World Health Organization

Global Health Issues

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Speaker key:

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OP	Dr Olivier le Polain
MK	Dr Maria Van Kerkhove
KO	Dr Kate O'Brien
AM	Dr Abdirahman Mahamud
SB	Dr Sylvie Briand
MH	Dr Mary Hamel
GG	Dr Gaya Gamhewage
NL	Nina Larson
AT	Alexander Tin
HB	Helen Branswell
JZ	John Zarocostas
JK	Jamey Keaton
AK	Akanimo Kufre

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FC Good afternoon. I am Fadéla Chaib speaking to you from WHO headquarters here, in Geneva, and welcoming you to our global COVID-19 press conference today. We will be discussing COVID and other health issues. Today, we are Wednesday, 26 April.

Let me introduce to you our participants here, in the room. We have Dr Tedros Adhanom Ghebreyesus, WHO Director-General. On the DG's right, we have Dr Mike Ryan, Executive Director for WHO's Emergencies Programme. We have Dr Sylvie Briand, Director for Epidemic and Pandemic Preparedness and Prevention. And we have Dr Mary Hamel, she is Senior Technical Officer, Team

Lead on Malaria Vaccines. And we have also with us, Dr Olivier le Polain, he's Incident Manager for the Sudan Response here, in Geneva.

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We have also with us Dr Maria Van Kerkhove, Technical Lead on COVID-19, and we have Dr Abdirahman Mahamud, who is the Director ad interim for the Alert and Response Coordination. And, last but not least, Dr Gaya Gamhewage, she's WHO Director, Prevention and Response to Sexual Misconduct. We have also several other colleagues online that I will introduce in due course, so welcome all. We will start by handing over to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Fadéla. Good morning, good afternoon and good evening. First to Sudan. The bloodshed we have seen over the past ten days in Sudan is heartbreaking in a country whose people have already suffered so much in recent years. WHO welcomes the ceasefire agreed between the parties. We urge all parties to fully respect it.

Already, the violence has taken a terrible toll on health. On top of the number of deaths and injuries caused by the conflict itself, WHO expects there will be many more deaths due to outbreaks, lack of access to food and water, and disruptions to essential health services, including immunisation.

WHO estimates that one quarter of the lives lost so far could have been saved with access to basic haemorrhage control but paramedics, nurses and doctors are unable to access injured civilians and civilians are unable to access services.

In the capital Khartoum, 61% of health facilities are closed and only 16% are operating as normal. Many patients with chronic diseases, like kidney disease, diabetes and cancer, are unable to access the health facilities or medicines they need. In the coming weeks, an estimated 24,000 women will give birth but they are currently unable to access maternal care.

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Vector control programmes to prevent transmission of dengue and malaria have had to stop. The risk of diarrhoeal diseases is high as the water supply is disrupted and people are drinking river water to survive. With nutrition programmes suspended, 50,000 children are at real risk and the movement of civilians seeking safety threatens the fragile health system throughout the country. Since the conflict began, WHO has verified 16 attacks on health, causing eight deaths.

WHO is also concerned about the occupation of the central public health lab by one of the parties in the conflict. Technicians no longer have access to the laboratory, which means the lab is no longer able to perform its normal diagnostic and reference function. We are also concerned that those occupying the lab could be accidentally exposed to pathogens stored there. WHO is seeking more information and conducting a risk assessment.

Power cuts are also threatening to make the few remaining stocks of blood stored in the Central Blood Bank unusable. WHO staff are risking their lives to support the urgent health needs. We are relocating our staff and their dependents to safety but we are making plans to continue our operations to

the best of our ability. WHO has stocks of essential medicines, blood bags, supplies for surgery and trauma care waiting for delivery but we need safe access to do that. As always, the best medicine in this situation is peace.

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Now, to the COVID-19 pandemic. In February 2020, just weeks after the first reported cases of COVID-19, WHO published our first Strategic Preparedness and Response Plan, the SPRP, outlining the steps countries needed to take to prepare for, and respond to, this new virus.

Next week, we will publish our fourth SPRP, which is designed to guide countries over the next two years to transition from an emergency response to long-term, sustained management of COVID-19. We're very encouraged by the sustained decline in reported deaths from COVID-19, which have dropped 95% since the beginning of this year.

However, some countries are seeing increases and over the past four weeks, 14,000 people lost their lives to this disease. An estimated one in ten infections results in post-COVID-19 condition, suggesting that hundreds of millions of people will need longer-term care. And, as the emergence of the new XBB.1.16 variant illustrates, the virus is still changing, and is still capable of causing new waves of disease and death.

We remain hopeful that sometime this year we will be able to declare an end to COVID-19 as a public health emergency of international concern but this virus is here to stay and all countries will need to learn to manage it alongside other infectious diseases. The new SPRP will support countries to make that transition.

Even as we support countries to respond to COVID-19, we're also working to keep the world safer against future epidemics and pandemics. Today, WHO launched the Preparedness and Resilience for Emerging Threats Initiative, or PRET. The acronym is deliberate. Prêt means ready in French.

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Rather than focusing on specific pathogens or diseases, PRET takes an integrated approach to pandemic planning by focussing on groups of pathogens and the systems they affect. To begin with, PRET will focus on respiratory pathogens, including influenza, coronaviruses, RSV and as-yet-unknown pathogens.

Pandemics are by definition global events, so PRET is designed to promote collaboration between countries but it's also designed to promote collaboration between sectors. As COVID-19 demonstrated, a pandemic is not just a health crisis. It affects economies, education, trade, travel, food supply systems and more.

PRET will therefore support countries to engage as many sectors as possible, as well as civil society groups, religious communities and young people. This integrated approach will help countries to review, test and update their pandemic planning efforts to ensure they have the right capacities and capabilities in place.

The COVID-19 pandemic was a powerful demonstration of the lifesaving power of vaccines. This week marks World Immunization Week. Although vaccines have played a key role in helping to curb COVID-19, the pandemic severely disrupted routine immunisation programmes around the world.

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Over the course of the pandemic, essential immunisation levels fell in more than 100 countries, leading to rising outbreaks of measles, diphtheria, polio and yellow fever. Between 2019 and 2021, an estimated 67 million children missed out on at least one essential immunisation, including 48 million children who missed out entirely.

This dramatic reversal follows almost a decade of stalled progress and has set back vaccination rates to levels not seen since 2008. In response, WHO and our partners have launched The Big Catch-up, a global effort to boost vaccination levels in children to at least pre-pandemic levels.

The Big Catch-up will have a particular focus on 20 countries around the world in which three-quarters of the children who missed out on vaccination in 2021 live. But all countries, rich and poor, have work to do in addressing the barriers to immunisation, whether it's access, availability, cost or disinformation.

Finally, yesterday marked World Malaria Day. Incredible progress has been made against malaria over the last two decades. Advances in nets, tests and medicines have helped prevent more than two billion cases and save an estimated 12 million lives. The world's first malaria vaccine has so far reached 1.5 million children in Ghana, Kenya and Malawi, and a second malaria vaccine is now in development.

These innovations have been made possible by investment in cutting-edge research and development but even with all of these advances, malaria remains a leading cause of death for people in low-income countries and still claims more than 600,000 lives each year, disproportionately affecting poor and marginalised populations.

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At a time when more investment is needed, the global malaria response faces significant shortfalls. World Malaria Day is a reminder of the urgent need to close investment gaps, scale up research and development, and expand access to malaria tools and services for the most at-risk populations. By using all the tools we have, old and new, we can move closer to the vision of zero malaria. Fadéla, back to you.

FC Thank you, Dr Tedros. Now, I will open the floor to journalists' questions. If you want to ask a question, please raise your hand using the Raise Your Hand icon and unmute yourself. We will start with Nina Larson, from Agence France-Presse. Nina, can you hear me?

NL Yes. Thank you. Sorry, can you hear me?

FC Very well. Go ahead, please Nina.

NL I just wanted to ask about the lab occupation in Khartoum. I was wondering if you had more information about who was behind it and what

happened and the specific risks that you're concerned about, what diseases, and if you're worried they could be released not only to the people in the labs but also into the population. If you could say a little bit more about that. Thank you.

00:16:10

FC Thank you, Nina. Dr Ryan.

MR We don't have complete information at this point around the incident. We know that the lab was occupied. It's a national public health lab and it was doing routine diagnostics and reference work for the public health and clinical services in Sudan and, as such, it was dealing with what we would consider normal pathogens for the country, and I'll let Olivier and Abdi detail that.

Certainly, this does represent an attack on health care. The occupation of a laboratory denies that service to the hospitals, to the doctors, to patients and at this time our primary concern is the health and welfare of the people of Sudan. And, right now, the major danger to the health and welfare of the people of Sudan is lack of access to clean water, lack of access to food, the risk of direct injury with guns and tanks and other weapons being used indiscriminately in civilian zones.

So, when we look at what are the major risks to the civilian population of Sudan, they are the risks. Having said that, having untrained personnel in a laboratory facility is not a good thing. That's why we train laboratory workers. That's why we have different levels of BSL, we have different levels of security of biologic agents, and we want to make sure that we have strong levels of biosafety in all labs, no matter where they are.

When lab workers are forced to leave a laboratory and untrained people enter that laboratory there are always risks but the risks are primarily to those individuals, first and foremost, to accidentally expose themselves to a pathogen. But there are always, obviously, secondary risks that someone might leave that laboratory and infect someone else.

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But, right now, the vast majority of people who have been infected with infectious diseases in Sudan are doing so because they're having to drink dirty water. They're doing so because they're crowded into basements and unable to access care. They're doing so because vaccination is not happening in young children.

So, when we look at biologic risks, as you put them, the main biologic risks to humans in Sudan is the fact that there's an ongoing conflict, there's an ongoing war, and the denial of public health and health services to that population is what represents the major risk to health and the major risk of infectious diseases.

Having said that, WHO is following-up, obviously very closely, with the authorities trying to, number one, establish what the current status is, whether the lab is still occupied and to try and get in as soon as possible with the national lab staff to do an assessment of the security of the disease pathogens that are held there.

We have no, and again before a next question is asked, we have no particular reason to believe that there's any other intention in this. The risk probably remains to those individuals who have gone in there. Many, many health facilities have been occupied, many government buildings and other things have been occupied.

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We want to make sure that the people occupying that building know the risks to themselves and we will try to continue to communicate those risks. But, as I said, the team on the ground, and with our biorisk and biosafety teams here, are carrying out a risk assessment to the best of our capabilities. But remember here, internet, telephones and other things are down in Sudan. Communications are extremely difficult.

Doing any kind of assessment at the moment on health status is very difficult and, again, the reason for that is violence, the reason for that is warring factions fighting over territory, fighting over control of Khartoum and other cities. And, unfortunately, it is the civilians of Sudan that are in the firing line, it is the health system in Sudan that's in the firing line and the major risk to the health and welfare of the people of Sudan remains a conflict and we need to keep the focus on that.

But, as I say, we will not ignore a situation where health facilities and particularly labs that hold samples are kept. There's always a biologic risk associated with that act but we need to put it into context with what is going on in Sudan right now. I don't know if you want to give details on the work going on, on that level, Olivier.

FC Thank you, Dr Ryan. Olivier le Polain, who is the Incident Manager for Sudan Response. Olivier.

OP Thank you very much. Not a huge amount to add from what Mike said. Of course, we're working with our colleagues in-country to understand the situation a bit better. There's a risk assessment that is currently ongoing to assess the potential public health risk of this event which, as Dr Ryan highlighted, is an attack on health care.

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The main risk with the lab at the moment is for a national reference lab not to be able to perform its normal public health duties which puts the population of Sudan at risk, of course, by not being able to detect epidemics if they come up. We are aware of some samples of pathogens that have been stored in the lab, measles, COVID, so SARS-CoV-2, TB, particularly RTB, cholera and vaccine. The polio virus assessment is ongoing to better understand what the public health risk might be with those.

And, of course, the risk as well of having untrained personnel or untrained individuals in the lab mishandling some of those samples potentially leading to themselves, exposing themselves to those infections is also a risk. But, again, the risk assessment is ongoing and we are following the situation quite closely and will report as we understand the situation better.

FC Thank you, Dr le Polain. Now, I would like to invite Alexander Tin, from CBS News, to ask the next question. Alexander.

AT Hi. Thanks for calling on me. On a separate topic, can you discuss the XBB.1.9 sublineage? How does that compare to the mutations, the growth and the symptoms that we're seeing with XBB.1.16? Then separately, given the measles outbreaks in the Western Pacific, do you think travel restrictions are warranted? And why do you think these outbreaks are happening now? Thanks.

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FC Thank you.

MK Thanks for the question. XBB.1.9 is a sublineage of XBB, which is a recombinant of two BA.2 sublineages. They have very similar characteristics to XBB.1.5 and also XBB.1.16. I mention those two specifically because we have two risk assessments that have been published that detail the increase in growth advantage that we've seen for these XBB sublineages and that would also include XBB.1.9.

We do see immune escape, which means people can be reinfected again despite being previously infected or vaccinated, but we have not seen a change in severity with the XBB sublineages. XBB.1.19 currently of the sequences that have been shared with GISAID and that we are able to analyse at a global level is around 10% of the sequences. Putting that into context XBB overall is dominant worldwide.

So, this just indicates to us that the virus continues to evolve and it will continue to evolve because the virus is circulating pretty much unchecked. And what we need to be able to do is to keep surveillance up so that we have people who are tested, first and foremost, to ensure they get into the clinical care pathway.

But, also, so that we can monitor the virus itself, understand what each of these mutations means, so that our Technical Advisory Group for Virus Evolution can carry out these risk assessments and so that our Technical Advisory Group for COVID-19 Vaccine Composition, this is the TAG-CO-VAC, can make updated and informed decisions about vaccine composition.

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And, in fact, they will be meeting very soon to discuss that because we have to remain vigilant. As the DG said, the virus is not going anywhere and we have to learn how to manage this appropriately. One of the things we need to be able to do is to look at these viruses very carefully and assess them robustly, rapidly, so that we can inform decisions that we provide to you.

FC Thank you, Dr Van Kerkhove. I would like now to call on Dr Kate O'Brien, who is our Director, Immunisation, Vaccines and Biologicals, to answer the second question about measles in the Pacific. Kate, can you hear me?

KO Yes. Just to follow-up on the question and the Director-General's opening statement, the outbreaks of measles that we're seeing, first of all are escalating in terms of number and in terms of size. We now categorise about 33 countries in the past year as having had what we call large and disruptive measles outbreaks.

And the reason for these outbreaks is a direct result of people in countries who are not immune to measles. I think you know that measles is one of the most infectious viruses, so a measles case that occurs will cause somewhere between 12 and 18 additional cases among people who are not immune to measles. And there are really only two ways you become immune to measles. The first is by being vaccinated, and we recommend a two-dose schedule, or having had measles in the past.

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So, the measles outbreaks are happening because of these, what we call immune gaps, large sections or substantial sections of the population that aren't immune to measles. The backsliding in the immunisation programme as a result of the pandemic over these past three years has resulted now in 25 million children in 2021 alone who didn't get vaccinated with measles vaccine, that's the first dose of measles, and an additional 15 million on top of that in 2021 alone that didn't get their second dose of measles vaccine.

So, this is the critical nature of being able to press the accelerator pedal to enhance the immunisation programme in 2023, to catch-up all of those people who didn't receive measles vaccine, to restore the immunisation programmes, and to strengthen them even further, so we don't have further left-outs moving forward.

You asked a question about travel restrictions. Measles is a virus that is found in many countries around the world. What is more important is that when people are travelling, especially if they're travelling to an area where a measles outbreak is going on, that especially for the children but for all individuals to know your vaccination status with measles vaccine or your past history with measles for those who were born before measles vaccine was available. So, that's the key thing to check before travelling to an area that has a lot of measles going on at the time. Thanks very much.

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FC Thank you, Dr O'Brien. I would like now to invite Helen Branswell, from STAT to ask the next question. Helen, over to you.

HB Thanks very much, Fadéla. I have a couple of questions. One is just a clarification and then my main question. The clarification is about the PRET initiative that WHO announced this morning. RSV is one of the pathogens that is included in the first unit, apparently. I'm puzzled by that because is it thought that RSV could cause a pandemic?

Then, the other question related to the Marburg outbreak in Equatorial Guinea. At points the WHO has indicated that it believes there has been potentially undetected chains of transmission, that some of the cases have not been linked to other cases or links have not been found. Does WHO still fear that that is happening? Thank you.

FC Thank you, Helen. I would like to invite Dr Abdi to take this question on Marburg. Yes, Dr Abdi on Marburg and then I will invite Dr Briand to take the first question. Dr Abdi.

AM Thanks, Helen. On the situation in Equatorial Guinea, we are seeing quite a detailed investigation done by our partners and the Ministry of Health

and just appreciating our US CDC colleagues for the detailed investigation done under the leadership of the government. As we said previously, the government has been sharing updates on Twitter. We had the last case onset reported on 20th April.

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I just wanted to clarify here some points that caused some confusion maybe of senior officials, also even in the media. When we talk about countdown, it is the last exposure, potential exposure. As we speak right now we have one patients still admitted and WHO has strict criteria when we start that 42 countdown is after that, when we have two negative tests for that. I want to take this opportunity to turn to Tanzania, which just started their countdown yesterday, on 21st April, after two PCR.

These two outbreaks that are happening concurrently are having different evolutions, ten weeks in Equatorial Guinea and around five weeks in Tanzania. But the lesson we have learned is that the virus can always surprise us again and again. In terms of the epi, what we are seeing as the trends are these are clusters that are interlinked. One of them we didn't know where it was, that, and eventually it is part of the existing cluster.

So, we are seeing interlinked clusters spread across geographically, whether it be Ebebiyin, Mongomo or Bata, but we haven't seen widespread community transmission. Having said that, the risk is still there ten weeks on. This may be the second largest MVD outbreak that we are dealing with, not only for Equatorial Guinea but also to the neighbouring countries. We just would like to take this opportunity to appreciate the leadership of the Ministry of Health, all the government apparatus, to safely contain this outbreak so that we don't see a spillover to the neighbouring countries.

MR If I could just supplement there. I think Abdi has said it all but I think it's important, I think many people perceive that haemorrhagic fever outbreaks, because of our West Africa experience or the Congo experience, are just explosive outbreaks but very often with haemorrhagic fevers they start with long chain transmission and the can continue in long chains that don't look particularly dangerous. It's just one case and then another case and maybe two cases and back to one case, but they're all linked.

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In many ways, once that virus is transmitting and being able to sustain itself there and you're not able to detect all those chains or you're not finding those cases, the danger is that that virus finds its way into a large funeral setting or that virus finds its way into an unprotected health care system. We saw that previously in Angola, a single case going into a hospital, a very, very unsafe practice of injection and we had literally tens of cases within a couple of days.

So, this is not to say that we've got a massive event continuing in Equatorial Guinea but we're going to need to have sustained, targeted surveillance going forward a number of weeks. We're going to need to maintain vigilance and also make sure that the population are on the alert, that people are incentivised to report this disease, not disincentivised, and that we see that continued sensitivity to the fact that patients presenting unusual symptoms,

presenting with bleeding symptoms to any health care facility need to be carefully investigated.

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I believe it's a reasonably straightforward job to shut this down but I think what WHO would like to see is continued vigilance, continued surveillance, continued open, transparent engagement with communities, and I believe this epidemic will end. But as we've seen in the past, one unusual event, one unfortunate amplification and we could be trouble. So, I think this is the concern we have.

We're not saying by any means that there's a massive undetected problem out there amongst the population in Equatorial Guinea. I don't think that's the case at all but while the haemorrhagic fever is spreading or moving in a human population we need to be extremely cautious and vigilant at all times.

FC Thank you, Dr Ryan. Dr Sylvie Briand will take the first question.

SB Thank you very much, Fadéla and Helen. PRET is really an initiative to strengthen preparedness against epidemics and pandemics of emerging threats. Of course, we don't know what kind of threats will emerge in the future, and that's why we need to have an approach that is very broad and make sure that we build resilient systems and capacities to be able to tackle different types of threats.

That's why we have convened this meeting and worked with a very large group of people to start this process by addressing a group of pathogens called respiratory pathogens. It includes, of course, COVID-19 but also any kind of other coronaviruses and also influenza, and RSV is part of them.

Regarding the specific work we have doing to start with this initiative, it is really, first, to learn the lessons from COVID because we have learned a lot during the past three years and we don't want to lose this experience. Second, it is to maintain also the capacities that were built during COVID because these capacities have grown in many countries, especially low and middle-income countries, and we don't want to lose these capacities.

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And third is really to integrate the innovation that we have seen during COVID, for instance, genomic sequencing and other capacities in labs or in surveillance or in vaccines, etc. So, this initiative is really important to prepare the world for further threats.

You have asked specifically on RSV. I think, again, the issue of RSV is that it is part of this group of respiratory pathogens and the advantage of RSV is that, like flu, it is producing seasonal epidemics or epidemics that are recurring epidemics.

Using RSV or seasonal flu is a very good exercise, I would say, to make sure that those systems we have in place not only are resilient to any kind of crisis, regardless of the size, but also that we can regularly use those systems in place to face a crisis and have this capacity to scale them up and down regulatory so that we make sure that in case of a major problem we do have everything in place and we can scale it up even further should it be a

pandemic. So, it doesn't mean that RSV, we consider it could be a pandemic pathogen but rather that we use any kind of opportunity to build a resilient system that can be scaled up in case of need. Thank you.

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MR Fadéla, if I could just add as well because I think the initiative is very important because we're all working together and our Member States are working together on a pandemic accord and the revision of the IHR. We're looking at the systems we need in the future and there's no question we need to improve how we protect communities, we need to improve our clinical care systems, we need to improve our collaborative surveillance, we need to build better access to countermeasures, we need to improve our coordination and our communication all across the board.

They're the attributes of a strong system but they're generic attributes, they're generic strengths. But if you then face a flu pandemic versus a pandemic of a vector-borne disease or a large-scale epidemic, the interventions are slightly different. If you have pathogens that mainly affect the lung and you require high levels of respiratory care and oxygen and ventilation, then those pathogens may be very different, but the demand on the health care system is very similar, so you can plan.

I think, Sylvie, the initiative that PRET is trying to drive is to bring those experts together from around the world in these different areas. We may have specific diseases that are viral or bacterial that could be spread by vectors. Plague is spread by a rodent vector. Yellow fever is spread by a mosquito vector. There are many rodent-borne diseases. There are many mosquito-borne diseases. So, if you just lump them together as vector-borne the interventions are very different. Controlling rodents in a wild environment versus in a domestic environment is a different challenge.

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So, unless you take your generic approach to building systems and you look at the risks and vulnerabilities in each and every country and you're able to say our particular risks, the things we're vulnerable to here, geographically, from the perspective of our biodiversity, from the perspective of the vulnerability of our community or the types of vectors we have, we have a range of diseases that we need to be ready for.

We all need to be ready for global flu but that varies around the world. And I think making sure that those systems in each and every country are adapted to deal with the threats that they may face, you need to bring that specificity. I think it's really important in the case of respiratory viruses that we are able to collectively look. We can't prepare for influenza and prepare for the next SARS pandemic separately. We have to prepare for them together because they're going to have very similar impacts on the same systems, diagnostics, and many other things.

So, I do think it's an important initiative and it's something that we're really, really glad to promote and I must say that looking at the enthusiasm in the room over that 2.5 days and the massive contribution that our partners from all around the world. Again, I think the remarkable thing about that meeting too is it wasn't just scientific partners in the room.

There were private sector partners in the room, there were civil society organisations in the room. This wasn't about purely taking a scientific approach to this. This was about taking a broad, multisectoral approach to looking at how do we make our systems that we're building ready for the next big respiratory pathogen. So, in that sense, I think it's a major step forward.

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FC Thank you. I would like now to invite John Zarocostas, from FRANCE 24, to ask the next question. John.

JZ Good afternoon. I'd like to follow-up on the remarks by Dr Tedros on malaria. I was wondering, Dr Tedros, given you started your career researching malaria, what will be required to make sure that supply meets demand? The projection we're hearing right now is that will be a shortfall in the new vaccine for malaria. So, what are your ideas and how quickly will there be a plant on the African continent which has most of the burden of this disease?

FC Thank you, John. Let me give the floor first to Dr Mary Hamel, who is our Team Lead on Malaria Vaccines, and then we will come back to Dr Tedros if he has something to complement. Dr Hamel.

MH Thank you for that question. You are correct that this demand for this vaccine has been unprecedented, with 29 countries already coming forward to Gavi, saying that they would like to introduce this vaccine. Already, applications are coming in and the demand far outstrips the supply that is currently available.

So, WHO and partners have made it a priority to work on increasing supply to meet the demand that is there. There are two ways that we are currently working on this. We work very closely with Gavi and other partners, and actually a roadmap has been laid out that is publicly available that speaks to this directly.

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But the two major ways are working with the current manufacturers as they proceed with the tech transfer or product transfer of the antigen, or TSS, to Bharat Biotech, a manufacturer in India which, when that product transfer is completed, we expect to see very, very large increase in volume.

The second way is through the development of a second malaria vaccine and, as Dr Tedros said, there is a second vaccine that's in development. It's in phase 3 trials and it's currently under review by WHO and our expert advisory groups. So, that vaccine, if it is found to be safe, effective, of high quality, then it could go quite a long way in helping to close the supply gap. I'll hand back to you.

FC Thank you, Dr Hamel. I believe Dr O'Brien would like also to say a few words. Dr O'Brien, you have the floor.

KO The second part of your question was about manufacturing on the continent of Africa. First of all, as you know, from a WHO perspective, very supportive and directly doing work to support the diversification of manufacturing, particularly on the continent of Africa.

We know of a number of countries and developers who would be interested in moving forward with malaria vaccine manufacturing. We do engage in discussions with manufacturers about tech transfer or about establishing manufacturing on the continent.

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And this particular antigen against malaria vaccine from either of the manufacturers, and there are more malaria vaccines in the pipeline, has been certainly identified as one of the ones that would be of particular interest for manufacturers on the African continent, and we're doing all that we can from our side to support those discussions and to support that possibility of pipelines moving forward with that manufacturing.

We're aware of positive discussions that are going on and we'll await announcements from manufacturers when the time is ready. But I really want to emphasise that whole effort on establishing greater diversification of manufacturing, particularly in regions where there are vaccines that are of particular importance in the region. We really see that as a high priority. Thanks.

FC Thank you, Dr O'Brien. I would like now to invite Jamey Keaton, from Associated Press, to ask the next question. Jamey, you have the floor.

JK Thank you, Fadéla. Did you say that Dr Gamhewage was on the call? I don't see her on the stage. Is she there?

FC She is.

JK Thanks. My first question really is a just a very brief question for Mike. Yesterday, WHO officials... Can you hear?

FC Jamey, we cannot hear you.

JK Can you hear me now?

00:45:55

FC Yes. Please, go ahead.

JK There's some noise on the line. Dr Michael Ryan, yesterday WHO said that there's something extremely... Sorry, there is a problem.

FC Yes. There is a problem, Jamey. We cannot hear you. You are cut. Maybe you can send your question by writing in the chat and we can try to answer it.

JK I'll send it to you by WhatsApp.

FC Thank you. Now, I would like to invite another journalist to ask the next question. We have a journalist from Southern Examiner, Nigeria. Akanimo Kufre, can you hear me? Kufre, can you hear me?

AK I can hear you. Thank you.

FC Thank you. Please, go ahead.

AK I can take two questions at a time, if you permit. First of all is an idea to journalists. How can we help mitigate against misappropriation of funds by partners to regional governments in the fight against malaria? Then, the

second one is if Nigeria is endemic, what is stopping WHO from having a vaccines lab and the vaccine production here, in Nigeria? What are the challenges that stop that?

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FC Thank you. Kate for the second part, I think. Kate, did you hear the question?

KO Yes. The second question was about what are the constraints around having vaccine for malaria actually manufactured in Nigeria, in particular. Perhaps the question was also about having manufacturing on the continent. Really, vaccine manufacturing is about which manufacturer has the means, the capacity, the rights to vaccines that have been developed and have been tested in clinical trials. So, certainly, there's no specific technical reason why a vaccine can't be manufactured in any country that has the facilities or the capacity, a manufacturer that produces vaccines.

With respect to the malaria vaccine, I think probably we should just ground on a couple of things, which is the first malaria vaccine that has now been introduced in three countries and, as Dr Hamel mentioned, there are a much broader number of countries that are now applying for support for the malaria vaccine through the Gavi mechanisms.

That's a vaccine that has been in development for over 30 years. It's the first time that there's been a vaccine against a parasite, which is a complex organism and a major scientific challenge to develop a vaccine that would have performance against protecting against severe disease from malaria.

So, the fact that we have one vaccine already that has taken over three decades to actually develop an effective vaccine is really a remarkable achievement and now we have a second vaccine that is very mature in the pipeline and, as Mary said, we're evaluating that.

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I just want to point out that especially for malaria vaccine, this is a very difficult, complex, technical area, not necessarily that making the specific vaccines is so technically complex but having gotten to this scientific point of establishing what kind of vaccine would actually provide protection has been quite challenging.

With respect to actually moving production to the continent or developing additional vaccines against malaria, it's really up to the manufacturers about where they'll do tech transfer, who has the capacity to take on the tech transfer and the partnerships that manufacturers are putting in place.

Again, we're very supportive of this happening, very supportive in any way that WHO can be helpful to advance those discussions and to advance, actually, that development of new vaccines and the manufacturing or certainly the first, and perhaps if the second gets fully authorised. We'll see if that can also happen. Thank you.

FC Thank you. I'm looking at my WhatsApp and the chat. There is no question from Jamey.

TAG Fadéla?

FC Yes.

TAG Thank you. I just wanted to add on the manufacturing. I just returned from South Africa, Cape Town. This was a follow-up visit from last year same time to follow-up on the mRNA technology hub that we have in Cape Town. The establishment, as you know, of the mRNA hub is to increase the local production capacity of developing or low and middle-income countries.

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This is because of the problem we faced during this pandemic, the equity problem, especially with COVID-19 vaccines and we have seen how the low and middle-income countries actually were treated. They were the last to get the vaccines for COVID and I think addressing that equity gap will be very important if we are going to prepare for the next pandemic.

That's why we have the hub in South Africa, the mRNA hub, and it's already helping 15 countries. During the meeting last week, when I was there, that was last Thursday, out of the 15 spokes, 14 countries were already there, countries including Argentina, Brazil, Indonesia, India, Bangladesh and other countries from Africa, like Senegal, Kenya, and from Europe, including Ukraine.

And we have seen really good progress in terms of the vaccine for COVID that was already developed by Afrigen, which is an institution that belongs to South Africa and all the 15 countries benefitting from that technology. Of course, the mRNA hub is now focusing on COVID vaccines but the same technology can also be used for TB, malaria and other diseases.

So, that kind of strategic investment is now a priority for WHO and to, of course, combat many of the major diseases in addition to COVID-19 which I said, although COVID-19 triggered the issue this will be used or building the local production capacity will be at the centre of the other diseases also we're combating.

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So, malaria will be treated likewise because, as has been said, as I said earlier, especially malaria is a problem in low and middle-income countries and it's not a problem of the high-income countries and investment on developing tools for malaria is really low.

We're happy that we have the first vaccine and that's helping, as Dr Hamel, said, and we have another vaccine in the pipeline. But we will also use new technologies like mRNA and focus on boosting local production and find new tools and produce them in low and middle-income countries to address the shortage we have or the equity problems that we face.

I'm really encouraged by what I have seen in Cape Town last week and we will continue to invest in that and many countries who are providing support to this initiative have also attended the meeting, especially donors, and they have already committed to continue investing in local production.

But one thing that has to be clear is it's the commitment from each individual country which is very important. Local production is not just to produce vaccines and combat disease. Local production should be part of the

economic development of a country. So, commitment from the government is very important. It's not just about local production to combat disease or for health security reasons. It also brings job opportunities. It means it could be a driver of the economy.

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If that's the case then, many countries now, what they're doing with local production is fill and finish, but in order to benefit from the whole value chain and use it as opportunity for job creation then investment in chemical industries that produce active ingredients will also be important because industry can only be more competitive it if increases it share in the value chain of the production and it cannot be limited to fill and finish alone.

So, we're discussing with countries to make sure that they have the commitment to take the production of tools, whether it's vaccines or treatment, as part of their development agenda, and not only as just producing tools but as part of their drivers for economic growth. That's why we call it a strategic investment and we will continue to help countries, to support them in this endeavour. Fadéla, back to you.

FC Dr Tedros, I think we will take a last question, in fact a written question by Jamey Keaton, from AP, that I will read to you. It's a question for Dr Gamhewage. What has been the impact of journalists reporting about cases of sexual exploitation, abuse and harassment at WHO, some old and long-running, to accelerate efforts to root out SEA at WHO, like the dismissal announced this week? So, Dr Gamhewage.

GG Thank you so much. Thank you, Fadéla, and thank you, Jamey, for the question. It's actually a great question. I think the first thing I want to say is WHO, and I personally, truly appreciate the spotlight that the media are putting on this issue because we know media attention on an issue really helps us change systems, and this applies for the whole of the UN and for any public institution.

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So, we're really grateful and we know it was media attention that really alerted us to the tragic and unacceptable situation in the Democratic Republic of Congo. But having said that, the second thing I want to say is that this is one element in a constellation of things. WHO started changing how we work, our structures, our culture, our processes over the last 18 months.

And because of the many of the changes we've made, changing our policy, changing our procedures, having much stronger investigations, capacity that is benchmarked, that is fast and fair and efficient, assessing the risk in all our programmes in all the locations where we're working, implementing special measures in health emergencies where you and I both know are really high risk, providing better victim support. And the investment the organisation has made in terms of money, in terms of time and in terms of people are having an effect that is changing our organisation.

The evidence I give for this is that currently, for example, just in the last year, our investigation team acted on not just the cases but have completed 120 investigations into sexual misconduct. 72 other investigations are ongoing. So,

you can see the media attention is very important and there are some high profile cases, but there is a lot of work that is being done and being achieved.

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And this is translating into impact and accountability because just in the last quarter of 2022 we either dismissed or terminated contracts of four personnel, just for sexual misconduct. This is the largest number in any given year and just this year, in the first three months, we have taken disciplinary action and dismissal in three cases. So, what I want to say is media impact is good but it is all of the things we're doing that is beginning to have an impact.

But the third thing, the last thing is I want to caution. Media spotlight should not harm the due process that is owned to everybody involved, the confidentiality of victims and survivors, the right of people who are accused to due process. It's only when we protect these things will the disciplinary action that we take stand. Otherwise it can be appealed and nobody will win.

So, I really look forward to media collaboration on this and media attention but I really caution you to really respect the process. WHO is making changes with or without media spotlight. Thank you.

TAG Thank you. I would like to add to this. I think Gaya had already addressed it. One, media helps. It's the eyes and the ears of communities, so keep up doing that and we appreciate your work. On the other hand, one thing I would like to stress, which Gaya also said in the end, is I think we see lack of balance in some of the reporting, factual errors, and when we try to correct the factual errors there is refusal from some of the media outlets even to correct the factual errors.

So, we believe that you're helping us but at the same time I would urge you to look inside. Of course, we don't focus on whether you have some factual errors and so on. We don't focus on that. We focus on especially some of the real challenges you're reporting and we address it and will continue to do that.

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But, at the same time, I urge you to really make journalism a balanced one. I have seen, not only on this one but on others where there are serious flaws. That doesn't help and at times, also, putting pressure on the due process, it won't help in the process. So, we would really appreciate it if you look inside but from our side we will focus on the issue and any factual issue you bring, we will take seriously, we're taking it seriously, and we will address it.

Otherwise, as what Gaya said, it's because we take it seriously that now accountability has improved, the backlogs have been addressed, the system is working relatively better. Many cases are coming to an end and we're making progress. Of course, we believe we have to do more. I think your reporting is helping but please also listen when we give you facts and please don't reject. Thank you. Fadéla, back to you.

FC Thank you, Dr Tedros and Dr Gamhewage. We have come to the end of our press conference. Thank you all very much for your participation. We will be sending you the opening remarks of Dr Tedros and the audio and video file of this press conference just after this briefing. The full transcript will be

available on WHO website tomorrow. Now, I would like to ask if DG has something to say or your last remarks were enough.

TAG Just thanking all the members of the press corps for joining us today and see you next time.

FC Thank you. Bye.

01:05:55