COVID-19

Virtual Press conference

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Speaker key:

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BA	Dr Bruce Aylward
SS	Dr Soumya Swaminathan
BE	Belisa
KOB	Dr Kate O'Brien
CH	Chen
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00:00:36

CL Hello and welcome to today's global COVID-19 press conference, and on other health emergencies. It is Tuesday 18th January 2022 and my name is Christian Lindmeier. As guests today, as participants we have a full room again and we'll start with Dr Tedros Adhanom Ghebreyesus, the WHO Director-General, Dr Mike Ryan, Executive Director for WHO's Health Emergencies Programme, Dr Maria Van Kerkhove, Technical Lead on COVID-19, Dr Soumya Swaminathan, Chief Scientist, Dr Mariangela Simao, Assistant Director-General for Access to Medicines and Health Products, Dr Soce Fall, Assistant Director-

General for WHO's Health Emergency Programme and responsible for emergency response.

And we have Dr Bruce Aylward, Senior Advisor to the Director-General and the Lead on the ACT Accelerator and we have online with us Dr Kate O'Brien, Director for Immunisation, Vaccines and Biologicals.

Simultaneous translation is provided in the six official languages and I believe we have Portuguese as well. With this, let me hand over to the Director-General for his opening remarks and one more time, thank you for standing by for the delayed start today. Dr Tedros.

00:02:18

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. The volcanic eruption near Tonga and subsequent tsunami requires an urgent response. With telecommunications down WHO is on the ground in Tonga helping co-ordinate the response by channelling information between UN agencies, humanitarian partners and the Tongan Government.

Information on the degree of destruction is still being gathered but WHO will do all it can to support the people and government of Tonga. I visited Tonga myself in 2019. I recognise how vulnerable to natural disaster and the climate crisis the country is but also how resilient and resourceful the people are.

All the very best from WHO and we will do everything to support Tonga.

Omicron continues to sweep the world. Last week there were more than 18 million reported cases. The number of deaths remains stable for the moment but we're concerned about the impact omicron is having on already exhausted health workers and overburdened health systems.

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In some countries cases seem to have peaked, which gives hope that the worst of this latest wave is done with but no country is out of the woods yet. I remain particularly concerned about many countries that have low vaccination rates as people are many times more at risk of severe illness and death if they're unvaccinated.

Omicron may be less severe - on average of course - but the narrative that it is mild disease is misleading, hurts the overall

response and costs more lives. Make no mistake, omicron is causing hospitalisations and deaths and even the less severe cases are inundating health facilities.

The virus is circulating far too intensely with many still vulnerable. For many countries the next few weeks remain really critical for health workers and health systems. I urge everyone to do their best to reduce the risk of infection so that you can help take pressure off the system.

Now is not the time to give up and wave the white flag. We can still significantly reduce the impact of the current wave by sharing and using health tools effectively and implementing public health and social measures that we know work.

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I'm proud COVAX delivered its one billionth dose over the weekend. Of course it's not enough and we should do more. At a time of omicron it remains more important than ever to get vaccines to the unvaccinated.

Vaccines may be less effective at preventing infection and transmission of omicron than they were for previous variants but they still are exceptionally good at preventing severe disease and death.

This is key to protecting hospitals from becoming overwhelmed. We have been able to track new variants like omicron and this virus evolution in real time thanks to efforts of thousands of scientists and experts around the world.

More than seven million whole genome sequences from 180 countries have now been submitted to GISAID, which was initially set up to track flu. This pandemic is nowhere near over and with the incredible growth of omicron globally new variants are likely to emerge, which is why tracking and assessment remain critical.

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New formulations of vaccines are being developed and assessed for how they perform against omicron and other strains. I'm concerned that unless we change the current model we will enter a second and even more destructive phase of vaccine inequity.

We need to make sure we share current vaccines equitably and we develop distributed manufacturing around the world. We can only beat this virus if we work together and share health tools equitably. It's really that simple.

On Friday WHO recommended two new COVID-19 treatments based on data from seven trials, again increasing the arsenal of tools used to fight severe illness and death, a rheumatoid arthritis drug called baricitinib and a monoclonal antibody called sotrovimab.

Again the challenge is that high prices and limited supply means access is limited. WHO is working with our partners in the ACT Accelerator to negotiate lower prices with manufacturers and ensure supply will be available for low and middle-income countries.

We urge manufacturers to use WHO's COVID-19 Technology Access Pool to share technology, know-how and voluntary licensing in order to facilitate increased production capacity globally, which would save the most lives.

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WHO's COVID-19 clinical management guidelines have been critical to policymakers and health workers so that they can access the latest information on how best to treat patients with COVID-19. Sharing clinical data remains critical so that WHO can generate up-to-date scientific evidence regarding omicron.

WHO invites all member states, health facilities and research networks to voluntarily contribute to the WHO global clinical platform for COVID-19, which is available through our website.

Next week the WHO executive board, which is made up of 34 member states, will meet to discuss the world's health challenges. The pandemic will remain at the forefront, particularly how to more effectively share tests, treatments and vaccines equitably and to meet the 70% vaccine target by July 2022.

However the impact of the pandemic on other health issues has also been devastating and member states will be discussing how we can stop the backsliding and recover together. WHO will be working to accelerate progress on negotiations around the pandemic accord as well as sustainable financing.

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If we're serious about strengthening health systems, preparing for future pandemics and tackling the litany of health challenges we collectively face in a heating world WHO and the whole global health infrastructure will need to be sustainably financed.

Reports from the global pandemic monitoring board, the independent panel for pandemic preparedness and response and the review committee on the functioning of the International Health Regulations all recognised the need for predictable and sustainable financing at all levels of the organisation.

We don't need more reports or speeches. Now is the moment for financing that fits the health challenges of our time. This month is Cervical Cancer Awareness Month and I'm pleased to see both action and advocacy taking place.

Yesterday Serbia announced that this year they would introduce vaccination against human papilloma virus or HPV, the pathogen responsible for 99% of cervical cancers. Serbia will join 116 countries worldwide that are vaccinating against this cancer-causing virus.

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My sister, Princess Dina Myart [?], who is a member of the WHO expert group for the elimination of cervical cancer, marked the anniversary of WHO's global strategy by calling for a comprehensive approach to vaccination, screening and treatment.

Princess rightly concluded that cervical cancer elimination is both possible and smart economics. Christian, back to you.

CL Thank you very much, Dr Tedros. With this we are opening the floor for questions from media. When you are called upon please unmute yourself. We have a long list already and we'll start with Laurent Siero from Swiss News Agency. Laurent, please unmute yourself.

LA Thank you for taking my question, a question on the tests because a South African study tends to show that salivary tests might be more accurate and more efficient to identify the omicron variant and that wasn't the case with delta.

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Does that mean that we should shift massively toward salivary tests in order to better identify that variant? Thank you.

CL Dr Van Kerkhove, please.

MK Thanks very much for the question. It's a good question. As you know, there are a number of tests that are available to detect the SARS-CoV-2 virus including the omicron variant. We have been evaluating all of the tests that are being used, PCR tests, the antigen-based tests that are out there, particularly the

EUL-approved ones as well as others that are being used around the world.

Some of these use the swabs up the nose and there's a pharyngeal swab, some from the throat and there are also tests that use saliva. We encourage the use of multiple types of test that can be used. I'm not aware specifically of the data you mention in the study that came out today but we do know that the tests that are in use right now remain sensitive to the omicron variant, they can detect this variant including the antigen-based tests, the PCR tests and saliva-based tests that are out on the market.

As you pointed out in your question, it's not the time to make a massive shift to recommend one or the other. What we really need to do at a global level is to ensure that testing is accessible, is affordable and is reliable in all countries and that testing is linked to action so that the patient that is being tested knows what to do.

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The goals remain to reduce transmission and so it's really important that we know where the virus is, where the virus is spreading and that people know how to get into the clinical care pathway to receive the care that they need. That is needed in all countries, not just in high-income countries or middle-income countries, in all countries.

So we have been working to ensure that affordable, reliable tests are accessible. We'd like to see more antigen-based tests being used because these are cheaper, they tend to be a lot cheaper, they tend to be quicker in terms of getting results back but again it's important that those results are used for public health and for that individual, to help that individual and that they're accessible around the world.

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CL Thank you very much, Dr Van Kerkhove. The next question goes to Corinne Critler from Bloomberg. Florin, please unmute yourself.

CO Hi. I just wanted to ask, in light of the reports out today about animals like hamsters being infected with COVID and being culled, I wanted to check on the latest insights from the WHO on the risk of animals harbouring the virus because I think there was a consensus a while back that such animals have little chance of infecting humans.

CL Thank you very much, Corinne. We'll go back to Dr Van Kerkhove.

MK Thanks, Corinne, for the question. We are working with a number of scientists around the world, experts around the world as well as our partners at FAO and OIE, our partner agencies, focused particularly on animal health and looking at animal susceptibility to SARS-CoV-2 across a wide variety of species.

This is done looking at experimental infection as well as natural infection that's detected out in wildlife and in domestic species. We understand there are a number of species that can be infected with SARS-CoV-2 and then of course there's the possibility - we call that a reverse zoonosis - it goes from humans back to animals and then it's possible for the animals to reinfect humans.

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That risk remains low but it is something that we are constantly looking at because what we don't want is to have, as this virus circulates it has the opportunity to infect people as well as animals.

So this is something we need to have better surveillance on, looking around the world at not only which animals are susceptible but to track this in animals over time.

I will use this also as an opportunity to say that of the seven million sequences that have been shared around the world and submitted to platforms like GISAID - and we're grateful for platforms that can house this material so people can analyse this - around 1,500 of those sequences are from animals.

So what would be very helpful for us and our partner agencies is to really understand the extent of this infection in animals as well, beyond people of course so that we can track this and understand what risk this may pose.

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So this is something that we are looking at. We don't talk about it very much up here but we have many working groups looking in animals, at the animal/human interface to look at the possibility of humans infecting animals as well as animals infecting humans back again.

CL Thank you very much, Dr Van Kerkhove. The next question goes to Gabriela Sotomayor from Progreso. Gabriela, please unmute yourself.

GA Hi, hola. Do you hear me? Yes.

CL Very well.

GA Okay. Thank you very much. My question is on Mexico. The President of Mexico said that omicron is a little COVID for people who are already vaccinated, it's a COVIDcito in Spanish, he said. But cases and hospitalisations in Mexico begin to increase exponentially, not enough tests are available in various parts of the country and there is a lot of worry about children.

Children have not been vaccinated, children between five and 12, very few children between 12 and 17 years old so there is a lot of concern because of the high index of childhood diabetes and also obesity.

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So my question is, with this scenario what is your forecast for Mexico and what are your recommendations? Thank you so much.

MR Thank you. This has been something that's happened with every wave and particularly with omicron, that an exponential rise in cases, regardless of the severity of the individual variant, leads to an inevitable increase in hospitalisations and deaths. We're seeing that not just in Mexico, we've seen that in North America, other parts of North America, we've seen that in Europe and we're beginning to see that in other parts of the world.

So that's certainly not unusual and WHO has been warning of this since early December, suggesting that speaking purely of this as a mild virus or less severe gives an impression that this would be less severe in its impact on the health system.

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That is not the case if the virus is able to spread uncontrollably throughout society and that's why we have advised continued adherence to measures to try and keep the virus under control while we protect the health system and get through this wave.

So I don't think the experience and the challenges faced by Mexico are exceptional compared to other countries. Certainly for the most part children who experience SARS-CoV-2 or COVID-19 have a mild course of disease.

There are a subgroup of children with underlying conditions that do potentially have a more severe course of disease and many countries have moved to include them in vaccination programmes and again, as the Director-General has said, the

pathway to a long-term control of the impacts of COVID-19 and ultimately on the pandemic itself lie in increasing the number of people who are vaccinated, particularly those who are vulnerable.

So I don't think the situation or the case of Mexico is exceptional. All countries are facing a very similar scenario right now as we try to get through this wave of disease. Maria, I don't know if you have anything to add.

CL Thank you very much for this. Let's move on to Shoko Koyama from NHK. Shoko, please unmute yourself.

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SH Hi, Christian. Thank you for taking my question. Regarding omicron, last week the technical advisory group on COVID-19 vaccine composition issued an interim statement. Quote - the composition of current COVID-19 vaccines may need to be updated to ensure that COVID-19 vaccines continue to provide WHO-recommended levels of protection - unquote.

I just wanted to clarify, do you consider at this stage such an update is necessary in terms of provide levels of protection against infection and disease by omicron? And if so what's your message to vaccine manufacturers? Thank you.

MR Thank you for the question. No, again the statement was clear that the vaccines may need to be updated and you'll also recall in the same statement the TAGCOVAC asked that researchers and manufactures could move ahead and produce small batches of vaccine that could be tested for their possible utility and use at a later stage.

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The issue here is that the vaccines right now that we have are providing very high levels of protection against hospitalisation and death against all of the variants. Every time someone gets a first dose or a second dose or in the case of a third dose in vulnerable people, not only are we increasing antibodies against the disease but we're helping the immune system become more mature in its response.

Dr Soumya may wish to speak to this but this isn't just a matter of boosting to get antibodies. This is a matter of how quickly does a mature and long-lasting immunity develop and there is a certain group in our population who may be immunocompromised or may have underlying conditions and

they don't generate a robust immune response with just the first dose or the second dose and they may require further doses.

Now they're called booster doses. In future we may have an extended primary course for a subset of our population. So from that perspective I think it's very reassuring. We were very blessed globally and lucky in many ways that so many of the original vaccines proved to be so effective against SARS-CoV-2.

We're also in that sense very pleased and grateful that the vaccines remain so effective against the omicron variant in terms of preventing hospitalisation and preventing deaths.

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No, at this point WHO does not have any immediate intention to advise a change in the composition of the vaccines but there are many considerations. I'd point you back to that document, and other journalists online. The committee do outline the specific considerations and the specific options that will be on the table and what they would like is to have that discussion in a data-filled environment.

What they're asking researchers and others to do is to go out, generate the data, bring that data back so that we can have a global discussion based on global needs where the public and the private sector can engage in a dialogue that allows us to collectively develop the next generation of vaccines and that this does not become a unilateral choice of any individual or any individual company or any individual system to be able to dictate what the world needs in terms of future vaccines.

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These are very important decisions and there is a lot to consider. There are risks and benefits every time you move away from a given set of therapeutic or preventive interventions. There are rewards in doing that if you've got new products that are better but there are also risks in doing that if you don't sustain the benefits you've got from the products you're already using.

So these are important policy considerations that must be driven by good data, an open, transparent discussion on what that data actually means and I suppose this speaks to the absolute heart of why science must be at the heart of the next phase of decision-making regarding what we collectively choose on this planet as any second or third-generation vaccines.

Bruce or Soumya may wish to comment.

CL Dr Aylward.

BA Yes, just to add a point to what Mike has just said, Shoko, because the way you hear this discussed in the press sometimes - sorry, now. I don't want to make enemies of the press who get it so right but sometimes this is discussed a little lightly as strain change or switch.

Remember, every time that you make that switch or you consider a switch in the strains there're real costs, it has an impact on production, it has an impact on output certainly in the short term, it often has an impact on cost, it has an impact on price, it has an impact on programme complexity as you try and roll these things out, it has an impact on your communications agenda.

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What we're trying to do here is put out a fire as fast as possible and take the heat out of this crisis by reducing the amount of hospitalisation and death, as Mike has said, get the pressure off the healthcare systems.

So any time you think about those strain changes it's going to have an impact on access and again the whole focus right now - the one thing we've learned is we've all got to get out of this together.

So this is why this is a very big decision to make those kind of changes so, as Mike said, there are real risks as one does this as well, it can have real impacts on your ability to optimise access and Mike made the comment some time back that the best vaccine is the vaccine that you can get as rapidly as possible and then we start building from there in terms of people's immunity.

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So I think it's always useful to think of the counterfactual in terms of important decisions like this as well.

CL Dr Swaminathan, please.

SS I just want to very briefly add that the TAGCOVAC was set up basically to keep track, to pull together the threads of data and evidence that are coming from all of the other different working groups that WHO has set up, including the R&D blueprint vaccine research group as well as the TAG on virus evolution and bits of evidence from all over the world essentially to determine firstly whether the existing vaccines need any change or not.

I think we want to emphasise again that we're tracking all of the vaccine effectiveness studies that have been done around the world and are very reassured by the fact that the current vaccines are protecting people against getting severely ill and getting hospitalised and dying.

We can see from the epi curves that Maria had talked about that the absolutely explosive increase in numbers luckily has not been accompanied or has been disassociated from the deaths that we've seen in previous waves.

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So the TAGCOVAC will look to see whether there is a change needed and if so they have several options that they will consider. The first one is of course to move to a variant-specific vaccine and again it's complex because one needs to take on board the fact that if you develop a very specific vaccine that's on a very specific spike protein, is that going to essentially undermine the response to another variant that may emerge in the future?

So the vaccines we're using currently are using the original strain and they're holding out well especially against severe disease, as we mentioned.

The other approach is to take a multivalent vaccine, to have maybe two different sets of epitopes from two different strains, maybe the original strain and a variant. The third and preferred approach is to go for a pan-coronavirus vaccine that will protect at least against all the variants of SARS-CoV-2 but eventually one would like to have a vaccine that protects against the other beta coronaviruses, the pathogenic SARS, 1-MERS, etc, or perhaps even the other groups of...

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So that's something in the future but we have to pursue all of these simultaneously. The industry is working, vaccine companies are investing in these different approaches and we've heard from the different companies what they're doing so that's also good.

But what's good for the world, what's going to be not only the most efficient but also affordable, cost-effective and practical approach for the world? Because again if we're coming back to vaccine equity it's not okay for one country to take an approach which then uses up available supplies which could have gone to vaccinating people around the world.

So we have to keep vaccine equity because we cannot get out of the pandemic and we've said this many times but it is very important because if we want to end the pandemic then we have to take an approach that is scientifically valid but also equitable. Thank you.

CL Thank you all. Next question goes to Belisa Godinho from W Magazine, Portugal. Belisa, please unmute yourself.

00:31:06

BE Hi. My question is, will the vaccine booster be the last dose to [unclear] global immunity to the COVID virus? Can you explain a little more on the subject? In other words, if everyone in the world had been vaccinated with the booster dose would the pandemic still exist? Thanks.

CL We didn't quite get the beginning of your question but I think we'll go on the... if everybody... Okay, let's try to repeat this, Belisa, just the beginning. We couldn't hear.

BE My question is, will the vaccine booster be the last dose to [unclear] global immunity to the COVID virus?

CL Will boosters give global immunity, lasting immunity to the virus? Is that what we heard?

SS I can start and maybe Bruce or Kate may want to come in. This question of the boosters is also something that we've been looking at very closely and again we've always said that we will follow the science.

What the science is telling us now - and we look across the different vaccines that are being used around the world because if you remember, there are three aspects that can affect immunity.

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One is the person and their own status. The older you are, the more underlying conditions you have or if you're on immunosuppressive drugs then your immune system may be weak and so you may need additional help to boost that immune response so it's the biological factors.

The second of course is the variant and we've seen that starting from the beginning, the ancestral strain different variants have had different levels of immune escape and with omicron we know that it has the highest levels of immune escape or immune evasion that we've seen across all of the variant so far. Beta and gamma also had that.

Then the third variable of course is the vaccine itself and there are differences between the different vaccines in how high the antibody response is, how long the protective immunity lasts and so on.

But again the good thing is that across all of the vaccines high levels of protection against severe disease, that's the outcome we're most interested in, protection against death. Against omicron many of the vaccines have shown a reduction in efficacy against infection and that's why we see a lot of breakthrough infections but these are mostly not resulting in severe disease so that's a positive.

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There is some waning which occurs over a period of time and we've seen that there's a slight drop in the protection again mostly against infection but also a little bit against the severe disease and we need more of those studies, we need to follow this out.

That is why we've said, putting all of those together, the aim is to protect the most vulnerable, to protect those at highest risk of severe disease and dying. Those are our elderly populations, the immunocompromised, people with underlying conditions but also healthcare workers because if a lot of healthcare workers get infected, as we see now, they can be out sick and we don't want them getting severely ill so to reserve boosters for that population.

There's no evidence right now that healthy children or healthy adolescents need boosters, no evidence at all so this is why the SAGE, which is our technical expert body that makes policy recommendations, has been meeting and will continue to meet, will meet later this week to consider this specific question of how should countries think about giving boosters to their populations with a view to protecting people, with a view to reducing deaths.

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Then of course we're looking ahead to the next generation of vaccines that perhaps will block infection more efficiently than the vaccines we have today and then we can think about really trying to control transmission.

But at this point in time our focus, considering that we still have so many unvaccinated people in the world, is to provide primary doses to those who've not been vaccinated so far while at the

same time trying to protect the most vulnerable in every country's population.

I don't know if anyone wants to come in.

MR Maybe just to supplement too because I think, Soumya, we've discussed this before. It's going to be unrealistic and it think people do have a certain fear out there that this booster thing is going to be every two or three months and everyone's going to have to go and get a booster.

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I don't think we have the answer to that yet. I think it's going to be very important. Again we're back to this issue of science and data, that we collect the data because having a third dose of vaccine may raise your antibody levels but your long-term benefit may not be the rise you get in antibodies.

It may be that that third dose is allowing your immune system to mature and I think it's important people realise that the immune response to the presence of a virus or to a vaccine in producing antibodies, that's a very simple understanding of what happens.

You get infected or you get a vaccine and your body produces antibodies and it fights the infection and the infection goes away and the next time it happens the antibodies just show up and they take care of the infection.

That's true to an extent but the immune response is a much more complex process, it's a very complex biologic process and it involves the B-cell system, the antibody system and the T-cell system which is mediated by cell immunity.

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That long-term maturation - the immune response matures over time and the more that someone is exposed or the more that someone is vaccinated that can add to the maturation of the immune response and the immune response can become much more long-term, much more robust when the virus or the challenge arrives back. We won't go into detail here.

I do think it's very important now that we have many people around the world getting third shots that we look at how the immune system is reacting to that and how long the protection is from a third dose.

There may be cases of people who have very poor responses to that or people who are very compromised or are very elderly. There may be a need for a fourth dose and I suspect over time

we will come up with an evolved way of looking at what we consider to be primary series.

It may be that a healthy adult has a primary series of two doses. It may be that someone in an older age group has a primary series of three or four doses. That's what we're learning and that's why we need to connect the data to be able to understand what the long-term best decisions are in deploying the vaccines that we have at our disposal.

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CL Thank you. I understand we have Dr Kate O'Brien, Director, Immunisation, Vaccines and Biologicals, who wants to weigh in.

KOB Thank you. Just a couple of things that I wanted to add to what has already been discussed around the table. The first is that everybody around the table has emphasised the importance that we follow the data, we really make policy according to what the evidence shows and are driven by the evidence.

I think this is such an important point because at this point, at this stage we're still in the early stages of understanding omicron and the performance of the vaccines against omicron. There are only four studies that have reported on hospitalisation outcomes of omicron, a number of others that have reported on infection but not necessarily that severe end of the disease spectrum.

Although this is actually quite extraordinary to have 14 studies altogether at this point on the performance of the vaccines given that omicron has just been around really for a couple of months, nevertheless there's a very important need for additional data to help guide the answers to the questions that you're asking.

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The second is that the vast majority of people who are still being hospitalised are those who are unvaccinated and I think we just can't go past this question without emphasising again that a question on boosters is really a question about making sure that everybody who is especially in the highest risk category has at least gotten first their primary doses because you can't be talking about boosters unless you actually have people who have received their primary doses.

Then the third thing I wanted to comment on also is how much we now know about being able to mix and match the vaccines and that's another area that seems to have the potential to convert added benefit, that some of the combinations of the

vaccines may be better in fact at doing what Mike just described around maturing and advancing the immune response, that every dose is not just one more dose compared with the others that have been received before.

But each dose actually does active things with your immune system, does very active things that develop your protection more and more in a way that is not just additive, it really is making your immune response a much more mature and responsive reaction to and protection for a future exposure. Thank you.

00:41:00

CL Thank you very much, all. A quick note, I understand there are some interpretations on the Zoom link. We're trying to fix it of course but one way out would be to watch the stream on the WHO site. It should be working well there. Next question goes to Chen Wihua from China Daily. Chen, please unmute yourself.

CH Hi. My question is regarding hearing Dr Tedros talk about the divide of the world into vaccinated and unvaccinated. I want to also seek your answer on this world divided by country, practising a zero-COVID policy like China and a few others and some countries who basically gave up, considering that omicron signals the coming of an endemic.

Some actually say - I don't know, is it true? - that a country practising zero-COVID will be actually vulnerable later because their population are not exposed enough to the virus. Thank you very much. What's your preferred way forward?

CL Thank you very much. Chen is comparing the various approaches. Dr Mike Ryan, please.

00:42:27

MR I think we have to be careful when we try to compare strategies because very often the starting conditions of this pandemic set up the opportunities that countries had so for example many countries in Asia took a very aggressive position at the beginning and kept numbers very low so a zero-COVID policy was open to them because they had good control on the virus.

Other countries really got caught, blind-sided by the virus and had very large and extensive transmission so it was very difficult for them to think in terms of zero-COVID because in fact many, many countries have never been out of COVID. They've gone from high levels of COVID to slightly lower levels, maybe to low

levels at times and straight back up so we've had these progressive waves.

So I think it's very difficult to say that one country's strategy is the right versus the wrong. Countries' strategy in the face of the virus is based on what the country is experiencing, what the opportunities are for the country.

The country has to make a judgment as to, for example, how good is its testing system, how compliant will people be and how co-operative will people be with public health and social measures.

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All of that has to be taken into account so I think it's difficult but it is also... We've heard people say, well, now the countries that have had a zero-COVID approach are at risk. But I would much rather be in the situation that, for example, South Korea finds itself in, which is low seroprevalence in the sense of low natural infection, high vaccination and only 6,000 deaths over the last two years.

I want to be in that group if I'm a country. If that means that my risk is increased because I've a lot of susceptible people that I haven't vaccinated then I will try and fix that, I will try and plug that gap and there are risks and those countries who have managed to successfully keep their COVID at a low level, protect their populations and now get their vaccination levels up higher, for them it's even more important that they continue to vaccinate and find and vaccinate those who haven't been vaccinated.

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It is really important for them but in some senses there's an implied criticism in that the countries that went for low COVID, who went to control the virus have now in some ways created a risk to their population. I would much rather be in a situation where the vast majority of my population had never got COVID infection, has now got high levels of vaccine protection and may have a slightly higher risk now because we didn't have massive COVID over the last two years.

So again I think it's important that we don't imply that these countries have taken a wrong way and zero-COVID has not been in many countries. Some countries have had a zero-COVID strategy but they've realistically known that it's impossible to get to zero unless the rest of the world does.

I think the zero-COVID approach has been in the main in countries a focus on suppressing transmission to the absolute maximum, protecting populations with vaccination, having very intensive surveillance, having a very flexible system of public health and social measures, a dynamic, flexible response aimed at keeping COVID transmission to the minimum, aimed at keeping the health system free of severe disease and using vaccination to fill in the immunologic gaps in the population.

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If that's a zero-COVID policy it has my full support but sometimes again I think the argument becomes slightly twisted, of people saying, of course it can't be zero, why do you have a zero-COVID approach, it's not possible.

I think most people who have had a zero-COVID policy know in their hearts that you can't get to zero-COVID in one country unless the whole world gets there but what they're trying to do is keep COVID to the absolute minimum to protect and preserve the health of their populations and to try and keep their health systems safe from the surges that other countries have experienced.

Having said that, some countries did not get a choice in this. They ended up with a massive wave of COVID in the beginning and they didn't have a zero-COVID option. They have basically had to swim against the tide and that's not easy either so again please do not take my words as saying that the zero-COVID approach was the one to take, as sometimes that happens at these press conferences.

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What I'm saying is, the strategic and tactical choices you get in any crisis very much depend on the situation you're in. Some countries made really good choices. Some countries didn't necessary.

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

MK Yes, I only want to come in not specifically on any particular country but to support that now is not the time to give up on a strategy. We're hearing a lot of people suggest that omicron is the last variant, that it's over after this and that is not the case because this virus is circulating at a very intense level around the world.

You will see in our weekly epidemiologic update that will be published in a few hours that there's another 20% increase in

cases in the last seven days with almost 19 million cases that have been reported to us and again that's a true underestimate of what is actually circulating around.

The deaths are holding steady, around 45,000 deaths per week and that shouldn't be happening because we have tools at hand and so it is not the time to give up on the comprehensive strategy that we have outlined, that many countries are using and, as Mike has said, implement them in different ways.

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But the goals of reducing severe disease and death remain, the goal of reducing transmission remains and we can do that now. So what we don't want to see is countries giving up, we don't want to see countries abandoning well-established, life-saving interventions - distancing, well-fitting masks, investing in ventilation where we live, where we work, where we study, avoiding crowds, making sure that we have good public health systems in place.

Now is the time to strengthen that because if we don't do this now we will move on to the next crisis. We need to end the crisis that we're currently in and we can do that at the present time so don't abandon the science, don't abandon the strategies that are working, that are keeping us and our loved ones safe.

What we can't do is believe in any false hope. There's so much hope that is out there in terms of ending this severe disease that people are dealing with, with the life-saving tools that we have now. This is a dangerous virus but there is hope out there because we can reduce severe disease and death significantly with earlier clinical care, with vaccines that are reaching those who are most at risk around the world.

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This won't be the last variant of concern so now is the time to support and invest in the surveillance systems that we have around the world so that we can detect these variants, that we can assess these variants with our partners around the world, so that we can improve the advice that we give at a global level, that's implemented at a local level, that we can advise on what the next vaccine composition will need to be if that needs to be changed.

So there's a lot to be hopeful for but we have to put in this work and I just want to take this opportunity to say, now is not the

time to abandon the strategy, abandon the science and abandon what we know works.

CL Thank you very much, both. We have Dr Bruce Aylward, please.

BA Actually it was covered by now but I think maybe, Chen, just to think about your point one other way about not throwing in the towel.

00:49:59

People are concerned about variants. This is a bit of the unknown, the joker in this crisis that we're dealing with and remember, if you give up you end up with more transmission, more people infected, which means that you get more replication of the virus, you get more mutations, more risk in terms of the variants, not just people infected.

So you've got to bear that in mind. There are consequences or additional risks that we are taking if you were to, so to say, throw in the towel, as I think people have used the expression here a little bit today. There are real consequences and we don't understand all of those consequences so to the point that Mike has made, Maria, you really want to reduce transmission as much as possible.

We don't fully understand the consequences of letting this thing run and most of what we've seen so far in areas of uncontrolled transmission has been we pay the price with the variants that emerge and new uncertainties we have to manage as we go forward.

00:51:00

CL Thank you very much, all of you. We go to Jacqueline Howard from CNN. Jacqueline, please unmute yourself.

JA Thank you so much for taking my question. My question is, as companies like Pfizer and Moderna work to develop omicron-specific vaccines could those variant-specific vaccines be used for primary vaccinations globally this year instead of the current vaccines?

So essentially would they replace our current vaccines or do you still see the current vaccines being of use for primary vaccinations and do you view the variant-specific vaccines moreso as booster vaccines? That's my question. Thank you.

CL Jacqueline, thanks very much. We'll look at Kate O'Brien for a start, Director, Immunisation, Vaccines and Biologicals. Kate.

KOB Yes, thank you. You've asked a great question and the answer is that we're really going to have to see the evidence on the vaccines before any decisions are made about what would be the best way to use the vaccines.

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The reason I say that is that of course what's being pursued is to improve the vaccines both for the performance of protection against disease but also, as Soumya said, to protect and improve the performance of protection against infection and transmission.

Really the characteristics of these new, reformulated vaccines, we're going to have to see what those characteristics are and what the difference is, if any, compared with the current formulations.

You laid out some interesting ideas that we're all thinking about of how they could be be used and that of course is really, as I said, based on the evidence of what those vaccines do but there's a whole other dimension to this which is the scale and the volume of vaccines that are needed around the world to protect people right now, here and now, not ten months from now or a year from now.

We've certainly seen in the past year that scaling vaccines and then deploying those vaccines into every country around the world is an undertaking that's not for the faint of heart in any way.

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So I don't think there should be any expectation that vaccines that are currently under development, making adjustments to the best anticipation possible, would suddenly become the entire source of supply for all vaccines around the world.

We have billions of doses that have already been deployed, billions more that are being deployed and really the focus has to be on continuing to get those primary immunisations into people even while this work is being done to establish whether or not these altered vaccines could perform in a better way and what the characteristics are that would best use those vaccines to impact on protection for people in all countries around the world.

So yet to be known and yet to be decided but certainly issues that our expert committees are already deliberating on, anticipating and eagerly awaiting the results of studies that are underway already. Thanks.

CL Thank you very much. Dr Swaminathan, please.

SS To add to what Kate said, again to repeat that existing vaccines are working very well, particularly in protecting people from getting severely ill so we've seen - and Kate mentioned this - that most of the people in the hospital in any country or city you take are unvaccinated so let's just remember that we have very good vaccines now and we need to use them.

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We need to vaccinate more people. For whatever reason they haven't been vaccinated. Many people even in countries where there are supplies, there are huge gaps in those populations as well and of course there are many countries in the world which do not have supplies, which is what COVAX has been set up to try to bridge.

So I think that's the message that we want to get, that we're not waiting for omicron-specific vaccines at all. These vaccines are working and we need to get them out to people. That's the first.

The second is of course the danger is that we'll be always trying to play catch-up with the next variant because it takes severe months to develop a variant-specific vaccine. It has to be tested, it has to go through regulatory approvals and that may take six months and then you may have another variant by then. There is no guarantee, as we've said repeatedly, that there won't be another variant and it could be very different from omicron.

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So that is why we need to take different approaches. Yes, variant-specific vaccines is one approach but then the better approaches may be to have multivalent vaccines or ideally to have a pan-coronavirus vaccine so multiple R&D approaches.

We have to continue to support R&D and the development of new vaccines and many organisations including CEPI, one of the COVAX partners, is doing that and that TAGCOVAC has been set up basically to make those recommendations.

So yes, I think this is a space to be watched but as of now I think it's reassuring, the data that we have.

CL Thank you very much, Dr Swaminathan. This brings us to the end of our briefing today. Thank you all very much for your patience and for standing by. As usual we will have the audio recordings posted right after the press conference and Dr Tedros' remarks of course and the full transcript will be online as of tomorrow morning. With this let me hand over to Dr Tedros for the final remarks.

TAG Thank you. Thank you, Christian, and thank you to all media colleagues who have joined today and see you next time.

00:57:19