Hello, all. I am Fadela Chaib, speaking to you from the WHO headquarters in Geneva and welcoming you all to our global COVID-19 press conference today, Friday 5th February. We have simultaneous interpretation in the six UN languages plus Portuguese and Hindi. I would like to introduce to you the WHO participants.
Present in the room are the WHO Director-General, Dr Tedros, Dr Mike Ryan, Executive Director, Health Emergencies, Dr Maria Van Kerkhove, Technical Lead for COVID-19, Dr Mariangela Simao, Assistant Director-General, Access to Medicines and Health Products, Dr Soumya Swaminathan, Chief Scientist, Dr Bruce Aylward, Special Advisor to the DG and lead on the ACT Accelerator, Dr Kate O'Brien, Director, Immunisation, Vaccines and Biologicals. Welcome, all.

Now without further delay I would like to hand over to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Fadela. Good morning, good afternoon and good evening. Earlier this week Captain Sir Tom Moore died with COVID-19. As you know, as he approached his 100th birthday last year Captain Sir Tom decided he would try to raise £1,000 for the United Kingdom's National Health Service by completing 100 laps of his garden. He ended up raising more than £30 million.

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For me Captain Sir Tom represents two things. The first is that everyone can make a difference, whether that's raising money, inspiring others, informing the public or simply deciding to stay at home to keep others safe.

The second is that Captain Sir Tom was a reminder of the value we should put on older people and everything they bring to our world. However there is a disturbing narrative in some countries that it's okay if older people die. It's not okay. No-one is dispensable. Every life is precious regardless of age, gender, income, legal status, ethnicity or anything else.

That's why it's so important that older people everywhere are prioritised for vaccination. Those most at risk of severe disease and death from COVID-19 including health workers and older people must come first and they must come first everywhere.

Globally the number of vaccinations has now overtaken the number of reported infections. In one sense that's good news and a remarkable achievement in such a short time frame.

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But more than three-quarters of those vaccinations are in just ten countries that account for almost 60% of global GDP. Almost 130 countries with 2.5 billion people are yet to administer a single dose. Some countries have already vaccinated large proportions
of their population who are at lower risk of severe disease or death.

All governments have an obligation to protect their own people but once countries with vaccines have vaccinated their own health workers and older people the best way to protect the rest of their own population is to share vaccines so other countries can do the same.

That's because the longer it takes to vaccinate those most at risk everywhere the more opportunity we give the virus to mutate and evade vaccines. In other words, unless we suppress the virus everywhere we could end up back at square one.

On Wednesday COVAX published its forecast for the distribution of vaccines to participating countries. This is a very exciting moment. Countries are ready to go but the vaccines aren't there. We need countries to share doses once they have finished vaccinating health workers and older people but we also need a massive scale-up in production.

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Last week Sanofi announced it would make its manufacturing infrastructure available to support production of the Pfizer BioNTech vaccine. We call on other companies to follow this example.

Companies can also issue non-exclusive licences to allow other producers to manufacture their vaccine, a mechanism that has been used before to expand access to treatments for HIV and hepatitis C.

The COVID-19 Technology Access Pool or CTAP enables the voluntary licensing of technologies in a non-exclusive and transparent way by providing a platform for developers to share knowledge, intellectual property and data. This sharing of knowledge and data could enable immediate use of untapped production capacity and help build additional manufacturing base, especially in Africa, Asia and Latin America.

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Expanding production globally would also make poor countries less dependent on donations from rich ones. These are unprecedented times and we applaud those manufacturers that have pledged for example to sell their vaccines at cost.

But manufacturers can do more. Having received substantial public funding we encourage all manufacturers to share their
data and technology to ensure global equitable access to vaccines.

And we call on companies to share their dossiers with WHO faster and more fully than they have been doing so we can review them for emergency use listing.

Last Friday we heard from health workers in Uganda and Pakistan who're waiting to be vaccinated. Today we're pleased to be joined by two health workers from high-income countries who have been vaccinated. First I would like to introduce Professor Gabriel Gold, who works in a geriatric department at the Trois-Chene hospital here in Geneva. Professor Gold, thank you for joining us. Please share with us your experience during the pandemic and your hopes for your work and indeed the world now you have been vaccinated. You have the floor.

GG Thank you very much for inviting me. I must say that vaccination for me was a huge relief. You mentioned the case of a centenarian who did so much and unfortunately suffered from the disease.

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It's important to remember that the sickest people with COVID-19 are very often the oldest and the most frail. I work in a hospital that has provided acute care to people with COVID-19, perhaps over 600 patients, since the beginning of the pandemic.

These people deserve top-quality care for their COVID disease but they also require a lot of help with other co-morbid diseases but most importantly sometimes with very simple things. It can be helping them sit up in bed, it can be helping them wash their face or brush their teeth or take a sip or water.

It can be just a reassuring presence because sometimes they may be lost or confused because they are so sick in unknown surroundings. This means that there is a very close proximity when taking care of such patients between patients who have a very severe, infectious disease and healthcare workers.

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Of course we use protection, whatever we need, the protective clothing and barriers and masks but the vaccine is really a key way to prevent the spread of the disease. Of course this is something that we worry about because we also have many other patients in the hospital who came in for other reasons who don't have COVID-19 and we want them to be able to go home
without COVID-19 so we want to make sure that we do not transmit this to them.

It also reassures us when we go home and we have our families, close ones as we want to be careful too about transmitting the disease there.

Vaccination is also an opportunity for health authorities to recognise the immense dedication that healthcare workers all over the world have put in to provide care for people with COVID-19; long hours, forgoing vacation, month after month and probably for many months to come. The health workers are there as long as they are healthy.

Vaccination is a way for healthcare authorities to first show their appreciation of these healthcare workers but also their understanding that if you want to provide care to people who really are very sick and need it you need trained healthcare personnel. They have to be healthy and vaccination is an important way to deal with that.

Vaccination enhances the motivation of people who have worked very hard and need to continue to work very hard to deal with this terrible pandemic. The pandemic occurs all over the world. People are getting sick all over the world. People need healthcare workers all over the world, they need healthy healthcare workers all over the world so we should vaccinate those people who are at risk so that we don't fill the hospitals and the care centres with as many patients.

And we need to vaccinate of course, wherever they are all over the world, healthcare workers who are providing this care. Thank you.

TAG Merci beaucoup, Professor Gold. Thank you so much and I welcome your support to accelerate vaccine roll-out globally. Now to our second guest, Cindy Frias. Cindy Frias is a mental health specialist nurse at the Hospital Clinic of Barcelona. Cindy, we look forward to hearing about your experience working on mental health during the pandemic and what it has been like for you to be vaccinated. You have the floor, Cindy.

CF Thank you very much for the invitation and for introducing me. Good afternoon, good morning and good evening around the world. My name is Cindy Frias and I'm a mental health specialist
nurse at the Hospital Clinic of Barcelona, the child psychiatry unit.

Today I'm here to explain my experience in this pandemic situation and all the vaccination process. I went to this public health emergency Spanish hospital and especially my hospital, the hospital clinic had to adapt a lot of measures that included the adaptation, reorganisation of clinical care units, hospitalisation units and even psychiatry units.

All this change brought pressure and challenges for the nurses and all the healthcare workers. This experience and this current pandemic has had an important impact on our emotional well-being from the beginning and until now because of the unexpected upgrade [?] of the situation and the high rates of transmission.

Likewise the increase of activity, the lack of staff, especially the nursing staff led to an increase in our working hours every day and that represented an important increase of stress for us. Even now I'm suffering these circumstances.

On the other hand regarding the direct contact with our patients, the measures; the nurses have had to reduce or limit the nursing care. The nurses have had to reduce the time for every visit to the patient rooms. We have had to use personal protective equipment for protection and maybe these measures have caused the nurse to express feelings of fear, anger and the sensation of less humanised care and lower quality of care.

Added to this situation the hospital restricted or limited family visits and outside patient walks and for those reasons those measures affected the emotional well-being of patients and of the families too.

However I think it's very important to highlight the adaptability to cope of all the nurses and all the healthcare workers, the resilience, the capacity of individuals to bounce back or cope in this new situation despite adverse circumstances.

The resilience and the capacity for adaptation of this health situation; it's important to understand as a process the positive adaptation to stress and adversity. In my case I think I also adapt to the situation, as most people or as most of my co-workers do but I have felt fear and anxiety because for example I have a
three-year-old son and I live with my mum and I have especially been afraid of infecting them.

I had to come to work every day and for that reason I think I was feeling that sensation or negative thoughts every day. Around the world a lot of nurses have been infected and many of them have died and a lot of them were young.

For example I would like to share with you my own experience because my aunt died in August from coronavirus and she was a nurse. She was an extraordinary nurse and she was only 51 years old. In fact I'm a nurse for her because she was my role model and she was, I repeat, an excellent nurse.

I always remember her as the best nurse in the whole world and she became infected while she was working. She died quickly because she had a comorbidity and she died a few weeks after the infection.

She was [unclear] situation, very deep for me. This loss increased my fear, my anguish, my anxiety, especially for my mom.

Therefore I view [?] this vaccination process like a great change, enormous scientific advances in relation to my work and I think it's fundamental. I received the COVID vaccine, I received the first dose on January 9th and the second on January 30th and I haven't had any side-effects, just a local pain in the arm but some co-workers have experienced some side-effects, minor side-effects.

Anyway, I have lived the vaccination experience as a light [?], a light of hope, a light of hope, a light on the road. I don't know if this is the right explanation or the right... I did a translation of my feelings. I see the process as reliable considering some negative aspects but I think the vaccination process is hope, is faith in the healthcare system.

I think it's vital that healthcare workers around the world are vaccinated because we need to do our work with security, with confidence and we need to be confident in the healthcare system. My family are very happy, my mom is happier for me and my family is happy and hopeful for the future and see the vaccination process, the COVID vaccine as something safe, close and maybe as a tangible fact.
I think most of my co-workers see the vaccination process as something very positive for us and I think we need this vaccine for all the healthcare workers around the world. Thank you so much.

FC Thank you. Thank you, Cindy, muchas gracias. We know many people have felt isolated during the pandemic and the work you do as a mental health nurse specialist is so critical. Thank you once again to both our guests today. We're glad both of you have been vaccinated and are able to keep doing your essential work. Thank you to both of you for the clear call you have issued for health workers everywhere to be vaccinated. Fadela, back to you.

FC Thank you, Dr Tedros, and to our guests. I will now open the floor to questions from journalists, reminding you that you need to raise your hand using the raise your hand icon in order to get in the queue. First question goes to Shoko from [Unclear]. Shoko, can you hear me?

SH Hi, Fadela. Can you hear me?

FC Yes, very well. Go ahead, please.

SH Thank you for taking my question. COVAX announced two days ago its interim distribution forecast for the first half of the year, predicting its distribution to 145 economies. I do understand COVAX prioritises first of all countries which aren't able to buy doses for themselves.

On the other hand I see some of the richest countries, such as Canada is expecting to receive doses in the first half of the year. I'm not trying to blame any specific country for receiving doses but why doesn't COVAX prioritise the economies which need doses the most? Thank you.

FC Thank you, Shoko. Dr Swaminathan.

SS Thank you very much for that question. As you know, COVAX was set up as a mechanism to provide equity in vaccine distribution across countries of all types; high-income, middle-income, low-income. It wasn't meant to only serve low-income countries and as you know, there are two types of countries participating in COVAX, the self-financing countries which pay in advance, make an advance commitment and then pay for the vaccines, and then the AMC countries, 92 of them, that get very subsidised or free vaccine.
It was also not clear at the beginning when the mechanism was designed that there would be so many bilateral deals so the idea was that there should be a global mechanism that was able to procure at the best possible price, have access to the widest range of vaccine candidates and then be able to distribute them globally based on the fair allocation mechanism that WHO set up with partners.

Over the last few months of course things changed and many countries went ahead and did bilateral deals and have their own supplies but the COVAX facility is not going to penalise countries for doing that. However in the first wave of allocations we are looking at whether countries have started vaccinating already or not and those countries - the DG mentioned 130 countries have not got a single dose of vaccine.

So there is prioritisation particularly for the early doses that are being shipped out in February and March for countries which do not have any vaccines at all. There's also the option for countries to opt out; countries that have got vaccines through other sources can opt out at any time of receiving so that those doses can then be reallocated to the other countries which may not have access to anything.

So it was set up to be a very fair mechanism. Things have changed over the last few months but we still want to stick to the original principles that we based it on. Thank you. I don't know if Drs Aylward or Simao want to come in.

Thank you. I would like now to invite Helen Branswell from Stat to ask the next question. Helen, can you hear me?

Yes, thank you, Fadela. Hello to you all. During your opening remarks this morning, Dr Tedros, you mentioned that the WHO would like companies to start sharing their dossiers faster to get emergency listings through WHO. Can you give us a sense of who has done it and who isn't coming to WHO to get an emergency listing fast enough? Thank you.

Thank you, Helen. Dr Simao will take this question.

Thank you, Helen. That's a very good question. WHO has launched what we call an expression of interest for companies to submit their dossiers, phase 2B and phase three only, to WHO. In
October last year we received 15 submissions, 13 that were considered eligible. We have issued one which was the Pfizer and we have four vaccine candidates in a very advanced stage.

What I'm going to tell you now is public; you can find it on WHO's website. It's updated weekly; the stage of the assessment of each of these vaccine candidates is on WHO's website. So we have at a very advanced stage already the two Chinese manufacturers, Sinopharm and Sinovac.

We have had a team of inspectors in China since the second week of January. They're waiting for the quarantine to finish and they will start inspections next week. We have two vaccines that should have a decision on 15\textsuperscript{th} January which are two AZ-derived vaccines. One is the Serum Institute of India and the other one is the SK Bio in Korea, which are vaccine producers that will provide to the COVAX facility so we'll have a decision.

What we want is that those vaccine manufacturers that have more advanced vaccine candidates, finalising phase 2B or phase three trials, to come to the WHO emergency use listing. Why is this important?

Because the WHO pre-qualification of vaccines has existed since 1986 so it's not a new product, it's not a new service that WHO does and it has pre-qualified 160 vaccines throughout all these years. This facilitates two things; firstly UN procurement by UNICEF and PAHO; and secondly it facilitates what we call the reliance mechanism.

It facilitates that countries that do not have strong experience in assessing vaccines because they do not have production or whatever can rely on WHO's assessment to do an emergency use authorisation or to allow entry into the country.

But WHO can only progress if it receives the information it needs from the companies; that's the call that we have. The criteria for the assessment are internationally agreed criteria and it does not differentiate whether it's a multinational manufacturer or a developing country manufacturer. These are internationally agreed criteria and they were published last year as well.

So we very much welcome that companies do provide the information according to these criteria that includes safety, quality, which you see in the clinical trials, but also good manufacturing practice. Thank you.
Thank you, Dr Simao. I would like now to invite Nina Larson from AFP, Geneva to ask the next question. Nina.

NI Hello, can you hear me?

FC Yes, very well. Go ahead, Nina.

NI Thank you for the question. The pandemic appears to be slowing across the world according to your latest epidemiological update. How much of that slow-down do you think is due to the vaccines that are out there now and how much do you fear the new variants could jeopardise that progress? Thank you.

FC Thank you, Nina.

MK You all looked at me to answer that question. Thank you, Nina, for the question. I think it’s a good point to highlight the fact that we are seeing declines in incidence in a number of countries and this is certainly good news. This is due to a combination of factors, most notably the public health and social measures that countries are putting in.

It's about the tried and true, the tested interventions that we know work, that break chains of transmission, that prevent infections, that prevent those that are infected from passing it to someone else. What we're seeing is that the use of active case finding, finding where the virus is, using the testing systems that are in place, the PCR tests, the antigen-based tests that many countries are using now and we hope more countries will start to use - because these are easier to use and are welcomed in a number of different types of settings - making sure that testing is strategic, that results get back quickly to individuals so that public health action can be taken which includes isolation of cases.

Good clinical care, making sure that patients enter the clinical care pathway and they're assessed rapidly based on their need. You heard from two amazing healthcare professionals about the importance of nursing and providing that direct care to patients in need.

Making sure that our health workers are protected, they're trained, they are trained in caring for patients with COVID, they are protected with the vaccine, they are protected with personal protective equipment and that they are trained in optimised care for individuals.
This also includes contact tracing so of the individuals who are infected we carry out contact tracing so those who have come in contact with infected individuals can have supported quarantine so that if they are to become infected they can't pass the virus to somebody else.

It includes governments and communities engaging and informing individuals about what they need to do. All of these different actions are really critical for breaking chains of transmission. Vaccines and vaccination are another incredibly powerful tool. Right now the use of the vaccines is focused on those most at risk from severe disease and those most at risk from infection.

Again you heard from these health workers who are so happy to have been vaccinated but we need equitable vaccines around the world to ensure that health workers all over the world receive this vaccine.

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So it's a combination of factors why we're seeing declines in incidence but I think what is really critical is that countries that are reducing transmission continue to take all measures they can to drive down transmission.

Individuals have a role to play in this with physical distancing that must continue, the wearing of masks but making sure that when you wear a mask your hands are clean before you put them on, when you take them off you dispose of those masks appropriately if they're single-use masks, making sure that you open windows, you avoid crowded spaces.

All of these actions are driving down transmission and all of these actions need to continue. It's a really critical period for countries that are having declined incidence, that they stay the course and that they continue to adhere to these measures that are in place and when appropriate based on the data, based on the localised situation open up very slowly and use this in a slow and a staggered way.

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So it's really important to stay the course. There are a number of factors; there's no one solution, as you've heard us say many times. This includes the vaccine and vaccination. We keep saying, do it all, and we mean to keep doing it all.
Thank you, Dr Van Kerkhove. I would like now to call on Ker Simons, NBC, to ask the next question. Ker, can you hear me?

Yes, I can. Good afternoon. Could I ask a couple of questions about the origins investigation, one housekeeping if you like? You've published a terms of reference last year on the investigation but the latest terms of reference published, I believe, in January are behind a password. I'm sure there's nothing to it but could I ask that somebody just helps us by removing the password so we can see the latest terms of reference?

Then more importantly, could I ask what you plan to publish at some point in the investigation and could I ask for a commitment that you will ensure that you publish more details than just conclusions, what questions were asked, what tests were done and what data was looked at? Thank you.

Thank you, Ker.

I can answer the second part of the question. I can't answer the first part of the question related to the password so we'll have to look into that because I'm not aware of anything online that requires a password.

[Inaudible]

Okay, we'll come back to you on that. I'm sorry, I can't hear. The team is, as you know, working now with Chinese counterparts and carrying out several different field missions. They visited hospitals, they visited labs including the Wuhan Institute of Virology. They have been visiting several different Centres for Disease Control at different levels, at the provincial level and the district level for example, and they're having constructive discussions with their counterparts.

There are many, many questions that are asked. Every question that is answered, there're always more questions that are asked. They are looking at data and analysing data together and they will be working on a report. After all of our missions we always have a report. The contents of that report are being drafted by the international team members as well as the Chinese team members. We don't have a view on that. That needs to be done by the scientists who are in the field.
The terms of reference, as you saw, that were published outline the suite of studies that are ongoing but as you can tell from that there are a number of studies that will be done and we will have some results but that's just the start; there will be more studies that will need to be continued.

So the report itself will not provide all of the answers; it was never intended to because that's just not possible but it will provide a summary and a report of what was done during the mission and of the findings of some of these early studies. I think that's as much as I can say right now and so we will provide that report when it is available, as soon as it is available.

MR There is no password associated with that link. Maybe the link is broken for you and I believe that on that webpage a paragraph was added to the web part but the terms of reference are there as before. So if you have a problem please contact our press team and they'll ensure that they help you through the process but it's not a protected file, never has been.

00:37:36

FC No, it wasn't. Ker, please do send me an email and we will try to fix this and to send you the right way to open the document. Thank you, Ker. I would like now to call on Catrine Fianco Bukonga to ask the next question. Catrine, can you hear me?

CA Yes, Fadela, perfectly, thank you. Good evening. Good evening to all of you. I have a question regarding the use of vaccines. As there is a shortage of vaccines certain countries have decided to use a combination of different products meaning Moderna, Pfizer, Sputnik 5, Sinovac. Is it a problem?

I would like to know, how is the follow-up organised to gather the data about the use of products for side-effects and other effects that have to be followed? Thank you so much.

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

SS I think that's an excellent question and there are a couple of elements to that. The first one is what is recommended. Currently what is recommended is the second dose of the same vaccine; most countries are recommending that and WHO has made - SAGE has made recommendations for Pfizer and Moderna vaccines and will do for the others as well.

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What is important is to do the studies, the research to find out if you can actually combine two different vaccines either using the same platform like a Pfizer and a Moderna both with the MRNA, or even more interesting would be to combine two different platforms so an inactivated vaccine followed by an MRNA or a spike protein vaccine.

So these research studies are beginning and it will take us some time to get those results. Meanwhile we are aware that some countries have made in their guidelines the provision in very rare cases to be vaccinated with a second dose of a different vaccine but that's certainly not the practice.

The WHO's had several rounds of discussions on this; we hosted a big research seminar with 2,000 people who attended two weeks ago. The idea was really to bring everyone together, the developers and manufactures as well as the scientists and academics working in the field, to identify the big knowledge gaps and the priorities going forward.

Questions like this were identified as top priorities, as was the question of what does one do with the different variants, what are the assays that need to be done in the lab, what are the clinical studies that need to be done, what are the different designs.

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So the plan is very soon, in the next few days to convene again perhaps a smaller group particularly including the vaccine developers to agree on what kinds of research studies need to be done, invite expressions of interest. Our partner in COVAX, CEPI, the Coalition for Epidemic Preparedness, has actually invited applications from people who want to do research studies but it would be a really good idea to co-ordinate that and we hope that WHO will play a role in actually bringing all of that evidence and data together as we did for therapeutics. It'll be important to really build that platform and the knowledge for vaccines as it's accumulating rapidly, information about vaccines both from the roll-outs that are happening now in countries and observational studies but also more randomised clinical trials are going to be needed to look at questions like the duration and the gap between doses as well as combining different vaccines.

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The feeling I get is that many manufacturers are actually quite interested in participating in a thing like this because I think in
the future it will be important for that data to be generated so we will make it as inclusive and transparent as possible. Thanks.

FC    Thank you, Dr Swaminathan. I would like now to invite Tomo Diguchi from Kyodo News to ask the next question. Tomo, can you hear me?

TO    Yes, perfectly. Can you hear me well, Fadela?

FC    Very well. Go ahead, please.

TO    Thank you. A question on the Olympic Games in Tokyo. The President of the Tokyo 2020 Organising Committee, Yoshiro Mori, said that the Olympic Games will be held in Tokyo this year no matter what happens, which means that he's not going to take into account how this pandemic unfolds in the coming months.

I'm sure the WHO can see the great importance of a risk-based approach. What is WHO's advice to a leaders like Mori who makes such comments, not recognising the situation based on scientific evidence and reality? Thank you.

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FC    Thank you, Tomo. Dr Ryan.

MR    Thank you. I know there is a collective desire around the world on everyone's part to move ahead with the Olympics. We've said it here before; it's a massive, important symbol of unity and solidarity around the world. What I do know is that the Government of Japan, the organising city of Tokyo and the IOC have been working diligently together and I am absolutely sure that they're taking every ounce of data into consideration as they move towards the Olympics.

We work with them and we input to the taskforce on risk management and we will continue to do so. The decision to host and continue with Games is a joint decision of the host country and the International Olympic Committee and I'm sure they will engage.

The desire to have the Games is a laudable desire and the will to move forward is a laudable will but I am sure the Government of Japan and all its officials will take all of the data into account as they move towards the Games and they will make the correct decision on behalf of the people of Japan, the athletes and potential spectators.

00:44:23
Thank you, Dr Ryan. I would like now to invite Isabel Sacco from EFE to ask the next question. Isabel, can you hear me?

Yes, good afternoon. Thank you very much, Fadela. My question is on [unclear] on treatment. This [unclear] is being widely used in many available countries as treatment for COVID patients and in several countries - for example in Latin America - is advised by the health authorities even if its efficacy is not completely proven, or its safety.

Many many people, plain people [?] are using this [unclear] also as a preventive. I would like to know what is the position of the WHO on this issue and when do you expect to have results from the [unclear] involving [unclear] in the Solidarity trial? Thank you.

Isabel, the last sentence was not very clear. Is it okay?

The question regarding all that I said is I would like to know the position of WHO regarding Ivermectin [?] and when do you expect to have results from the trial involving this drug in the Solidarity trial?

Thank you, Isabel. Dr Van Kerkhove will take this question.

Yes, I will start and Soumya's going to answer the second part of the question. Currently we haven't made a recommendation on the use of Ivermectin but we're closely following the research that is ongoing related to this drug, which has shown some promising results in some trials for the treatment of COVID-19.

We're aware that there's currently data available of about 1,500 study patients, just slightly less than that, from 11 studies and there's data expected from up to more than 7,000 patients in 56 studies and these studies are of varying quality.

We have a WHO steering committee that is tracking these studies and closely looking at them in order to trigger the guidance and when we have enough information to look at guidance and updating our guidance to change policy. This may begin in the coming weeks.

So any of the changes that come from WHO-recommended treatments follow an expedited but an incredibly complex review which will be shared with the public at the earliest time that we can. Do you want to cover the second part? Thanks.
Thanks, Maria. Just to clarify that Ivermectin was not prioritised for inclusion in the Solidarity trial. As you know, we have an expert committee that looks at which drugs should go into the Solidarity trial and we're just in the process of finalising the next set of drugs that would be tested in the Solidarity trial but Ivermectin is not part of it.

Just to add to what Maria was saying, we have this process of the living guidelines update which means that we're tracking all the developments in the treatment of COVID-19 in the different clinical trials that are going on all over the world and we do living updates of the meta-analysis so as every trial gets completed it gets added on and it adds to the weight to the evidence and then the guideline developing group actually looks at the evidence and then makes a recommendation and then that gets updated on the living guideline platform.

They're now looking at aisle six inhibitors, they're looking at Heparin-like anti-thrombotic agents, they're looking at Ivermectin the next couple of weeks and then at a few other drugs. So we'll keep updating the guideline but it's really based on examining all the evidence from all the clinical trials.

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The problem is there are many small trials which sometimes give you misleading results and people get either very excited or very depressed about a result which is actually scientifically not valid. So we have to be very careful when we interpret results from these small trials and we need to really review the evidence as a whole. Thank you.

MR    Again very often in situations like this - and this is where we need all of science to work together - we often see observations when you'll see it written in the newspapers in vitro you can demonstrate that a particular drug can kill the virus or inhibit the virus in vitro. That means in a test tube or on a dish. That doesn't necessarily mean in a human body and there are all kinds of issues there.

Also astute clinicians over the years often observe that a drug that's been used in one disease, for one indication can potentially be used in another and they make observations on that and often they publish what's called a case study or a clinical series. They publish and say, look, I've observed this, I've treated a few patients, I think this might work.

00:49:37
That's then often picked up and put into small-scale clinical studies where you do prospective; you wait to get the patient, you use the drug and you collect your data. The difficulty we have with that situation is that can often, as Soumya said, lead to conflicting information; many, many small studies; one says it might work; others say it doesn't.

What you need are large-scale clinical studies that can definitively answer the question. It doesn't mean the drugs are bad or good. It just means we cannot give a definitive answer on that but it is important to recognise too that all of these drugs - and you will hear people say, oh, these drugs are safe or they're well-tolerated.

Most drugs are but all drugs have side-effects so therefore it's really important that we have evidence that shows that the benefit of taking a drug outweighs any risk of taking that drug. So the widespread use of a drug on the basis of a hunch is not necessarily the best way forward.

Having said that, it's really important that physicians and doctors and nurses are out there observing because very often breakthroughs come from unusual observations so we want to see that continue but we also want to bring all of that data together in a way that it can drive long-term policy.

00:50:53

FC   Thank you, Dr Ryan. I would like now to call on Abdullah Ohassan from Morocco; Morocco Media News. Abdullah, can you hear me? Abdullah?

TR   Yes, I can hear you. Good afternoon. Thank you for giving me the floor. I would like to ask, why are we not building a factory to create vaccines here in Morocco so that we can provide vaccines on the African continent? Thank you.

FC   Maybe Dr Simao will answer and, Abdullah, you have the translation too.

MS   Thank you very much, Abdullah. This is a key issue as we fight this pandemic, the need to increase manufacturing capacity in different parts of the world so your point is very well made. It depends a lot on the government interests and the investments that are needed but WHO is pushing for what we call the CTAP, which is a platform that allows for technology transfer, for voluntary licensing of intellectual property and that also fosters through the technology transfer the strengthening of capacity at country level.
Let me say, there is one global partner with WHO on increasing manufacturing capacity which is the Developing Countries Manufacturing Network. That comprises, I think, 50 manufacturers in developing countries. That can help also in this process but your point is well made and it's very important that all countries take stock and assess their technological capacity to receive technology transfer and also assess their legislation to allow for that. Thank you very much.

FC Thank you, Dr Simao. I would like now to call on Shane from CCTV to ask the next question. Shane, can you hear me?

SH Yes, I can hear you. Can you hear me, Fadela? Thank you. A question for Dr Mike Ryan and Dr Maria Van Kerkhove. [Unclear] the virus is a complex scientific issue. Then more recent studies and reports have shown that clues to the existence of the virus have been found in human environmental samples preserved in multiple places in the world before December 2019.

At present an international expert team led by WHO is conducting the zoonotic source research with Chinese experts in Wuhan in China. Do you have plans to send similar expert teams to other relevant countries for global research co-operation, countries in the south as well? Thank you.

FC Thank you, Shane.

MK Thank you for the question. There are a number of different pieces of work that WHO is working on. You mentioned the waste water. I think you've probably heard me say before, in any situation, any study that has been published, either waste water studies or sera or clinical samples that were collected and tested in 2019, we are following up on.

We are doing this through our international laboratory network and we are reaching out to the individual researchers directly. We involve our regional offices as well and we're discussing with them the findings that they have, whether these are pre-print studies - because some of the reports that you're mentioning actually have never been published in peer-reviewed journals but nonetheless we're still following up with the researchers themselves to find out if we can do some further collaboration an further work if there are any remaining samples that exist and some follow-up.
So there are a number of collaborations that are underway but every one that has been reported that we are aware of we are following up directly with individual researchers.

Thank you. I think I will take the last question from Ann Gilland, the Telegraph. Ann, can you hear me? Ann?

Hi, yes, sorry, unmuted. Thanks very much for taking my question. I had a question for Dr Simao. At the beginning in the answer to Helen Branswell's question you said on January 15th - and I'm presuming February 15th - you're going to make an announcement about two vaccines. Is one of those the AstraZeneca vaccine, is that correct, whether you're going to issue the emergency use licence?

Also I just wonder why it's taken so long because you've had the data for quite a long time. Thank you.

Thank you, Ann, and apologies if I said... It's February 15th. Our technical advisory group that will assess it as independent experts meets in Geneva to assess two vaccines. One is the Serum Institute of India which is an AstraZeneca vaccine and the other is the SK Bio, which is also an AstraZeneca vaccine being produced in the Republic of Korea.

 Actually let me make it very clear because we only received the dossier from the Serum Institute on 15th January so we didn't have this data for a long time. We received the full dossier for the India production on January 15th and last week, I think on 29th January, we received the last data for the AstraZeneca SK Bio.

What we have are these rolling submissions so this data only came to WHO a very few weeks ago, just to make this very clear. What we had beforehand was the AstraZeneca core data because you know that AstraZeneca has eight manufacturing sites. We had, I think, early in January the regulatory authority in the UK assessing and giving a conditional use for some batches of the UK-based manufacture.

Then we have the EMA assessing the core data for the two European-based manufactures. So what we do is, the core data we assessed and it serves for any of the AstraZeneca sites that will come to COVAX and apply for WHO. But WHO for the COVAX facility needs to assess the SII. It's an AstraZeneca-derived vaccine but it has a different production site, and also for the SK Bio.
So very clear that we only had this data very recently, the full dossier. Thank you.

Dr Ryan, you have the floor.

Just before the DG takes the floor I'm going back to the very first question that was asked because I think was a very pertinent question. We talked about, are we turning the corner. The problem sometimes with corners is you don't see what's around that corner and this virus still has a huge amount of energy.

There's a massive force of infection still associated with this virus. This is like a floodwater; just because the floodwaters have dropped an inch or two it doesn't mean the flood's going to go away because it's still raining upstream.

From our perspective communities around the world deserve huge credit. For the last number of weeks compliance and buy-in and participation from communities and lock-downs and stay-at-home orders and wearing masks and avoiding crowded places; that's what's pushed the virus down.

The virus isn't going away by itself and it won't. It will go away when we put it away and communities deserve credit for that. It's been a tough number of weeks for people of many countries and it's beginning to pay off and adding vaccine into that equation is going to double and triple the pay-off in the lives that we can save.

But we have to follow through and we have to do everything to continue pushing that number down. Remember what happened the last time someone said, we're turning the corner.

Thank you. Thank you, Mike, for that intervention. I would like to add to that; since the vaccinations started, as Maria said, it could have some impact but there are some observations from our data even before starting the vaccine where there are significant declines in the number of cases and deaths.

I would actually like to bring one country especially with a very significant decline starting from September and that's India. On 14th September the weekly number of cases was 646,000 and now in the week of 25th January 91,000 per week so from 646,000 to 91,000 is significant so it was a constant decline.
Then not only cases; if you take the number of deaths in September again, the week of September 14\textsuperscript{th} the number of deaths per week was 8,166. Now in the week of January 25\textsuperscript{th} it's 935 deaths per week. This is also very significant so continuous decline.

This shows us that if we can do the simple public health solutions we can beat the virus. Now with the vaccination, with the vaccines added we would even expect more and better outcomes but the decline actually started before the vaccines started and this actually is good news because with the vaccines added the outcome could even be better.

But our consistent advice to all countries is do it all; all the public health measures plus vaccine; better impact. Thank you so much and thank you for joining us today. See you at our next presser. Bon week-end.

FC Thank you, Dr Tedros. I remind journalists that they will be receiving the audio file and Dr Tedros' opening remarks right after this press conference. The full transcript will be available to you tomorrow morning on the WHO web...

\textbf{01:02:40}