Global Health Issues

Virtual Press Conference
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Speaker key:

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JH	Dr Joachim Hombach
MK	Dr Maria Van Kerkhove
MR	Dr Mike Ryan
TA	Dr Tim Armstrong
BG	Belisa Godinho
HE	Helen Branswell
SA	Simon Ateba
GT	Ginga Tamura
EP	Erin Prater
JR	Jennifer Rigby
KC	Kerry Cullinan
PP	Priti Patnaik
ML	Manuel Lino

00:00:25

CL Hello and welcome to today's global health issues press conference, right here, from the WHO HQ in Geneva. It is Tuesday, 24 January. My name is Christian Lindmeier and I will take you through today's press conference.

We have, as usual, simultaneous interpretation available in six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus Portuguese and Hindi. If, in the course of the briefing, you want to ask a question, please don't forget to raise your hand with the Raise Your Hand icon and unmute yourself when it's your time.

Now, let me introduce the panel and we, again, have a huge list of speakers today. First and foremost, Dr Tedros Adhanom Ghebreyesus, WHO Director-General. We have Dr Mike Ryan, Executive Director for WHO's Health Emergencies Programme. On his side is Dr Hanan Balkhy. She's Assistant Director-General for AMR and also the Acting or the Ad Interim ADG for Access to Medicines and Health Products.

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We have, on the other side, Dr Maria Van Kerkhove, Technical Lead on COVID-19 and then Dr Abdirahman Mahamud, the Director Ad Interim for Alert Response and Coordination. We have a good number of colleagues online and I will introduce them when we get to them. So, thanks for now and, with this, I hand over to the Director-General for his opening remarks.

I understand we have a technical issue. So, we'll hold for a moment. We already had some before but we managed to fix them. Now, it looks like we could move ahead. Let's try again. Let me try again to hand over to WHO Director-General.

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. Since the beginning of December, the number of weekly reported deaths from COVID-19 has been increasing. In total, in the past eight weeks more than 170,000 people have died of COVID-19. That's just reported deaths. The actual number of deaths is much higher.

Almost exactly three years on from declaring a Public Health Emergency of International Concern, our highest level of alert, this week the Emergency Committee on COVID-19 will meet to discuss whether the current situation still constitutes a global emergency. While I will not pre-empt the advice of the Emergency Committee, I remain very concerned by the situation in many countries and the rising number of deaths.

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While we are clearly in better shape than three years ago, when this pandemic first hit, the global collective response is once again under strain. Too few people, especially older people and health workers, are adequately vaccinated. Too many people are behind on their boosters. For too many people antivirals remain expensive and out of reach, and too many people don't receive the right care.

Fragile health systems are struggling to cope with the burden of COVID-19 on top of caring for patients with other diseases, including flu and RSV. Surveillance and genetic sequencing have declined dramatically, making it more difficult to track known variants and detect new ones and there is a torrent of pseudoscience and misinformation circulating, which is undermining trust in safe and effective tools for COVID-19.

My message is clear. Do not underestimate this virus. It has and will continue to surprise us, and it will continue to kill unless we do more to get health tools to people that need them and to comprehensively tackle misinformation.

COVID-19 is not the only threat facing humanity. Since the turn of the year, I have spoken about the myriad threats that demand an unprecedented response, from cholera to conflict to the climate crisis. The number of people

in need of humanitarian relief has increased by almost 25% compared with last year to 339 million people. 80% of humanitarian needs globally are driven by conflict and around half of preventable maternal and child deaths occur in fragile, conflict-affected and vulnerable settings. The world cannot look away and hope these crises resolve themselves.

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That's why we are calling on donors to support WHO's Health Emergency Appeal for US$2.5 billion. These funds will support WHO and its partners on the ground, helping the most vulnerable people in over 50 ongoing emergencies, including 11 Grade 3 emergencies, which is our highest level. With funding and urgent action we can save lives, support recovery efforts, prevent the spread of diseases within countries and across borders, and help give communities the opportunity to rebuild for the future.

Without it, we will not reach all the people that need help the most. Like former Prime Minister Gordon Brown said at the launch of the appeal, hope dies when drugs, vaccines and treatments are unavailable, but hope will come alive if we can fund the medicines, provide the doctors, equip the health workers and avoid preventable deaths and suffering.

Over the past four months, several countries have reported incidents of contaminated cough syrups for children. Last year, WHO raised the alarm by issuing medical alerts in October focused on the Gambia, in November about Indonesia, and earlier this month regarding Uzbekistan.

The cases in these three countries are associated with more than 300 deaths, but we know that at least seven countries have been affected. Most of the deaths have been in children under the age of five. These contaminants are toxic chemicals used as industrial solvents and antifreeze agents that can be fatal even in small amounts and should never be found in medicines.

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This week, WHO released an urgent call for countries, manufacturers and suppliers to do more to prevent, detect and respond quickly to contaminated medicines. Governments must increase surveillance so they can detect and remove from circulation any substandard medicines identified in the WHO medical alerts.

They must also enforce legal measures to help stop the manufacture, distribution and use of substandard and falsified medicines, and manufacturers must purchase pharmaceutical grade ingredients from qualified suppliers and conduct comprehensive testing before using them. And suppliers must always check for signs of contaminated medicines and only distribute or sell medicines authorised by, and from sources approved by competent authorities. All unnecessary deaths hurt but when children die that pain is magnified and demands a requisite response.

Yesterday, WHO published a major report on trans fat showing that globally five billion people remain unprotected from these toxic chemicals that are used in many foods and increase the risk of heart disease and death. In 2018, WHO launched and our partners issued a global call to eliminate trans fat, which have zero known health benefits but carry huge health risks.

At the time, only 550 million people were protected by policies prohibiting the use of industrially produced trans fat, mostly in high-income countries in Europe and the Americas. Today, 43 countries, accounting for one third of the world's population, have implemented such policies. Last year, India became the first lower-middle-income country to adopt best-practice policy.

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Bangladesh, the Philippines and Ukraine have all passed policies that will come into force in the coming years, and Nigeria and Sri Lanka are expected to pass their policies soon. So, there has been major progress but there is still a lot more to do. I salute those countries and manufacturers that have already stepped up and call on all countries and all manufacturers to get rid of trans fat once and for all because food should be a source of health, not a cause of disease.

And I want to close by saying we deplore the abduction of WHO colleague, Dr Mahamadou Diawara, who was taken by unidentified assailants from his car on 23rd January in the town of Menaka, in northern Mali. We're working with local authorities to investigate the abduction and ensure our colleague's quick return to his family. Health workers should never be a target. Christian, back to you.

CL Thank you very much, Dr Tedros. Yes, some grim new at the end. With this, we'll open the floor for questions. Again, please raise your hand and unmute yourself when it's time. First question goes to Belisa Godinho, from W Magazine, Portugal. Belisa, please unmute yourself.

BG The case of more than 300 deaths of children under five years old in Gambia, Indonesia and Uzbekistan caused by medicines contaminated with high levels of diethylene glycol and ethylene glycol circulated in the markets. In the press release you sent to the media and W Magazine it said that case is extended to seven countries.

Is there is a possibility that the situation is affecting more than seven countries in the world? Are they fake or mishandled drugs? Do these toxic elements also affect adults or is the problem being eradicated? Thank you.

00:13:18

CL Thank you, Belisa. Before we go on to Dr Hanan Balkhy, may I remind everyone to please only ask on question because we have a long panel and a long list of raising hands already. So, please, everybody restrict yourself to one question. Thank you and now to Dr Hanan Balkhy, again ADG for AMR and the Interim ADG for Access to Medicines and Health Products.

HB Thank you very much for the question. It has several sub-entities to it but, yes, this is a chemical that can affect adults and children to start with. The mechanism that's in place through the supply chain is to make sure that we have no near misses. We don't want harm from death or disease or hospitalisation and the reason for this specific statement coming out by the WHO yesterday was to ensure the proper processes to do surveillance to identify these contaminated medications do not reach the children and, if they already been on the market, that they can be pulled back.

This is a process that's very well known for all types of medications and even medical devices. It's not a new process. The reason for the concern and the call of the Director-General, even today, is to emphasise to the governments and, specifically, the regulatory authorities to really have proactive surveillance mechanisms in place as much as possible to be able to detect the presence of these medications.

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Please refer to the three links in the statement that refers you back to the Medical Product Alerts, that gives you the details, even with pictures and photos of what these medications look like. The spread of these medications depends on the marketing authorisation of these products. So, they might be produced in one country but if there's market authorisation in other countries, they might be there.

There's also unofficial markets and that's why the whole idea is that we pick this problem up from as many points as possible, for the parents to see the colours and the names of these medications to ensure that they do not give them to their children, for the hospitals, for the primary health carers, for the doctors.

So, the concern that we have and the reason why we are bringing this back again, even though the medical product alerts went out, is these medications are common medications. Some of them are cough syrup. They have antipyretics in it, they have acetaminophen in it, and the chemical that's added to the product is what's causing the death, the unnecessary death of these children.

That's why it is very important for significant vigilance that takes place and also for the unidentified cases of death. We noticed this and we were able to pick it up because it happened in a group, in a cluster. It was an unusual scenario. But there might be children out there exposed to these medications that we're not even aware of and that's why we are trying to be very transparent about the need for everybody to come together through the supply chain to address this issue. I hope this enough, Christian. I think I don't want to go a bit longer. Thank you.

00:16:40

CL Thank you very much. No, that's very fine, indeed, and we also had the opening remarks by the Director-General. Next question goes to Helen Branswell, from STAT News. Helen, please go ahead and unmute yourself.

HE Thank you, Christian. Yesterday, the Food and Drug Administration in the United States indicated that it is going to ask it's vaccine advisory group, VRBPAC, later this week to give it some advice on the issue of whether or not COVID vaccines should be made an annual vaccine and whether, in fact, older people might need two doses annually and, furthermore, that the vaccine should be updated on a regular basis, like flu vaccine is, to try to keep up with the evolution of the virus.

I think this would go to Dr O'Brien, if she's on the line. Does WHO feel we're yet at a point where we know whether or not people will need to be boosted

annually and that keeping up with the virus is tenable and even needed? Thank you.

00:17:51

CL Thank you very much. We don't have Kate O'Brien with us today but we have Dr Joachim Hombach. He's Executive Secretary at the SAGE or for the SAGE and he's also at the Immunisation, Vaccines and Biologicals Department there. So, Joachim Hombach, if you're there please go ahead.

JH Thanks very much, Helen, for these questions and, of course, we have seen the agenda of the Vaccines and Related Biological Products Advisory group of the FDA. We have currently a recommendation on additional booster vaccinations, which is a recommendation which is really risk-based.

So, we are recommending repeat booster vaccinations for people who are at increased risk of severe disease. These are, of course, older people, people with immunocompromising conditions, pregnant women, and we have also health workers which are a little bit in a different category.

The big question is how often do we need repeat vaccination? And I don't think we have a definitive answer and we need to see how things are evolving. It depends, of course, on the evolution of the virus and obviously, generally, on the duration of protection.

We know that even our second booster there is some degree of waning. What we, however, also know is that with the accumulation of infection and vaccination, the so-called hybrid immunity, we establish a pretty robust level of immunity and it is conceivable that annual vaccination would be suitable.

You basically have to find, if I may say so, the sweet spot between waning immunity and the benefit and the effort of providing an additional vaccination. It could well be that it is annual. We also have to say that for the time being COVID hasn't really come down to the usual seasonality that we see for other respiratory viruses. The virus is still fairly unstable, so this is a bit of an anticipation that we end up in a seasonable pattern as we have it, for instance, for influenza.

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So, I think it remains to be seen but I think it's very important that these discussions are happening. It's very important that we start to lay out what could potentially be a way forward but I don't think we have, for the time being, definitive answers. So, that's where we are. We are also looking at our policies, which I just mentioned, our so-called good practice statement we have on repeat booster vaccination and we have to see where the evidence is carrying us.

But we all want to come, obviously, and I think this is driving the US advisory group, we all want to come to simplified vaccination recommendations and also vaccination recommendations that we can plan ahead, which is of course very important for countries and for programmes, but we still live with significant uncertainties. Thanks.

CL Thank you very much, Dr Hombach. We have Dr Van Kerkhove to add.

MK Thanks very much. Just on the process, itself, to add to what Joachim has said. It is really important that there is a strong process in place for WHO to be able to advise on the composition of the COVID-19 vaccine. There's a process in place and it starts from surveillance activities of understanding what is circulating, known sublineages of Omicron or potential new variants that may be detected in the future.

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We have a technical advisory group for virus evolution that is assessing each of these subvariants and looking at certain characteristics, their transmissibility, their immune escape, severity and whether or not there's any impact to the interventions that are in use, diagnostics, therapeutics and vaccines.

We also have a technical advisory group for COVID-19 vaccines that evaluates this and will make recommendations on any changes that may be needed to the vaccines, and it is really critical that WHO is at the centre of this, working with partners around the world, working with regulators, working with partners to be able to assess this in real time, to anticipate any potential needs going forward and then, of course, we have SAGE, which Joachim highlighted, looking at the policies.

As Joachim pointed out, there's a lot of uncertainties going ahead. There's also a lot of uncertainties in terms of what is circulating and our ability to assess them. So, it is absolutely critical that surveillance continues so that we can monitor what is in circulation, that the studies are underway to evaluate the effectiveness of our vaccines going forward and any changes that may be needed.

TAG-CO-VAC, this technical advisory group for COVID-19 vaccine composition remains really critical to be able to be make those recommendations as we go forward. There was a statement that was issued by this group in the past. They will be making statements as we go forward because this virus will be around. But, as we said, we don't know the periodicity of this yet. We haven't seen SARS-CoV-2 settle into a pattern, in terms of its virus evolution, and we have not yet seen a seasonal pattern, particularly in the temperate regions of the globe. And we may get to that but we're not quite there yet.

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CL Thank you very much, Dr Van Kerkhove. I have something going on today. Next question goes to Simon Ateba, from Today News Africa. Simon, please unmute yourself.

SA Thank you, Christian, for taking my question. This is Simon Ateba with Today News Africa, in Washington. The WHO Director-General Tedros just spoke about misinformation around COVID that may be contributing to the latest rise in cases and death. I would like you to provide more clarification. Is questioning the effectiveness of the current vaccines part of that misinformation?

For instance, the Washington Post recently published a story that showed that 58% of all COVID deaths in the US in August were from people who were vaccinated or boosted. The newspaper concluded that it is no longer the

pandemic of the unvaccinated. So, I'm just wondering, with such reports and such data, with people now attacking the managing director of Pfizer on the street for making billions of dollars from their vaccine, is it fair to say that the current vaccines aren't as effective as the WHO has said they are, especially when it comes to new variants. Thank you.

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CL Thank you very much, Simon. Again, too many questions in one. We have really long list. We'll start with, again, Dr Hombach for that part and then we'll see if we add. Cheers.

JH Thanks very much, Simon. I don't know the specific article you're referring to but let me just make a few general comments. First of all, I think there's plenty of studies that really demonstrate the effectiveness of the vaccines and of vaccination and, while many of the studies have some inbuilt methodological issues, I think the message is crystal clear in terms of the effectiveness of vaccinations, in particular against severe disease.

Now, however, one thing which I think people need to be clear is the vaccines are not perfect and, if vaccination coverage is very high, you will see an increasing proportion of the severe cases also in the people who have been vaccinated. This is simple arithmetics and this is something we have seen for other vaccines, of course, as well and the same type of allegations have been made.

But I think, here, you need really to cut across this and need to understand that if you have a very high vaccination coverage as, for instance, you have in the United States, you have a certain amount of breakthrough disease and then you may see more cases actually ending in hospital with a history of vaccination than those who have not been vaccinated at all.

I don't have the precise numbers here but this is a simple arithmetic exercise that at some point materialises if you achieve high vaccination coverage with a vaccine which is not perfect but is working very well. And I think these data and this type of information needs to come out, needs to be communicated very clearly. I think that's all I can offer to this at that point in time. Thanks.

00:26:58

CL Thank you very much and Dr Ryan, please.

MR Just on the specific area of misinformation. When reputable media outlets, scientists and others do analysis and present that analysis to the public that's not misinformation, the individual questioning whether or not they should take a medical product. Everyone should consider what they put in their own bodies. Everyone should ask questions.

We are there and the media are there, and others, to answer those questions and explore those questions. That's not misinformation. Misinformation is when information gets out there that is grossly incorrect, that is promoted that is incorrect or disinformation, information that is purposely designed to be incorrect.

So, I think we need to separate what is robust dialogue around options and what we do as a society and what's best for our kids, what's best for our older

persons, and governments consider that, and that is done in public and in transparency. And that's important that that's available and that discussion happens. That's not misinformation, that's dialogue, that's consultation, that's transparency.

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But misinformation and disinformation are different. This is when information is used to affect how people make decisions, where the base of that information is essentially incorrect, where information is used as a weapon to manipulate how people make conclusions.

And in that situation, that's what we're fighting here. We're not fighting dialogue and we're not fighting questions. We're not fighting people asking or governments asking or the media asking the right questions. And in that dialogue sometimes there's confusion and it takes some time to work it out, and that's part of the process too.

And we go and we gather more evidence and we try and then find. Rational questions are asked. Then, we may not have full evidence to have that discussion. We go find that evidence and we come back and have the discussion again. That's a process. It's not always pretty, it's not always immediate but that's what we have. It's open and transparent. But the misinformation and disinformation and the act of manipulation of people's feelings and people's decisions, this is what we're against and we feel that that has been growing as well, and we don't want to equate these two processes.

The robust discussion around our futures, the robust discussion around policy is important. It needs to be open, transparent and out there and be open for media scrutiny as part of the process. But we're seeing more an increase in abusive behaviour, targeting again, isolating health workers, a lot more negative language and a lot more misuse of information. I don't know if Maria or anyone else may add.

00:29:36

CL That was very robust. Thank you very much, Dr Ryan and Dr Hombach. Next question goes to Tamura Ginga, from NHK Japan. Tamura, please go ahead and unmute yourself.

GT Thank you for taking my question. This is Ginga Tamura, NHK Japan. I think my question is to Dr Van Kerkhove, as my question is about surveillance and sequencing. I understand the importance to maintain surveillance and sequencing of the virus for possible new variants, as WHO stressed, but on the other hand are people well adapted to the new normal lifestyle where people are testing by home kit tests easily or just isolating themselves without testing after three years of a PHEIC? So, what is the advice from WHO to countries or people on how we can balance surveillance and new normal? Thank you.

CL Thank you very much, Tamura. Dr Van Kerkhove.

MK Thanks very much. This is really an excellent question and a poignant one right now because we get this question all the time from our Member States. How do you calibrate the response going forward? We don't expect countries to keep the level of surveillance and testing that they had at the

peak of this, which was really around the start of last year when we had Omicron first being detected around the world and having those massive peaks in testing.

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As you've pointed out, self-testing has increased around the world and there's different reasons for testing. One is for us to monitor this virus. We need to have a good handle on what is circulating. So, one of the reasons for testing using PCR-based testing, using sequencing, is to be able to understand what viruses are in circulation so that we can adjust the strategies going forward, so that we can determine through that process that I described previously do we need to make a change in terms of what WHO recommends to keep people safe, to keep people alive.

The second reason for testing is really to ensure that patients get into that clinical care pathway as quickly as possible. If someone is using a self-test at home they will know whether or not they are infected and what they need to do to protect their loved ones around them, either in their home or at work but also to ensure that if they need access to those antivirals, if they need to get clinical care, that they enter that clinical care pathway as quickly as possible.

Four years into this pandemic, as we start this fourth year, there are so many therapeutics that exist early on in disease presentation to prevent severe disease but also late in disease to prevent death. So, getting patients into that clinical care pathway is another really important reason.

The other reason is that so we can monitor what's happening in at-risk groups, people who are over the age of 60, people with underlying conditions, immunocompromised, and to determine if there's any changes in the pattern in disease presentation or severity in these at-risk groups, these people who are at risk of developing severe disease and dying. So, there needs to be a reason for that.

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What we are working with countries is to calibrate surveillance going forward to meet those objectives, to meet the immediate needs of SARS-CoV-2 and dealing with the pandemic in all countries, but we are also trying to strengthen the groundwork going forward to have integrated respiratory disease surveillance as we go forward.

SAR-CoV-2, COVID is not the only disease that is circulating. We have flu, we have RSV, and there are systems that are in place that look at sentinel-based systems or hospital-based systems. We have wastewater surveillance, we have sero-surveillance.

We have a lot of different components of surveillance that countries are utilising to understand the current situation but also ensuring that they have the labs, they have the workforce, they have the financing, they have all of the equipment that they need to ensure that they have better surveillance for respiratory diseases and also infectious diseases.

So, there's a lot of reasons for surveillance but we don't expect surveillance to be maintained at such an intense level as it was in the beginning. Many countries now are working very hard to calibrate their surveillance going

forward but there needs to be a purpose. Why test? What's the reason? And there's a lot of good reasons to do so at an individual level but also at a community-based level so that we can ensure patients get that clinical care that they need to save the lives that we can now.

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MR Maybe I can supplement as well because what we've seen is a huge expansion in the capacity of the world to do laboratory-based diagnostics across the world, particularly PCR-based diagnostics, and all of you out there have heard of PCR, but PCR-based diagnostics can make diagnosis of many different diseases, so it's not just specifically for COVID.

The Director-General welcomed the Minister of Health for Somalia here yesterday and also to the launch of the Health Emergency Appeal. Before COVID, Somalia had zero capacity for PCR-based diagnostics, in the whole country, nothing. Now, there are 30 facilities spread right across Somalia capable of doing PCR-based diagnosis.

Do we want to lose that in the world? Do we want to lose those detectors, those smoke detectors out there where the fires may begin? And just to continue that analogy of smoke detectors, when you do have smoke detectors in your house or in your building, you need to make sure they're in the right places. You have to cover all the key places. You need to make sure there's enough of them, you need to make sure they're working, and you need to take action when the alarm sounds. That's what we mean by integrating and making resilient networks around the world that can do multi-disease diagnosis, that can share that information quickly, that we don't leave gaps in the system.

Not only is the current contraction of COVID diagnostics concerning us in the short-term, in terms of how we can track COVID, but we cannot afford to lose this precious infrastructure, the human resources, and the physical resources we've all invested in to track COVID can track so many other things. So, I think there are two issues at stake here, one short-term and one very long-term, in terms of pandemic preparedness for the future.

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CL Thank you very much, both. Next question goes to Erin Prater, from Fortune. Erin, please unmute yourself.

EP Thank you so much. I'm curious if there's any update on the status of the Ecuadorian girl with H5N1 and have there been any additional reports or any reports, sorry, of human-to-human transmission in her village or elsewhere? How big of a risk does H5N1 pose to humans? Thank you.

CL Erin, I don't believe we have anybody available for this part of the question today. Please write that to Media Inquiries because also Dr Briand, who was online, had unfortunately to leave. So, please write that to mediainquiries@who.int and we'll take it from there. Thank you very much. Next question goes to Jennifer Rigby, from Reuters. Jennifer, please go ahead and unmute yourself.

JR Hello. Thanks for taking my question. It's just to do with the contaminated cough syrups. What I wanted to ask is this kind of incident crops

up, as you know, every few years in different countries. What needs to be done on a more fundamental level to stop this happening?

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HB Thank you very much for the question. Again, maybe we kind of alluded to it but it's always good to repeat what is the actual ask and I think what we're trying to say here is that, in the production of medications, there could be substandard products coming out because of unintended contamination.

There's also contamination throughout the supply chain that can take place. These instances are not eradicable, if you will. They will continue to happen as long as we're producing medications and we're producing medical devices. So, I think the big ask here is that and we're working with our Member States also on enhancing the oversight, the regulatory processes.

But I think there is also the issue of spot surveillance or focused surveillance to identify any potentially contaminated medications for them to be removed from the market as soon as possible, which is very well known in the regulatory bodies. They know the language and you know it as consumers, recall of medications or devices to prevent harm. So, I think this is one of the issues. There has been in 2012, I think, the establishment of the Member State mechanism which has put nine specific objectives.

They've been working quite closely on the outcomes and the assistance that they can provide for our Member States, along with WHO, on how to strengthen the capacity of our countries and the regulatory authorities within the countries to be able to perform their duties when it comes to oversight on such issues and to also be able to do the surveillance within the markets to prevent unofficial and unregulated markets from being active, and for also educating the patients on where to purchase their medications from, and to ensure that they are provided through the healthcare systems and through the pharmacies by quality medications. So, I hope this addresses the question that you've asked. Thank you.

00:39:08

CL Thank you very much, Dr Balkhy. Next question goes to Kerry Cullinan, from Health Policy Watch. Kerry, please go ahead and unmute yourself.

KC Thank you. The Executive Board Meeting starts on Sunday and runs next week. I wondered whether perhaps the Director-General or one of the officials could identify the three or four most important discussions that will be taking place. Thank you.

CL Thank you very much, Kerry. I have with me, here, Dr Tim Armstrong, who is Director for Governing Bodies, and I believe he would be best to help you out with these points. Thank you.

TA Thank you. Thank you very much for those questions. In fact, the Executive Board starts on Monday, 30th January and runs until 7th February. It's a long Executive Board meeting. There are many, many agenda items, some 40-plus items for discussion but if I were to highlight the top three, if you like, I think the focus is very much on the programme budget. The Member

States will be discussing the new programme budget being put forward for 2024 and ’25, the sustainable finance in the organisation.

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Member States improved an increase of assessed contributions at the last World Health Assembly and there is some discussion now moving that forward. We recognise that there is a great deal of support required from Member States and partners for the increase of the assessed contributions moving into the next biennium for us to be able to support Member States for the issues, some of which we’re discussing here today.

I think the final thing I’d mention out of top three, if you like, is the position of the World Health Organization and our support for the global health architecture, recognising that there is a need for a reinforced central role for WHO and in our ability to support Member States, in particular in the global health emergency architecture. So, they’re my top three, if you like, and I’ll hand the floor back. Thank you.

CL Thank you very much, Dr Armstrong. Next question goes to Priti Patnaik, from Geneva Health Files. Priti, please unmute yourself.

PP Hi. Thanks so much for taking my question. I’m sorry but I have to ask the question also regarding the contaminated medicines causing deaths of children in some countries. What I wanted to understand was are there any specific measures at all that WHO can initiate through Member State processes against specific manufacturers and responsible authorities that would really help? Thanks so much.

HB Thank you very much. This is almost like a wish if we can have that authority to prevent harm at all levels, not just contaminated medications. But I think the work that we’re trying to do is to assist our Member States, specifically those that are receiving medications not produced on their own lands, for example, that they have that ability to check for the medications that are coming into their markets, to ensure that they’re able to test them for falsified and substandard medications.

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So, the work that we’re trying to do is to support our Member States for their capacity building in doing so. What we’re also trying to enhance, and we’re speaking very clearly about this, is the transparency and information-sharing so that we can better investigate the sources of the contaminated medications.

And with each time we are faced with some of these scenarios, there’s a big learning process on where did the contamination happen. What was the cause of it? Some of it comes from error. Some of it comes due to the desperate need of some countries for certain medications, that they end up going into these unofficial markets.

So, the causes of the contaminated medications are so large, it’s not one fix that’s going to prevent this from happening again and I think we’re trying to work on all the fronts but the reason why we are being vocal about it, especially on this specific event today, is to encourage that recognition of this being a problem, to ask for more transparency and cooperation among the

different Member States on the issue of contaminated medications, especially when these are happening as incidents of mistakes or errors.

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These can all be fixed and the way that they can be fixed is by talking about them transparently, trying to understand where did the problem happen and rectifying them. So, I think that's the way forward for us and we really are looking forward to cooperation from everyone. Thank you.

CL Thank you very much, Dr Balkhy. Now, next question goes to Manuel Lino, from MIWISCONSIN. Manuel, please go ahead.

ML Hello. Thank you for taking my question. I was just wondering if the WHO is considering uniting efforts being done about long COVID around the world and if this is considered an emergency.

CL A general question about long COVID and what we are thinking and doing about it. Thank you very much. Dr Van Kerkhove, please

MK Thanks for the question. Long COVID, we've talked about this several times at many of these press conferences. This is part of the clinical care pathway in helping people who have been infected with this virus in dealing with COVID and the long-term effects from it.

We take this very seriously and we are looking at this from a comprehensive point of view. This is organised under our clinical management pillar of the response but also thinking longer-term and how we deal with COVID-19 patients in the medium and into the long-term.

So, we look at this in several different aspects. One is looking at recognition, having proper case definitions so that people can be identified in countries to ensure that they receive that appropriate care. Second is around clinical care and the management across all of the different organ systems.

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We are still learning about long COVID. We're still learning about the disease that primary infection causes, reinfection causes, and how long COVID affects the different organs in the body and working with clinicians around the world for adults, including paediatricians as well, to ensure that appropriate care can be advised.

This is part of the process of the evidence-based guidance, the living guidance that we have been working on for the past three years and will continue to work on going forward to make sure that we have the right clinical management advice out there for patients with long COVID, post COVID-19 condition, and also to ensure that we have more research to better understand this.

Don't misunderstand me. We are not limiting our work because funding is not available. We are asking for further funding and for funding agencies to ensure that they also consider research, cohort studies in high-income and low-income countries, following patients over time so that we can understand post COVID-19 condition, what patients are dealing with and so that the right care can be provided across the disease spectrum.

So, there's a lot of work in this area and this is something we are advising governments to deal with now because there are some estimates out there that maybe one in ten infections could result in long COVID or post COVID-19 condition. There is some research that's out there that suggests that many people who have post COVID-19 condition will recover but we don't have all of the answers yet on this.

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And we need governments to plan, to ensure that post COVID-19 condition is part of the clinical management within their systems and integrated into clinical management systems for the short, medium and long-term.

CL Thank you very much, Dr Van Kerkhove. And, with this, we come to the end of today's press briefing. Thank you all very much also for keeping your questions short, so this way we managed to get through a good list of questions even though we still have a few outstanding.

Now, we'll be sending, as usual, the audio files and Dr Tedros' remarks right after this press briefing and the full transcript should be available tomorrow in the course of the day. Any follow-ups, please write to mediainquiries@who.int and, with this, let me hand back to Dr Tedros.

TAG Thank you. Thank you, Christian. Thank you to all members of the press for joining us today and see you next time.

00:48:32