

COVID-19

Virtual Press conference

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Speaker key:

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GA	Gabrielle

00:00:37

FC Hello everyone. I am Fadela Chaib, speaking to you from WHO headquarters in Geneva and welcoming you to our global COVID-19 press conference today, Monday 8th February. I would like to start this press conference by sending my apologies for the delay in starting this press conference. Sorry for that. We will have three special guests today, whom Dr Tedros will introduce

shortly. We have simultaneous interpretation in the six official UN languages plus Portuguese and Hindi. Let me introduce to you the WHO participants.

Present in the room are WHO Director-General, Dr Tedros, Dr Mike Ryan, Executive Director, Health Emergencies Programme, Dr Maria Van Kerkhove, Technical Lead for COVID-19, Dr Mariangela Simao, Assistant Director-General for Access to Medicines and Health Products, Dr Soumya Swaminathan, Chief Scientist, Dr Bruce Aylward, Special Advisor to the Director-General and lead on the ACT Accelerator and Dr Kate O'Brien, Director, Immunisation, Vaccines and Biologicals. Welcome, all.

Now without further ado I will hand over to Dr Tedros for his opening remarks and to introduce our three guests. Over to you, Dr Tedros.

TAG Thank you. Thank you, Fadela. First of all I would like to apologise; sorry for keeping you waiting. We had a meeting that took longer than we expected, many of my colleagues here and myself so apologies for that.

00:02:18

Good morning, good afternoon and good evening. Yesterday a new case of Ebola was reported near the city of Butembo in the Democratic Republic of the Congo. Butembo is in the North Kivu province where a previous outbreak was declared over in June last year. The woman who sadly has died was married to an Ebola survivor.

Thanks to the enormous capacity built during the latest outbreak provincial health authorities have significant experience in responding to Ebola and in preventing onward transmission. More than 70 contacts have been identified and WHO is supporting local and national authorities to trace them and provide care where needed.

So far no other cases have been identified but it's possible there will be further cases because the woman had contact with many people after she became symptomatic.

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Vaccines are being sent to the area and we hope that vaccination will start as soon as possible. WHO has sent a rapid response team to provide support as needed.

The Oxford AstraZeneca vaccine is one of several that have been shown to be effective in preventing severe disease,

hospitalisation and death from COVID-19. The emergence of new variants of the virus has raised questions about the potential impact of those variants on vaccines.

Yesterday South Africa announced that it was putting a temporary hold on the roll-out of the Oxford AstraZeneca vaccine after a study showed it was minimally effective at preventing mild to moderate disease caused by a variant first identified in South Africa.

This is clearly concerning news. However there are some important caveats. Given the limited sample size of the trial and the younger, healthier profile of the participants it's important to determine whether or not the vaccine remains effective in preventing more severe illness.

These results are a reminder that we need to do everything we can to reduce circulation of the virus with proven public health measures. Several countries are succeeding in suppressing transmission, including those where new variants are circulating.

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We all have a role to play in protecting vaccines. Every time you decide to stay at home, to avoid crowds, to wear a mask or to clean your hands you're denying the virus the opportunity to spread and the opportunity to change in ways that could make vaccines less effective.

It also seems increasingly clear that manufacturers will have to adjust to the evolution of the virus, taking into account the latest variants for future shots including boosters. We know viruses mutate and we know we have to be ready to adapt vaccines so they remain effective.

This is what happens with flu vaccines, which are updated twice a year to match the dominant strains. WHO has an existing mechanism for tracking and evaluating variants of the virus that causes COVID-19. It's vital that countries continue to report these variants to WHO so we can co-ordinate global efforts to monitor their impact and advise countries accordingly.

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We're now expanding that mechanism to provide guidance to manufacturers and countries on changes that may be needed for vaccines. These developments highlight why it's so important to scale up manufacturing and roll out vaccines as quickly as possible and as widely as possible to protect people before they're exposed to new variants.

We also need to continue designing and conducting new trials and we need to keep a close eye on the impact vaccines are having on epidemiology, severe disease and death so we can use vaccines to maximal effect. WHO's Strategic Advisory Group of Experts on Immunisation or SAGE has met today to review the Oxford AstraZeneca vaccine and to discuss these new developments. Tomorrow I will meet with the Chair of the SAGE to discuss its recommendations.

To say more about the new study in South Africa and its implications I'm pleased to welcome Professor Salim Abdool Karim, the Co-Chair of South Africa's Ministerial Advisory Committee on COVID-19. Professor Abdool Karim, thank you for joining us today and you have the floor.

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SAK Thank you very much, Dr Tedros. It's indeed a pleasure and an honour to be here with you. I'll just briefly share with you the reasons behind the South African decision and how we are viewing the situation.

Put very simply, we have been monitoring how the different vaccines are stacking up in terms of their laboratory assays, whether they're tested in a pseudo [unclear] assay or in a live virus plaque assay. To day five of the eight vaccines that we've been monitoring have had these laboratory assays.

What they show is that vaccine-induced antibodies have greater difficulty neutralising the 501YV2 variant than they have against pre-existing variants. We saw substantial declines in some vaccines and less so in others so for example with Pfizer and the Sinopharm vaccines we saw minimal reduction in the potency of the antibodies and minimal changes in neutralisation activity.

However with other vaccines such as the AstraZeneca vaccine we saw very substantial reductions in neutralising activity. We don't fully understand what those laboratory results mean so we need clinical data. Fortunately three of the vaccines have been tested in South Africa where the 501YV2 variant constitutes about 80 to 90% of the circulating viruses.

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The first results that we heard were from a vaccine produced by Novavax and there we heard quite concerningly that the efficacy of the vaccine was 89% in the UK but only 49% in South Africa. That was the first indication that efficacy levels would be diminished in addressing the 501YV2 variant.

Most recently we saw this week the release of a study; it's quite a small study with 2,026 participants, largely young individuals and one of the important things is that the trial used a dosing interval that is quite short compared to the newer, longer intervals that are being proposed by AstraZeneca.

So looking at that what was shown was that while the overall efficacy of the AstraZeneca vaccine was 66% in the largest study that included the UK, Brazil and South Africa, the South African data on its own showed only 22% efficacy. It should be noted it has a very wide confidence interval that includes even 60% protection in that confidence interval.

But that study which looked at only mild and moderate infections raised concerns, not because we were not expecting some diminishing activity but it was the level to which it was diminished. So now we are unclear and uncertain about the efficacy of the vaccine in preventing hospitalisation and severe disease.

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We know from the overall trial that the AstraZeneca vaccine is effective against other pre-existing variants. We're just not confident about its efficacy against the 501YV2 variant and so we've proposed an alternative approach, a new approach to the way in which we roll out the vaccine.

One proposal that's currently being considered is to roll it out initially just in a stepped manner where the first step includes about 100,000 individuals that are vaccinated in which we monitor the hospitalisation rates. If they are below the threshold that we're looking for then we're confident that the vaccine is effective in preventing hospitalisation and then we can roll it out. Alternatively if it's above that threshold then we need to look at alternatives.

So put very simply, we don't want to end up with a situation where we've vaccinated a million or two million people with a vaccine that may not be effective in preventing hospitalisation and severe disease.

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We think that in order to do so we have a more prudent way in which we can do that which is to make an assessment and then roll it out on the grander scheme so all that has been suggested at this point is to delay the roll-out of the AstraZeneca vaccine until we have the processes in place to undertake this kind of

stepwise implementation approach. On that note, Dr Tedros, thank you very much.

TAG Thank you. Thank you so much, Professor Abdool Karim. We appreciate everything you're doing in South Africa and globally in the fight against COVID-19, as you have done for so many years in the fight against HIV. You have our respect and appreciation, Professor.

In the next few days WHO expects to make a decision on the emergency use listing of the Oxford AstraZeneca vaccine for the two sites in India and the Republic of Korea which will produce it for COVAX. We're committed to using all available data to make these assessments.

In the meantime COVAX continues to prepare for its first quarter distribution and to add to its vaccine portfolio. To discuss the implications of this new development in South Africa for COVAX I'm pleased to be joined today by Dr Seth Berkley, the Chief Executive Officer of GAVI. Seth, welcome once again and you have the floor.

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SB Thank you, Dr Tedros, and also thank you, Professor Karim. It's good to have you here with us. You don't have to be an epidemiologist, as Dr Tedros said, to know that these viruses evolve and mutate over time. I think the events of the past weeks, the emergence of these new variants - and this has been a sequential conversation we've heard about the B117, known as the UK one. We just heard about the South African one. There's also one in Brazil that is known as P1.

What this serves to highlight is that our scientific response needs to adapt if we're going to successfully beat this pandemic. It isn't simple, it isn't going to be one strain globally. So from the perspective of COVAX, the vaccine pillar of the ACT Accelerator, there are a number of lessons that are important from these events.

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The first is that manufacturers must be prepared to adjust to COVID-19 viral evolution including potentially providing future booster shots and/or adapted vaccines if found to be scientifically necessary. We don't know that now but that is something that obviously needs to be carefully followed.

It's also clear the trials have to be designed and maintained to allow efficacy to be assessed over time and to be of sufficient

scale and diversity to enable clear interpretations of their results. We know that we need much better global genomic surveillance and that has to be backed by rapid sharing of data to allow for the global co-ordination of response.

Then lastly - and I know this has been said but it needs to be emphasised - priority needs to be given to vaccinating high-risk groups everywhere to ensure maximum global protection against old and new strains and to minimise as best the vaccine can the risk of transmission because we know the more that the virus is allowed to spread, the more it is allowed to be transmitted the more opportunity it has to adapt and mutate.

All of this underlines the need for a global multilateral solution based upon the principles of equitable access. It also underlines the need for a diverse portfolio of vaccine candidates suitable for all contexts, settings and events.

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In terms of COVAX we have signed advance purchase agreements with AstraZeneca and the Serum Institute of India and we've published plans to distribute nearly 350 million doses in the first half of the year, hopefully starting later this month should the emergency use listing be forthcoming that Dr Tedros just talked about and of course this is the first of many vaccines.

We'll also be looking at the SAGE guidance that you heard about in terms of their views on the best use of this vaccine in different groups and in different areas. We're continuing to work through our partner CEPI - and Richard Hatchett, CEPI's CEO, is on this call - to optimise and extend the value of these existing vaccines.

We're looking to continue to procure new candidates for our portfolio for use later in the year including ones that would be adapted for the new variants if scientifically indicated.

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As we have done up until now, we'll continue to keep you updated on all these developments as and when they occur. So thanks for giving me the chance to speak and back over to you, Dr Tedros.

TAG Thank you. Thank you so much, Seth, and we look forward to our continued partnership to roll out vaccines. I would also like to welcome Dr Richard Hatchett, the CEO of CEPI, which is a key partner in COVAX. Richard is also available to answer questions from journalists. Thank you once again to all our guests and apologies for the delay. Fadela, back to you.

FC Thank you, Dr Tedros and our guests. I will now open the floor to questions from members of the media. I remind you that you need to raise your hand using the raise your hand icon in order to get in the queue to be able to ask your question. I would like now to start this session by inviting Sophie Mkwena, SABC South Africa, to ask the first question. Sophie, you have the floor.

SO [Inaudible].

FC Hello? Sophie?

SO Yes, my name is Sophie Mkwena from SABC in South Africa. I just want to find out from the panel; we know that during the Spanish Flu in 1918 the pandemic was deadly to senior citizens and later to the young generations because of the very same problem of perhaps the change of the virus itself.

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Did the scientists, particularly people with better know-how, not anticipate that this virus would mutate and we might have problems so that the developers of the vaccine and manufacturers must take that into consideration?

Because what guarantee do we have that during the third wave it will not have another form and previous vaccines won't be effective?

FC Thank you, Sophie. Your question is well understood.

MR I can start; Maria can continue. I think the issue is in 1918 we didn't even know this was an actual virus causing influenza at that time so therefore there were three distinct peaks in terms of age groups in the 1918/1919 pandemic. We had the classic peaks in the very young and classic peaks in the very old but what we had very unusually was a huge peak amongst young individuals, particularly amongst young men.

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Some of that may have been due to the virus; some of that may have been due to the mixing of people and the bringing together of young men in camps. But it was a fulminant disease that killed very, very quickly and had that very distinct shape.

The first, second and third waves; the second wave was larger than the first wave and again we don't know that but the virus may have become more fit to transmission in the human population in a first wave, may have been better adapted in the second wave and that's what happens.

Flu viruses adapt and they evolve over time and you see that every year as we change the vaccine strain every year, the strains that are in the vaccine. We look at the predominant strains, the most successful strains that are circulating and the ones that are causing clinical illness. We track the epidemiology of the viruses, we track the type of the viruses, we track the proteins on the surface of the cells, we track their genetic sequences and every year we're able to give clear instructions to manufacturers on how to adapt influenza vaccine.

I think that with the same kind of approach here, with the same sort of diligence both in epidemiology, in genetic sequencing and in doing the observational and other studies we're going to need to do to understand vaccine efficacy I believe we can track this virus.

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We have the tools that they did not have in 1918 or 19 and we have the means to adapt and be flexible and react to what we see so I'm confident that if the scientific, public health and governmental worlds come together we can have a strategy that will adequately adapt to the emergence of variants.

MK Yes, and if I could outline a little bit about that strategy because it is developing over time and it is getting stronger over time, as this is the first coronavirus pandemic the world has ever seen we have established surveillance systems around the world, as you know, looking for where the virus is, by tracking individuals who are infected with this virus.

But along with that scientists and virologists have been tracking the virus itself and any changes in the genome of the virus itself, looking at mutations in the virus evolution which is a natural process for all viruses and all pathogens.

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What we've been doing through our virus evolution network and our laboratory network and through the improvements of genomic sequencing around the world; countries have been sequencing viruses in their countries and they have been sharing those viruses on publicly available platforms like GISAID and others so that the changes in the virus can be evaluated, they can be studied and that we can determine what they mean.

Because even if viruses change all the time what is really critical is to have an assessment framework in place so that we can determine if any of these changes result in a change in

transmissibility, reflect any changes in disease presentation and severity and importantly if any of these changes have any impact on available and future diagnostics, therapeutics and vaccines.

Recognising that this was important for us to be monitoring we formulated our virus evolution working group in June to have an assessment framework to determine what studies were necessary in the lab where we could look at specific mutations or also variants of interest because we need to determine which ones of those are important to become variations of concern.

Now what we're looking to is, building on existing systems like we have for influenza, how do we take the knowledge of the way that these vaccines behave in terms of their neutralising response and in terms of the impact of these vaccines - but not only vaccines, also therapeutics and diagnostics - to say, this is important and therefore there may be a change necessary for the vaccine.

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So that is a process and a mechanism that is being enhanced, as the Director-General said in his speech today but again we're not starting from scratch. This is what scientists do. It requires a robust framework to detect these mutations and variants. It requires strong collaboration across scientists and labs around the world so that studies are done to actually properly assess the potential impacts of these viruses and also to inform vaccine composition.

So there's a lot that's in process here. It will become stronger as the months go on and it really requires the help and the persistence of everything from epidemiologic surveillance all the way through good collaborations with manufacturers.

FC Thank you. I would like now to invite Mr Richard Hatchett, CEO, CEPI, to add some elements. You have the floor, sir.

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RH Thank you and, Sophie, thank you for the question. Just to say that, as Maria and Mike have indicated, we certainly have anticipated that the virus could mutate. In fact scientists working in laboratories have anticipated some of the mutations and this is one of the values actually of doing the science. It allows us essentially to look into the future, to look at possibilities that may occur and to help us look out for mutations that would be of concern and interest, as Maria just outlined.

Certainly the emergence of the new strains in South Africa, Brazil and the UK has given cause for concern. We have taken a risk management approach not only through COVAX but globally in terms of the approach to vaccine development and have undertaken the development of vaccines on a wide variety of platforms; the mRNA vaccines of course; the viral vector vaccines like the AstraZeneca vaccine that we've been discussing; recombinant protein vaccines; and inactivated vaccines.

Having that diversity of vaccine candidates actually provides us with a large number of tools which we need to explore now to see which work best against the variants that we have. We can also look potentially at combinations of the vaccines that we have and of course we must accelerate the development of new strain-specific vaccines and a large number of companies have already begun to undertake that work.

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If the evolution of our understanding of these viral strains suggests that we do need to progress these vaccines into clinical trials and then into use we will do that as quickly as we possibly can.

FC Thank you, sir. I would like now to invite Jon Cohen from Science to ask the next question. Jon, you have the floor.

JO Thank you so much for taking my question. I well recognise that this study in South Africa didn't have enough people or old enough people or people with comorbidities to answer the severity and hospitalisation and death question but we have a lot of data from other studies that suggests that vaccines that don't work particularly well against mild and moderate disease could possibly still keep people out of hospitals and prevent deaths.

I also recognise that WHO doesn't tell countries what to do but I'm curious what outside people and experts think about South Africa's decision to suspend the use in healthcare workers right now in order to wait to form the trial that Salim described.

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So I'm curious if you could address that; what do you think of that decision to suspend the use right now given the potential that it could prevent people from being hospitalised and dying?

FC Thank you, Jon. Dr O'Brien will take this question.

KOB Thanks for that question. I think underlying the question is really a recognition of what a dynamic situation it is right now. The evidence has come out very recently within the past 24, 48 hours. As the Director-General indicated, the Strategic Advisory Group of Experts on Immunisation at WHO met today along with the investigators from the trials that are being conducted in the UK and Brazil, along with AstraZeneca and along with the investigators from the South Africa trials as well.

So everybody's looking at the data right now and there are a range of ways that this can be approached but I think what was most clear that came out from the SAGE meeting is that in looking at the evidence on the AstraZeneca vaccine across a number of trials it is very clear that it has efficacy against severe disease, hospitalisations and deaths.

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Among the variants and different variants there are some indications of reduction in the efficacy - some more, some less depending on which variant, which population - and also of the neutralising antibody responses.

But we also have evidence that there is the likelihood that the retention of meaningful impact against severe disease is a very plausible scenario for the product against the B1351 variant. So as South Africa deliberates on how they will handle the situation, recognising that there are a range of products that they're looking at and how to get more data on exactly what would inform a greater and broader policy; these are discussions, as we've heard, that continue to be underway about exactly how they will use the vaccine that they have in hand to its maximum benefit and assure that there is evidence that can inform not only a broader policy in South Africa but helps to inform policies around the world.

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So we'll see the final wording that comes out from SAGE on the use of the vaccine but there was a very positive view about proceeding with the use of the vaccine including in settings where variants are circulating with a big emphasis on collecting information that would really help in the weeks to come and in the months to come to inform an optimisation of those uses in different countries in different settings around the world.

FC Thank you, Dr O'Brien. I would like now to invite Christophe Vogt from AFP to ask the next question. Christophe, can you hear me?

CH Yes, I can hear you. Thank you for taking my question. I was just wondering about everything we heard now about the AstraZeneca vaccine and I can see how complicated it is but how much does it affect the roll-out, the number of vaccines that you can roll out and when for the COVAX facility? It is the bulk of what you plan to use for vaccination in the next six months so I was just wondering if you can give us an answer, and also after what Dr O'Brien just said, that maybe we should just roll out and use it to prevent more severe cases. Thank you.

FC Thank you, Christophe. Dr Seth Berkley will take this question.

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SB Thank you for the question. Before I answer that question let me just add one point to Kate's excellent question and that is we learn more about these vaccines as we work with them and one important point about the AstraZeneca vaccine is it was studied originally with a dose interval between two doses of a month.

That vaccine has now gone through trials and observational studies have shown that in fact a longer dose interval increases the immune response and also increases the efficacy of the vaccine. So these types of learnings will occur with new vaccines and that also means that in a study like the South African study it was not optimised for what we know today as the way to get the most immune response out of it, etc. This is part of the debate and discussions that need to go on right now.

But going back to the question, the AstraZeneca was really the first vaccine. Of course we also have a small number of doses of the Pfizer vaccine now as well as early vaccines in the portfolio but the idea was to try to get a very large portfolio of products and we have done that.

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So we will be seeing other vaccines enter the portfolio and be available for participants of COVAX in the second quarter. It is true that initially it'll be mostly AstraZeneca and Pfizer that are moving forward but then there'll be more vaccines and of course, as Dr Hatchett said, one of the things we'll be looking at is whether any or all of these vaccines need to be adapted and adjusted either in the way they're being used or even in the actual make-up of the vaccines.

So this is an evolving science, as you heard from Kate, and we will continue to work as COVAX to ask the question, what is the best way to move forward. But at the moment at least - and we'll wait for the SAGE guidance - it looks like the AstraZeneca vaccine is an efficacious vaccine. It's been reviewed by a number of stringent regulatory authorities and got approval and had studies in many countries including efficacy against severe disease, as you've heard, including efficacy against some of the changing variants and therefore we suspect that we will continue to roll that out and will continue to follow the effects of that vaccine over time.

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FC Thank you, Dr Berkley. I would like to invite Professor Salim Abdool Karim to also provide some elements to this question. Professor, you have the floor.

SAK Thank you very much. Just to add a quick comment that even in the South African setting we were scheduled to roll out the AstraZeneca vaccine in just over a week from now. We anticipate that the initial start date of vaccinations will be largely unaffected or at most be affected by a few days but instead of rolling out AstraZeneca vaccine we will be rolling out the Johnson & Johnson vaccine.

That'll give us a bit of time and leeway to ensure that we're collecting the necessary data as we roll out the AstraZeneca in a stepwise process so it doesn't really materially affect our start date. It may affect the rate at which we escalate if we start running short of doses but as it stands it should not affect much else. Thank you.

FC Thank you, Professor. I would like now to invite a Brazilian journalist, Sara Teofilo from Coriero Brasilense to ask the next question. Sara, you have the floor.

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SA Hi. Thank you for taking my question. Still on the subject of the variant in South Africa and the suspension of the use of the Oxford vaccine, in Brazil we also have a variant identified in Amazonas, as was said here today and we know it is a different variant but does the Organization have any orientation to Brazil? Should the Government suspend the use of the AstraZeneca vaccines and use the other vaccines until we know this variant does not interfere with the effectiveness of the vaccine?

FC Thank you. Dr Swaminathan, you have the floor.

SS Thank you for that question and again just to repeat what others have said, we are learning a lot, there are uncertainties still, we don't have answers to all questions. The SAGE, the Strategic Advisory Group of Experts on Immunisation, is reviewing all the evidence that's available on each of the vaccines from all the different studies starting from very early clinical all the way to the phase three trials and also taking into account what we know about the different variants and experiments that are being done both in the laboratory looking at neutralisation assays and if there's any clinical evidence, taking that into account.

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We'll make recommendations based on the available evidence and of course these can be updated and revised as more data becomes available. All of our guidelines are meant to be updated, they're living guidelines and we will do that but again based on the best available evidence.

Countries of course will make their own decisions based on initial information that they may have and we can help them and work with them to make those decisions. One thing I would like to say is that there is an urgent need to collect more information and data so even as countries are rolling out vaccines, whatever the vaccines may be it's really important that we put in place mechanisms to either do clinical trials where we can randomise for example the question about the optimal timing between the two doses; the question of efficacy in different age groups; the question of is it better to use one vaccine followed by a different vaccine as a booster dose.

All of these questions need to be answered and we would like to promote that kind of good research whether it's trials or whether it's observational studies, cohorts that are monitored for both effectiveness and safety and then have a global database where we keep learning so that we use these vaccines more effectively.

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Even as, as Richard Hatchett from CEPI was saying, we are investing in the development of more vaccines, those trials need to be done as well. So I think the next few months are going to be important for us as we roll out, to keep on learning and adapting our strategies. I don't know if you want to add anything, Kate.

KOB Yes, if I can just add a couple of things, we did speak at SAGE about the P1 variant and the AstraZeneca vaccine and had

an update on the expectation about when we would have more information that would be evidence to inform decisions like this.

I think it's so important that we recognise that information is going to continue coming out and we really have to sail a steady ship based on the preponderance of evidence and not lurch from one particular report or another report because in science there is variability in the biology of how vaccines work in different populations at different points in time, among different groups in populations.

So what's really critical is as evidence emerges to look across all of the elements, the structural biology of the virus itself and the variants, the nature of the vaccines that we're actually looking at, the ages of the people that were in clinical trials, the kind of disease that was actually monitored in the clinical trials.

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Each of these elements has an impact on what the expectation would be about the performance of the vaccine and therefore comparing from one piece of evidence to the next really can't be done without a sort of level playing field.

So I think people really have to be ready to appreciate that we will have evidence that's going to come out that is going to at times have the appearance that it doesn't add up to one complete story and that's because we're painting the picture in parts and pieces and bits as time is going on.

But when we put all that evidence together we have a clear way forward of the way in which we can most effectively use the vaccines while we're learning all the time about optimising those products.

FC Thank you, Dr O'Brien. I believe Mr Richard Hatchett has something to add. You have the floor, sir.

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RH Thank you. I just wanted to follow up on Dr Swaminathan's comments. She mentioned a number of studies that need to be undertaken. I just wanted to flag that COVAX through CEPI has issued a call for proposals. We've set aside \$140 million to support the conduct of such studies and that call was opened about ten days ago so we will support these necessary studies to understand how to best use these vaccines.

FC Thank you, sir. I would like now to call on Nadia Doui, a Tunisian journalist from L'Economist Maghreba. Nadia, can you hear me?

TR Good evening, everyone. I'm a Tunisian journalist and I work at the magazine L'Economist Maghreba. I'd like to ask your question in French if that's all right.

This is my question; it's about the new variants, especially the South African and Brazilian variants. There are many questions about these variants and some people are being singled out as carrying this variant and even if they have a PCR test that has been negative some people suspect that they could still be carrying those variants.

00:44:05

FC Nadia.

MK I can start and others may want to come in on this. I'm not sure if I understand the question completely but it's about the variants and about the viruses that people are infected with. I think first and foremost we need to not stigmatise anyone that is infected with the SARS-CoV2 virus, full stop, regardless of if it's the wild-type viruses that are circulating from the beginning or these new variants that are circulating.

All of us are doing everything that we can to keep ourselves safe and keep our loved ones safe and if we happen to be infected with this virus we need proper protection, we need proper care and understanding from our loved ones and our employers so that we can get better and we can take the necessary public health measures to prevent us from spreading that virus to someone else.

There is a lot that is not well understood about all of these different virus variants that are being detected but as you have heard us say, there are many studies that are underway and we are learning about these variants and this virus every day in real time.

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There are collaborations that are set up, there are relationships that WHO and our partners have with researchers in country who are carrying out studies as we speak, as we sit here, explaining this to you because everyone is working towards better understanding of how the viruses transmit, the disease that they cause, the severity that one may have if they're infected with

these virus variants and of course any potential impacts of our countermeasures like diagnostics, therapeutics and vaccines.

So while we don't have all of the answers - we never will - we have systems in place to make sure that there's surveillance, that there's data sharing, that there's co-ordination around research that needs to be done, that there is a mechanism by which those results can be shared, there are expert panels that are discussing these regularly to interpret what these mean as we know it at the time that we discuss it and, really importantly, that we outline the studies that are necessary going forward.

But I do want to highlight again that we shouldn't stigmatise anyone who is infected with SARS-CoV2, the virus that causes COVID-19. We just need to make sure that we understand we're in this together and we provide the appropriate care and understanding for those who are infected and their loved ones who are contacts and need to get through this.

00:46:32

FC Thank you. I would like now to invite Pen Gui from People's Daily, a Chinese journalist, to ask the next question. Pen Gui, are you with us? Hello, can you hear me?

PG Can you hear me?

FC Yes. Hello. Hello?

PG Hi. Can you hear me?

FC Yes, we can hear you. Go ahead, please.

PG Thank you for taking my question. China declared last week that it had decided to provide ten million doses of vaccine to COVAX. Can you share more information about that, about the collaboration with China? Thank you.

00:47:26

FC Dr Swaminathan, you have the floor.

SS Yes, thank you for that question. As you know, we want to work with developers and manufacturers of vaccines all over the world. We need as many good, safe and efficacious vaccines as possible. China has several vaccines under development and we're speaking with all of them and we are also looking at the dossiers for Sinopharm and Sinovac.

The team is in China, as Dr Simao mentioned and we've also heard from them that they would be willing to discuss with the COVAX facility provision initially of ten million doses over the

next few months so we're very encouraged by that. This is not a donation as we understand but it will be a provision to the COVAAX so they will be discussing with the COVAX facility the terms and conditions under which this can be procured based of course upon the emergency use listing by WHO as well as the guidance from SAGE. Thank you.

FC Thank you, Dr Swaminathan. I would like now to invite Simon Ateba from Africa News Today to ask the next question. Simon, you have the floor.

00:48:46

SI Thank you for taking my question. This is Simon Ateba for Today News Africa in Washington DC. Hospitals in Malawi are now on the brink of collapse, overwhelmed my patients impacted by a COVID-19 variant first identified in South Africa.

When the country needs only 40,000 vaccine doses to vaccinate healthcare workers to continue to treat others and this is the situation in other countries in Africa where healthcare workers need to be vaccinated first to take care of other people, what are the WHO, COVAX and others doing to ensure that healthcare workers are vaccinated right away, not in two weeks or in three weeks?

If I may ask, apart from rejoining the WHO is President Biden doing anything to help Africa's vaccination effort? Thank you.

FC Two questions, Simon. Okay. Dr Bruce Aylward will take your first question.

BA Thank you very much. Simon, everybody is deeply concerned about the roll-out of vaccines globally and everyone - it's not just WHO; everyone we work with is doing everything possible to scale up and ensure countries that have not yet been reached with products can be reached.

00:50:06

So WHO is doing this in the context of the COVAX pillar of the ACT Accelerator that we work within and Seth may want to make comments on this as well but there's really a four-part approach we're taking to this right now and we're doing all of this right in parallel.

The first is to try and ensure that those products that we've contracted large volumes for and that we know are efficacious and safe get through the regulatory process as rapidly as

possible and that is the AstraZeneca vaccine, as Kate and others have spoken to already.

The second thing we've been doing is working to expand the portfolio of vaccines, as Dr Berkley mentioned so we're looking at other products that have already been licensed. The Pfizer vaccine; we struck a deal with Pfizer two weeks ago and we're looking at expanding on that.

The third piece of work that we've done within the COVAX facility is to establish the capacity to take donations and doses that are shared from countries that feel that they are in a position to be sharing doses so we've established the capacity to do that, which can be done immediately.

00:51:12

Then the last thing that we're doing is we're working to assess other potential suppliers. I think Mariangela or someone referred already to the fact that we have team on the ground in China that's assessing the facilities at Sinovac and Sinopharm.

At the same time we're looking at their dossiers, their data to see if those products would be suitable for consideration in the facility so we've got a broad, four-pronged at least programme of work.

The other thing that we're doing is as we do those things in parallel if things look very promising we're going out with countries with indicative volumes of vaccines. As you saw, Dr Berklee's team from GAVI issued what we call the indicative volumes to be able to tell countries, here's how much vaccine you can expect in the coming months so that they can prepare and prepare their timelines appropriately.

Then linked to that we're also already informing not just the countries but informing the manufacturers of these products, look, this is a list of countries that you may need to be shipping vaccines to within the next week as some of these products will have a final position on their regulatory processes.

00:52:28

So, Simon, please rest assured that everybody working in COVAX, the partners working with them are doing everything possible to make sure that products arrive everywhere as rapidly as possible. But remember we made a commitment when we established COVAX that we would make sure the vaccines that we deliver are safe, efficacious and quality-assured.

We made that promise to the world, to the people of the world and it takes time to examine everything possible on these vaccines and make sure that they meet what are quite stringent regulatory requirements so that when they go out people have the absolute confidence that these products are going to work and that they're going to be safe.

FC Thank you, Dr Ryan.

MR Just on the specific issue of Malawi and certainly South Africa has seen a very rapid rise in cases and that rise is - that's falling now and a number of countries in the southern African area including Malawi have seen a similar very rapid rise in the number of cases. I believe they peaked in Malawi with 1,316 confirmed cases on 22nd January.

00:53:38

That number has now fallen to 320 on 7th February and that's been a persistent fall in the number of cases. Gain that's testament to all the other work the Government of Malawi are doing in terms of testing and isolating and quarantine and treating cases. That's happened in the absence of vaccines.

We've seen similar falls across Europe even in areas where there's been a high proportion of variant strains associated with transmission. Overall when we look at variant strains in some areas the data would suggest that they can be up to 30 or 50% more transmissible but they're not able to get around our defences.

When those public health and social measures are applied, when people wear their masks, when people stay away from crowds, when people wash their hands, when people avoid crowded places and when governments take the necessary action those numbers fall.

00:54:33

We need to continue to have those numbers fall and clearly understanding the impact of the variants on transmission and on vaccine efficacy and others is very important but I think the message is the measures we currently have in our toolkit work and we need to apply them. They are our first line of defence, they are what are going to stop this disease getting out of control.

This will keep the number of variants down and allow the vaccines to come in and do their job and the primary job of vaccines right now is to reduce hospitalisations and death. Right

now the data on, I think, all of the vaccines in all of the situations is they're working to do that.

We may need second and third-generation vaccines to do more, we may need better vaccines to do more than just stop deaths and stop hospitalisations but right now we have the tools to stop both by adequate control of disease at community level and by the use of vaccines to protect the most vulnerable and our front-line health workers.

In emergency management you've got to do what you can do now, you've got to face the realities you face now and the realities we face now are we can suppress transmission and we can save lives.

00:55:43

If we do that we can take the next steps and rest assured, the team here, Kate and Soumya and Annamaria and the R&D blueprint and Richard and everyone outside; they're working hard to find those solutions on the vaccine side and working hard with our colleagues on the flu programme to develop a system to monitor this and do this in a sustainable way.

But I do think we need to focus on what we have at our disposal. No-one would like more than us - and going back to previous questions, we still want to see health workers and vulnerable people all over the world vaccinated, that is still a primary objective of this organisation.

I think the partners in the ACT Accelerator, the partners in COVAX led by the DG are making every effort to ensure that we can maximise the fair and equitable distribution of this vaccine that is saving lives and can save more lives.

00:56:39

FC Thank you. I think we will take the last question from Gabrielle Steenhauser, Wall Street Journal. Gabrielle, can you hear me?

GA Yes, I can. Thank you so much. Can you hear me?

FC Very well. Go ahead, please, Gabrielle.

GA Given that it's going to take some time to get more evidence on how the AstraZeneca vaccine works with the South African variant shouldn't COVAX maybe prioritise other vaccines such as the Pfizer vaccine for countries in southern Africa where this same variant is prominent at the moment? Can't you shift some of these vaccines to those countries so that the front-line

healthcare workers get the best protection that is available right now?

FC Thank you. Dr Swaminathan, you have the floor.

SS Maybe I can start and then Dr O'Brien can come in. There are several issues here. The first one is [sound slip] we mustn't start concluding that this vaccine doesn't work at all. What we've seen is data from a small study. It's indicative, it is telling us we need to collect more data, we need to study more.

But from all the available evidence AZ vaccine and all the other vaccines that have been approved so far reduce death, reduce hospitalisation and reduce severe disease and that's our goal for the first part of this pandemic, to reduce mortality, to end all preventable deaths and so we must continue to scale up vaccines.

00:58:21

About which vaccine, it depends on what's available in the COVAX facility at the particular time and also what's feasible and, as you know, the Pfizer vaccine has some special requirements; ultra-cold chain storage and transport, which is not available in all countries in Africa or in other parts of the world.

So we've done an extensive mapping and Kate can speak to how this has been looked at at the country level. So that's an important issue but also it's the supplies. The COVAX facility had made prior arrangements to get a lot of supplies of the AZ vaccine in millions of doses whereas the Pfizer; we have a very limited supply, especially in the first part of the year.

So there are all of these considerations and the important thing is to get these vaccines out to healthcare workers and other high-risk groups as soon as possible. Do you want to add some points, Kate?

00:59:21

KOB Yes, I think the other thing to mention is that for pretty much all of the products we do know that the efficacy against severe disease is a higher efficacy than against mild disease or just infection. We're starting to get some evidence around infection without people actually having disease.

So we do expect this gradient and I think especially for the AstraZeneca product the absence of evidence is the key thing about what is the performance of the vaccine against severe disease of this particular variant.

The expectation is that it will have - there's a very plausible scenario where it will have efficacy of some magnitude against that severe disease. So I think what we want to also emphasise here is the reason to have a portfolio of vaccines in the COVAX facility and that are being pursued from a development perspective is that different vaccines are going to have different performance characteristics and when we get to a point of supply where we have that flexibility to be optimising products where we now have information about how they can best be used...

01:00:36

And I think this is what we're talking about, about the optimisation but the optimisation isn't just about the product itself; it's about how you use it and so we've referenced before the information that is now more and more clear that the longer the interval between the two doses of this product the higher the efficacy is.

So again I think what we're trying to emphasise is that we have a number of choices that any individual programme can make about how to make best use of what's available at a particular moment in time; extending intervals, using products in some age groups with preference over other age groups where we're really targeting an age group or a particular group largely for the protection against severe disease or another group that doesn't have such high risk of that but we're more concerned about mild or moderate disease.

So the choices that an individual country makes about how best to use the products that are at hand is going to be a rather organic process at this period of time where we're still learning so much about each of the products and the supply is increasing over time and availability for any one particular geography has variability compared with another geography.

01:01:59

FC Thank you, Dr O'Brien. I believe Mr Richard Hatchett has something to add. You have the floor, sir.

RH I just wanted to build on the comments that Dr Swaminathan and Dr O'Brien made with respect to the utility of the vaccines that we have. Obviously there is a world full of the wild-type virus that the AstraZeneca virus is known to work against so it is vastly too early to be dismissing this vaccine as... This is a very important part of the global response to the current pandemic and we need to find better vaccines probably against the variants that are emerging but we still have a lot of information that we need to gather.

Mike made a very important point that I think is worth underscoring; it's absolutely crucial to use the tools that we have as effectively as we possibly can and that may mean ultimately when vaccine supplies increase thinking about deploying certain vaccines to certain geographies.

We don't have that luxury yet but we do have a suite of vaccine tools that we can probe and understand how to use them most effectively. In the current state we are working rapidly, many of the companies are working rapidly, as I said, to develop new vaccines that are specific for the emerging strains and we are also looking at second-generation vaccines that have different attributes and that may provide broader protection.

01:03:42

Ultimately ideally we would like to develop broadly protective COVID and even coronavirus vaccines so there is a staged approach to the necessary research and development that is absolutely critical, to continue to support that research and development so that we understand the tools that we have, we optimise them and we develop the new tools that we will need for the future. Thank you.

FC Thank you, sir. I would like now to invite Dr Tedros for his final comments. Over to you, Dr Tedros.

TAG Thank you, Fadela. I would like to start by thanking our guests today, Professor Abdool Karim, Dr Berkley and Dr Hatchett. Thank you so much for joining and for your partnership and also thank you to all who have joined today, to the media community and look forward to seeing you again in our upcoming or next presser. Thank you; all the best.

FC Thank you, Dr Tedros. I remind journalists that we will be sending the audio file and Dr Tedros' remarks right after the press conference. The full transcript of this press conference will be posted tomorrow on the WHO website. The press briefing is now closed. Thank you.

01:05:04