong immune response but also of being able to pivot and to be able to tweak the vaccine composition relatively more easily than some of the other platforms can do.

They are more expensive and they can be made more user-friendly in terms of the temperature storage and so on, which is what's happening with second-generation vaccines. But I think it's still not too late and we would be very happy to work with any company that wants to come in and share the technology through the mechanisms that WHO has set up.

Thank you and I wonder if the DG or anyone else would like to add to that.

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CL I think we're very good. Thank you very much, Dr Swaminathan. Next question goes to again somebody we haven't had before, I think, and that's Alli Florescu from Sky News. Ali, please unmute yourself.

AL Hello, thanks for taking this question. You've called omicron an unprecedented challenge and we've seen further restrictions in many European countries - Netherlands, Denmark, Ireland. Do you think that the British Government are unwise to

wait to see more data before going further with restrictions in England?

CL We'll go to Maria Van Kerkhove first and then see whether [?] Dr Ryan wants to add.

MK Thanks for the question. I think Omicron is definitely a variant that is anticipated, as were the other variants of concern that are emerging. I think our recommendation has been not to wait to act.

The information that we are receiving from South Africa - and again we thank our colleagues there who have been really tremendous in providing information almost in real time as data are generated - are giving us some clues into how omicron is behaving.

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It is a certain population, it's a different population. Delta was in low-level circulation. It is important to see how omicron unfolds in other countries and we're seeing it across the world right now. The big question is whether or not omicron will outcompete delta, whether or not omicron and delta will co-circulate.

But you have to remember that in Europe, Europe was seeing a huge wave of infections that began in June and had been increasing steadily since June and we have repeatedly said to countries, not just across Europe, to put in targeted, layered approach measures so that transmission can be reduced, particularly as we lead up to the holiday seasons where we see people spending a lot of time with each other, as we enter the winter months in the northern hemisphere when people spend more time indoors than outdoors.

I think we've been very clear on asking everyone really to not wit to act. We also appreciate that decisions that are made are not just based on health, they're based on other reasons as well so we issue the guidance, we issue the considerations that need to be taken but countries need to take the decisions that they feel are correct.

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What we are learning about omicron is certainly we have this increased transmission but the information on severity is still uncertain. We don't have that complete picture yet and it is too early to conclude whether or not omicron is less severe than delta or is as severe as delta.

We do have some data suggesting that rates of hospitalisation are lower, some information that people who are hospitalised don't need as much oxygen or invasive ventilation but again we have not seen this variant circulate for long enough in populations around the world, certainly in vulnerable populations.

We did learn some information this week that omicron as it enters older age groups, older people with omicron tend to have more severe disease. That's unsurprising. We know people have died from omicron. It's too early to conclude and I think that's really critical right now because the data is a little bit messy.

It's not messy because there aren't amazing scientists around the world working on this. It's just because it's being generated right now and so we have been asking people to be cautious, we've been asking governments to be cautious and to really think, especially as these holidays are coming up and there are very difficult decisions.

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As the DG said on Monday, there are very difficult decisions that need to be taken in terms of making sure that we keep ourselves safe. There're plenty of ways that we can celebrate holidays and I know that none of this is ideal.

I speak personally for myself. We've made changes to our own holiday plans but these are difficult decisions that we have to make, each of us and I hope more people are seriously considering what they should do in their own context and make the right decisions for them.

But for us, our statements are around, don't wait to act, use a comprehensive approach, put in the measures that are targeted, that are layered, that are time-bound, that are not lock-down, it doesn't necessarily mean lock-down and then adjust them as necessary, as you learn more, as the situation unfolds.

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We won't be in this situation forever. That we can certainly say but it will be difficult for the time being.

CL Thank you very much, Dr Van Kerkhove. Dr Mike Ryan, please.

MR I think Maria has answered that question extremely well. Governments are accountable to their own population to provide what they believe, based on scientific advice, is the best form of care and the best strategy to protect those individuals.

I just hope in this case that we're not... Again as I said in my previous answer, we need comprehensive, layered responses that we can turn up and turn down as we need and not necessarily panacaeas.

Hope in this case is not a strategy. We need to be putting in place the necessary measures to be able to reduce transmission to the minimum while recognising - and we need to recognise this - the inherent social and economic costs of such measures and governments have to balance both.

There is a difference between science, evidence and policy. Policy comes when governments are able to look at the health, economic and social consequences of any particular decision but certainly from the perspective - we saw this last winter in many, many countries.

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The idea of saying, well, we'll do nothing now and then we'll see what we do in the new year. That certainly, to me, does not ring of an approach that's science or evidence-based so I would much rather if governments were to take the decisions they have to take based on the evidence they see before them, taking into account the social and economic consequences of those decisions.

CL Thank you very much, Dr Ryan. We'll move to Simon Ateba from Today News Africa. Simon, please unmute yourself.

SI Thank you for taking my question. This is Simon Ateba with Today News Africa in Washington DC. It's been six weeks since the omicron variant was first detected in Botswana on November 11th. I was wondering if you can tell us, how many confirmed cases of the omicron variant do we have now globally and especially in Africa and how many deaths have been directly linked to the omicron variant globally?

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And if I may quickly add, here in the US despite President Biden's ban on only African nations the omicron variant has become the dominant version of COVID-19 here. As you look back, is this further proof that outright bans are indeed not effective, not based on any science and only give us a false sense of security? Thank you.

CL Thank you very much, Simon. Dr Van Kerkhove, please.

MK Hi, Simon. Nice to hear your voice. I actually cannot answer your question with as much specificity as I would like in terms of how many case of omicron have there been, how many deaths have there been due to omicron.

The reason for that is because to be able to detect omicron we need sequencing or we have a proxy with one of the tests, with this S gene drop-out. So I don't have a number for you. What I can say is where it's circulating.

It's been detected in 106 countries. Many of those have been travel-related but we do know that there's a bias right now because of the announcement of omicron as a variant of concern. The amount of testing or sequencing that's happening among travellers also changes so the picture is a bit mixed.

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We do know that there is some community transmission of omicron in a number of countries and we're tracking those and getting information from a number of those countries and we do know that people with omicron have died.

So it is difficult to give an answer to that because we don't have the complete systems in place globally in terms of linking surveillance for the PCR and the antigen-based testing, the links with the sequencing of those people who have tested positive for PCR tests or antigen-based tests and having that information reported to us so there's also a time lag with that.

But it is circulating and we do see the full spectrum of disease with omicron, everything from asymptomatic presentation, asymptomatic infection all the way through hospitalisation, severe disease and death.

The big question is what is the proportion of those individuals who are infected with this variant that are mild, that are asymptomatic or that go on to severe disease and die. We do know that people who are vaccinated have a much lower risk of developed severe disease and death to both delta and omicron so we stress the importance of vaccination when it is your turn.

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Regardless of what information we do find out about omicron and the different vaccines that are in use it is better to be vaccinated than not so if you hear anything from us today please hear that and get vaccinated when it's your turn and fight like hell for vaccine equity for everybody else around the world.

I don't know if the second part of your question was on travel. Was it on restrictions, is that right, Christian? Certainly we have seen the use of travel restrictions. I think we've answered this question many times now in terms of the use of travel restrictions and how they have been applied, particularly to this variant.

We do know that restricting movement can delay but cannot stop the spread of these types of variants and certainly as more omicron is detected, as sequencing is done it's likely that this variant had been circulating for a little bit of time at least, we don't know for how long.

But what has been quite striking with this is the inconsistent or strange use of travel restrictions in this particular situation in targeting only some countries that had detected omicron versus not.

00:48:27

What is really critical for WHO is that we have surveillance systems and reporting systems based on trust, that people know that they can report this information without being penalised. I think the Director-General has been very, very clear in his messaging around this and from the organisation around not penalising countries for reporting this type of information.

CL Thank you very much, Dr Van Kerkhove. Next question, which might be the last for the day, is from Helen Branswell from Stat News. Helen, please unmute yourself.

HE Thank you very much, Christian, and thank you for taking my question. Happy Holidays to you all. I wanted to circle back, if I could, to Dr Swaminathan's answer a few minute ago about the fact that the TAG COVAC is working to develop criteria that could be used to determine when the strain in the vaccine should be updated and what that strain ought to be when that decision is made.

00:49:36

I'm wondering if you could tell me, Dr Swaminathan, do you have buy-in from the manufacturers that they will take part in or follow the guidance of the WHO on this or do you think at this point that they may make their own decisions based on what they see as an economic advantage?

CL Thank you very much, Helen. Of course Dr Swaminathan.

SS Thank you, Helen. That's a very important question and I think Dr Ryan may want to come in as well because of the experience that WHO has had with the influenza programme where, as you know, it's the WHO that provides the strains for influenza vaccines for the northern and southern hemispheres every year.

Certainly the manufacturers work with the WHO and wait for the WHO to pronounce that before they actually go ahead and make their vaccines so I think that's really worked very well.

Here we're talking about of course a new virus, lots of unknowns. We have new platforms now, the MRNA platforms which, clearly the manufacturers are able to make these variant-specific vaccines.

We know for example that many of the manufacturers had started making vaccines for beta for example, for the beta variant of concern and even for the delta and so it's a question of making a prototype vaccine. I think they've started.

00:51:18

I do think that many manufacturers want guidance from WHO because of the fact that WHO has access to a lot of information, a lot of expert groups and expert advice on what sequence or sequences would be best-positioned to be in such a vaccine.

But this is still an evolving area just because of the fact that, as Maria was saying earlier, we know this won't be the last variant of concern and if you have to make a decision between going with an omicron consensus sequence, which is very far away from the original Wuhan strain, are you still going to get that cross-protection?

Because tomorrow we may have another strain that's closer to the original Wuhan strain, and so on. So there are lots of questions and I think what the committee's now going to dig deep into is really looking into the co-relations between the genotypic changes, the mutations and the phenotypic changes and trying to come to an agreement on which are the most critical changes in the virus that end up changing its phenotypic properties, whether it's transmissibility or immune evasion.

00:52:40

Perhaps it's those sequences that would need to be included so that a future vaccine could provide protection but again it's complex. There's only so much you can do in a vaccine, as you know, there are limitations to what can be done and so I think

what the committee is also doing is actually inviting manufacturers to their meetings.

I know that last time for example there were at least six manufacturers who participated in their meeting and they're meeting every week. So through this dialogue I think there'll be a much better understanding and I think it's important that the WHO committee, which has been tasked with this, should really be the one that tells the world what sequences should be used for the target.

Then of course you also have new-generation vaccines coming along and other types of vaccines like the nasal vaccines and so on so at the same time - and the DG mentioned the Solidarity vaccines trial that has basically been set up in order to test the vaccines that have still not gone through phase three and generate enough data, including on the nasal vaccines and so on, so that we can generate more data on whether those are being more effective.

00:54:04

So I don't know if I've answered your question entirely but I'm sure that at the committee continues to meet and deliberate we'll put out the minute from their meetings as well as their guidance from time to time. Thank you, Tarik.

CL Thank you, Dr Swaminathan. Dr Ryan, please.

MR Seasons greetings to you as well, Helen. I think we have been... Rogerio was on earlier. There's a huge collaboration going on between regulators. The research and development blueprint for epidemics continues to engage thousands of scientists from around the world on the upstream research regarding what we understand about this new variant, what we understand in terms of vaccine escape and what may be needed in terms of new target product profiles for any evolution of vaccine.

00:55:02

We have the TAG for virus evolution which is really working with us to track the evolution of the virus and then obviously the TAG COVAC, which is really looking at COVID vaccination and composition of vaccines and that's very much aligned and in parallel to the work we do on influenza which, I know, Helen, you're very well aware of.

The TAG COVAC, I think, has over 30 experts on it. These people are vastly experienced both in terms of what we do in flu but also what we do in coronaviruses and, as Soumya said correctly,

they're really looking now at what is the phenotypic behaviour of this virus, how it behaves in the real world antigenically to see whether or not the current vaccines are providing the levels of protection that they need to.

Again a lot of the data up to now has been protection against infection, not protection against severe disease, hospitalisation and death that vaccines were really set up to prevent so we still have to see what that is but that doesn't mean we shouldn't be doing work in the meantime.

The TAG COVAC, I think, will meet again tomorrow and will also meet again tomorrow with the manufacturers to have that continued discussion.

00:56:17

Again if we cast our minds to the 70-year history of influenza surveillance around the world, this is truly, truly, truly a partnership between science, member states and the private sector and the manufacturing pharmaceutical companies and everyone plays their part.

Twice a year we get together with all of that data, all of those scientists and then create a selection of vaccine composition which is then passed on to the manufacturers and the manufactures are absolutely outstanding in the way that they engage with WHO, with our advisory groups on that work.

We believe that we help people through getting the right composition of vaccine. We also help manufacturers by creating a very transparent process of selecting the strains for each year's vaccine for north and south, allowing all manufacturers to participate on an equal footing.

We believe now there are many, many potential manufacturers out there for COVID vaccines as well and also Soumya referred to some of the new vaccines that are in trial, nasal vaccines and non-injectable vaccines and other things.

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The manufacturers' world, the pharmaceutical world now is much broader than it was for these vaccines for now and for going forward and it's really important that we engage with the broadest range of manufacturers and create that level playing field, that transparency around what WHO and its experts believe are the most effective designs for vaccines.

And in the short term looking at variant-specific vaccines or combinations of those and again, as Soumya said, looking in the longer term at new vaccine platforms and new types of vaccines that give more conserved [?] protection against a broader range of epitopes in terms of the virus itself.

So there's both work to do in the short term and in the long term but again right now... If we lurched into producing omicron-specific vaccines we could lose effectiveness against currently circulating strains as well.

So I think Rogerio put it really well. We have to be fast enough to make a good decision but at the same time we have to be able to consider all of the relevant data. So it's finding that combination of careful consideration of the data and making that decision in time to be able to give the right information to industry to be able to produce the appropriate vaccines.

00:58:50

This needs to be a strong and depending partnership between the public, the private, the academic sector in order to get these decisions made in the most timely way.

CL Thank you so much, Dr Ryan. Now we come to the end of this briefing. I thank you all for your participation. A quick note. We're trying to give you all a break for next week and did not schedule a regular press briefing yet but, as you know, things are constantly developing so if there's a need we will call upon you but for now the plan is to give you a week off next week.

That means this was the last briefing of this year and I thank you all very much for being with us for this whole year and thanks to the translators here who've been with us too. We'll be sending the audio files and Dr Tedros' remarks right after the press conference as usual. The full transcript will be posted on the WHO website tomorrow morning and with this, thank you and over to Dr Tedros.

00:59:56

TAG Thank you. Thank you, Christian. I just have one correction from the statement I read earlier where I said the global priority must be to support all countries to reach the 40% target as quickly as possible and the 70% target by the middle of next year, not this year. I said this year, I'm sorry for that. The 70% target is for next year.

Then maybe just one issue. We had the first question about the virus and what we know and what the challenges are. I think

after two years we know the virus better now and based on that we have very effective tools and going forward there is hope and that's why my statement said we should end this pandemic by 2022.

The reason for that is because I have and we have as WHO confidence that we know the virus now very well and we have all the tools. The issue is implement all the tools we have as comprehensively - vaccines plus the other public health measures.

When we do that we should also take care of equity because unless we vaccinate the whole world, unless we apply the comprehensive approach all over the world I don't think we can end this pandemic.

01:01:38

But I think - I will repeat again - we know the virus better, we have effective tools and we need to add to that comprehensive implementation and equity and hope 2022 will end this pandemic.

Thank you again and I would like to wish all who celebrate it a very merry Christmas. Merry Christmas and see you in our upcoming presser. Thank you.

01:02:11