TJ A warm welcome to everyone from Geneva, from the headquarters of the World Health Organization. My name is Tarik and I will be with you today for the regular WHO press briefing on global health issues. This press conference has simultaneous translation in six UN languages, plus Portuguese and Hindi, so journalists who are with us today can ask their questions in those languages.

Today, with us, we have a number of WHO panelists and I will introduce them starting, obviously, with Dr Tedros, WHO Director-General, who will shortly give his opening remarks. Also with us today, we have Dr Kate O’Brien, who is the Director, Immunisation, Vaccines and Biologicals, Dr Rogério Gaspar, who is Director of Regulation and Prequalification. We have Dr Sylvie Briand, who is the Director of the Epidemic and Pandemic Preparedness and Prevention Department.

With us, also, is Dr Maria Van Kerkhove, Technical Lead on COVID-19, and Dr Rosamund Lewis, our Technical Lead on monkeypox. As you may see our name plates, we will be shortly joined also by Dr Mike Ryan, Executive Director of our Health Emergency Programme, Dr Ibrahima Socé Fall, Assistant
Director-General for Emergency Response, as well as Dr Soumya Swaminathan, WHO Chief Scientist. We will start with Dr Tedros’ opening remarks. Journalists who have questions, please click the icon Raise Hand, and then we will come back to you after opening remarks. Dr Tedros, the floor is yours.

00:02:30
TAG Thank you. Thank you, Tarik. Good morning, good afternoon, and good evening. Last week, the number of weekly reported deaths from COVID-19 was the lowest since March 2020. We have never been in a better position to end the pandemic. We are not there yet but the end is in sight.

A marathon runner does not stop when the finish line comes into view. She runs harder, with all the energy she has left. So must we. We can see the finish line. We are in a winning position but now is the worst time to stop running. Now is the time to run harder and make sure we cross the line and reap the rewards of all our hard work. If we don’t take this opportunity now, we run the risk of more variants, more deaths, more disruption and more uncertainty. So, let’s seize this opportunity.

Today, WHO is releasing six short policy briefs that outline the key actions that all governments must take now to finish the race. It’s a summary based on the evidence and experience of the last 32 months of what works best to save lives, protect health systems and avoid social and economic disruption. These policy briefs are an urgent call for governments to take a hard look at their policies and strengthen them for COVID-19 and future pathogens with pandemic potential.

We urge all countries to invest in vaccinating 100% of the most at-risk groups, including health workers and older people as the highest priority on the road to 70% vaccine coverage. Keep testing and sequencing for SARS-CoV-2, and integrate surveillance and testing services with those for other respiratory diseases, including influenza. Make sure you have a system in place for giving patients the care that is right for them and integrate care for COVID-19 into primary healthcare systems.

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Plan for surges of cases and make sure you have the supplies, equipment and health workers you will need. Maintain infection prevention and control precautions to protect health workers and non-COVID patients in health facilities. Communicate clearly with communities about any changes you make to your COVID-19 policies, and why. And train health workers to identify and address misinformation, and develop high-quality health information in a digital format. The briefs contain more detail on the specific actions governments can take and are now available online.

Since New Year’s Eve 2019, and every day since then, WHO has worked without rest to warn the world and to give people everywhere the tools they need to stay safe, save lives, and keep societies functioning. We’ve helped countries to build oxygen plants and treatment centres. We’ve shipped millions of masks, gowns, tests, vaccines and more to countries that need them, all over the world.
Doctors, nurses and other health workers have relied on WHO’s guidelines to protect themselves and treat their patients. We have advised governments on how to find the right mix of public health measures. With our partners in COVAX, we’ve delivered more than 1.7 billion doses of vaccine around the world, and low-income countries have relied on us for three-quarters of their vaccine doses. We’re supporting low and middle-income countries to develop their own vaccine manufacturing capacity.

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We have supported countries to maintain health systems and services under pressure. We have fought misinformation and disinformation, and every single day we continue to bring the world’s experts together to share the latest scientific knowledge, monitor trends, analyse the evidence and advise the world. That’s what we will continue to do until the pandemic is truly over. We can end this pandemic together but only if all countries, manufacturers, communities and individuals step up and seize this opportunity.

I’m incredibly proud of our incredible people and the incredible things they have done throughout the pandemic and which they continue to do even while responding to numerous other emergencies around the world. In Pakistan, we’re continuing to support the government to respond to the floods that have affected 33 million people and damaged almost 1,500 health facilities, leaving millions of people without access to health services.

Even as the water recedes, the health needs are rising. Together with the Ministry of Health, we are coordinating the response to those needs by leading an urgent assessment of which health services have been affected the most, in which areas. We’re preparing for and responding to outbreaks of measles, cholera and malaria, and supporting treatment for respiratory, skin and eye infections, typhoid, malnutrition and more.

Immediately, after the floods struck, WHO allocated US$10 million from our Contingency Fund for Emergencies, which we are using to deliver essential medicines and other supplies across 26 districts. This includes tents for temporary health facilities, water purification equipment that can produce enough clean water for 5,000 people per day and oral rehydration sachets for one million people. We will continue to stand side-by-side with the people of Pakistan now and as they recover and rebuild.

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Meanwhile, the downward trend in the global monkeypox outbreak is continuing but, as with COVID-19, this is not the time to relax or let down our guard. This is the time for all affected countries and communities to keep doing what is working. Countries and health workers still need support to prepare for, to recognise, to test and to treat cases, and to prevent infections. We especially urge affected countries to share genome sequences, so we can better understand how the virus is evolving.

Finally, this Saturday, 17th September is World Patient Safety Day. Our focus this year is on Medication Without Harm. Medicines are powerful tools for protecting health but medicines that are wrongly prescribed, taken incorrectly or are of poor quality, can cause serious harm and even death. Globally, one in 20 patients suffers avoidable medication harm and unsafe medication
practices, and medication errors account for half of all avoidable harm in medical care.

WHO is working to reduce medication-related harm and prevent this needless suffering by supporting countries to inform and empower patients, by improving the naming, labelling and packaging of medicines, by supporting health and care workers to avoid errors, and by improving medication systems and practices to reduce the risks of harm.

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This World Patient Safety Day, cities around the world will light up monuments in orange as a statement that everyone has a role to play in medication safety and achieving Medication Without Harm because no one should be harmed while seeking care. Tariq, back to you.

TJ Thank you, Dr Tedros, for your opening remarks. We will now open the floor to questions. Just to remind journalists that if you want to ask a question in any of the six UN languages, Portuguese or Hindi, please press the icon Raise Hand and we will try to come to you. We will start with the first question, and we have Erin Prater, from Fortune. Erin, please unmute and go ahead.

EP Hello. Thank you. Good morning. Earlier this year the White House predicted a fall/winter surge of 100 million COVID cases. Since then, Omicron boosters have been released. What is your forecast for the US and the world when it comes to COVID this fall and winter? Some experts seem to be tempering their projections. And which variants might cause any surge that occurs? Secondly, what can you tell me about what we’ve learned about the evolution of the monkeypox virus in relation to the current global outbreak? Thank you.

TJ Thank you, Erin. We have two questions there, I think. We will start with Dr Van Kerkhove on COVID.

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MK Thanks for the question. As we’re in the third year of this pandemic, we are looking at different possible scenarios of how this virus will continue to circulate. It’s circulating at a very intense level around the world at the present time and, in fact, the number of cases that are being reported to WHO we know are an underestimate. So, we feel that there are far more cases that are actually circulating than are being reported to us.

We expect there to be future waves of infection, potentially at different timepoints throughout the world, caused by different subvariants of Omicron or even different variants of concern because, as you’ve heard us say before, the more this virus circulates, the more opportunities it has to change. But those future waves of infection do not need to translate into future waves of death because we have tools that can prevent, people can prevent infections, can prevent transmissions and, critically, the use of vaccines and vaccination. Early use of antivirals can prevent people from developing severe disease and dying.

There are some estimates that are out there that have been modelled. It depends on the assumptions that those models use in terms of how many cases we might expect. It also depends on the population level immunity in each population, the type, the number of vaccines that have been
administered, whether by age, by underlying condition, if boosters have used. So, the short answer, which I’m making quite long, is that we expect there to be continued waves of infection.

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There’s a lot that we need to do to be able to handle this. The policy briefs that the Director-General announced that were published today target actions, outline targeted actions that we want to see governments focus their energy on. We recognise that COVID-19 is not the only crisis that governments are facing but this crisis, this pandemic has solutions and there are a lot of tools that we need to be able to use.

Given the concurrent crises that governments are facing, we need some critical actions to focus on reducing morbidity and mortality and also reduce the spread. So, there’s a lot that can be done. Again, we expect there to be future waves of infection but that doesn’t necessarily have to translate into future waves of death because there is so much that we can do.

TJ Erin, I am not sure we understood the second part of your question on monkeypox. Would it be possible, please, to get Erin back to ask that question? Sorry for that Erin.

EP Yes. Thank you so much. My question is simply what can you tell me about what we’ve learned about the evolution of the monkeypox virus in relation to the current global outbreak? I believe that the CDC had said there are at least two strains of monkeypox circulating but curious if anything else has been learned.

TJ Dr Lewis, please.

RL Thank you very much. Yes, there are two clades already known of the monkeypox virus. As you know, they have been recently renamed by a group of experts convened by WHO to facilitate that conversation. We now know them as Clades I and II, Clade I being the one that has primarily circulated in Central Africa and Clade II being the one that has primarily circulated in Western Africa and the rest of the world.

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Clade II actually is composed of a number of variants and the outbreak currently is primarily related to variant IIb but also there are cases that are due to variant Ila, and these are being found in different parts of the world. So, in fact, we do have a complex epidemic unfolding but the vast majority of cases are still linked to Clade IIb.

And WHO, along with experts, of course, are carefully monitoring this to see whether there are significant implications regarding to any genetic differences or differences in how the virus interacts with the human immune system. We will continue to monitor this and we’ll let you know if we have more information. Thanks.

TJ Dr Ryan.

MR Just maybe to add to Maria’s comment because the question was about US projections. I think it is very prudent for countries to build scenarios for the future. They’re not predictions. They’re about planning for future scenarios which may or may not occur. What we want to do is build scenarios
to say we can avoid that scenario by doing this or we can mitigate the impact of such a scenario by doing this now.

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And that’s about vigilance and that’s about readiness and I think that’s what we need. Even as the pandemic wanes and as the number of cases may drop or the impact may drop, we are going to have to maintain high levels of vigilance because we still have a highly mutable, evolving virus that has shown us time and time again in two and a half years, how it can adapt, how it can change.

So, how do we, as public servants, continue to track this virus, continue to monitor, continue to maintain high levels of vigilance while allowing our communities to get back to living their lives with the level of protection that they need? And that’s the balance here, is balancing what is the right to exist and right to have lives and livelihoods and, at the same time, maintaining that vigilance and readiness in the background, doing everything we can.

I think that’s something of a balance that we’re going to have to strike in many areas. We’re doing the same in climate. I think risk management, readiness and all of these principles that we need to put in place are very fledging in our society right now. We’ve paid lip service to preparedness, lip service to readiness for many, many years.

This is going to be a constant process from now on. It’s not that we’d go away, put all the tools away and come back in ten years’ time or 20 years’ time and do it all again. I think we’re going to need a much higher level of alertness and of readiness and ability to scale responses in response to any threat that may emerge in the future, and I hope that’s the way forward.

Just on what Rosamund said. I do believe, Rosamund, that IIb, which has been responsible for many of the cases in this current outbreak, was recognised many years ago. It is not a new variant. It has been recognised decades ago as a circulating variant of this virus. The virus has obviously continued to evolve but I just don’t want people to go away thinking that there’s a new variant that has caused this outbreak.

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RL  Correct. Thanks very much, Mike.
TJ  Thank you very much, everyone. Again, we have many journalists online. If you have a question, please raise your hand. That’s the easiest way to ask your question. But we do have a journalist from Anadolu News Agency, Ömer Yildiz, who sent us a question in writing. And the question is can we have a breakdown on the cholera outbreak in Syria as there is no unity in numbers? That’s Ömer Faruk Yildiz, from Anadolu News Agency. Maybe, Dr Fall.
SF  Thank you, Tarik. I think this is a very important question. We have received a report of a cholera outbreak from the Syrian government on 10th September. At that time, the number of cases reported was 936, mainly in Aleppo, but we also have cases in other governorates, including Deir ez-Zor, Raqqa, Al-Hasakah, but most of the cases happen in Aleppo.

As you know, cholera is a big risk in situations where you have inequity in access to water and sanitation, where you have a high level of poverty and, clearly, in all humanitarian crises, cholera is a main risk. That’s why WHO is
working with a number of partners around the global coordination for cholera control and so far, since the beginning of the year, we have delivered more than 20 million oral cholera vaccines, just to show the magnitude of the problem.

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We are working very closely with partners and the government in Syria to make sure that the surveillance is active and we are also implementing preventive measures to protect lives. We will continue following the situation. It’s already assessed as high risk at country level. We have had what we call a grading with our regional office and country office. It is already at Grade 2 in our system, meaning it is very serious and we will continue to work very closely with all actors. Thank you.

MR   Tarik, if I might just add because I think historically, and we’ve seen this with cholera in the past, cholera is very much an indicator disease. It reflects the level of protection in society, access to safe water, access to sanitation, access to hygiene, overcrowding. And when you start to see cholera emerge in multiple places in a situation like this, yes, it reflects we have an epidemic, but what is truly reflecting is that the underlying health situation of the population in Syria is deteriorating, the services they can access is deteriorating.

These people have been suffering for a decade and more. So, I do think, as we respond to the cholera outbreak, we need to recognise that it is the humanitarian situation, it is the conditions in which people are expected to live, it is the environments in which they’re having to occupy, overcrowded, without access to proper services, without access to proper water and hygiene.

So, I do think we will respond and are responding to the cholera outbreak. The world needs to respond to what is now a chronic crisis with millions of people living in harm’s way day after day after day. I say this again in relation to many crises. We have very complex emergencies right now. The average age of a humanitarian crisis is 17 years. It’s not 17 weeks, it’s not 17 months, it’s 17 years.

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We have fragile conflict-affected and vulnerable areas in which crisis is the norm, it’s not the exception, and we have millions and millions of people living in these settings. They’re exposed to measles because they’re not vaccinated. They’re exposed to meningitis, they’re exposed to cholera, they’re exposed to tuberculosis, they’re exposed to starvation, but all of those are consequences of the conditions in which these people are living.

Tedros has spoken about Health for Peace and Peace for Health. We cannot have health without peace. We cannot deliver long-term services that are needed like safe water and sanitation. These are things that require infrastructure, they require capital investment. They take years and decades to build. They take minutes to bomb out of existence. We see the same happening, unfortunately, in Ukraine.

So, I do think, as we respond to these types of events, we have to reflect on the fact that these events occur for a reason. These events occur because we
are literally leaving hundreds of millions of people living in harm’s way in the context of conflict without peace that can deliver for the health of these populations.

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TJ Thank you very much, Dr Ryan and Dr Fall. We will have to make this press briefing shorter today, so we will thank all the journalists for being with us today and we hope to see you again next time. With this, I give the floor to Dr Tedros for his closing remarks.

TAG Thank you. Thank you, Tarik. Thank you to press members for joining us today and see you next time.