



**Transcript of virtual press conference with  
Gregory Hartl, WHO Spokesperson for Epidemic and Pandemic Diseases,  
and Dr Sylvie Briand, Project leader in the Global Influenza Programme,  
World Health Organization**

**13 May 2009**

**Gregory Hartl:** Welcome to the WHO's daily briefing for today Friday 13 May 17:00 o'clock in Geneva. I would like to begin as usual by updating you with the latest figures that are available. As of 6:00 a.m. GMT this morning, 13 May 2009, we have had 33 countries officially reporting 5728 confirmed laboratory cases of influenza A(H1N1) infection. Those figures and more complete figures are on our web site. I would like to hand over now to Dr Sylvie Briand, Global Influenza Programme.

**Dr Sylvie Briand:** Before starting I would just like to clarify just two issues, because we have had a lot of questions on the resistance of this virus to antivirals I would like to clarify that this virus is sensitive to oseltamivir and zanamivir – the neuraminidase inhibitors. There must have been some confusion with the seasonal virus – the seasonal H1N1 – that has shown last year and the previous years some level of resistance to these antivirals, but it is not the case with this new A(H1N1) virus. This means also that WHO's recommendations have not changed, and they are the same as before.

Today I want to talk a little bit about the severity of a pandemic and of the impact of a potential pandemic. As you know, WHO has increased the level of awareness from Phase 4 to Phase 5 recently and there are lots of questions whether this mean an increase in severity? In fact, I would like to clarify that the Phases that WHO has defined are mainly based on the transmission of this virus: is it a human-to-human transmission able to lead to community outbreaks? and what is the geographical spread of this virus?

But the severity itself is assessed by other means, with the gathering of more detailed data, because it is not as straightforward as it is for example for the geographical spread. And there are also lots of questions about: will WHO issue a kind of a severity index for the global spread? – I mean the global event. In fact this is an issue that has been discussed on many occasions in technical consultations before we issued the latest pandemic preparedness guidance, because it was really concerning. The assessment of severity is a key part of the information that will help national governments to plan for their response. Therefore, it is an issue that we have talked a lot about and we have also discussed whether it was feasible to have an index, at global level, as you have for example for hurricanes – where it goes on the [unintelligible] scale from one level to another.

In fact for influenza, this kind of index is not very helpful, especially at global level because severity will vary from place to place. What we have seen in previous pandemics, and even in the same country, is that you can have different levels of severity. And through out the pandemic itself, in previous pandemics, you have different waves and each wave

can have its own level of severity. Therefore, to have one indicator to describe all this variety of situations was not very helpful.

What is important to understand is that severity is basically based on three components:

1) The first component is the virus itself: its virulence and its transmissibility. We already know some of the characteristics of this virus and of the disease it is provoking. We know now that most of the cases are mild and do not require treatment, however, we know also that there will be severe cases in people with underlying conditions, but also probably in young healthy adults. We know that this virus transmits easily and so, with this information, we can already have an idea of the severity of the disease itself.

But this is not the only component, what is very important to understand is that this virus and the disease it is leading to, will happen in a certain community, a certain population, so we need take into account the vulnerability of this population. What are the factors that enable us to characterize the vulnerability of a population? First, the pre-existing immunity because some of these viruses have been circulating before at a very low level, even if it is not the same virus, could be a virus that it is close to, and may have lead in some individuals to a certain level of immunity. This is an information we do not have at the moment because it is very difficult to assess the immunity of a population. But it may explain why the disease can be very severe in some populations and less severe in other population. So these are factors we will take into account.

2) The other factor – the vulnerability of a population – is also a pre-existing condition, underlying condition, meaning the proportion for example of people with chronic lung disease, proportion of people with chronic cardiovascular disease, diabetes, immunodeficiency, etc. If the proportion of individuals with such conditions is high then we can expect a higher number of severe cases in this population as well.

3) The third factor that is really important also to understand the impact of a disease in a society, is what we call the capacity of the society to fight against this disease, or what we call also, the “resilience” of this community. The resilience is basically all the interventions that this community will put in place to reduce the transmission or to better treat the severe cases. At the end of the day, these interventions will have an impact on the number of deaths or the number of cases.

So you see, because severity is not one factor, only like the case fatality ratio for example, it is very hard to have an index, especially at global level. However, what we are trying at the moment is to gather as much information as possible on the virus, on the disease, and to provide this information to countries so that they can assess their own level of vulnerability and therefore put in place interventions that are needed to fight this disease. This is basically the work that we are doing at the moment.

**David Brown, the Washington Post:** I am wondering if one could generalize, as it is difficult to generalize, but it seems to me that the virus has a very high attack rate in young people and a larger than expected proportion of severe disease that requires hospitalization, which is very unusual for an influenza virus. Can you say that, is it possible to make this generalization?

**Dr Sylvie Briand:** In fact usually flu provokes a lot of mild diseases, especially in young people. Here, in this particular disease and with this virus, what we see in fact is that there are lots of cases in young people and we have seen, especially in Mexico for example, a number of severe cases in young adults. This is not typical of seasonal influenza. This is really a characteristic of this disease. Will this feature be found in other countries, this is something we cannot tell now, this is why we are cautious with our assessment of severity

because we know that even if it is the same virus that is circulating in many countries at the moment, what we do not know yet is the vulnerability of each population, and so the disease can behave differently in different places in the world.

**Jason Gale, Bloomberg:** It sounds like the vaccine industry really had a question over the severity of the illness and that was something that they were trying to weigh up in order to determine whether they should switch to making a shot for H1N1 this new strain. And now it sound like there is sufficient evidence to show that this is actually more pathogenic than seasonal flu. Is that going to give them enough to sway them to producing a shot for this new virus when they have the seed vaccine available?

**Dr Sylvie Briand:** I think what has been said already is that the production of the new vaccine has started. We are not waiting to have more information. The seed viruses have been produced and we use this time to gather more information. Because, as I said, we have three factors about the impact: the virus, the vulnerability of the population and the interventions we can put in place to reduce the impact of a severe disease. All these factors will be taken into account in the decision. Not only the virus itself or the disease it produces but also looking at the population in which the vaccine will be distributed. We need to carefully target probably at-risk groups so that there is a best use of the vaccine and making sure that we are not exposing these people to maybe seasonal influenza as well. So we have to weight different factors and this is why the decision is not just a “yes” or “no”: it is more complicated than that.

**Jonathan Lynn, Reuters:** Could you tell us what it would take for the WHO now to reduce its pandemic alert Phase from 5 to 4?

**Dr Sylvie Briand:** Well, at the moment we have a number of countries reporting imported cases and also contact cases from these imported cases. So, we are still looking at the curve, how it increases, how it decreases and if it will lead to sustained-community transmission. If the thing goes down and we have then no more reported cases of imported cases, and if the epidemic goes down in countries that have currently a very high transmission level, then we will reconsider the situation. Basically, we are just looking at the figures and trying to see how things will evolve.

**NHK, Japan television:** Two questions. In your document of assessment of severity and you mention secondary attack rate. Could you explain a bit about this and the difference between the new virus and usual seasonal influenza. And secondly, yesterday Dr Shindo talked about 10% of hospitalization rate, how much is it higher than usual seasonal influenza?

**Dr Sylvie Briand:** Secondary attack rate is an indicator that we use to try to measure the transmission of the virus. From one person infected, how many persons will be affected from this person. So, we have a number of indicators to try to calculate how much this virus is transmissible and these indicators are really useful because it enables us to compare this virus with other seasonal viruses, and also this virus with other diseases that have epidemic potential. So we have some ranges and this enables us to understand more how it is transmissible.

The data we have at the moment on attack rates are clinical attack rates and we are only counting the cases that have clinical symptoms. More investigations are needed to really have an overview of how many people are really infected, because some of these people may not show symptoms and then are not counted. So we are still assessing these indicators of transmission of the virus. Regarding the hospitalization rate, this is an indicator for us to

assess somehow the burden on the health care system. If we know the number of people showing symptoms and if 10% of these people are going to hospitals and are hospitalized, this is a good indication for countries that are not yet affected on how they can get prepared to attend such a number of patients. So, of course, it will vary from country to country because each country has its own health care system and the way they triage patients is different, but it gives you an idea – rough idea – of the burden that the health care system will have to bear in the coming days.

The point with seasonal influenza is more that we have different kind of patients, because seasonal influenza usually you have quite high hospitalization rates for elderly people and here I mean what we have seen at least in Mexico, is that young people can also be hospitalized and have severe forms of illness that require hospitalization. So this is the main difference.

**John Cohen, Science Magazine:** I understand that vaccine has some seed stocks to pile up and then full scale manufacturing. Is there a day, a week in time that WHO has set to make the decision whether to go to full scale manufacturing?

**Dr Sylvie Briand:** We are still having scientific discussions on how to assess the information that is available and so the date itself is not fixed.

**Marcel, Sao Paulo, Brazil:** I understand that it is difficult to assess the severity of this disease because it depends on the reaction of each population, but would you agree with some assessments made, including by US CDC, that the virus itself is less dangerous than was previously thought in the beginning?

**Dr Sylvie Briand:** There are in fact some characteristics of the virus, I mean they have identified some genes that are more virulent and can give more virulence to the virus itself. Especially people are often comparing this virus to the 1918 pandemic virus as a kind of standard for comparison. It seems in fact that this virus does not have this kind of characteristic. However, as I said before, this is not enough to say that it will be mild because first of all, apparently, it is quite a new virus so most of the population is completely naïve to this virus. The way a population will react to this new pathogen is something that can still be a quite severe reaction.

**Shade, Brazil:** My question is about the donation that Roche did yesterday to WHO of 5.6 million doses. We had no explanation of this donation, whether it was an agreement, if it was an agreement, what kind of an agreement was this, and does it entail any responsibility by WHO in this agreement?

**Dr Sylvie Briand:** I do not have the details of this specific agreement, but what was planned in fact is that we initially had a donation of antivirals but for adult doses, so what Roche has given recently is paediatric doses to have an increase on the reach of this donation, but I have no details on this particular agreement.

**Patterson, TBS:** You have mentioned different things that affect the vulnerability of certain countries and some of those things, such as pre-existing conditions or the interventions that a country will put in place, seem to me at least to be partly related to how wealthy that country is and what the health care system is like in those countries. Now given that Japan, for example – which is the country we represent – is a fairly wealthy country and has a reasonably good health care system, can we assume from that, that Japan is a less vulnerable country than say some of the others, say for example Mexico?

**Dr Sylvie Briand:** It is always very difficult to predict how this disease will behave in a particular country for the reason I mentioned before. What we want to highlight with this factor is that certainly some developing countries are more vulnerable in a sense that they have a high proportion of population that is malnourished and that are probably, is more, let us say, fragile for this particular disease. Part of this is the reason why we try to support even more these countries, to make sure that before this virus arrives they have put in place the necessary measures to, at least, mitigate its impact. But what is important to highlight as well is that some developing countries, especially for example in West Africa, have been used to cope with epidemics: meningitis epidemics, cholera epidemics, yellow fever epidemics and so on. So their health care system, even sometimes under-resourced, is also quite prepared to handle crisis. So this is why we prefer to highlight the resilience of the country, the capacity of the country that is not mechanically related to their resources. They have also some capacities they can put into place and enable them to deal better with this threat.

**Nature Biotechnology:** I am just trying to understand the potential for vaccine makers in the medium term at least, to produce pandemic vaccines even presumably that they are already producing seasonal vaccines according to your biannual recommendations. And maybe you might explain that to me?

**Dr Sylvie Briand:** Part of the difficult decision is that we have two hemispheres that have flu at different times of the year. The seasonal vaccine is used one season by the southern hemisphere and then is used another season by the northern hemisphere. Usually the composition differs as well, so it is two production processes. We do not use necessarily the same vaccine in the north and in the south. This is well planned and it is in place, so manufacturers have these kind of production plans already ongoing. Adding the production of a new vaccine could be done separately or at the same time, and this is where the strategic decision is: we need to carefully assess the benefit of one vaccine for seasonal flu, the benefit of the vaccine for the new A(H1N1) virus, and balance the different benefits regarding the risks and the severity of each disease. This is why the decision is not on/off. It is really: let's review the situation and let's find the best way to minimize the number of deaths and protect better all populations in the south and in the north.

**Kyodo News, Japan:** I have two questions. The first one is about some guidance on severity: how long does it take if you could issue that guidance. Does it take some weeks or months to get it? Do you think you need to issue that kind of guidance before you change the alert level, next time? My second question is that today we had news raised by the Australian scientist that the new virus may be produced by human error. What is your comment on that news?

**Dr Sylvie Briand:** On the severity, rather than a guidance, we have already issued some considerations on the web site, and it is more a kind of concept paper outlining the key issues to consider. Then what we are doing is that we have a list of indicators that enable us to assess this disease and this virus, and they are the indicators that we are using when we discuss with countries and we try to gather detailed information. Basically we have this list of indicators and we use them to assess, first the disease itself, and help countries to assess their own vulnerability. Rather than a guidance, I would say, it is more a concept paper plus some operational tools to make the best use of the information we have and to better support countries in planning.

When we discussed the core guidance, the Pandemic Preparedness guidance, we said that the severity assessment would be part, of course, of the assessment and we want to put a lot

of attention on that, but it was not linked with the Phases because of the reasons I have explained. It is difficult to have an uniform index at global level. We will continue to look at this severity assessment and to improve probably the details in which we can go about this disease and this virus, but in terms of linking necessarily Phases with severity, let's see if it is useful, but probably not so useful.

These are really two different concepts. The Phases were really to assess the geographical spread, and this spread can apply to any kind of pandemic, basically. It is a good indicator of the intensity of the transmission, but severity is something that may vary, that will vary, and so if we link it with the Phases, it will not enable us to make an adequate assessment over time. It will just fix the severity, which is not probably the best indicator for us to adapt our response and to tailor our public health intervention, according to this assessment.

**Gregory Hartl:** On the second question about this paper and the origins of the virus. This paper is, as we all know, publicly available and we have asked scientists in our Collaborating Centres and animal health specialists to look into this and see what evidence there is one way or the other, but it is way too soon to say anything on this claims, and in any case, WHO's main tasks at this point in the Phase of the A(H1N1) event are to assess the current risk, the spread of the current risk, the development of the current risk, and to help our Member States be prepared to respond. Those are what are the most important for us.