

COVID-19

Virtual Press conference

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Speaker key:

CL	Christian Lindmeier
TAG	Dr Tedros Adhanom Ghebreyesus
KA	Kai
AG	Agnes
MK	Dr Maria Van Kerkhove
MR	Dr Michael Ryan
BA	Dr Bruce Aylward
SI	Simon
SS	Dr Soumya Swaminathan
NI	Nikolai
PR	Priti
SO	Sophie
LA	Latika
NE	Dr Nedret Emiroglu

00:00:22

CL Hello and good day to wherever you are listening to us today. It is Friday 14th May 2021. Apologies for the delayed start today. Therefore let's get started. My name is Christian Lindmeier and I'm welcoming you to today's global COVID-19 press conference. Simultaneous translation is provided in the six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus Portuguese and Hindi.

Now let me introduce the participants in the room. Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Dr Mike Ryan, Executive Director of 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 Bruce Aylward, Special Advisor to the Director-General and the Lead on the ACT Accelerator.

With this let me hand over to the Director-General for the opening remarks. Dr Tedros.

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. Earlier this week I was vaccinated against COVID-19. It was a bittersweet moment. On the one hand vaccination is a triumph of science and global solidarity. Alongside public health measures vaccination is key to controlling this pandemic and I'm very grateful to the health workers at the Geneva University Hospitals HUG, for helping me play my part.

However my thoughts were very much with the health workers around the world who have been fighting this pandemic for more than a year. The fact that so many are still not protected is a sad reflection on the gross distortion in access to vaccines across the globe.

Last September in The Economist we warned about the threat of vaccine nationalism and some said we were being alarmist. In January I spoke about the potential unfolding of a moral catastrophe. Unfortunately we're now witnessing this play out.

In a handful of rich countries which bought up the majority of the vaccine supply lower-risk groups are now being vaccinated. I understand why some countries want to vaccinate their children and adolescents but right now I urge them to reconsider and to instead donate vaccines to COVAX.

Because in low and lower-middle-income countries vaccine supply has not been enough to even immunise health and care workers and hospitals are being inundated with people that need life-saving care urgently.

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At present only 0.3% of vaccine supply is going to low-income countries. Trickle-down vaccination is not an effective strategy for fighting a deadly respiratory virus. India remains hugely concerning with several states continuing to see a worrying number of cases, hospitalisations and deaths.

WHO is responding and has shipped thousands of oxygen concentrators, tents for mobile field hospitals, masks and other

medical supplies and we thank all the stakeholders who are supporting India.

But it's not only India that has emergency needs. Nepal, Sri Lanka, Vietnam, Cambodia, Thailand and Egypt are just some of the countries that are dealing with spikes in cases and hospitalisations. Some countries in the Americas still have high numbers of cases and as a region the Americas accounted for 40% of all COVID-19 deaths last week. There are also some spikes in some countries in Africa.

These countries are in heightened response mode and WHO will continue to provide support in all ways possible. COVID-19 has already cost more than 3.3 million lives and we're on track for the second year of this pandemic to be far more deadly than the first.

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Saving lives and livelihoods with a combination of public health measures and vaccination, not one or the other, is the only way out of the pandemic. Vaccine supply remains a key challenge but this week I have been pleased to see leaders and manufacturers working to address some of these issues.

First there have been a number of new country announcements about sharing vaccines with COVAX, which is the fastest way to ensure equitable roll-out of vaccines. Second, new deals involving tech transfer and sharing of know-how between international manufacturers to scale up vaccine production has been announced.

Third, leaders including the Prime Minister of Spain, Pedro Sanchez, have called for all trade barriers to be lifted as soon as possible. Muchas gracias. As we welcome this momentum WHO has again convened researchers and scientists from around the world to update the research and innovation roadmap to take stock of what we have learned and identify the most pressing knowledge gaps.

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From the outset of this pandemic WHO's R&D blueprint for epidemics played a facilitating and co-ordinating role, convening expert networks to drive progress across a range of thematic areas and connecting key funders to focus on identified research priorities.

In the past 18 months major advances have been made in the understanding of modes of transmission, epidemiological trends,

clinical management, development of point-of-care diagnostics, treatments and a large number of vaccines.

Social and behavioural scientists and ethics experts have also worked to ensure that research was up to the highest ethical standards. The research forum is being webcast live over two days and I challenge them to deliver complete solutions that take the development, evaluation and deployment of tools from their beginning to their end, prioritising both equity and efficiency.

I urged them to expand collaboration between expert groups and partners and utilise global research capacity that has not yet been sufficiently leveraged, particularly in lower-income countries.

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Finally I urged them to further promote large-platform trials across the world. This is the fastest way to prove the efficacy of new diagnostic treatments and vaccines. It's amazing how far the world has come in less than 18 months but I have high hopes that breakthrough innovation will continue at record pace.

Yesterday I announced the winners of the second WHO Health For All film festival and I have been thinking since about the importance of telling stories to increase awareness, build solidarity and foster positive change.

I was struck by how each film winner creatively reflected new situations and different realities, highlighting challenges but also a way through. Watching the news sometimes it might seem that the world's problems are intractable but I want you to know that WHO will keep fighting to defend the health rights of all people everywhere in the world.

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The one thing they had in common was that to beat the challenges of our time we must bridge our divides and craft new stories together. This week Muslim brothers and sisters have been celebrating Eid al-Fitr and I want to end by wishing Eid Mubarak to everyone celebrating. Stay safe and again, Eid Mubarak. Christian, back to you.

CL Thank you very much, Dr Tedros. This opens the floor to questions from the media and let me start with Belisa Gohinho from [unclear] in Portugal. Belisa, please unmute yourself.

Belisa, please unmute yourself if you can hear us. Right, we'll come back to Belisa if we can reconnect. Apparently that opens

the floor to Kai Kupferschmidt from Science. Kai, please unmute yourself.

KA Thanks, Christian. Thank you. I wanted to ask all of you about the reaction to the IPPR report. Specifically there're a number of recommendations in there and I'm curious whether you feel that they are the right recommendations. There's the recommendation to restrict the future DGs to one term of seven years.

There're other recommendations to make the WHO more powerful like having standing visas for experts to allow them to go into countries to investigate outbreaks. Just in general terms do you feel that the report basically lays out a roadmap also for WHO reform for the next few years?

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TAG Thank you. Thank you, Kai. On the reports, as you rightly said, it's not only IPPR but we will have a report from IHR review committee; we will have a report from IOAC, the independent oversight advisory committee so there are sets of recommendations from them as well.

And there are other platforms also who are sending us recommendations so one thing we need to do is we will pool all these recommendations together and discuss with member states. As you know, we will have an assembly soon, at the end of this month and then all recommendations will be assessed so very difficult now to comment on one or the other recommendation.

In addition to the three we're encouraging other stakeholders and institutions also to give us ideas and recommendations so that's going to be a credible process and this pandemic is really unprecedented and we have to be open-minded and learn and use the recommendations that are coming in as best we can to prepare the world for the future. Thank you.

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CL Thank you very much, Dr Tedros. Next question goes to Agnes Pedrero from AFP. Agnes, please unmute yourself.

AG Good afternoon, everybody. It's a question on the US. The US has decided to waive the mask requirements when people are fully vaccinated so I wanted to know, what do WHO think about that move? Do you consider it a safe move or dangerous? Is it a recommendation that WHO plans to make, do you plan to waive

the mask requirements when people are fully vaccinated? If which, under which conditions? Thank you.

CL Thank you very much. We'll hand to Dr Van Kerkhove, please.

MK Thanks very much. As you know, WHO recommends the use of masks as part of a comprehensive strategy towards controlling COVID, part of many different measures that are used to prevent the spread.

In setting up policies to use masks as part of that strategy it's very contextual. It's about how much virus is circulating around in the country; it's about the amount of vaccines and vaccinations that are rolling out, it's about the variants of interest, the variants of concern that are circulating.

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We have to keep all of this in mind when thinking about how to adjust the policies associated with the use of masks so it is contextual so all of these considerations need to be taken into account.

Controlling COVID, controlling the circulation of SARS-CoV-2 virus is key. No matter what else is happening around, if there are variants or not, if vaccination is around, how much virus is circulating is really important. The use of vaccines, which vaccines, the age of the person, the underlying conditions, whether they've had one dose or two doses, are fully vaccinated or not; all of this needs to be taken into account.

So it isn't a simple yes-or-no answer; it's about setting that risk-based approach and using masks appropriately in the setting. I'll remind you that in some countries they've been able to control COVID and they've been able to adjust their public health and social measures including the use of masks without the use of vaccines.

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I always think of Australia and New Zealand and I picture people in the stadiums, going to sporting events and so any adjustment that is made, whether it's masks or physical distancing, all of these considerations need to be put in place.

We're not out of this yet. There are uncertainties ahead because of these virus variants. We just have to stay the course, do everything that we can first and foremost to prevent infections, reduce the spread and save lives.

MR Just supplementing what Maria said because you asked, would WHO be issuing specific advice. I think in this case we need to re-emphasise that clearly getting vaccinated protects you from serious illness and death and in the case of many of the vaccines where the data's available significant impact on your likelihood to infect others or be infected by others.

But, as Maria said, this is all in the context of the local transmission conditions. In Australia and New Zealand even when there weren't any vaccines people could take their masks off because there wasn't any virus. Even in situations where you have high vaccine coverage if you've got a lot of transmission then you wouldn't take your mask off so you cannot make one decision without the other.

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In the instance of a country that wishes to reduce or take away a mask mandate or take away other public health and social measures, that should only be done in the context of considering both the intensity of transmission in your area and the level of vaccination coverage.

Obviously if you have high vaccination coverage you should have low community transmission but we're in a strange period of being transitioning as vaccination coverage increases and as transmission levels go down. We're at a point where many countries are facing a situation where the transmission hasn't completely ended and people aren't completely vaccinated and that's where we are on the curve; one is meeting the other.

As long as we can sustain the public health measures, as long as we can keep the distance and as long as we can reduce exposure while we get vaccination levels to the highest level then countries will be in a much stronger position when they do get to higher vaccine coverage levels to start saying to people, you don't have to wear a mask any more.

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So Maria's absolutely correct in that regard so each country will need to look at those two issues - vaccine coverage and the local incidence rate in any given setting - as to whether the mandates for public health and social measures can change. I don't know, Bruce, if you have a comment.

BA Thanks for the invitation, Mike. I would reinforce what Maria and Mike have just said. In previous press conferences we've been asked about places that are having escalating

outbreaks in the face of rising vaccination coverage because they've not reached all of the population, there are still other drivers and that's the reality.

Right now you want to be doing everything possible to get your transmission down to as low levels as possible and take advantage of every countermeasures, every societal or behavioural measure one can to do that and countries will make decisions for various important context-specific reasons, exactly as Mike said.

At global level the World Health Organization; the wonderful thing about being an organisation of 194 member states is the diversity of what they will do and the ability to learn. There's no complete right or wrong in this crisis. We're learning as we go, we all are and what's happening in different countries right now as they get higher vaccination rates will help inform that global policy as we go forward.

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CL Thank you very much, all. Next question goes to Simon Ateba from Today News Africa. Simon, please unmute yourself.

SI Thank you for taking my question. This is Simon Ateba with Today News Africa in Washington DC. I would like the WHO to react to a recent report that a very small number of people who had been fully vaccinated have tested positive for the coronavirus. I was wondering what that means and how long do various vaccines protect against the virus.

If you may allow me, on President Biden, his administration would like to share the AstraZeneca vaccine it's not using now by July. I was wondering if the WHO has called the White House to ask for those vaccines now. Thank you.

CL Thank you very much, Simon. We'll hand to Dr Soumya Swaminathan, Chief Scientist.

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SS Thank you for that question. I think we need to understand what is expected of vaccines and how they work. We are very fortunate that the majority of vaccines that have been developed and tested are highly effective at preventing disease and particularly at preventing the severe forms of the disease which result in people having to be hospitalised and needing critical care and ventilation.

So again, the majority of vaccines approved until now or almost all of them that are being used are accompanied by reductions in the need for hospitalisation and definitely in the deaths that occur in the groups that are being immunised.

However these vaccines are all not 100% effective at preventing infection. The good news is that they do prevent infection in the range of 70 to 80%, again from the data that's coming out now. From real-world studies in countries that are scaling vaccination we are learning more and more about how these vaccines behave at the population level rather than how they behave in clinical trials.

So we know that they do protect against infection but not completely so you can still get infected, you can have asymptomatic or mild illness or even moderate symptoms even after being vaccinated so that's not a complete surprise.

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Again that's why the WHO has said that vaccination alone is not a guarantee against infection or against being able to transmit that infection to others. It may be a rare occurrence but it could still occur and that's why we need the other protective measures like the mask-wearing and the distancing and so on until countries get to the level at which a large number of people are protected and where virus circulation, the transmission goes to very low levels, as Dr Ryan was explaining.

So very few countries are at the point now where they can drop these measures by individuals and by governments because the virus is at such low levels. In most countries we still need to continue to do that.

What is also important is on the research side to continue to document the performance of vaccines and so the WHO has put out guidance on designs for research studies, both for randomised trials when you're testing a vaccine for the first time or comparing vaccines but also for vaccine effectiveness studies.

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Once they've been rolled out we need to study both the effectiveness and the safety of these vaccines in different populations. Different countries have used different regimes; some have used standard duration of the gap between first and second dose; other countries have used longer gaps; some have used a mix-and-match approach for the second dose.

So all of this, if it's documented properly, will give us a lot of information. Finally, I think we also need to continue to do the studies with the efficacy of the vaccines against the different variants. As we're seeing these different variants emerge and increase in numbers we need to accompany the effectiveness studies with sequencing of the breakthrough infections so that we can also do an analysis and understand about vaccine efficacy against particular variants.

Again, at this point in time most of the vaccines in use are effective against severe disease whatever the variant that's circulating in the country but this is an evolving area and we need to continue to collect high-quality information. Thank you.

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CL Thank you. For part two we'll go to Dr Bruce Aylward.

BA Thank you very much, Christian. To the point that Soumya just made, sometimes we talk at the population level about the impact of vaccines and the possibility of breakthrough transmission, etc. There was a very nice piece actually yesterday by a journalist who's been fully vaccinated who did actually get the disease and just contrasted his situation with another person at a very similar age and situation as his. It was a science journalist who wrote a very nice piece and just contrasted the clinical course that they made and really brought to life that while he may still get infected he thinks it was the vaccine that probably saved his life.

A journalist with a lot of experience in science reporting; I thought it was an interesting piece to see it at that human level. In terms of that second issue about donations of vaccines and whether we're in touch with countries that have the potential to donate to COVAX in particular, yes, absolutely.

I think there was a specific question you had, Simon; are we in touch with the United States. Absolutely; we have been for some time and the US has been absolutely fantastic in reaching out to us as well. It's a two-way conversation about how to optimise the use of potential doses.

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This is not an issue unique to that country; we're in conversations with many, many countries that potentially can provide some of their doses and we have to be careful because we often talk about excess or surplus doses and these countries all explain, as we talked about last week with Sweden, that no-one has surplus

doses, everyone's trying to use all of their doses to the greatest possible impact but they recognise that sharing those doses may help ensure greater impact overall.

In that regard what countries are looking at is how can they get their greatest reach, get to the most countries and that is through COVAX. We've got to 122 countries, some of the most disadvantaged. How can they get out there as as a possible? Clearly that's through COVAX.

After the French signed the agreement within 24 hours the doses were in the target country; we were working out with Mauritania. How can it have the highest possible impact and most equitable distribution? Again through COVAX. We have that global view through the COVAX facility to ensure that countries that aren't receiving enough doses to reach their healthcare workers, reach their older populations can reach them.

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So that's the conversation, Simon. It's with a very broad range of countries. It's an ongoing discussion and with the United States in particular they've highlighted that they want to be ready when the doses are ready because there's this idea that there's a huge stockpile sitting somewhere but there's a lot of work to releasing batches, ensuring that they've been through all the steps necessary.

So we're working in parallel to ensure when doses can flow they go as fast as possible to have as high an impact as possible in as many places as possible.

CL Thank you very much, Dr Aylward. The next question goes to Nikolai Vroning from the BBC World Service. Nikolai, please unmute yourself.

NI Hello. Thank you for taking my question. I'm going to ask about post-COVID syndrome, which is placing mounting pressure on healthcare systems all around the world and people keep suffering tremendously from the consequences months after official recovery.

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In the USA they suggest classifying post-COVID syndrome as a disability. What's the WHO position on that and as a follow-up, what do scientists know for sure about what causes long COVID, post-COVID syndrome and what are the prospectives, the possible outcomes? Thank you.

CL Thank you very much, Nikolai. Over to Dr Van Kerkhove.

MK Yes, thank you. I'll start. This is a really good question and it's a huge area of work right now. Your question was what do we know for certain and I can say we don't know anything for certain but there's a lot of research that's underway. For individuals who have been infected with the SARS-CoV-2 virus, as you know, there are some people who have an acute infection, they recover from that illness, that disease that they've had and there are individuals who are suffering from some long-term effects.

We're working with our clinical management group, our rehab group, brain health, mental health; many, many, many different disciplines are working together to understand this post-COVID syndrome. Even to just define it, to put boundaries around what it is and what it isn't requires a lot of research.

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Dr Tedros and I and others have met with patient groups for almost a year now, maybe not quite a year, and they have asked for recognition that this is a real thing and it is a real thing. We're trying to better define the case definition of what it is. There have been several seminars that we've had, workshops that we have had with researchers around the world from many different disciplines - because this affects many different organs - to define post-COVID syndrome, making sure that we have good research, cohort studies that are following individuals who may not have had a diagnosis early on in the pandemic because testing wasn't as widespread as it needed to be in the beginning for example.

But we want to make sure that these cohorts of individuals cover areas around the world, that they don't just cover patients from high-income countries so we're working to set up these studies, these multi-centre studies looking at the long-term effects and what it actually means.

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Then lastly to make sure that we have good rehabilitation. What does rehabilitation need and how do we tailor that to make sure that people receive the care that they need, whether they had a diagnosis or not?

So there's a lot of work that is underway. We do know that this is real, we do know that this affects many different organs. What we're trying to do is to have good, systematic data collection to

be able to inform the treatment protocols, the rehab protocols so that anyone can get the care that they need around the world.

But really this is a dangerous virus. There's a lot that we need to learn from this. This teaches us that even though some people may have what is classified as a mild disease there may be a short-term disease and then there may be some long-term effects.

So we really need to do what we can to study this, to make the best treatment policies, rehab policies we can.

CL Thank you very much, Dr Van Kerkhove. The next question goes to Priti Patnek from Geneva Health Files. Priti, please unmute yourself.

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PR Hi, good afternoon. Thanks for taking my question. This is about remdesivir. We see that a lot of people in India are using up the precious resources they have to buy up a drug that WHO has said is not effective for treatment of COVID-19 in hospitalised patients.

It's a bit puzzling because a number of countries are also donating doses of remdesivir. and we also understand that the company is expanding production. Could you comment on this? Thanks.

CL Thank you very much, Priti. Just looking around, who may want to start. Dr Swaminathan, please.

SS Thank you, Priti. I can start and others might want to come in. The area of therapeutics and treatments for COVID-19 obviously is of great interest to people and unfortunately has not had as much dramatic progress as we've seen in the vaccines or even in the diagnostics for example.

So while a large number of clinical trials have been done and are ongoing - we're tackling something like 9,000 clinical trials in our registry - there've been very few large trials which have given concrete results on some drugs and I think the first one and still, I think, the most important one is the role of steroids, corticosteroids and dexamethasone, in the treatment especially of severe COVID, severe and critical cases of COVID-19. Those who require oxygen and those who require ventilation benefit, there's a mortality benefit.

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The Solidarity trial is probably the largest trial in the world to have tested remdesivir. All the other trials - there were four or five others, much, much smaller. Also the Solidarity trial was able to look at mortality because it's a large trial and mortality is really the endpoint that most clinicians and patients would want to see and impact on.

As far as remdesivir, and the impact on mortality was concerned there was no difference in this large trial and also in the meta-analysis compared to the control group. This is why the WHO guideline development group, which is a completely independent group of experts, nothing to do with the research group and which looks at evidence that's synthesised across all of the different studies done across the world - and as you know, we now perform something called a living meta-analysis and a network meta-analysis which looks at the impact of different drugs when they're used in combination or alone - found that remdesivir, did not have a benefit in terms of mortality or in terms of deterioration.

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What it did do in the trial conducted by the NIH was it reduced hospitalisation duration so one has to look at the benefits versus the costs of a drug and that again depends on the country context. In some countries reducing hospitalisation by four days would be an advantage. In other countries that is not the major driver and it should be based more on the impact on patient outcomes, which is again mortality or deterioration.

So our guideline at the moment recommends against the use of remdesivir. We will look at emerging evidence and update our guidelines as it becomes available but I think it's important for physicians and doctors to be aware of the latest evidence and to use it - whichever drug it is to use it judiciously and wisely and at the right time and also to look at the benefit versus the cost.

Obviously every country makes their own treatment guidelines based on the evidence that's available and based on their local context and so we would leave it to the country to adopt WHO's guidelines and adapt them as they see fit but there really needs to be analysis of benefits and costs when a drug is being used to treat COVID-19.

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Again it's steroids, it's antithrombotics and it's oxygen. Oxygen is probably the most essential and the most life-saving right now of all the drugs and all countries need to be prepared now with the

oxygen supplies that they're going to need if and when cases go up. Thank you.

CL Dr Mike Ryan, please.

MR Thanks, Soumya. Just to re-emphasise Soumya's point, this isn't just in relation to drugs like remdesivir. This also relates to drugs like ivermectin and others and WHO has issued guidance on that and the manufacturers themselves have issued strong guidance saying, please, use our drug for the proper reasons and using the proper evidence.

Also I think this is one of these situations where you need to use the right drug at the right time in the right patient. That's why primary healthcare and having trained doctors and nurses in the front line of a health service that can do a proper clinical examination of a patient and decide which drug, which care that patient needs; that's what's missing in our health systems. Yes, we're missing commodities but our systems are also missing capability, the capacity to triage patients, the capacity to treat patients, the capacity to diagnose those patients and beyond a diagnosis of COVID is to assess the severity of that disease and that patient and assure they get the proper care.

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An example of this would be something like dexamethasone, which is a powerful steroid which we call a powerful anti-inflammatory. That drug is life-saving when given at the right time in the right patient because it doesn't stop the virus; it stops the dramatic inflammation that results in oxygen not transferring into the blood.

When that stops and you have inflammation and the person can't get oxygen from their lungs to their blood the combination of oxygen given by a mask or ventilator with dexamethasone can be absolutely life-saving.

But dexamethasone or steroids don't stop the virus. Giving steroids very early in the course of disease to otherwise well people has its own side-effects and can be detrimental so again I would just appeal that we need to have a health-centred approach to this and just using pharmacies to get cocktails of drugs in the hope that these drugs may help you...

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I understand the instinct and everyone wants to help their own family and everybody wants to access the best possible healthcare but these drugs are tools and like all tools they can

have great benefit but they can also hurt you if they're not used properly.

CL Dr Van Kerkhove, please.

MK Sorry. I'm going to come in as well because it's such an important question. Both Soumya and Mike mentioned oxygen. Oxygen is something that is life-saving, medical oxygen is life-saving and WHO and partners have been working around the world to scale up oxygen availability in countries. This is a work in progress because this is a medicine, this is a treatment that does not have a substitute.

We recently launched a website - I think it was launched even today - around some technical consultations around the medical use of oxygen. These are for medical providers to be able to give this life-saving medicine to people who are sick with COVID but not just COVID; with pneumonia, with other life-threatening diseases.

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But the most important thing that every single one of us can do in terms of keeping ourselves safe is prevention so if you could prevent yourself from being exposed to this virus you prevent yourself from getting infected in the first place.

That's the best medicine of all and so anything that you can do to keep yourself safe, do it because it's so much easier to keep yourself alive through all of this if you're not infected with this virus. Once we get to the point where someone is infected, entering that clinical pathway, that early initial assessment to have your oxygen checked with one of those oxygen saturation... to see what type of clinical care you need; this is really critical.

Then we have medicines like dexamethasone for people who are severe and critical but it's really, as much as we can, about prevention so do what you can, keep yourself safe, keep your loved ones safe, know what your risk is every day throughout your day and take steps to lower the risk of being exposed to this virus in the first place.

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CL Try all very much. The next question goes to Sophie Mokwena from SABC. Sophie, please unmute yourself.

SO Thank you. I just want to ask a question around the current development in countries such as South Africa. For a year we've dealt with first wave, second wave. Now people are fearing

a third wave and because of what we saw during the second wave when there was this new variant the fear is now that we are likely to have another variant when we experience the third wave, particular at the peak of the third wave.

Already South Africans are panicking; the numbers are rising. Have you detected something in sub-Saharan in terms of the rising numbers and this fear of a new variant that might be to be detected if you go to a third wave? As people who are experienced in these issues what's your view, are we likely to see a new variant?

CL Thank you very much, Sophie. Handing over to Dr Van Kerkhove.

MK Thanks, Sophie, for your question. Your question, the way that you posed it, was about a fear of a third peak or a third wave in South Africa. One of the things I'm most impressed with in South Africa is the ability to get through that first peak, that first wave or that second peak or that second wave. You know what to do, the country knows what to do in terms of detection.

The sequencing capacity across South Africa has increased dramatically over the course of this pandemic. The scientists across the country who are sequencing, using intelligent sequencing of samples around the country, supporting other countries on the continent for sequencing where they don't have capacity themselves, sharing of that information.

In fact many of the scientists have been working directly with us, with our virus evolution working group sharing their findings about what is circulating, which mutations are being detected and what it means, carrying out the research to look at transmission, severity, neutralisation; all of that.

So the capacities in country for detection are strong. The work around the use of public health and social measures; again you in South Africa detected the B1351 and that is a variant of concern, showing us that the application of public health and social measures could drive transmission down.

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So what I would hope is that that fear is really turned into something productive. Just be at the ready. You have the systems in place to be vigilant, to be at the ready, to know what to look out for, to know what the warning signs are in case there is a slight upsurge.

We are all of us living in a globally connected world. Variants are circulating. More variants will certainly be detected but we know what to do so we need to be ready to detect, be ready to quickly act, put those measures in place so that any slight increase, any of these cases or clusters do not turn into community transmission.

Having an engaged population to know what to do is part of this army, so to speak, to fight against this virus. So I think you in the country, people around the country, researchers around South Africa have taught us, have taught the world what to do. We need to constantly learn from each other so what we are seeing in other countries can be adopted in South Africa and vice versa.

So I would like to see that fear be turned into something productive, turned into something of strength because I think the country knows what it needs to do to be able to detect and respond to any virus.

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CL Thank you. Dr Mike Ryan, please.

MR Yes, just to follow up and commend South African public health authorities and researchers and others, South Africa showed the way at the end of last year, beginning of this year when we were confronted with a large wave with the detection of a new variant and there was a lot of concern at that time.

South Africa controlled that wave of disease which included significant transmission with that variant by applying the same measures it had for the first wave and it didn't have the access to vaccine to do that. So it clearly demonstrated that good surveillance, knowing where your problem is at subnational level, understanding intensity of community, matching your public health and social measures to the local need, keeping your eye on the big picture at national and local level, investing in surveillance and linking that to genomic surveillance - and again South Africa is one of the leading lights in the world in being able to link real-time genomic surveillance to public health action and congratulations for that.

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It's putting all of those things together that's allowed South Africa to keep this under control but South Africa also faces its own problems with health access and we have many, many people living in conditions in which this virus could spread very easily so constant vigilance is needed.

But I do think we should take a moment to recognise when countries get it right and when they apply all of the resources that are at their disposal even though those resources are not perfect and use public health tools to the best possible benefit of a population.

CL Dr Swaminathan.

SS I just wanted to add that we had Professor Abijeet Banarjee today, the economics Nobel laureate, speak at the research forum and he talked about the economic impact of this pandemic and the impact on poverty and on the lives of people who were already living on the edge, who've been further impacted and particularly when countries have had to put in stringent measures and shut down normal life, people who earn a daily-wage living are the ones who get affected; migrants and others who have to go to work every day.

00:46:36

So he suggested several actions that governments could and should take to protect those, to make sure that people are not starving, that children are not going to get undernourished and he called it good economics but it's also the right thing to do.

So I would invite people to listen to this talk which is going to be up on our YouTube channel. It's being broadcast live now but it's going to be there and we've had some excellent talks also by Michelle Bachelet, the UN High Commissioner for Human Rights, Professor Peter Singer, well-renowned philosopher and ethicist, really talking not just the pure science of it but also how it's impacted people and what we need to do to address their other needs. Thanks.

CL Dr Ryan.

MR I just want to follow up on that because I think it's worth saying more. The research and development blueprint for epidemics and all the partners in it; in WHO Soumya's team and mine; we co-lead on the project but the real driver is those thousands and thousands and we were just remarking before the meeting, Soumya, just how this group had grown from hundreds to thousands and thousands of scientists around the world working together across so many different areas and coming together unselfishly to share knowledge.

00:47:58

Knowledge is power when it comes to this virus so we'd again like to thank all of our partners. They're not listening to this press

conference, thank God; they're all upstairs talking about really important stuff like understanding how better to control this virus for the next year and laying out the roadmap.

I'd like to thank Soumya for her leadership in this and I do think this demonstrates that if you can link science to action - we do it here through the work that Soumya leads on science and Mariangela on technology and pre-qualification and myself and so many others.

Our organisation is only the best when it brings together the power of science, the power of public health practice, the power of health systems and the power of our capacity to respond quickly. So it's a really impressive thing to see and I point you all to go and look at that conference when it's rebroadcast.

00:48:55

CL Thank you very much, all. Looking at the time, I think we can squeeze in one last question as we started late. That would be Latika Bourke from Sydney Morning Herald. Latika, please unmute yourself.

LA Thank you. Always lucky last. In April the WHO released a statement following the seventh meeting of the IHR emergency committee and one of those temporary recommendations you made to state parties was to - quote - reduce the financial burden on international travellers for the measures applied to them for the protection of public health, eg, testing, isolation, quarantine, vaccination.

So I wanted to ask you in the context of hotel quarantine, where countries require this to enter the country should the governments or the citizen be paying for that? Because, Dr Mike Ryan, I know we've talked before about vaccine passports leading to huge inequity. It strikes me that this is actually something that's going to become a public health measure but actually trap people in terms of their own financial circumstances if they can't travel for urgent, pressing needs and, say, even separate medical healthcare in the home countries.

00:50:01

CL Thank you very much, Latika. Dr Ryan.

MR Yes, thanks, Latika. It's a complex question because there are obviously very severe resource implications specifically around issues like quarantine for travellers arriving in a country. Dr Nedret Emiroglu is with us as well and Nedret may be able to comment on this as well.

I think the recommendation as well from the IHR - and this is a general principle in the IHR - is that the traveller in the case of restrictions should not suffer economically from measures that are used to improve and protect the health of the population as a whole because that then is unfairly burdening an individual with the costs of a public health action.

So when you go into quarantine because you're a case in a country you should get the support of the government and not have to pay for that if you're put in a quarantine hotel. Let's say you're a case in a country and there is a quarantine hotel or somewhere you go or you're a contact and there's a quarantine hotel. If you're a citizen and you're a contact and you go to a hotel and then someone charges you for the stay then you'd imagine the state would pay for that.

00:51:14

It's not so clear when visitors are coming from outside the country because they're non-citizens but the purpose of the measure is to protect the citizens of the country which the other person is entering. That's the stated purpose so in that sense what has to be worked out is who should bear the burden of that protection; the state doing the protection of its own citizens or the traveller coming into the country?

Countries have policies for entering and if people breach those policies of entry then the state could turn and say, well, you've entered on false pretence, therefore you must cover the cost of your quarantine.

But if someone has entered with full disclosure and someone's entered with full disclosure within the policies of the country then what I think the committee were saying to governments is that they really do need to consider that they should be covering the costs of that.

00:52:00

But that is very difficult; not all countries can do that so therefore it's a recommendation from the committee that all states should seriously consider the arrangements they put in place, how those arrangements are put in place and the fairness of those arrangements vis a vis the traveller.

Because one of the principles underpinning the IHR is that we have the maximum amount of effort to reduce the international spread of disease with the minimum impact on those who are travelling and trading and therefore we have to balance those

two within that with the primary interest being in the public health. Nedret, if you'd like to add.

NE Thank you. Thank you very much, Mike. You covered most of it but maybe two points. They repeated this recommendation during their last meeting due to two reasons actually. One is to standardise the approaches; they would like to have a harmonised, standardised approach not only to costing and who pays for it but also the overall travel restrictions or requirements in terms of vaccination, testing and quarantine.

The other area they would like to really emphasise is that this should not further push the inequity so that has to be one of the areas that needs to be protected by some of the mechanisms.

00:53:28

CL Thank you very much. That was Dr Nedret Emiroglu, co-chair of the WHO Secretariat to the Commission. Thank you. With this we reach the end of today's press conference and again sorry for starting late. Thank you all for your participation. We will be sending the audio files and Dr Tedros' remarks right after the press conference and the full transcript is again available as of tomorrow.

If you have any follow-up questions please send an email to mediaenquiries@who.int and apologies to all those who we didn't get to today. Many thanks and handing over to Dr Tedros for the final remarks.

TAG Thank you, Christian, and thank you to all colleagues from the media for joining us today. See you in our upcoming presser and bon week-end.

00:54:19