Hello, to everyone and welcome to WHO COVID-19 press briefing. My name is Tarik Jasarevic, welcoming you from WHO Headquarters here, in Geneva. We have a number of speakers today, as well as a special guest that Dr Tedros will introduce in his opening remarks.

We, as always, remind you that we have a simultaneous interpretation into six languages, plus Portuguese and Hindi, and I would like to thank the interpreters who are here with us. Journalists who are watching us on Zoom can press the button Raise Hand to get in the queue for asking a question, and only one question. We already have a list of journalists who are ready to ask something for our experts.
Let just me remind you who is with us today from WHO. We have Dr Tedros, WHO Director-General. Dr Mike Ryan is also with us, Executive Director of Health Emergencies Programme. Dr Maria Van Kerkhove, Technical Lead on COVID-19. We have Dr Mariângela Simão, Assistant Director-General, Access to Medicines and Health Products. With us is also Dr Bruce Aylward, Senior Advisor to the Director-General and the lead of ACT Accelerator.

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We also have with us Dr Nedret Emiroglu. She is the Director of Country Readiness Strengthening. Also, we have Network Leader, Flavio Salio, on Emergency Medical Teams, something that we will be discussing more today. So, with this, I will give the floor to Dr Tedros for his opening remarks.

TAG Thank you, Tarik. Hvala. Good morning, good afternoon and good evening. I know that globally there is currently a lot of concern about the Delta variant and WHO is concerned about it too. Delta is the most transmissible of the variants identified so far. It has been identified in at least 85 countries and is spreading rapidly among unvaccinated populations.

As some countries ease public health and social measures, we’re starting to see increases in transmission around the world. More cases means more hospitalisations, further stretching health workers and health systems, which increases the risk of death.

As we have said, new variants are expected and will continue to be reported. That’s what viruses do, they evolve, but we can prevent the emergence of variants by preventing transmission. It’s quite simple. More transmission, more variants. Less transmission, less variants.

That makes it even more urgent that we use all the tools at our disposal to prevent transmission. The tailored and consistent use of public health and social measures in combination with equitable vaccination. This is why WHO has been saying for at least a year that vaccines must be distributed equitably to protect health workers and the most vulnerable.

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Over the past 18 months, WHO staff all over the world have done an amazing job supporting countries to respond to COVID-19 but WHO cannot be everywhere and we can’t do everything. One of the most important ways WHO coordinates the response to COVID-19 and other emergencies is through our global network of Emergency Medical Teams.

Emergency Medical Teams, or EMTs, are groups of health professionals including doctors, nurses, paramedics, support workers and logisticians who provide care for patients affected by an emergency. EMTs are made up of dedicated professionals who have permission to take time away from their regular jobs to respond to emergencies, either nationally or internationally.

When emergencies strike, EMTs are mobilised to support the national response, treat patients, provide training and supervision, strengthen coordination and ensure standards are met for quality of care.

Globally, WHO has certified teams from 20 countries who have gone through a rigorous process of quality assurance to ensure they meet internationally
agreed standards. A further 87 countries either have teams that are in the process of being certified by WHO or are developing systems to quality assure their own national teams.

Since the beginning of this pandemic, WHO has facilitated the deployment of over 180 international EMTs and experts worldwide. These teams have provided specialised care to patients, additional bed capacity, and advised local health providers in case management.

Some of the most recent deployments of emergency medical teams were in Djibouti, Papua New Guinea, Fiji and Costa Rica. In Lebanon, nine Emergency Medical Teams were deployed following the blasts in Beirut last year to treat patients, re-establish maternal and child care and to support COVID-19 care at public hospitals. In Greece, teams from Norway and Germany were deployed following a fire at a refugee camp on the island of Lesbos, to support the COVID-19 response, together with other essential health services.

Last week, WHO and partners published new standards for the deployment of Emergency Medical Teams in a range of situations, from natural disasters to epidemics and conflict situations. This represents a major step forward in ensuring Emergency Medical Teams meet shared standards for quality of care, whether they are deployed nationally or internationally.

To say more about WHO’s Emergency Medical Teams initiative I’m delighted to welcome Amb Toni Frisch, the Chair of Emergency Medical Teams Strategic Advisory Group. Toni has played a critical role in guiding the EMT initiative over many years. Toni, our respect and appreciation for your leadership and welcome. You have the floor.

Thanks very much, Mr Director-General. First of all, I would like to congratulate Dr Tedros and Dr Ryan on WHO’s response to the pandemic under their leadership. I was really very much impressed. On behalf of the Emergency Medical Team network I would like to extend my sincere gratitude for their commitment to support the Emergency Medical Team initiative. As Chair, I have seen that this was a decisive moment and, really, a breakthrough.

In recent decades we have seen numerous major emergencies which have deeply impacted millions worldwide. WHO’s constant role in addressing these emergencies has been a significant achievement in itself, in the interests and for the good of all persons in need.

WHO’s Emergency Medical Team mechanism has brought in greater quality assurance and a level of standardisation. We all have always sought to establish predictability and reliability but it is now also increasingly and better able to demonstrate flexibility.

The newly published EMT classification and minimum standards, the so-called Blue Book and Red Book, can be adapted and adjusted based on the local context, can contribute to build and strengthen the local health emergency workforce that can then be offered to other countries when needed.
Over the next years, I look forward to continue to see an increase in national and international Emergency Medical Teams that meet these standards and continue to serve as essential components of a country’s emergency preparedness and response.

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I would like to underline that these Emergency Medical Teams are not just responders, more of all they are contributing in an important way to build up local structures and capacity and, of course, this is, for me, a satisfaction. We see that, in a very close partnership, all are making and trying to make best use of local experience and of local knowledge.

I would, therefore, thank all who have contributed and supported me and, of course, the Director-General, Dr Ryan and the colleagues and, of course, also the colleagues in the Emergency Medical Team Secretariat. Thank you very much and I have done this function with satisfaction. It was an honour and a privilege for me, challenging going through this crisis. I thank you very much that I have this chance. It was a real honour. Thanks very much.

TAG Thank you. Thank you so much, Toni. Thank you, Ambassador. Thank you so much for your leadership for this vital initiative. Vielen dank.

On Wednesday, a market outside the city of Mekelle in the Tigray region of Ethiopia was bombed, killing and wounding civilians. Ambulances were blocked for more than a day from attending the scene and evacuating the wounded for medical care. WHO is currently providing lifesaving trauma and surgical supplies to a hospital that is treating survivors who are able to reach care. Attacks on civilians anywhere are completely unacceptable and so is denying them access to immediate care because we lose lives. Tarik, back to you.

00:13:21
TJ Many thanks, Dr Tedros, and also thanks to Amb Frisch for his remarks. We also have Dr Emiroglu and Mr Salio to speak more about Emergency Medical Teams. We will now open the floor to questions and I will remind journalists that you can ask questions any of the six UN languages and Portuguese, as well, but please try to have only one question, so we can take as many as possible. We will start with Priti Patnaik, from Geneva Health Files.
Priti, please unmute yourself and ask your question.

PP Good evening. Can you hear me?

TJ We can hear you.

PP Thank you so much for taking my question. My question was actually related to the event earlier in the week. I was unable to ask the question then. I was wondering if it is possible to shed some light on the kind of licensing deals that will happen under the mRNA tech transfer hub, whether it is strictly going to be bilateral or whether, technically, the hub can work with the COVID-19 Technology Access Pool. Thanks a lot.

MS Let me start. Thank you, Priti and maybe Dr Soumya is online. She can complement and give more detailed more information. Of course, we are working with the mRNA hub and also C-TAP inside the current system and
that includes the payment of royalties to any technology-holder that puts the technology to the manufacturing hubs but also into C-TAP.

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As to the question on how they relate. You know that the COVID Technology Access Pool is not only focusing on vaccines, it is focusing also on therapeutics and diagnostics, and we have currently negotiations with five diagnostic companies and two of the vaccine producers.

But, it is very important to highlight that there are convergences between the two activities. The Vaccine Manufacturing Task Force has three workstreams and the C-TAP partners are a part of Workstream 2 and Workstream 3 and are part of most of the working groups, the mRNA and others, long-term manufacturing capacity including the tech hub because it has worked like technology innovation and IP. It has regulatory and clinical practice, it has governance issues, and these are related to the voluntary nature of the platform that C-TAP has that includes the sharing of knowledge but also the licensing of IP through the Medicines Patent Pool. I don’t know if Dr Soumya is online.

TJ My thanks, Dr Simão. Dr Swaminathan, in case you would like to add something.

SS Do you hear me?

TJ We can hear you, Dr Swaminathan. Please, go ahead.

SS Just to add to what Mariângela said, that we are at the beginning of the process and so we haven’t yet finalised what kind of deals and how many deals. Our hope is that it will be a multilateral hub, a technology transfer hub, which means that the donor of the technology would agree to have a non-exclusive licence that would go to multiple recipients, but these details still need to be worked out and we should know more in the coming weeks. Thank you.

00:17:23
TJ Thank you very much, Dr Swaminathan. Unfortunately, we don’t have a video of you but we heard, very well, your remarks. We will now go to the next question. We have with us Belisa Godinho, from W Magazine of Portugal. Belisa, please unmute yourself.

EG Thank you for taking my question. Europe is preparing to put into force the COVID digital passport with a view to reducing bureaucracy in the travel processes and the movement of people safely between countries, complying with the pandemic prevention protocols. Portugal will start internally with COVID-19 certification in the next few days in the situation of government in the capital. Could you inform me if the COVID digital passport will be extended to the rest of the world? Thank you.

TJ Belisa, we didn’t completely hear your question. We understand it is about COVID passports. Dr Ryan may take this.

MR Thank you for the question. First and foremost, the Emergency Committee of WHO, under the International Health Regulations, has been clear that WHO should not be recommending a requirement for vaccination as
a condition of travel. This is particularly related to the scarcity of the vaccines and the fact that there is such an inequity in distribution of those vaccines, plus uncertainties regarding the extent to which vaccination prevents infection or transmission of the disease. The committee will meet again in a couple of weeks and reconsider those earlier recommendations to the Director-General.

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WHO has been working closely with the European Union and others on the digital vaccination certificate. Again, Dr Soumya is online and may wish to speak to that. WHO has issued standards to developers of similar systems in other countries around how such data could be collected with the view to being able to digitally register vaccination for the purposes, within country, of understanding vaccination rates and coverage and the metadata that goes with that.

The issue of international travel is both a certification and policy issue. WHO is working with countries who have requested that the international Yellow Card be potentially used as a way of registering vaccinating and we are supporting countries in that. We’re also looking at developing an electronic version of that yellow vaccination card.

However, the trust frameworks that are required to create a global system for managing that and all of the anti-fraud elements are considerable. So, WHO is focused on issuing the data standards to countries who wish to develop similar systems and focusing on supporting countries who want to develop digital vaccination records, which are very important not just for travel but, as I said, for the whole national vaccination drive. We will continue to do that as well as developing options for a digital version of the yellow international vaccination card that so many of you know.

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But, again, let me say the difficulty in this regard is that, right now, any imposition of such a requirement for vaccination around the world does, in effect, deliver a double inequality, as individuals from countries who have no access to vaccine will then have no access to travel. Therefore, it is very important that if we’re going to impose restrictions on the travel of individuals, we must at least attempt to do that from a level playing field of having access to vaccine.

So, for example, in the case of yellow fever, WHO does recommend for yellow fever the vaccination of travellers going to endemic areas but that is on the basis of the universal access to that vaccine at a fair price. So, therefore, all of WHO’s recommendations related to vaccination requirements are always on the basis that there is fair and universal access to that product. Thank you.

TJ Thank you very much, Dr Ryan. So, if there is no access to vaccine, there wouldn’t be access to travel if this would go ahead. Let’s go to the next question. Will Stone, from NPR.

WS Hello. Thank you for taking my question. It’s expected that hundreds of millions of vaccines will be sent to countries in the coming months by COVAX or directly by other countries. Once those vaccines do arrive are you concerned that countries will have difficulty actually administering these
vaccines and what can be done to ensure that vaccines aren’t wasted or returned? Thank you.

00:22:32
BA Thank you very much, Will. I think if we look first at the situation globally as COVID-19 vaccines were rolled out, you’ll remember as they were rolled out in high income countries the newspapers were full of reports of challenges that countries were facing as they tried to implement a vaccination programme with vaccines that required ultra-cold chains, that were targeting adult populations, that required a workforce that went well beyond the regular workforce that was available for public health programmes.

So, you saw the challenges that were faced by industrialised countries, countries with strong healthcare systems, strong primary healthcare systems had a real challenge rolling these products out. Now, they had the disadvantage, that very small volumes were available for a very long time but the advantage was they learned to overcome those challenges and build up the systems to be able to deliver those.

You asked the question, Will, are we worried about something like this when hundreds of millions hit countries with weaker systems? Of course. There is going to be a concern that, just as every country that has rolled out these vaccines has had a challenge, countries with weak systems will have challenges, as well.

Now, they have some advantages. A lot of countries that are highly vulnerable, in terms of this disease because of low vaccine coverage and low income status, they have decades of experience of running mass campaigns for large parts of their populations, so they have a lot of experience with mobilising populations, mobilising folk to be able to do this, putting the cold chain pieces in place.

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They’re still going to have a challenge, though. We recognise that, of course. As a result, since last October, we’ve working with the countries to try and help develop really detailed national vaccine deployment plans that look at every single aspect of the rollout across nine or ten different dimensions and then vetting those plans, testing those plans, testing with initial doses.

So, yes, there is going to be a challenge but these challenges can be overcome, Will. The biggest problem these countries face, and I have to say I get a little bit frustrated with the big focus on the delivery challenge countries will have because we have a supply challenge.

Will, we have, through COVAX this month, zero doses of Astra Zeneca vaccine, zero doses of SII vaccine, zero doses of J&J vaccine and I’m worried about supply. There is a theory of constraints. You deal with them in the order in which you face them and countries do not have products.

Every head of state that calls the Director-General or calls us to talk about this issue, they say, look, we have our whole country we can mobilise. We can turn on the leaders, the local leaders, the religious leaders but we’ve got to have security of supply to be able to do this.
So, yes, there are real issues. We’re trying to tackle those. The first thing we need is a supply of vaccine, a predictable, sustainable supply of vaccine. The second thing that we need, then, is in-country financing. We need the multilateral development banks, the friends of these countries, the donor community to really come together and put the financing in place to help with the in-country delivery because they need a lot of money to be able to do this, just like we did in industrialised countries.

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They need that money to hire the additional workforce. We’re going to need a huge surge workforce to do this, to help deal with all the different issues. So, yes, there’s challenges but let’s deal with the right challenges in the right order and make sure that people have the vaccine so they can overcome barriers, just like every other country has. Invest in the countries with financing but first and foremost the supplies.

Will, I don’t make light of what a bit challenge it is but I want to make sure that we do not penalise countries with weak systems because I keep hearing it again and again, they’re not going to be deliver these products. Just look at how well so many countries, very low income weak system countries, have been able to pivot and use all of the products that we get them.

For every story about some country has had some product expire or some country has had to ship the vaccine somewhere else, there are dozens that are putting it to very, very good use, dose by dose. So, we have to tackle the problems in the right order.

Yes, we have to be ready for delivery and I’m sorry to go on about this but you can’t deliver what you don’t have and the situation, right now, is dire. We have got, like Mike talked about and the DG, an escalating Delta variant, right. Look at the situation in Africa, a 50% increase week on week now, five weeks in a row of cases, multiple variants of concern there.

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Less than 2% of the population vaccinated and, as I just said, every single one of our suppliers is unable to supply during this period because others are making demands on those products, others who are vaccinating very young populations that are not a risk. We’ve got to tackle the problems in the right order. Sorry, I sounded irate in that. Will, thanks for asking the question. It is so important.

MR It is hard to upstage you, Bruce. Again, I think for years and years and years, many countries in the south are much better than countries in the north at delivering mass population-based vaccination. They’ve proven it again and again with yellow fever, with meningitis, with cholera, with Ebola, with polio, with measles, again and again. Millions and millions of people have been vaccinated in single rounds of vaccinated injectables, non-injectables, orals in the most extreme circumstances.

Quite frankly, and I’m not saying to this you as journalists, I know this question is being asked so you have every right to ask it and reflect that concern but the level of paternalism, the level of colonial mindset that says we can give you something because we’re afraid you won’t use it. I mean, seriously, in the
middle of a pandemic that is the logic that may underpin the non-distribution
and non-sharing of vaccine? I’m not saying that’s your sentiment as a
journalist. Your job is to ask the questions but if that’s reflecting a mindset or
justification for not sharing, then we really are in trouble.

00:29:17
TAG Thank you. I think Mike had already said it in a very blunt way but I
would still like to add because it is very, very important. The question, as Mike
said, you’re asking a question and there is nothing wrong in asking a question
but the problem is if countries use it as a pretext not to share or not to give
doses.

The reason we’re really concerned and why Mike said and Bruce said what
they said, it happened in the past. You know about HIV treatment and what
some of the arguments were and where some were trying to justify that,
especially in low income countries, people cannot use HIV treatment which is
very complicated, so we cannot share it with them.

That attitude has to be a thing of the past. What I would like to assure those
who are prepared to give vaccines is we have done our homework with the
World Bank, assessing countries, identifying the gaps, helping them with filling
the gaps but, at the same time, they have experience of using or implementing
mass campaigns for several years. They have the experience but we also try to
work with them to see if there is any gap.

So, the problem now is a supply problem. Just give us the vaccines. Some
people were asking me about vaccine hesitancy in Africa and then I said that’s
not the problem. There is not vaccine, so why do we even talk about vaccine
hesitancy. The problem is vaccine supply and, even now, it is not the
absorptive or the delivery problem that is a problem. There is no vaccine. You
can’t even talk about delivery or absorption capacity when there is no vaccine.

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The problem is lack of access to vaccines and that’s causing a two-track
pandemic. Those who have vaccines are getting better significantly and they
are opening up their society. Those who don’t have vaccines are facing a
serious COVID situation with serious surges in cases and deaths due to COVID.
That’s the reality now.

So, let’s be real. What we need is vaccines. The problem is lack of vaccines.
It’s not delivery. It’s not a problem in absorption, by and large. We can have
that, maybe, when we have more vaccines. It’s lack of vaccines. It’s not
hesitancy. It’s lack of vaccines. And, the situation in many countries, in low
income countries, especially in Africa, it’s very worrisome.

I said it many times and I sent a tweet, actually. I posted a tweet yesterday
about the worrying trend in Africa. It’s becoming so dangerous and the
difference, now, is between having a vaccine and not having a vaccine, the
differences between the have and have-nots, which is now completely
exposing the unfairness of our world, the injustice, the inequality. That’s it.

Let’s face it. That’s the problem. We need vaccines now. That’s the issue.
Then, let’s try, if absorption or delivery is a problem. Let’s see it, if hesitancy is
a problem. It’s not. Of course, there could be a problem but that’s marginal,
that is a secondary issue. We need vaccines now to save lives and let’s not go around the bush now. We need vaccines. That’s the problem.

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I want to tell you another story. I had a meeting with Allocation team. There is an advisory group we established that can help us to allocate vaccines that are coming through the COVAX. They’re frustrated, they’re disappointed because there is no vaccine to allocate. No vaccine. So, there is no allocation if there is no vaccine. What do you share if there is nothing to share? That’s the reality.

So, let’s focus and, as media people, please, you know the truth. Just focus on what is failing. As an internationally community our world is failing. As a global community, we are failing. We are repeating the same mistake as HIV/AIDS, which took ten years to reach the low income countries after it was already rampant in high income countries and the H1N1 vaccines that were delivered to low income countries after the epidemic was over.

Do we want to repeat the same thing. Can’t we learn from what happened in the past? I think you know the answer. Please, help us mobilise so the world comes back to its senses and help us open the world. The whole world is sick and tired of lockdowns. You can see it from how the citizens of the high income countries are behaving now. They are so happy. It is opened up. Restaurants are full. The streets are full.

Everywhere you go you see crowds, as if there is no pandemic. Then, you go to countries where there is no vaccine access, still lockdowns. And, the whole world is sick and tired and whole world wants to be opened up and the tools are in our hands to open it up. So, we need vaccines. Thank you.

TJ Thank you very much, Dr Tedros, Dr Ryan and Dr Aylward on this very important message to put things into perspective. Let’s go to the next question, Imogen Foulkes, from BBC. Imogen.

00:36:27
IF Hi. Can you hear me okay?

TJ If you can speak a little bit louder, please.

IF Okay, I will. I will make it as brief, as possible. I’m afraid it is related to Europe but you said, right at the start, you’re worried about the Delta variant. Do you think the plans for big events and the plans for travel around Europe that many countries are going into now, is this premature? Would you urge any form of caution here? Some countries, Switzerland, for example, also seems to be abandoning some of the mass testing it was doing.

MK Thanks very much for this question. Of course, we urge caution. We have been urging caution every single day up here, talking about a risk-based approach to what we are seeing. The global situation is incredibly fragile. You just heard three extremely passionate responses to part of the problem of what we are seeing here with regards to vaccination and the inequities that we are seeing around the world.

The other is in the inappropriate, ineffective use of public health and social measures. When I say that, that does not mean lockdown. It means targeted,
tailored, timebound use of proven tools that actually prevent infections, that prevent those who are infected from transmitting to others, that save lives right now as vaccines are rolling out.

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What we need to look at is our actions have consequences. This is true everywhere in the world and it depends on the circulation of the virus around you. The Delta variant is a dangerous virus. It is more transmissible than the Alpha variant, which was extremely transmissible across Europe, across any country that it entered. The Delta variant is even more transmissible.

We are seeing trajectories of incidents that are almost vertical in a number of countries around the world. Europe and many countries are seeing a decline in cases but there are a lot of events that are occurring across the region, a lot of events, whether these are large events related to sporting events or religious events or even backyard barbeques. All of these actions have consequences and the Delta variant is spreading readily among people who are unvaccinated.

So, even countries that have high percentages, remember the entire population is not yet vaccinated. The entire population has not yet reached their second dose or the full course of dose, and the vaccines are aimed at preventing severe disease and death. They’re incredibly effective at preventing severe disease and death, including against the Delta variant and the sub-lineages of the Delta variant that we are seeing.

Remember, we have four variants of concern that are circulating. We have seven variants of interest that we are tracking and a number of other alerts that are on our radar in terms of understanding what constellation of mutations are out there.

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The virus will continue to evolve and, right now, our public health and social measures work, our vaccines work, our diagnostics work, our therapeutics work, but there may be a time where this virus evolves and these countermeasures don’t. So, we need some kind of movement to pull ourselves together to drive transmission down and keep it down.

The events that are happening will have consequences. We are already starting to see some consequences of these events with increasing transmission again. The Delta variant will make that epidemic curve exponential. So, please, do what you can to keep yourself safe and take decisions individually about what I need to do every day.

I know there is a lot, I said this a year ago, there is a lot that all of us want to be doing but there is not a lot that we need to be doing right now. Let’s keep those travel corridors open for essential medical professionals that need to get supplies our and to help people around the world who are in need and just think about what we can do to lower our risk. Know what the risk is. Lower your risk. And, we need that at the policy level.

So, there’s a lot that we need to be doing right now and I think every single day. It’s not for the next couple of months. It’s not for the fall that we need to be thinking about this. We need to thinking about it right now because every
single decision that we make, leaders make has consequences, good and bad.

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TJ Thank you very much, Dr Van Kerkhove. Let’s got to the next question. We have, from NBC, Dawn Kopecki. Dawn, please unmute yourself.

DK Hi. Thank you for, taking my question. I would like to ask about reports in Australia that it takes anywhere between five to ten seconds of exposure to the Delta variant to transmit it versus ten to 15 minutes of exposure to transmit other types of variants. If those reports are true, what about the Delta variant makes it that much more transmissible? For example, is it more airborne or does it transmit more easily through fomites? Thank you.

MK Thanks for the question. You ask, actually, quite an interesting one that could take me a long time to answer but I won’t do that. In terms of how this virus transmits between people, we know that it is mainly between close contact and there are infectious particles that travel from an infected person to another. These can be larger droplets or smaller aerosols.

Mainly, that is happening in close contact, typically within a conversational distance but you could also have transmission at a longer distance through these aerosols and particularly in settings that are indoor where you have poor ventilation. In terms of the timing of transmission, we know what is riskier rather than not. Indoors is riskier than outdoors. Indoors with poor ventilation is even more riskier than even indoors with good ventilation.

What we don’t know, what we don’t have a good handle on is the infection dose. How much virus needs to be in that particle, in that droplet, in that aerosol, in that combination of droplets and aerosols to actually constitute transmission? We know that it could be a short duration and it could be longer. We know that longer exposure is riskier.

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In terms of the Delta variant, there are a lot of studies that are underway. I’ve probably had a half a dozen calls this week, just looking and working with groups around the world on specific studies to address the question around the infectious period of somebody who is infected with the Delta variant compared to the Alpha variant or the ancestral strains.

We haven’t seen any difference in the duration of infectiousness, meaning how long somebody can pass the virus to another person. We are learning a little bit more about the CT value, the amount of virus that somebody may have. There may be lower CT values, which means more virus compared to the Alpha, but that data is really preliminary and we’re just waiting for some more studies to be done to explain that.

What I can say is that when we take measures to prevent transmission, we take measures to prevent transmission against droplet and aerosol and airborne. We need to take all of those measures into account. There are some studies that also look at CCTV, that actually follow individuals and track them over time to see when infection occurred. It is incredibly difficult to track. It is incredibly difficult to study. What we know, what we have a good handle on is what is more risky rather than what is less.
This is why I say know what you can do to keep yourself safe. Take those measures. Wearing that mask. Making sure you have clean hands when you put on and you take off a mask. Make sure that if you are indoors, that you have good ventilation. In some situations it is as simple as opening up a window, if is safe to do so.

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There is a lot that can be done but we have to make sure, again, we remain vigilant about what it is that would facilitate spread and then take those measures to really reduce the opportunities for the virus to spread.

MR Just to reinforce what Maria said and maybe just summarise. Any change in the virus genetically can lead to different behaviours in the virus. It gets better or worse at certain things. It becomes, in the word that virologists use, fitter, and more adapted to infecting humans. That can be that it causes the infected person to produce more virus, therefore potentially making that person more infectious. It can cause the virus potentially to survive longer in the environment in droplets or in aerosols or on surfaces. The virus can have a longer survival.

It can shift the infectious dose. In other words, the virus may be more efficient at infecting cells and then you need less virus to cause and infection and that is really, maybe related to your question regarding the number of seconds versus minutes. How much virus do you need to be contaminated by or inhale before you reach a dose that causes you to have an infection?

That’s not even fully known for previous strains and it’s not fully understood for these newer strains, Delta strain included. All of those factors may affect the route of transmission. You may have viruses that will develop a capacity to spread using different routes of transmission and then the site of infection, itself, can affect the outcome for the patient. In other words, is the infection in the upper airway? Is the infection deeper in the lungs?

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So, there are all kinds of different ways in which a virus can gain an advantage over the other viruses in infecting humans and in doing that it tends to replace all the other viruses because it is just fitter and more adapted, from an evolutionary perspective, to the human body.

Therefore, we have to look, when we talk about stopping the transmission of variants, and Maria has said this for a year and a half, it’s the same things we need to do. We need to ensure that people who are sick and infected don’t get the opportunity to infect others. We have to ensure that the environments we work it, be it the air or the surfaces in the environments we’re in are appropriate sanitised.

We have to reduce our own exposure, so we get exposed to less virus, which is the infectious dose, and we have to ensure we’re wearing masks and doing other things to prevent us inhaling particles that will cause us to be sick.

So, it doesn’t change what we do but what it does is, it should remind us that we need to do all of those things and we need to do it much more fastidiously. We need to do it with much more care. While the virus may change in how it does its business, we need to intensify what we’re doing now because the
same things will work but we just need to be more cautious, more diligent and more dedicated to that task, and that’s really tough when all we want to do is go back to our normal lives.

00:47:08
So, I do think it’s a really important question you ask and one in which the science is progressing but it doesn’t change what we need to do to stop transmission of the virus as Maria has outlined many times, including just now.

MK Sorry, I want to add one more thing because I also want to leave you with the fact that there are several groups that are looking into this in detail. What Mike just mentioned in terms of what the virus is doing that could infect you more easily.

Through our Virus Evolution Working Group and through researchers around the world, we’re looking specifically at the mutations and some of the mutations that are identified and all of the variants of concerns in fact allow the virus to adhere to the cell more easily, for example. So, that’s one of the reasons why we’re seeing increased transmissibility.

We have others looking, through or epi groups and our lab groups and our Infection Prevention and Control and our Ventilation Working Group, of looking at the studies that are done. For example, this week we were having some discussions around transmission of the different variants in healthcare facilities, for example. Is there something different that is happening there or not?

What we can say right now is, as Mike said, as I said earlier, the measures that are in place do work and I think this an important message to reinforce. There’s a lot of questions around what needs to be changed and what we would like to say, what I would like to say is that it need to be reinforced.

00:48:28
We know what works. We need to do it and we need to do it consistently, we need to do it comprehensively and we need to intensify those actions because the best treatment is actually prevention. So, that’s what we need to be focused everywhere in the world, remaining vigilant. Thanks.

TK Many thanks, Dr Van Kerkhove and Dr Ryan. We have time maybe for one or two more questions. So, let’s go to Agence France-Presse and Robin Millard. Robin.

RM Thank you. On the of vaccine access, are we any closer to getting other emergency use listing-approved vaccines into the COVAX scheme? Thank you.

BA Thank you. As you know, as Mariângela updated recently, there’s been two vaccines, actually three, that have recently received WHO EUL, including two products from China, Sinopharm and Sinovac, as well now. It’s a total of eight vaccines - Mariângela, have I got the number right - for which we have EUL. That includes the ones we talk about usually as well as the J&J vaccine, Moderna vaccine.
Now, there are discussions ongoing. You saw just the other day that we have published on the 23rd June, on the Gavi website, the supply forecast for the COVAX facility and you will see in that, that there is a list of specific vaccines that we have already deals with, that we are looking to bring into the facility,

00:50:10
But, then, we also have a number of candidates that we are in discussion with that have recently received WHO EUL, with the hope that we’ll be able to bring those into the facility as well to both expand and make more diverse the products we have.

So, we have a more robust supply but then also to expand the supply, as well because some of those newly EUL products are some of the largest producers of vaccines in the world, as you are aware. So, those discussions are very much ongoing.

MS Just to complement quickly, Robin, because it is not only about new vaccines coming in were EUL, like Sinopharm and Sinovac, but it is also there is intensive work ongoing right now within WHO to expand the existing EULs because the EULs are done to specific manufacturers in sites. It is done according to sites of production. So, there’s a lot of work ongoing to expand.

We have expanded EUL for the Astra Zeneca European sites, the manufacturers. We are expanding some of the vaccines that will be donated like J&J, and Pfizer and Moderna sites. Then, we are working with the companies to include other sites to increase the possibility of these companies to actually supply the COVAX facility with vaccines coming from other sites.

We also have new submissions coming in. At least three new submissions are starting right now with pre-submissions, new meetings happening. So, we would expect that in probably a month or two we would have two more EULs, new vaccines coming in to the COVAX facility. Thank you.

00:52:23
TJ Many thanks, Dr Simão and Dr Aylward. Let’s try to have our last question for today, Paulina Alcazar, from Ecadena, Cancún, Mexico. Paulina, please unmute yourself.

PA Hola. Gracias, Tarik. [Spanish].

BA First, thank you for the question and, first, to a point that Mike emphasises repeatedly, we still live in a world that is only partially vaccinated that has a lot of susceptibility, a lot of vulnerability. So, what we’re saying is once you’ve been fully vaccinated continue to play it safe because you could end up as part of a transmission chain. You may not actually be fully protected. Sometimes the vaccines don’t work in people, etc.

So, I think the first message we want to be careful about is saying once you’re vaccinated you can just ahead and do whatever. Yes, you can reduce some measures and different countries have different recommendations in that regard but there is still the need for caution.

As we’re seeing, there are new variants emerging and we’ve been talking about the Delta all day today. You have to continue to be appropriately
cautious. We’re still in a world that is full of this COVID virus and it’s a virus that is still evolving. Most importantly, we’re still in a world with a lot a people who are not protected and could suffer severe disease or death if they get exposed to this. So, first message.

**00:54:36**
In terms of the time that it takes, you want to be at least two weeks after your full vaccination schedule, so if it’s a single-dose vaccine, such as the J&J, it would be at least two weeks after that when you would be considered protected. If it is a two-dose vaccine, two weeks after your second dose.

Now, sometimes that depends a little bit. Different countries say different things but that is generally the timeframe that we look at to ensure that the majority of people who would have received those doses would be protected. Sometimes people can be protected earlier. Immunity can start to accrue earlier, but that is the general timeframe we look to.

**MS** Just complementing quickly, because it is super important and that is one of the reasons why WHO is so concerned in pushing for an increased supply of vaccines to countries because it’s important to have two doses. If the vaccine is two doses, you have to have two doses. Countries that have the availability, they need to ensure that people have access to the two doses and people need to go for the second dose.

As we have we been saying, and Paulina this is super important, vaccine alone won’t stop the community transmission and we need to ensure that people follow the public health measures that Dr Maria Van Kerkhove was speaking today. People need to continue to use masks consistently, be in ventilated spaces, hand hygiene, respiratory etiquette, the physical distance, avoid crowding.

**00:56:26**
This still continues to be extremely important, even if you are vaccinated, when you have a community transmission ongoing, which is the case of Latin America, in general, where you have a high level of continuous community transmission. So, people cannot feel safe just because they had the two doses. They still need to protect themselves.

**TK** Thank you very much, Dr Aylward and Dr Simão. With this, we will conclude today’s press briefing. We do apologise to journalists whose questions we were not able to take but we will surely have an opportunity next week. I also would like to thank Amb Toni Frisch for his attendance today and I give the last word, first to Amb Frisch and then also to Dr Tedros for his closing remarks.

**TF** Thanks very much. First of all, I would come back and say and underline that I was deeply impressed by the appeal of the Director-General General, stating very clearly the actual case. It is clear there is a lot to do and we have really, as far and as much as possible, to try to reduce inequality and do as much as we can.

I am happy, if I may say so, that I could also, within COVID-19 but also in other emergencies, contribute a bit together with other EMTs. True, we are working together and hope that we could help a bit and alleviate suffering worldwide.
Thanks very much, again, for this opportunity. It was an honour for me to do that and to have this function. Thanks, Mr Director-General.

TAG Thank you. Thank you, Toni. Thank you, Ambassador, for your leadership of EMTs and please accept our gratitude and thank you also for joining us today. Thank you also to our media colleagues for joining us today and look forward to seeing you in our upcoming presser. Bon weekend. Have a nice weekend.

00:59:06