

Global Health Issues

Virtual Press Conference

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Speaker key:

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GS	Dr Gaudenz Silberschmidt
KZ	Katrin Zöfel
EP	Erin Prater
AT	Alexander Tin
MA	Muhammet İkbâl Arslan

00:00:03

TJ Hello to everyone from the headquarters of the World Health Organization in Geneva, August 25th. My name is Tarik and I welcome you to our regular WHO press briefing on global health issues.

We have a number of WHO experts here, in the room, but also online who will be there to answer your questions. As always, we will start by introducing our WHO colleagues here, in the room. With us is Dr Tedros, WHO Director-General. Dr Abdirahman Mahamud, is ad interim Director for the Alert and Response Coordination Unit. Dr Maria Van Kerkhove, Technical Lead for COVID-19. Dr Rosamund Lewis, Technical Lead for mpox.

We have also with us Dr Gaudenz Silberschmidt, who is Director of Health and Multilateral Partnerships and External Relations at WHO, Dr Teresa Zakaria is a Technical Officer within the programme of Health Emergencies, Dr Meg Doherty, Director of Global HIV, Hepatitis and STI Programmes, and Dr Carmen Dolea, Head of the International Health Regulations Secretariat. We have a number of other colleagues online who may be asked to answer questions.

Journalists who are online, please identify yourself and you may already click the Raise Hand button to be in a queue for questions. We have also a couple of special guests at today's press briefing that Dr Tedros will introduce in his opening remarks. With that, I give the floor to Dr Tedros.

00:01:50

TAG Thank you. Thank you, Tarik. Good morning, good afternoon and good evening. Two weeks ago, I issued standing recommendations for countries on the long-term management of COVID-19. I said, then, that COVID remains a global health threat.

Although data available to WHO continues to decline, we have seen increasing reports of hospitalisations, ICU admissions and deaths in some countries. We continue to call on all countries to strengthen surveillance, sequencing and reporting so we can assess the risk of new variants such as EG.5 and BA.2.86, and we continue to call on all countries to implement the standing recommendations to save lives and prevent the burden of long COVID.

Just over a year ago, I declared a public health emergency of international concern over the global outbreak of what was then called monkeypox and is now known as mpox. So far, more than 90,000 cases and 156 deaths have been reported to WHO from 114 countries. However, we know the true number of cases and deaths is higher, due to under-reporting in several countries.

Outside Africa, most cases are among men, and in cases where sexual orientation is reported, most cases are among men who have sex with men. In May of this year, I declared an end to mpox as a public health emergency of international concern. The number of reported cases, hospitalisations and deaths globally has declined steadily since August last year.

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However, we have seen a significant increase in cases in the last two months in Asia and cases continue to be reported regularly in Africa. As I did with COVID, I established a review committee to advise me on standing recommendations to support countries to manage mpox in the long-term.

On Tuesday this week, on the advice of the committee, I issued those recommendations, in seven major areas. First, all countries should develop and implement national mpox plans, with the aim of eliminating human-to-human transmission. Second, to maintain control and achieve elimination, countries should ensure mpox is closely monitored and sustain outbreak surveillance.

Third, all countries should enhance community protection through risk communication, working closely with community representatives and organizations, and by combating stigma and discrimination. Fourth, all countries should initiate, support, and collaborate on research on mpox prevention and control. Fifth, all countries should provide information to travellers who may be at risk on how to protect themselves and others.

Sixth, all countries should deliver optimal clinical care for mpox, integrated into programmes for HIV and other sexually transmitted infections, and other health services as needed. And seventh, all countries should work towards

ensuring equitable access to safe, effective and quality-assured vaccines, tests and treatments for mpox, to reach those most at risk or in need of care.

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To say more about the committee's work and its advice, I'm pleased to welcome its Chair, Prof. Preben Aavitsland, from the Department of Global Public Health and Primary Health Care at the University of Bergen, in Norway. Prof. Aavitsland, thank you for your leadership of the committee and for the strong recommendations you have proposed. Tusen takk. You have the floor.

PA Thank you, Dr Tedros. As you mentioned in May 2022, the world was caught off guard when a little known disease, then called monkeypox, surged in Europe among men who have sex with men before swiftly spreading to America and other continents.

The disease, however, is not new. It has occurred for decades, albeit at a relatively low incidence, in several African countries where it spills over from animals to humans and, in some cases, causes small outbreaks through close contacts, such as in households.

This problem did not catch much attention. In fact, the disease has been so neglected that it has not even made it to the official list of neglected diseases. This last 15 months, with 90,000 cases registered, we have seen an explosion of knowledge about mpox as the outbreak has subsided.

Firstly, we learned that mpox is also a sexually transmissible disease which may spread widely among some groups of men who have sex with men and potentially other groups characterised by high rates of new sexual partners, while it seems to pose less risk outside these groups.

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Secondly, we learned that outbreaks of mpox transmitted between humans can be stopped effectively through swift case detection, contact tracing, targeted communication to heighten symptom recognition and mitigate risky behaviours, as well as strategic vaccination. This means that elimination of human-to-human transmission of mpox is within reach.

If this fails, however, global circulation of the mpox virus persists. The potential for new outbreaks remains among people who have multiple sex partners. Furthermore, the spectre of establishing new animal reservoirs and viral evolution towards heightened transmissibility looms ominously. It is against this backdrop that nations must unify to eliminate person-to-person transmission of mpox and prevent zoonotic spillover.

During the public health emergency of international concern, spanning from July 2022 to May 2023, our response efforts against mpox were guided by temporary recommendations issued under the International Health Regulations. Now, as we create an enduring strategy towards elimination, countries preparedness and response actions can be steered by the standing recommendations set forth under the IHR.

The review committee was asked by the Director-General to give him technical advice on the contents of standing recommendations to Member States. Members of the review committee came from all regions of the world and

were appointed to the committee for their expertise, their independence and their commitment to global health. I thank them for their work on this report. I am pleased to see that the report was of use to the Director-General. Thank you.

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TAG Thank you. Thank you, Prof. Aavitsland, and thank you once again for your leadership of the review committee for both the mpox and COVID-19 standing recommendations. As Prof. Aavitsland said, engaging communities is key to the response to mpox. In fact, it's key in every area of health. Listening to the voices of individuals and communities is essential to addressing the challenges they face.

Strengthening WHO's work with civil society has been a key priority for WHO as part of the transformation we have been making since I began as Director-General in 2017. We have set up the WHO Civil Society Task Force for Tuberculosis, the WHO Advisory Group of Women Living with HIV, the WHO Civil Society Working Group on Noncommunicable Diseases, and other ways to engage with civil society on specific health issues.

I have also held regular dialogue with civil society on topics including long COVID, healthy ageing, sexual and reproductive health, traditional medicine, climate change, sustainable financing and more, to hear directly from them on their challenges and proposed solutions. But we recognise that we must make engagement with civil society more systematic across the three levels of WHO and establish ways to listen to the voices of the people that WHO serves.

Yesterday, we launched the WHO Civil Society Commission, to advise us on how we can work better with the communities we serve. To say more about the work of the Civil Society Commission, I'm delighted to welcome the Co-Chair of its steering committee, Dr Lisa Hilmi.

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Lisa is Executive Director of CORE Group, bringing together health practitioners and public health professionals to improve community health practices for underserved populations. Lisa, thank you for joining us today, and thank you for your leadership of this important new initiative. Over to you.

LH Thank you very much, Dr Tedros. Good afternoon, colleagues of WHO and the press. Good afternoon and thank you very much for your time today to hear about the newly-appointed WHO Civil Society Commission and Steering Committee.

My Co-Chair, Ravi Ram, from Kenya, couldn't be here today but he is here in spirit and it is our honour to be the Co-Chairs for the Civil Society Commission's Steering Committee. Our WHO Secretariat Chair of the CSO Commission, Dr Gaudenz Silberschmidt, is with you today in Geneva.

This is a historical decision by Tedros and WHO to formalise and legitimise how WHO works with civil society in an intentional manner. There is a lot of work to be done as traditionally civil society has not always been engaged in a relevant manner in the past. It is a learning process and we're excited to be on this journey with WHO.

Civil society represents a wide array of non-governmental and non-for-profit organisations. They have an active presence in the community, national, regional and global efforts to prevent, detect and respond to health issues, from humanitarian to development context. They have a vital role in all global health issues.

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The Civil Society Commission was a concept that took several years of discussion between Dr Tedros, WHO and many civil society representatives. It's important to note that before Dr Tedros was even elected in his current role as the Director-General, he was actually consulting civil society. So, it is promising that he has taken action on the vision and that the Civil Society Commission will be institutionalised in WHO.

Dr Tedros has already appointed these key focal points among WHO staff that are charged with working in a meaningful manner with civil society, such as in the immunisation section, maternal child health, sexual reproductive health and more, and they will also work very closely with the CSO Civil Society Commission.

The Commission is set up to provide information, guidance and recommendations that may inform WHO's work on key issues related to the interactions between WHO and civil society, with the aim of strengthening these and global health governance processes where WHO is engaged.

The WHO Civil Society Commission is not a separate legal entity. It derives its legal status from WHO. There was an open call for applications, which is still ongoing. So far, over 350 applications have been received and about 119 have been processed and more are coming in.

We welcome all civil society organisations committed to improve global health to join WHO's CSO Commission and we look forward to their engagement and though leadership for addressing the critical health issues. CSOs can apply to join the WHO CSO Commission on the webpage, which is part of the WHO website.

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The diversity of civil society is represented in the Steering Committee and the Commission, a diversity of geography, as well as technical expertise. There are disability organisations, women's groups, HIV organisations, faith-based youth groups and more.

Through our initial meetings of the Steering Committee we've outlined some preliminary priorities and down the road a bit, with the CSO members of the Commission, we'll further develop these. Some of these preliminary priorities include establishing the systems and the good governance mechanism for the CSO Commission.

To enable this strong foundation, we'll be establishing a method for strong and meaningful Civil Society Commission engagement. Right now, we have 119 members. It is only going to grow. We have to ensure representation, diversity and voice, as well as gender-transformative considerations in all areas of engagement.

We'll be developing the civil society engagement strategy and implementation of this strategy at the country, regional and global levels in collaboration with WHO and the WHO CSO Commission Secretariat. This will include consultations with civil society and global health platforms to inform about the various strategies.

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And we will ensure this meaningful CSO engagement on key WHO activities, including the development of the WHO General Programme of Work 14, sustainable financing, the pandemic accord, and many other strategies. We'll be able to offer our technical expertise, our voice and advocacy for WHO.

We also hope this collaboration at the global, regional and country levels will enhance the mutual understanding of how WHO works, as well as how civil society works to demystify the role of CSOs in addressing these health issues. So, there will be some capacity-building, some development of tools.

We also hope to meaningfully engage with the WHO Youth Council and the other councils within WHO. We want to ensure alignment, plan engagement mechanisms and address the strengths and challenges of CSO engagement through open dialogue and solution-based strategies.

We've asked the Director-General to support the Civil Society Commission to ensure we're able to accomplish our mission through regular discussion, consultation, advocacy, financial resource and permitting space, openness, flexibility so we can support WHO in their strategies through meaningful action without tokenism.

It is important that the Civil Society Commission can actually accomplish its goal and catalyse civil society members to support and guide WHO. I'm happy to report that Dr Tedros has already pledged his unwavering commitment and financial support, and we're looking forward to working with him and WHO generally to address global health priorities. Thank you, and I look forward to your questions.

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TAG Thank you. Thank you so much, Lisa, once again and I look forward to working with you very closely in the months and years ahead. Before we move to Q&A, a few words on a couple of other issues.

Last week, I had the honour to be in India for the G20 Health Ministers' Meeting. One of the main health outcomes of India's G20 Presidency is the launch of the Global Initiative on Digital Health.

Over the last two decades, the power and potential of digital technologies for health, including artificial intelligence, has exploded. One of the main challenges we face is significant fragmentation, driven by the proliferation of new digital tools.

The Global Initiative on Digital Health will help to overcome this fragmentation by converging and convening global standards and best practices. Most importantly, the initiative puts countries at the centre, listening to what they need, aligning resources to support them, and providing robust building blocks which enable local entrepreneurs to support public health priorities.

Alongside the G20 Health Ministers' Meeting in India last week, WHO also held the first global summit on traditional medicine. Throughout history, people in all countries and cultures have used indigenous knowledge, natural resources and traditional, complementary and integrative medicine to meet their needs for health and well-being.

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For hundreds of millions of people, traditional medicine is simply medicine. They rely on it for their health and well-being. And many of the most important treatments in so-called conventional medicine have their origins in traditional medicine, including artemisinin, the backbone of malaria treatment, drugs for childhood cancers, aspirin, contraceptive pills and the smallpox vaccine.

Of course, traditional medicine has its own value, independent of what it contributes to conventional medicine and yet, too often, traditional medicine is stigmatised or dismissed as unscientific.

Let me be very clear: WHO is committed to developing a scientific basis to support the safe and effective use of traditional, complementary and integrative medicine in all countries but to ignore traditional medicine is to ignore a key component of health care for a large part of the world's population.

Last year, I had the honour of launching the WHO Global Centre for Traditional Medicine in India, with Prime Minister Narendra Modi. The centre will scale up capacities to build the evidence and data to inform policies, standards and regulations for the safe, cost-effective and equitable use of traditional, complementary and integrative medicine. Tarik, back to you.

TJ Thank you, Dr Tedros, Dr Hilmi and Prof. Aavitsland, for your remarks. Before we start with questions, just to remind journalists to identify themselves and raise their hand by clicking the button. Let's start with the first question and that is Swiss Radio. We have Katrin Zöfel with us. Katrin, unmute yourself, please.

00:24:55

KZ I hope I'm unmuted now. Hi. It's Katrin.

TJ Hi, Katrin. Yes, we can hear you.

KZ Perfect. My question is regarding the surveillance of the coronavirus, SARS-CoV-2. I understand that there is probably not enough surveillance and maybe you can give me a few more details on why continued surveillance of cases, death, hospitalisation, also long COVID and variants might be important.

TJ Thank you very much, Katrin. Dr Van Kerkhove.

MK Thanks, Katrin, for this question. Surveillance for COVID, surveillance for the virus that causes COVID, SARS-CoV-2, remains critically important for us to be able to track so that we can understand the viruses that are in circulation.

The virus continues to evolve and there are a number of variants that are in circulation, some of which we've recently classified as variants under

monitoring or variants of interest, and all of these are under Omicron. Surveillance is really important so that we can track trends and we can understand severity, we can understand its impact in the population at a population level.

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While we are certainly not in the same situation of the pandemic that we were in a year ago or two years ago, SARS-CoV-2 circulates in all countries right now and it is still causing a large number of infections and reinfections, of hospitalisations, of admission to ICU and of deaths, and we know a number of individuals around the world, a large number of individuals around the world are suffering from post-COVID condition or long COVID.

Just some statistics on surveillance that has been declining in the last year. Out of 234 countries and territories, WHO has data on cases in 103 of those. That does not mean that the virus is not circulating in a number of countries that are not reporting.

We only have data on hospitalisations from 19 countries and territories. We have data from 17 countries on ICU and we have data on deaths from 54 countries, and this out of 234 countries and territories. So, we don't have good visibility on the impact of COVID-19 around the world.

Surveillance is not only important for tracking the variants but it's also important for individuals to know if they're infected or not so that they can receive the appropriate clinical care that they need, so that they don't require hospitalisation, and if they do require clinical care, that they don't progress to severe disease and death.

So, it is really important that surveillance continues and this is on the shoulders of governments right now. Governments have worked incredibly hard over the last three and a half years to increase PCR-based capacities, to increase the workforce to deliver clinical care, to implement and utilise vaccines that are safe and effective at preventing severe disease and death, and these are the systems that need to remain because the virus has not gone away.

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While we are no longer in the crisis, as the DG declared, that we are no longer in a public health emergency of international concern, the threat for COVID remains and this is why surveillance remains absolutely critical. And one of the elements that the DG recommended in the standing recommendations issued earlier this month was about surveillance, ensuring that surveillance continues but also reporting continues as well.

TJ Thank you, Dr Van Kerkhove. We have a couple of other reporters online but I would just like to read a question for Dr Hilmi that we received in a chat, asking about the Civil Society Commission. Are universities that have NGO status eligible for Civil Society Commission membership? If you can just maybe clarify briefly on membership.

LH Thank you so much. There is a review process on the website and civil society of all types is welcome to apply. The guidelines are on the website and

there will be a process of review. So, really, civil society at the global, regional and national levels are welcome to apply.

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TJ Thank you. Dr Silberschmidt.

GS Thank you and building on what Lisa just explained, we try to take all those who are considered as NGOs, as civil society, and who act thus. So, it might be as part of a university but if the entity acts like an NGO civil society, we do look at it, and our review process looks at are they actually civil society and do they fulfil other due diligence criteria of WHO, such as no tobacco or arms links or not excess private sector influence. That is what we are currently going through with the due diligence process.

TJ Many thanks, Dr Hilmi and Dr Silberschmidt. Let's go to the next question. Erin Prater, from Fortune. Erin.

EP Hi. Can you hear me?

TJ Yes.

EP Wonderful. Thank you so much. A few questions here. Did the WHO modify its definition of a VUM to fit BA.2.86 and if so, why? My second question, if I can ask through you, if that's okay, will FL.1.5.1 be designated as a VUM anytime soon? And my third is what would it take for the WHO to grant BA.2.86 a Greek letter? Thank you.

TJ Thank you, Erin. Dr Van Kerkhove.

MK That was three questions but I think we'll permit. Yes, we did modify slightly our definition of a variant under monitoring and the reason for this was we wanted to incorporate our understanding of mutations into this classification, into this definition.

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BA.2.86 has more than 30 mutations in the spike protein. While we have only detected so far around nine or ten cases of BA.2.86, we felt that this warrants closer monitoring because of the sheer volume of change that we've seen. Right now, we've seen detection of BA.2.86 in Denmark, Israel, the UK, USA, South Africa, and we have evidence of BA.2.86 also in Switzerland, in Thailand, in wastewater sampling.

And we need to make sure that in the backdrop of declining surveillance, declining sequencing, in delays in terms of those countries who are continuing to sequence and share those sequences with publicly-available platforms, that time is becoming longer and longer. Our ability as the World Health Organization and with the Technical Advisory Group for Virus Evolution to do risk assessments is declining because we don't have the data readily available.

So, we felt that a slight change in the definition was required and this is why we've indicated that BA.2.86 is a variant under monitoring. It depends if we will change this classification to a variant of interest or a variant of concern, it depends in terms of its circulation.

Right now, we've only seen a few detections. We are not able to estimate its growth rate because we have so little data. We don't have data yet on severity or any indication of a change in severity. We don't see any epidemiologic link between the cases that have been reported, which signals to us that there may be more circulation.

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But we can predict with certainty what will happen with this variant or with any variant, so we have to make sure that surveillance remains strong, we have to make sure that reporting remains strong, so that these assessments can be made.

I can't remember the third question. Help me, Tarik. Oh, what would it take to give a Greek letter? Our Greek letters are reserved for those that are classified as variants of concern and we feel that is really important.

There are a lot of nicknames that are being used for the variants, we understand that, that are being used in the media, but for our communication purposes we will use a Greek letter when we have a variant of concern and we won't hesitate to use those Greek letters should they be needed.

TJ Thank you, Dr Van Kerkhove. I hope this answered also questions that we received from RTBF, Johanne Montay. Johanne, if that is not enough, please send us an email. Now, we will go to the next question, Alexander Tin, from CBS. Alexander, please.

AT Hi. Thank you for calling on me. I also have two questions on BA.2.86. First, can you just clarify what is currently known about symptoms? I know you said there was only ten cases but any detail would be appreciated. Then, second, to clarify something Dr Van Kerkhove said earlier, does that mean that BA.2.86 is currently still considered an Omicron variant? Thank you.

00:34:14

MK Yes. The latter part of that, yes. BA.2.86 is still considered part of Omicron, although the number of mutations makes it highly divergent from BA.2 and the circulating XBB variants. We have classified it as a variant under monitoring. It is part of Omicron and we will give it a different Greek letter should we classify that as a variant of concern.

In terms of the profile of disease among the individuals who have BA.2.86, it's still quite early days. We do know that none of the individuals were immunocompromised, which is quite interesting we find, but I think what we would need to make sure we understand is the full spectrum of disease that is caused by BA.2.86.

My reservation in giving a lot of detail around this is I don't want to draw any conclusions coming from eight or nine patients. We know that these variants that are in circulation, and I think what is important for the general public is that SARS-CoV-2, any of these variants, any of the Omicron variants that are in circulation can cause the full spectrum of disease, everything from asymptomatic infection, all the way to severe disease and death.

Your likelihood of developing severe disease and dying is reduced with vaccines, the many safe and effective vaccines that are in circulation, that are

in use right now. Early access to clinical care and antivirals reduces the risk of developing severe disease. So, that is what is important for the general public in our view.

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We will give a full profile and do a risk assessment of BA.2.86 as soon as we have more information. We expect the number of cases to be increased because we classified it as a variant under monitoring and there could be more detections in countries from wastewater surveillance, which is something that countries have been utilising for a year or two during the COVID-19 pandemic, which is really helpful to understand what is circulating among populations as individual case detection and individual case reporting is reported to WHO.

TJ Thank you, Dr Van Kerkhove. Muhammet İkbāl Arslan, from Anadolu News Agency. Muhammet.

MA Thank you, Tarik, for taking my question. Last year, almost 61,000 people died in Europe because of the extreme heat. We have also a really hot summer this year. Do you have any number?

TJ Muhammet, can I just interrupt you for a second? We don't really hear very well. Is there any chance you speak a little bit louder and slower, so we can understand the question?

MA Yes. Can you hear me now?

TJ Please, go ahead.

MA Last year, 61,000 people died in Europe because of the extreme heat. We have also a very hot summer this year. Do you have any numbers on heat-related deaths for this year in Europe?

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TJ Thank you very much. This is a question about a heatwave. I'm just checking if we have how many people died from the heatwave, if I'm not wrong. I'm not sure if we have Dr Maria Neira online with us but what I know is that we had figures for last year in Europe and that was European Health Institutes that published this study, that was published now, in July, saying that last summer, so summer 2022, that was the hottest in history, we had over 61,000 heat-related deaths in 35 European countries.

So, these are the figures that we have for last year. Obviously, it is too early to have figures for this year. And what we can do, maybe, Muhammet, is to put you in touch with Dr Maria Neira and her team for any follow-up questions. Now, let's go back to Katrin, from Swiss Radio. She has a follow-up question.

KZ Hi, there. Thank you so much for taking my second question. It's actually a follow-up on your first answer, Maria. When communicating now about corona you know the reality that people think, well, finally at last it's just a flu and why bother still doing surveillance, why bother having accurate case numbers and so on. And that's just the reality people are experiencing in daily life and I find it very hard to answer that because what you are saying is just so different. Do you have any information that might help bridge that gap?

MK Thanks, again, for the follow-up. Indeed, what you've pointed out is that it is incredibly difficult to communicate right now the risk and the threat that we see for COVID-19 because effectively, around us, the world has moved on and everybody is living their lives. And we welcome this. We are glad that the world is back, opened up again.

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But the virus continues to circulate, so while we're in a much better situation with COVID than we were a couple of years ago, the virus still poses a threat and it poses a threat for a number of reasons. One, is because the virus is evolving and its changing and we cannot predict with certainty what those changes will mean. Will it be more transmissible? Likely. Will it be more severe? We don't know. And we need to prepare for that.

We need to use the systems that we have in place, of surveillance, of clinical care, of supporting our exhausted workforce to be able to care for patients, particularly those who are at risk of severe disease, over 60, immunocompromised, people with underlying conditions, to make sure that they receive the clinical care that they get, to make sure that vaccines are utilised optimally. Making sure that you get a booster if you are required to get a booster according to the recommendations in your country and the risk group that you are in.

But the virus, right now, is reinfecting a large number of individuals, millions of people each week. We don't have a good gauge on how many reinfections or infections there actually are because surveillance has declined but we do have some indication on trends of impact and what I mentioned on the hospitalisations.

We are seeing a number of countries, primarily in Europe, but this has to do with reporting, that are seeing increases in hospitalisation in the last month. And this is the northern hemisphere temperate regions, where we're in our summer period, and that is not expected if you are thinking of a respiratory pathogen like influenza that typically has peaks in the winter months in the temperate regions of the globe.

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These are concerning to us because as the world has opened up, the governments are dealing with COVID and mpox and, in some countries, they're dealing with Ebola, they're dealing with plague, they're dealing with earthquakes, they're dealing with fires, they're dealing with extreme heat.

And so those beds that are needed in hospitals, if they're filled up with a COVID patient that we could prevent, that bed is not available for somebody else. And so there's more that needs to be done in terms of surveillance, in terms of reporting but also ensuring good clinical care, making sure that we use the safe and effective vaccines.

So, while the world is moving on and individuals are moving on, we are telling governments that they cannot. They need to continue to keep up these systems that are in place for COVID and use those for influenza, use those for mpox, use those for other infectious threats that their populations face

because what you have done for COVID in the last three and half years is beneficial for all infectious pathogens.

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We hear countless times from governments saying what we put in place for COVID was useful for mpox. What we've put in place for COVID was useful for cholera, is useful for the other threats that they face. That's what we are trying to discuss.

So, while the world is moving on, individuals need to know what is their risk as they live their lives. If they are in a vulnerable group, make sure you are boosted, make sure you think about what you're doing. And if you're in a population, if you're in a crowded area, wear a mask. Make sure that we look at ventilation in the indoor spaces where we work, where we live, where we go to school and to make sure that we know what that risk is around us and among those who we love.

But governments can't drop the ball. That's the biggest message that we have. Governments have to remain vigilant for COVID because the threat is not gone.

TJ Thank you, Dr Van Kerkhove. With this, we will conclude the press conference. I would like to thank also Dr Hilmi and Prof. Aavitsland, and I give the floor to Dr Tedros for closing remarks.

TAG Thank you. Thank you so much. Again, I would like to thank Dr Hilmi and Dr Aavitsland for joining us today and for your leadership. I would also like to thank the members of the press corps who joined today and see you next time. Thank you.

00:44:10