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Letter to the Editor

Answer to Paredes et al. commenting on “COVID-19 vaccines under the International Health Regulations – We must use the WHO International Certificate of Vaccination or Prophylaxis”


We thank Dr Paredes et al. for their comment to our editorial (Petersen et al., 2021) on the potential use of International Health Regulations (IHR) and immunizations against SARS-CoV-2.

Dr Paredes writes: “We feel that this recommendation may exacerbate global COVID-19 vaccine inequities during this pandemic” and “Focusing on ensuring the COVID-19 vaccination of travelers – a privileged population in high-income countries—is hard to justify from a health equity perspective”.

While we agree with Dr Paredes on the importance of equity regarding the distribution of vaccines against SARS-CoV-2, there is no conflict with its inclusion in the IHR’s application for enabling safe travelling. The COVAX initiative, a collaboration between the Centre for Epidemics Preparedness Innovations, the Global Alliance for Vaccines and Immunisation and the World Health Organization, (COVAX, 2020) is one of the strategies towards equity. We feel that what we propose will facilitate travel, reopening of society, and opportunities to rebuild livelihoods damaged by the travel industry’s shutdown. Some countries, including Austria, Denmark and the United Kingdom, are presently developing national, digital “immunity passports” very much equivalent to the WHO’s Yellow immunization certificate, and we hope these can be accepted under the IHR in the future.

We would argue that under the IHR those with proven immunity (positive serology) or verified immunization should be exempted from travel restrictions no matter which part of the world they come from, thereby enabling the gradual and safe reopening of society.

Dr Paredes et al. question whether immunity is long-lived. We indeed have limited information on long term immunity. However, as we propose in our editorial, a conservative estimate could be 6 months, and we need to be practical so that proven immunity can be operational. Perhaps a proportion may lose protective immunity earlier, but at least it would allow travel with very limited risk of transmission.

In one study, nucleoprotein- and spike protein-specific immunoglobulin G antibody titres were found to remain stable for at least 4 months post-diagnosis (Wajnberg et al., 2020). A recent review concludes that “Overall, the evidence from observational studies in both SARS-CoV and SARS-CoV-2 infection, along with the promising data from clinical trials across 42 vaccine candidates, provide sufficient reason to speculate that a vaccine for SARS-CoV-2 will be safe and could provide lasting protective immunity that even if not lifelong might persist for years” (Kim et al., 2020). Another study

found virus-reactive memory B cells (MBC), suggesting that even if antibody levels wane, long-lived MBCs remain to mediate rapid antibody production (Nguyen-Contant et al., 2020). A study of T-cell immunity to SARS-CoV found reactive T-cells 17 years after the infection (Le Bert et al., 2020)

In conclusion, we believe that travel and reopening of businesses and cultural activities will be facilitated when people can demonstrate documentation of immunity, whether natural or after immunization. Health equity is an important separate issue that is not handled through the IHR but by other organizations which we agree need support and encouragement.

Conflict of interest

No conflict of interest to declare.

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Ethical approval

Approval was not required.

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