Global Health Issues

Virtual Press Conference
11 January 2023

Speaker key:

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LM	Lisa McClennon
AM	Dr Abdirahman Mahamud
PB	Dr Philippe Barboza
SB	Dr Sylvie Briand
KO	Dr Kate O'Brien
DM	Donato Mancini
EP	Erin Prater
JZ	John Zarocostas
JR	Jennifer Rigby
CF	Catherine Fiankan-Bokonga
BG	Brenda Goodman
ST	Sarah-Taïssir Bencharif
LP	Lauren Pelley
GS	Gabriela Sotomayor
KO	Kemi Osukoya
PP	Priti Patnaik

00:00:33

CL Hello and welcome to WHO and today's virtual press conference on global health issues, including COVID-19 and other health emergencies. It's Wednesday, 11 January 2023. My name is Christian Lindmeier and I'll take you through today's press conference. Simultaneous translation is provided in

the six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus Portuguese and Hindi.

00:01:04

Now, to our quite large podium of experts today. First and foremost, Dr Tedros Adhanom Ghebreyesus, WHO Director-General. Dr Mike Ryan, Executive Director for the WHO Health Emergencies Programme. Dr Maria Van Kerkhove, Technical Lead on COVID-19. Then, we have Dr Sylvie Briand, Director for Epidemic and Pandemic Preparedness. We have Dr Rogério Gaspar, Director for Regulation and Prequalification. Next to him is Dr Kate O'Brien, Director, Immunisation, Vaccines and Biologicals. We also have Dr Abdirahman Mahamud, the Director Ad Interim for Alert and Response Coordination.

We also have a number of colleagues on the line including Dr Bruce Aylward, who is Senior Advisor to the Director-General, Dr Ana Maria Henao-Restrepo, she's Coordinator for R&D Blueprint, and we have Dr Rosamund Lewis, Technical Lead on monkeypox. We have a couple of more colleagues that we will call upon in case we need them to come online. In case you want to put a question, please use the Raise Your Hand icon on your screen. And, with this, let me handover to the Director-General for his opening remarks.

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. Today marks the end of the Ebola outbreak in Uganda, four months after the first cases were reported. I congratulate the government, the people of Uganda and health workers, some of whom lost their lives, for their leadership and dedication in bringing this outbreak to an end. And we thank donors and partners for swiftly mobilising resources, and vaccine developers for making candidate vaccines available in record time.

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Even in the absence of approved vaccines or therapeutics for this type of Ebola, Uganda was able to use proven public health tools to contain the outbreak. This outbreak has finished but WHO's commitment to Uganda has not. We remain committed to strengthening Uganda's health system as part of its journey towards universal health coverage.

Now to COVID-19. It's now three years since the first sequence of SARS-CoV-2 was shared with the world. That sequence enabled the development of the first tests and, ultimately, vaccines. Throughout the pandemic, testing and sequencing helped us to track the spread and development of new variants but, since the peak of the Omicron wave, the number of sequences being shared has dropped by more than 90%, and the number of countries sharing sequences has fallen by a third.

It's understandable that countries cannot maintain the same levels of testing and sequencing they had during the Omicron peak. At the same time, the world cannot close its eyes and hope this virus will go away. It won't. Sequencing remains vital to detect and track the emergence and spread of new variants, such as XBB.1.5. We urge all countries now experiencing intense transmission to increase sequencing and to share those sequences.

Investment in testing at-risk people to ensure they receive adequate care and in tracking the virus remains vital. There is no doubt that globally we are in a vastly better position than we were a year ago. Since February last year, the number of deaths reported to WHO each week has dropped by almost 90% but since mid-September the number of weekly reported deaths has been stuck between 10,000 and 14,000 deaths per week.

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The world cannot accept this number of deaths when we have the tools to prevent them. Last week, almost 11,500 deaths were reported to WHO, about 40% from the Americas, 30% from Europe and 30% from the Western Pacific region. However, this number is almost certainly an underestimate given the under-reporting of COVID-related deaths in China.

Most of those dying are at-risk groups, including older people. During the last six months of last year, people aged 65 or over accounted for almost 90% of all reported deaths. But, once again, the data we receive from countries is inadequate to give us a clear picture of who is dying and why. Only 53 out of 194 countries provide data on deaths that are disaggregated by age and sex.

As we enter the fourth year of this pandemic, we ask all countries to provide this data. The more data we have, the clearer a picture we have. We continue to call on all countries to focus on fully vaccinating the most at-risk groups, especially older people, and we continue to call on all people to take appropriate precautions when necessary to protect yourself and others. You may not die with this disease but you could give it to someone else who does.

Now to Syria. This week, the United Nations Security Council extended the authorisation for cross-border humanitarian operations for an additional six months. For WHO and partners this is welcome news and critical for us to reach more than four million people in north-west Syria with life-saving health and humanitarian support.

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This decision comes at a time when the humanitarian situation is worsening in Syria. Humanitarian needs have reached their highest levels since the conflict began. Syria is now facing a harsh winter and a cholera outbreak that has already affected tens of thousands. WHO will continue to work with partners to deliver aid but the solution that the people of Syria need more than any other is peace.

Syria is not the only country facing a devastating cholera outbreak. Since January of last year, 31 countries have reported outbreaks, 50% more than in the preceding years. The outbreaks themselves are both more widespread and deadly than normal.

While we have had large cholera outbreaks before, we have not seen such a large number of simultaneous outbreaks. The common denominator for many of these outbreaks is climate-related events, such as storms, floods and droughts. Haiti, Malawi and Syria are among the worst-affected countries.

In October, the International Coordinating Group that manages the global cholera vaccine stockpile suspended the standard two-dose vaccination regimen for cholera, using instead a single-dose approach to extend supply.

Production is currently at maximum capacity, and despite this unprecedented decision, the stockpile remains very low. In the past few weeks, four more countries requested vaccines, which are extremely scarce.

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With an increasing number of outbreaks that are larger geographically and in number, we call on countries that have experienced cholera outbreaks before to increase preparedness for potential outbreaks. We thank EuBiologics, based in the Republic of Korea, for maximising production and for its efforts to develop a new vaccine with the potential for larger production.

We continue to call on other manufacturers to do the same. We also call on partners to support the response to the ongoing outbreaks, especially to reduce the unacceptably high case fatality rate. Christian, back to you.

CL Thank you very much, Dr Tedros. With this, I open the floor for questions and, again, please use the Raise Your Hand icon and unmute yourself when it's your turn. First on my list is Donato Mancini, from the FT. Donato, please go ahead and unmute yourself.

DM Hi. Good afternoon. Thanks for taking my question. Very briefly on China, is your assessment of the situation that Beijing is still lying on case numbers and deaths or have you seen an improvement there? And, more broadly, on an Associated Press investigation that ran this morning on sexual assault within the WHO, given it seems to be quite a frequent occurrence, are you weighing structural changes to the organisation that would avoid such incidents in the future? Thank you.

CL Thank you, Donato. Two very different questions. They're very important but that gives me a moment to remind everybody, please one question only. We have a long list of hands up already and we want to get to as many as possible. So, please limit yourself to one question. But, we'll start with Dr Van Kerkhove for COVID.

00:11:57

MK Thanks. Your question gives us an opportunity to give you an update on the conversations that we have been having with colleagues, technical partners and government officials in China over the last several weeks. We, as an organisation, have had several calls with colleagues across the country. We've had a Member State information session last week where we briefed and colleagues from China briefed all WHO Member States, giving them an update on the current situation and their response.

So, we have had additional information provided to us on how China is managing the current situation, how they are scaling up their response in terms of the clinical management capacities, in terms of beds, ICU capacities, clinical management, in terms of treatments of patients across the different spectrum of disease, how they are focusing on their vaccination efforts and increasing vaccination coverage across the whole population and really focusing on targeting at-risk groups, at risk for developing severe disease and dying. So, that has been welcomed information.

However, there are some very important information gaps that we are working with China to fill. First and foremost is to have a deeper understanding of the

transmission dynamics of COVID across the country and really understanding the breakdown in the increases or decreases in hospitalisations around the world, the ICU capacity and the burden, in terms of intensive care across the country and those COVID-related deaths by urban and rural areas, by different provinces across the country.

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Also, looking to see if we can have more information on the sequences. We have had further information from China on which viruses are circulating in China and China CDC has reported to us that the sequences that have been detected are mainly these BA.5 sublineages. But, we have requested further information to have those sequences be shared publicly so that a deeper analysis and more of a phylogenetic analysis can be done so that we can look mutation by mutation to really assess what is circulating there.

We've offered support through our Technical Advisory Group on Virus Evolution to support that epidemiologic analysis and looking at it in detail. The channels of communication are open. China colleagues are contributing to discussions, including technical management and others.

We will continue to have those discussions to seek further information so we can better assess what is happening there but, again, just remember this virus is circulating intensely everywhere. This fight against COVID-19 is not over. As the DG has pointed out in his reporting of the deaths around the world, 11,500 people died globally and that is an underestimate of the true number of deaths that are out there.

There is a lot more work we can do. There is a lot more countries can do. We need to maintain surveillance. We need to maintain sequences from around the world so analysis can take place, so risk assessments can take place, so we can ensure any changes to our response, any changes to our advice are done in a timely manner.

00:15:06

CL Thank you very much, Dr Van Kerkhove. I understand we have some audio technical issues on our social network channels but we will continue here with the press conference in case you can hear us and if you can't hear us this will be available online. But, I think the journalists and colleagues online can hear us so we can go ahead with the press conference. Dr Ryan.

MR To add to what Maria has said and to answer that question directly, WHO still believes that deaths are heavily under-reported from China and this is in relation to the definitions that are used but also the need for doctors and those reporting in the public health system to be encouraged to report these cases and not discouraged.

However, having said that we do, as Maria said, want and are working ever closer with our colleagues in China to try and understand better the transmission dynamics but we still do not have adequate information to make a full comprehensive risk assessment and therefore we will continue to try to encourage access to that data.

But, also recognise in the same breath that China has done a lot in the last number of weeks, particularly to strengthen its own internal capacities to

service the clinical needs of its own population in terms of expanding hugely the number of designated hospitals, ICU beds, fever clinics, in adapting the clinical management pathways to include earlier diagnosis, the prioritisation for diagnosis for people with vulnerable underlying conditions, with older age and prioritising the use of antivirals early in the course of disease.

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There is also a shift in the definition away from COVID pneumonia as the reporting disease to COVID infection as the main basis for disease reporting and we hope that that will encourage more reporting and more reporting to WHO of the true situation on the ground in China.

It is difficult for us to understand and many of you out there will have heard about peaks and the disease peaking in certain areas, having peaked in certain cities, increasingly impacting rural areas. But, it's not possible for WHO to give you a detailed breakdown on that because we simply do not have that data.

We continue to ask for that data but at the same time can recognise the efforts being made by colleagues in China to beef up their clinical support to people affected with disease and particularly to refocus on primary healthcare and early treatment of people with underlying conditions.

So, we would really, really encourage our colleagues in China and we will continue to engage them when we have planned follow-up meetings in order to be able to engage them in better understanding the transmission dynamics on the ground in China.

CL Thank you very much. And for the second part of Donato's question on allegations of sexual abuse, we have Lisa McClennon, She's a Director and Senior Advisor to the DG. Lisa, please go ahead.

00:18:31

LM Thank you. Thank you very much for the opportunity. I just wanted to address the question, just wanted to let you know that we are fast, we're rigorous, we're thorough, we take a contemporary and survivor-centric approach to the matters that are referred to us.

And this effort, this increased effort and focus and increased resources towards this matter began over a year ago and we have been able to clear up several cases that had perhaps languished in the past and are working these types of cases in real time.

Again, we take a survivor-centric approach to the investigations. We encourage people to report any instances of wrongdoing, particularly those involving sexual misconduct, and we work as hard as we possibly can to protect those who make such reports. There are multiple channels through which the reporting can be made and we encourage those who have information to use those channels. Thank you.

CL Thank you very much and to clarify, Lisa McClennon is Director at the Office of Internal Oversight. Again, please stick to one question. Next question goes to Erin Prater, from Fortune. Erin, please go ahead and unmute yourself.

EP Thank you so much. I'm curious if there's an update on the risk assessment on XBB.1.5 from TAG-VE or otherwise. Thank you.

CL Thank you very much and back to Dr Van Kerkhove.

00:20:17

MK Thank you. WHO has just published or will be publishing very, very shortly, a risk assessment with advice from the Technical Advisory Group on Virus Evolution, the TAG-VE, on XBB.1.5. This is one of more than 500 subvariants that WHO is currently tracking worldwide. XBB.1.5 is a further sublineage of XBB which you may have also heard about, which is a recombinant of two BA.2 sublineages.

We've recently published this risk assessment online, which looks at all available data that we have on this particular variant, looking specifically at growth advantage, looking at immune escape, looking at severity and making an assessment with available information to determine what we might expect in terms of its behaviour and its circulation worldwide.

The technical advisory group met on 5th January and we've had some subsequent meetings with colleagues from US CDC where most of the sequences of XBB.1.5 have been identified. And based on its characteristics, it is part of Omicron. It is an incredibly transmissible variant like all of them are. It does have a growth advantage compared to other sublineages of Omicron but the data that we have to assess XBB.1.5 is currently very limited.

Most of the information we have is from only one country and that's the United States and we're grateful for the information that they have been sharing with us. We do know from the available data that it does have growth advantage, it does have similar properties of immune escape like we've seen with XBB.

We don't yet have data on severity and that is under assessment in the United States but also elsewhere. The data that we're looking at is to determine whether or not there's a change in severity. There's no indication of an increase of severity or decrease of severity compared to other Omicron subvariants.

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I think it's important to note that this type of a risk assessment that we do is quite common for WHO. This is the latest subvariant that we're doing a risk assessment of but we will do more of these. As the virus continues to circulate, more changes are expected, more subvariants will be identified.

And what is really critical out there is that we continue to have surveillance strengthened, so that we have SARS-CoV-2 surveillance from around the world which is integrated into dealing with respiratory diseases and other respiratory diseases like influenza, and that sequencing continues and is shared, so that these type of robust risk assessments can be done, can be updated and can be shared.

So, I think what is important for you who are out there, the virus is circulating and there's a lot that you can do. And I think I just want to end by saying that despite the subvariants that are circulating we, as a global organisation, and

with experts around the world, will continue to assess these and report on these as quickly as we can with information that is available.

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But, getting vaccinated, getting boosted is really critical, making sure that you take measures to lower your risk every day, distancing and improving ventilation, wearing of a mask, knowing what your risk is where you are based on your own self, as well as those around you. So, lot's to do here but the risk assessment, if it's not published right now, it will be published very shortly. But, you'll see that online and it's a short document and we will be doing more of these as the pandemic progresses.

CL Thank you very much, Dr Van Kerkhove. Next question goes to John Zarocostas, from The Lancet. John, please go ahead and unmute yourself.

JZ Can you hear me there?

CL Very well.

JZ Good afternoon. Just to follow-up on what Maria just mentioned. Is the recommendation of WHO to have wearing of masks indoors and in transportation, not only in countries suffering from big infection rates at the moment like China but worldwide, because here, at the United Nations, as of 9th January, wearing masks indoors in Geneva was lifted yet Dr Kluge yesterday suggested the importance of wearing masks. So, where is the situation? Can we get some clarity?

CL Thank you very much, John, for the opportunity to clarify. Maria.

MK Hi, John. Thank you very much for the question. WHO has had recommendations for the use of masks as part of this comprehensive approach to dealing with COVID since the beginning of this pandemic and those measures are still recommended.

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Wearing of a mask is really important contextually. First of all, for our health workers, wearing of masks and respirators is really, really critical, making sure that they have appropriate personal protective equipment, making sure that there is other personal protective equipment that used when dealing with suspected or known COVID-19 patients. That was not part of your question but I just want to make that clear.

In the community, for the general public, WHO does recommend the wearing of masks when you're indoors, in particular when there's crowding, when ventilation is poor or you don't know what the ventilation is. And that can include a variety of different types of settings like public transport but it can also include buildings. We're in a room right now where we have very good ventilation, we're distanced apart. So, context is important.

We were reminded yesterday at the Q&A that Mike and I did to remind everyone that transmission is a factor of a combination of things, the distance that you are from someone, the setting that you are in. And it does matter, the ventilation that is in the room, how much time you spend in that location, but the measures that are also in place.

There's a number of other factors that are important as well but masks are one of the measures that we recommend when you are indoors, when you cannot distance. If you are infected for sure, to make sure that you wear a well-fitting mask over your nose and mouth, you have clean hands, etc. But, yes, this is one of the recommendations that we continue to advise and we are working with governments to tailor the use of this in the right types of contexts.

00:26:30

CL Thank you for this clarification. Next question goes to Jennifer Rigby, from Reuters. Jennifer, please go ahead and unmute yourself.

JR Hello. Thanks for taking my question. I just wanted to ask about Lunar New Year travel in China. Is WHO working with China on how to deal with the risks of that and the mass movement of people? Thanks.

CL Do we change now? Let's go to Dr Abdi Mahamud, Director of Alert Response and Coordination. Thank you.

AM Thank you for that question. It's really important. As we mentioned previously, the Lunar New Year is the time of happiness and we like all the families to come together at the same time, but that celebration should not lead to cause unhappiness and death and despair in the families.

We've been working with our China colleagues and, as Maria mentioned earlier, they have quite a number of strategies in terms of people travelling from a hot spot to low risk areas, in terms of testing, in terms of the fever clinics. But, to understand better we require that data is segregated at the lowest level. From our engagement today, they do have a plan and they have public messaging. The want people, after three years of zero-COVID, families together but at the same time they don't want to flare up and cause a subsequent wave.

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From the data we gathered today, in terms of policy and in terms of procedure, it's what we have been recommending across all countries, but we have to get the details of their data and particularly the epidemiological data that points out hospitalisation, the testing, the number of testing conducted, the positivity rate, so that when you are moving from one high risk, going to a low risk area or coming back, it will have an implication on that. So, in short, the answer is we are working with them and we are looking forward to more details from them.

CL Thank you very much, Dr Mahamud. The next question goes to Catherine Fiankan, from France 24. Catherine, please go ahead and unmute yourself.

CF Thank you. Good afternoon, Christian. Good afternoon to all of you. I would like to come back on what the DG mentioned about cholera, and particularly cholera in Haiti. I would like to know where the cholera vaccination campaign stands and if it is heavily affected by the violence and insecurity over there, particularly in Cité Soleil, which is an area of Port-au-Prince. And I would like to know if you have recent data, meaning data from the beginning of this year. Thank you so much.

CL Thank you very much, Catherine. And I believe we have Dr Philippe Barboza with us online. He's our lead on cholera. Happy to let him go ahead. He's not yet quite connected. We'll see whether we have him. Is he ready to go? Yes. Please, Philippe, go ahead.

00:29:42

PB Thank you very much for the question. Can you hear me?

CL Try again.

PB The vaccination campaign in Haiti is progressing well. The authority and the partner are currently doing some mop-up campaign to increase the vaccination campaign, so we do not have at this point of time the finalised figure for the first vaccination. But, despite the difficulty, I think it's really important to highlight that with the help of the partner present in the field and the national authority and everybody, the campaign has been progressing well despite the difficulties.

As far as the figures, we can share the last two figures by email but overall the situation is stabilising. We have also to be a bit careful about some possible delay in reporting during the festive period but the situation is stabilising. It does not mean that the situation is over, that there is no more cholera, but since a few weeks it's relatively stable. Over.

CL Thank you very much, Philippe. Apologies for a bit of an echo in the sound but I think it was audible. So, thanks for this and we move ahead. Next question goes to Brenda Goodman, from CNN. Brenda, please unmute yourself.

BG Thank you for taking my question. Can you hear me okay?

CL Very well. Go ahead.

00:31:26

BG It's been about a year since WHO named a new variant and the virus has continued to evolve. So, I'm curious. Have you changed the criteria that you use to give new variants Greek letter names.

CL Thank you very much and back to Dr Van Kerkhove, please.

MK Thanks, Brenda, for the question. We do get this question quite often and you're right. Omicron, this variant of concern, has been circulating for more than a year now and, as we've mentioned, there are many sublineages that we're tracking.

The assignment of the Greek letters was a way in which would help us to be able to publicly communicate differences in viruses that are circulating and assigning that name, meaning that these viruses had different characteristics than the previous variants of concern.

We still use the nomenclature, the scientific nomenclature, the nomenclature by PANGO, by Nextstrain to be able to talk about the different sublineages that are there. All of the sublineages of Omicron are behaving the same way in the sense of transmissibility and growth rate.

We are seeing sublineages that have further growth advantage. They have to, otherwise they wouldn't able to compete against the other variants that are in circulation. So, we do expect increased transmissibility over time. We also look at immune escape and we expect further immune escape as immunity wanes over time and these viruses have the ability to reinfect individuals. We're in the fourth year now and we look at severity, we look at the impact of our interventions, including the use of diagnostics, therapeutics and vaccines.

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So, we still use the scientific names there. All of the subvariants of Omicron are behaving very similar to one another in the sense of their transmissibility, their severity, their immune escape and the impact of our interventions. When that changes we will be using these Greek letters.

We're not afraid to use these Greek letters or to assign different subvariants but we have a criteria by which we do this through our Technical Advisory Group on Virus Evolution. We also link this work with other advisory groups like our TAG-CO-VAC, which is the technical advisory group to advise on COVID-19 vaccines and whether or not there needs to be change in the composition of those vaccines.

We also work with SAGE, which outlines the policies for the use of vaccines in human populations but the naming of this really has to do with the behaviour of these sublineages and they're all very similar. As we go forward, the TAG-VE is discussing ways, with the global expert communities and people around the world, how we are going to be classifying these as we go forward.

This virus is here to stay. We're looking at antigenic characteristics of the viruses, similar to what we do for influenza, and we're trying to ensure that we have the right data to be able to assess these. And if we can come up with different ways in which we describe these viruses into the future, that will also be announced. But, so far, Omicron is divergent in the sense that we have so many sublineages that are circulating but all of these are still classified as Omicron, as variants of concern.

00:34:40

CL Thank you very much, Dr Van Kerkhove, and with this we move on. Next is Peter Kenny, from South Africa News or Anadolu. Peter, please go ahead. I understand Peter is not connected anymore. Then, we move on to Sarah Bencharif, from Politico. Sarah, please unmute yourself.

ST Good afternoon and thank you so much for taking my question. A number of European countries have implemented measures targeting travellers arriving from China. They've implemented pre-departure testing, wastewater surveillance, etc., and the idea being the early detection and prevention of new variants.

But, we already know there's another subvariant circulating in the US and I'm just wondering what does the WHO think of this decision. Why is it in place? What do you make of countries putting it in place for China where we have not yet identified a new variant but not putting them place for the US, where we already have? Thank you.

CL Thank you very much, Sarah. And we go to Van Kerkhove

MK Sure. I can start. I think we've addressed this question previously, in the sense that there's a lot of information that's been needed to come from China to really understand the situation there. And the DG has spoken about this and Mike has spoken about this before, about understandable that countries are putting in place some precautionary measures that they feel are appropriate because of the lack of information that's coming.

00:36:12

As more information becomes available countries are making assessments of how they are going to deal with their own populations. We do note that testing is not a requirement for travel and that has not been something that has been advised throughout the pandemic as a requirement. But, more information is coming as we understand the current situation in China. More is needed to better understand that but we have commented on this in terms of the understandability of what countries are putting in place.

We do hope that countries take a risk-based approach to this, they make updated risk assessments based on information that is available and that the measures that are put in place, they look at these measures over time so that measures can be lifted and adjusted accordingly.

MR I think, Maria, with relation to the United States and XBB.1.5 I think you and the team have been involved in a risk assessment with colleagues on the US side and published it today, the US CDC. So, there's been radical transparency on behalf of the United States in terms of engaging with WHO regarding the data and the impact of that data. I think that's the issue here.

Number one, we're not encouraging travel restrictions everywhere. What has been imposed in relation to China is not a travel restriction. It is a measure that countries rationalise that they're using on the basis that it's not possible for them to make a full risk assessment until they understand the full genetic epidemiology, until they understand the cases, the deaths, the transmission dynamics.

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So, in the absence of that data, countries have made a decision to take a precautionary approach and the DG, myself and others have said that that's understandable in the circumstances of that situation. These aren't restrictions in travel, they're adaptive measures so countries can measure that risk as people arrive in their country.

In that sense, the two situations are different. It doesn't mean that situations won't arise around the world where subvariants need to be analysed in a different context. It's really how quickly that can be done, how open and transparent the partners are in sharing that information, and then how quickly those measures can reassessed.

And we always advise that measures put in place for any reason should be time limited, should be limited in scope to the risk assessment associated with those measures and should be reconsidered in due course in order to be adapted. So, again, you just cannot compare these two situations. They're not comparable in that sense.

CL Thank you very much, both Dr Van Kerkhove and Dr Ryan. Next question goes to Lauren Pelley, from CBC Canada. Lauren, please unmute yourself.

00:39:09

LP Good morning from Toronto. Thank you for taking my question. The global burden of long COVID right now, we've seen a growing body of research that suggests most people do recover but it seems there are certain symptoms and certain people it persists a year or more. So, how would the WHO describe the current burden of long COVID and what further research would you like to see to better understand the mechanism of what's at play and why certain people are still bearing the brunt of this?

CL Do we are start with Dr Van Kerkhove again?

MK Yes, thank you. This long COVID, post COVID-19 condition is something that WHO and our partners are deeply concerned about. We've talked about this before and much more research is needed to really better understand the extent of burden of this around the world and how long this burden will last over time.

Our clinical management team is working with many different departments across WHO, in terms of brain health and mental health, rehabilitation and with experts around the world, across the different types of clinical management aspects, in terms of cardiac care and brain health, respiratory health, etc.

And what we are targeting is making sure that there is recognition of post COVID-19 condition in which this can be described and analysed. We have a case definition that has been published. It is being adapted for children as well because children can also have post COVID-19 condition or also known as long COVID, so that we can understand and compare across countries.

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We don't have very good global estimates. There are some modelling estimates that have been published pre-Omicron and it is substantial. But, we need to better recognise what it is, to describe it. We need much more research and there's a lot of work in terms of setting up cohort studies around the world to follow patients over time in a systematic way, not just in high-income countries but in low-income countries as well, so that we can better track and understand progression.

Many people do recover, you are absolutely right in that, but some patients have persistent symptoms that last across many different body organs over longer periods of time. Lastly, we need a lot of research in terms of rehabilitation and clinical care. Many countries are focusing on dealing with post COVID-19 condition as a separate entity, in terms of their clinical management and their health systems.

This needs to be incorporated into clinical care so that when a patient shows up, no matter where they are in their disease spectrum, when they have an acute infection, acute disease, they've recovered and maybe they're starting to have these post COVID-19 signs and symptoms, that they are tracked over time and that they are cared for over time.

So, we have a huge portfolio of work here. It's just the beginning, in terms of the work that we are doing with our partners. Much more research needs to be done to better understand this, especially for treatment and care, but we need financing for this. There's not a lot of financing for post COVID-19 condition for research and if we can plea to funders who are out there, to governments who could focus on this, this is really where we need some attention.

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So, thank you very much for asking the question. We always try to talk about post COVID-19 condition when we discuss COVID because this is something that we concerned about and we need to be focused on. But, there is much more work that needs to be done in this space, including recognition, research and rehabilitation.

CL Thank you very much, Dr Van Kerkhove. Next question goes to Gabriela Sotomayor, from Proceso, Mexico. Gabriela, please unmute yourself.

GS Hola. Thank you. Thank you for taking my question. Happy New Year to all. Dr Tedros mentioned that few countries are sharing information on virus sequencing and other data. I would like to know which countries are not doing so. Where can we the list? For example, if Mexico is sharing the virus sequencing with you, the country registered more than 30,000 cases in one week, etc. So, I would like to know that. Thank you so much.

CL Thank you very much, Gabriela.

MK Thanks. I'm answering a lot of the questions today. Sorry about that. The data on which countries are sharing sequences is publicly available. There are several online platforms in which countries can share sequences, one of which is GISAID. This is the one we quote often and you can look online. You have to login to it but there are many that that are looking online that look at where the sequences are coming from, the results of that sequencing.

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And then there's an analysis that is done, looking at how the virus is changing and you and can see some phylogenetic trees, there's some graphs that are on there. So, that data is publicly available. At present, I could get the exact numbers wrong but there's about 90-91 countries that are currently sharing sequences.

We want to be clear that we're not stating, as a global organisation we're not saying that everyone, everywhere needs to be sequenced, that all of these sequences everywhere have to be shared. But, what we do need are countries across the world to be testing and sequencing a subset of their patients.

It's really important that we are able to track the known variants and detect new ones and to detect any signs that there may be something different, so within countries looking at populations that are at risk for severe disease, patients that are hospitalised, patients who die, making sure that a subset of those individuals are sequenced and those sequences are shared so that we can look at this over time and we can make comparisons across countries, we can make comparisons over time, we can look at the disease spectrum, etc.

So, that data is publicly available and you can look at that and you can see exactly how many sequences are being shared by Mexico and even over time. And this is something that is a global good. This is something that countries are doing for themselves, in terms of their own assessment about what is circulating within their borders but this is really important.

00:45:16

Viruses do not respect borders and so the sharing of this information is a global good. It adds to our collective assessment of the current situation and helps us plan going forward into the future.

CL And Dr Ryan, please.

MR With specific reference to COVID and what's uploaded on databases one issue is, first of all, a sample has to be taken. It's not like an antigen test and then it goes in a safe bin after. The sample has to be sent to a lab that can actually do sequencing and it's that sample methodology, who gets sampled and where do those samples get sent to, and that testing process.

That has resource implications and many countries have cut back on the resourcing of testing. So, the massive expansion in testing has contracted back as countries deal with other health priorities and many other issues that they're facing, but that drawback in testing has probably gone too far and now we're not getting enough testing done.

There's also then the reporting of that within the country, within the public health system in the country, and then there's the uploading of that data onto international databases. If there's inefficiency at any point along the way, in terms of sampling, testing, internal reporting and uploading, then you can have a huge impact upstream or downstream in terms of how many sequences are available globally.

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And then there's analyses that need to be done, maybe to fully understand within a subvariant all of the different variations of that and sometimes that needs a lot of input from outside and there needs to be a lot of work done, maybe with reference labs and others, to help countries to understand that and do secondary analysis and really come to grips with those analytics. So, countries need to be continuing to do that.

We would like the world over time to be moving to a much more multi-disease approach for respiratory pathogens, being able to deal with influenza, SARS-CoV-2, RSV virus, in a more sentinel basis, in other words not having to measure the virus everywhere, a little bit like weather stations around the world. There's not a weather station in every square metre of ground around the world. We put our weather stations in strategic places and from that we build up a pattern of the weather for the whole world.

We need better surveillance of respiratory viruses globally. We've improved that greatly over the last number of years, thanks to the work particularly of the Global Influenza Surveillance and Response network, GISRS, and there is a huge network of labs out there doing that.

That is still heavily skewed to the North and many developing countries still struggle to have the capacities to do that. Sylvie Briand is with us, and Sylvie oversees much of this work, but I do think there is a need to continue doing specific COVID testing and each country needs to make a decision to prioritise that, particularly for vulnerable people, so they can get into the clinical care pathway.

00:48:17

One of the problems is, if you don't get diagnosed with COVID and you're an older person and you're vulnerable, then you don't get the antiviral, and that's a problem. It's not the testing is the problem. The problem is you may not qualify to get the antiviral because you haven't been tested.

So, there's a testing need to get into treatment and then the second issue is to continue doing strategic testing so you can monitor the evolution of the virus. More and more, we would like to see that monitoring of the virus integrated with other respiratory pathogens and we believe there's a pathway to do that.

But, if countries now overcorrect and completely disinvest in diagnosis and in genetic sequencing, then we'll unfortunately end up having to rebuild infrastructure that's already been built and allowed to decay. And that's been the history. Tedros has spoken about this many times.

The history of the world is we invest at the time of crisis, then we disinvest, and then we wait, and then we get hit with the next crisis and then we wonder what the hell we did because we got rid of the infrastructure we would have used if we'd only kept that infrastructure in place.

I think this is just a cycle that has gone on and on and on and on. We hope to break that cycle this time and I think taking a multi-disease, multi-diagnostic approach in a much more comprehensive sentinel system for the world would be the way forward but maybe Sylvie you want to make a comment on that because I know that's your wheelhouse.

00:49:41

CL Dr Briand, please.

SB Absolutely. I think it's important to see those pandemic events as really global events. It has been mentioned many times but we are all on the same boat, so we all have to understand where is the virus and what is the circulating virus.

And to add also to what Mike said, I think it's very important to understand that a lot of those testing activities are also related to national capacities, and that's why WHO is supporting a lot of countries to strengthen their capacities, in particular in genomic sequences. And a way to make sure that the world is globally more strong in those technologies is also to have networks of labs and working together.

It's not only each lab doing its own job, but it's also a lab with a need to be trained or have more capacities being twinned up with other labs in other countries. So, I think all this activity around building global networks of laboratories so that as human beings and as the entire humanity, we can

know where is our enemy. And our enemy is currently a very small virus that you cannot see, so it's very important that we are all joined up to make sure that we can monitor the spread of these viruses and understand better also when we have an emergence of new variant that is more dangerous. Thank you.

00:51:18

CL Thank you very much, all three. Next we go with Kemi Osukoya, from Africa Bazaar. Kemi, please go ahead and unmute yourself. Kemi, can you hear us? If yes, please go ahead and unmute yourself.

KO Thank you so much for taking my question. If you will allow me, I want to move it a little bit away from the COVID question. I want to ask you about non-communicable diseases in Africa. There has been a prevalence, an increase in cancer, diabetes and cardiac diseases in Africa, especially cervical cancer among women.

Could you talk about what you're doing? We know that since the pandemic began in 2020 there has been a decrease globally of people getting checked and having mammograms. So, could you talk about what you're doing specifically in Africa to bring more awareness to women taking advantage of the treatments that they are able to do to combat cervical cancer and other diseases?

CL Thank you very, Kemi. I'm looking around if we someone with us who could maybe give it a stab at answering. It doesn't look like it. So, if you could please send that over to us as a question to mediainquiries@wto.int and we'll try to give it a stab. Thank you very much. Excuse me.

Next question goes to Alexander Tin, from CBS. Alexander please go ahead and unmute. Alex is also not with us anymore. Then, maybe last but not least, we can maybe squeeze one in, is Priti Patnaik, from the Geneva Health Files. Priti, please go ahead.

00:53:27

PP Hi. Can you hear me?

CL Very well.

PP Good afternoon. Thanks for taking my question. This was about the price increase announced, a proposed price increase announced by companies like Moderna on the COVID-19 vaccine. What kind of impact do you think it will have on vaccination, especially using mRNA vaccines? And Pfizer had already announced a proposed increase last year. Thanks so much.

CL Thank you very much, Priti. Dr Kate O'Brien.

KO Vaccine access is one of our key priorities and something that we've been working toward throughout the whole of the pandemic and really it's just such a critical issue to assure that every country has access to the vaccines that are needed to protect individuals.

I won't, of course, go into the highest priority groups. We've commented on that numerous times but access is a key issue and COVAX is an important component of access for low-income and low-middle-income countries and will

continue to provide vaccine doses to meet all of the demand that countries have so that countries can pursue and achieve the coverage that they have set as their ambition.

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The issue about pricing of vaccines is a market issue. It has quite a bit of influence for countries who are procuring vaccines on their own but we also have very significant tiered pricing of vaccines through the COVAX facility and through the Gavi negotiations with manufacturers on those contracts. And there are countries that are donating vaccines to the COVAX facility to allow for hundreds of millions of doses to be available to meet all of the demand that countries have.

So, in the short term, these are issues really around tiered pricing, they're around high-income countries that are procuring vaccines, but these are also really important questions for middle-income countries that are still responsible for the procurement of their vaccines and those regional systems for pooled procurement and for countries achieving the best prices that they can for access.

What I think is really important is that countries need to look at their portfolio of vaccines. As you know, there are a variety of platforms of vaccines, mRNA vaccines that you referred to, but there are other platforms. There are the inactivated vaccines, the protein adjuvanted vaccines, the viral vector vaccines. And each of these have high performance against the hospitalisation, serious disease and death and they have different programmatic characteristics, as well as different pricing characteristics.

So, especially as we move through this pandemic period and as countries consider what their long-term, ongoing programmes are going to be on COVID vaccine, that mix of vaccines and that portfolio of vaccines are important decisions that countries need to make so that they can optimise the vaccines that are being offered in their countries for this range of issues, performance, affordability, programmatic ease of deployment.

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So, those are all really important attributes that allow for access and full availability of vaccines for those who most need vaccines across a range of countries and a range of opportunities to procure vaccines. Thanks.

CL Thank you very much, Dr Kate O'Brien. This brings us to the end of our press briefing today and I want to thank you, really, for sticking to your one questions because this meant that we got through a long list of questions already today, even if we still have media colleagues out there trying to ask a question. But, we got through most of them, so thank you again.

Apologies also for the sound issues we had apparently on social media but we will send the audio files and Dr Tedros' remarks right after the press conference and, as usual, tomorrow during the day we will post the transcript. For any other questions please turn to Media Inquiries. With this, I'll give it back to Dr Tedros.

TAG Thank you. My appreciation to members of the media for joining us today and see you next time.