

Global Health Issues

Virtual Press Conference

27 September 2023

Speaker key:

MH	Dr Margaret Harris
TAG	Dr Tedros Adhanom Ghebreyesus
GP	Prof. Groesbeck Parham
MR	Dr Mike Ryan
MK	Dr Maria Van Kerkhove
SB	Dr Sylvie Briand
BG	Belisa Godinho
MA	Muhammet İkbāl Arslan
HB	Helen Branswell
GS	Gabriela Sotomayor
NL	Nina Larson
DM	Donato Paolo Mancini

00:01:05

MH Hello, everybody. This is Margaret Harris in WHO headquarters, Geneva, welcoming you to our global press briefing on current health issues today, 27th September 2023.

As usual, we'll start with opening remarks from our Director-General, Dr Tedros Adhanom Ghebreyesus, and he will be joined by some special guests today. I will then open the floor to questions and our panel of technical experts, both here in the room and online, will be available to answer your questions.

In the room we have Dr Tedros in the centre. And to Dr Tedros' right we have Dr Michael Ryan, Executive Director of our Health Emergencies Programme. Next to Dr Michael Ryan is Dr Sylvie Briand, our Director of Epidemic and Pandemic Preparedness and Prevention.

To Dr Tedros' left we have Dr Maria Van Kerkhove, our Technical Lead for COVID-19. Next to Dr Van Kerkhove we have Prof. Groesbeck Parham, the Co-Chair of the Director-General's Expert Group for the Elimination of Cervical

Cancer. We also have a large panel of experts online, as I mentioned, and we will call upon them whenever appropriate. Now, without further ado, we will go to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

00:02:30

TAG Thank you. Thank you, Margaret. Good morning, good afternoon and good evening. First, as the northern hemisphere as the northern hemisphere winter approaches, we continue to see concerning trends for COVID-19.

Among the relatively few countries that report them, both hospitalisations and ICU admissions have increased in the past 28 days, particularly in the Americas and Europe. Meanwhile, vaccination levels among the most at-risk groups remain worryingly low.

Two-thirds of the world's population has received a complete primary series but only one-third has received an additional or booster dose. COVID-19 may no longer be the acute crisis it was two years ago but that does not mean we can ignore it.

Countries invested so much in building their systems to respond to COVID-19. We urge countries to sustain those systems to ensure people can be protected, tested and treated for COVID-19 and other infectious threats. That means sustaining systems for collaborative surveillance, community protection, safe and scalable care, access to countermeasures and coordination.

Now to cholera. Last week, WHO published new data showing that cases reported in 2022 were more than double those in 2021. Preliminary data for this year suggest 2023 is likely to be even worse. So far, 28 countries have reported cases this year compared with 16 during the same period last year.

The countries with the most concerning outbreaks right now are Ethiopia, Haiti, Iraq and Sudan. Significant progress has been made in countries in Southern Africa, including Malawi, Mozambique and Zimbabwe, but these countries remain at risk as the rainy season approaches.

00:05:07

The worst affected countries and communities are poor, without access to safe drinking water or toilets. They also face shortages of oral cholera vaccine and other supplies, as well as overstretched health workers, who are dealing with multiple disease outbreaks and other health emergencies.

WHO is providing essential supplies, coordinating the on-the-ground response with partners, supporting countries to detect, prevent and treat cholera, and informing people how to protect themselves.

To support this work, we have appealed for US\$160 million and we have released over \$16 million from the WHO Contingency Fund for Emergencies but the real solution to cholera lies in ensuring everyone has access to safe water and sanitation, which is an internationally recognized human right.

Now to Libya, which is no longer in the headlines but remains in a state of crisis following the devastating floods a few weeks ago. Officially, more than 4,000 people are dead, more than 8,500 are missing, and more than 30,000 have been displaced.

Only a third of hospitals and half of primary health centres remain fully functional due to structural damage to health facilities and hospitals, lack of medicine and medical equipment and shortages of health workers. Affected communities are facing the threat of mosquito- and water-borne diseases, and acute mental distress.

00:07:07

WHO is working closely with Libya's Ministry of Health to assess the needs on the ground, provide supplies and restore primary health care services, especially for routine immunisation and mental health. To support this work, we have appealed for US\$11 million and released \$2.3 million from the Contingency Fund for Emergencies.

Now to the United Nations General Assembly in New York last week, where world leaders gathered for a record three high-level meetings dedicated to health issues. At each, they approved political declarations containing strong commitments.

At the first meeting on pandemic prevention, preparedness and response they committed to conclude negotiations on the pandemic accord and amendments to the International Health Regulations by May next year to ensure equitable access to vaccines and other medical countermeasures, to address mis- and disinformation, to strengthen the global health workforce, to invest in strengthening WHO, and more.

The second high-level meeting was on universal health coverage, which all countries have committed to achieving by 2030 in the Sustainable Development Goals. In the lead-up to the meeting, WHO and the World Bank published new data showing that half the world's population are not fully covered by essential health services and that two billion people face financial hardship due to out-of-pocket health spending, including 1.3 billion who are impoverished by it.

00:09:03

In the political declaration, countries made more than 50 commitments to progressively expand access to essential health services to reverse the trend of catastrophic out-of-pocket health spending, to strengthen primary health care, to expand access to essential medicines, to promote active and healthy lifestyles, to ensure universal access to sexual and reproductive health services, and much more.

The third high-level meeting was on tuberculosis. TB kills more than one million people every year. In the political declaration, countries committed to reach 90% of people with TB prevention and care, to use the WHO-recommended rapid test as the first method of diagnosis, to provide social benefit packages to all people with TB so they don't endure financial hardship, to close funding gaps for TB implementation and research, and to license at least one new TB vaccine.

Developing a new vaccine is especially important. In that regard, WHO has established a TB vaccine accelerator council led by health ministers, which held its first meeting during the General Assembly.

We thank Member States for the three political declarations. Now is the time to act. We look forward to supporting all countries to turn these commitments into realities.

00:10:42

Finally, to cervical cancer. WHO's commitment to universal health coverage means we are working to address all causes of death for all people in all countries but we are particularly focused on the most significant causes of death and disease for the most vulnerable groups.

Every two minutes a woman dies of cervical cancer, 90% of them in low- and middle-income countries. Cervical cancer is the leading cause of cancer-related death among women in Africa but it's the one cancer we can eliminate thanks to vaccines against human papillomavirus, which is responsible for the vast majority of cases.

Almost three years ago WHO launched a global initiative to eliminate cervical cancer, by expanding access to vaccination, screening and treatment for women in all countries. Last year, WHO recommended that one dose of vaccine offers comparable protection to two doses for girls and women under 21 years of age, meaning the global supply of vaccines can be used to protect many more women and girls.

This week, the Expert Group on Cervical Cancer Elimination met to review progress and advise on the future direction for the initiative. To say more, I'm pleased to welcome Co-Chair, Prof. Groesbeck Parham, who is joining us here in Geneva. Prof. Parham, thank you for your leadership on this vital issue and you have the floor.

GP Thank you, Dr Tedros. It is truly an honour to be here and to have the opportunity to talk just a bit about the recent deliberations of your expert group. As you have said, following the launch of the Cervical Cancer Elimination initiative, the Director-General's expert group was established.

00:13:06

The purpose of the group is to advise you on possible new areas for innovation, intervention and acceleration of the implementation of cervical cancer prevention and treatment services across the globe but, as you have said, with a particular focus on areas in the world where the burden is highest. That's where the poorest and most marginalised women reside. The scope of the advice that can be given to you can be strategic or technical in nature, as well as approaches to advocacy and resource mobilisation.

For this year's meeting, which was our fourth, we assembled a group of well-informed individuals from both inside and outside of WHO to provide technical updates on the three pillars of your global strategy, which are HPV vaccination of young girls, cervical cancer screening of adult women, and treatment of women who are discovered to have pre-cancer or invasive cancer during the screening process. These are the three pillars.

Following the presentations, the experts were allowed to deliberate in closed session amongst themselves for over two days. While the final recommendations that will be sent your way are still being formulated, the initial reflections of the expert group consist of the following.

Number one, there should now be a heavy emphasis on country-specific support for the implementation of the three pillars. We know how to vaccinate young girls. We know how to screen adult women. We know how to surgically treat women who are found to have early-stage invasive cancer. We know how to provide radiation treatment to cure the vast number of women who are found to have advanced disease.

00:15:21

They felt that we need fewer guidelines, fewer guidance from WHO but more resources that focus on supporting field workers in the countries that have the highest burden of the disease.

Number two, all three pillars should be implemented collectively, not just HPV vaccination for young girls but also screening of adult women, and a certain percentage of those women who are screened are going to be found to have invasive cancer, so the infrastructure should be present to treat those women.

Number three, there was acknowledgement, as you mentioned, of the current evidence supporting the one-dose HPV vaccination and other potential game-changing innovations, such as artificial intelligence-based cervical cancer screening. Those studies are in progress right now.

And number four, information hubs need to be created that facilitate countries sharing their successes. There are too many countries, the group felt, were operating in silos. For instance, Rwanda has had great success in vaccinating greater than 90% of their young girls. Zambia, Malawi, Lesotho have discovered how to screen large numbers of women in some of the poorest settings in the world.

The radiation therapy centres in Tanzania and Uganda have been in existence for decades and have been successful in providing radiation therapy for women who have advanced disease. And there are new models for surgical training that allow surgeons to be trained in their home environment to prevent them from leaving and maybe never coming back home.

00:17:24

These are just some of the initial reflections of your group and we will be forwarding the final recommendations over the next few months. Again, thank you for allowing me to be here to share this information.

TAG Thank you, Prof. Parham, for your leadership on this vital issue and I look forward to working with both of you in the months and years ahead as we work towards our vision of ending cervical cancer. So, thank you so much, Professor, again.

GP Thank you.

TAG Margaret, back to you.

MH Thank you very much, Dr Tedros and Prof. Parham. Now, I'll open the floor to questions. If you haven't already, please raise your hand on the Zoom so we can be sure. We do already have quite a lot of people in the queue, so we want to make sure we don't miss you out.

And, of course, state your full name, your agency and try to stick to one question, and do please keep your questions as short as possible. Now, we'll start with Belisa Godinho, from W Magazine. Belisa, please unmute yourself and ask your question.

00:18:40

BG Hello. Thank you for taking my question. How is the issue of the mutation of the COVID virus and other pandemics that may arise in countries that have recently suffered from natural disasters, such as Libya or Morocco or related with Nipah in India or even in the war situations like Ukraine, being managed? Thank you.

MH Thank you, Belisa. That's a complex question. Would you like to start, Dr Ryan?

MR It's a very broad-ranging question but maybe I can begin and others may want to come in on it later. There's no question in our own collective cultural memory, the overlap of conflict, infectious diseases and hunger have always been very close allies in the suffering of humankind.

There's no question that currently on the planet there are zones of very high biodiversity, very fragile ecosystems that are in zones of fragility and zones of conflict in which we have people living in extreme poverty and lots of migration and movement. So, we're in a very unstable situation on the planet right now in terms of the drivers of evolution of viruses and then the consequences of their emergence in human populations.

There are two factors. One is the chance that a disease may emerge. We're driving that. The consequence that virus or bacterium will have on a human population has also increased because people's basic health status has decreased. They're on the move. They're migrating. They're refugees. They're not properly nourished. Then, thirdly, they don't have access to care when they do get sick. So, there are a whole range of factors.

00:20:31

In the case of flooding, just to be clear, there are lots of people who ask in the cases of natural disasters and flooding whether dead bodies represent a major problem. It is an issue but it is not, by any way, a big issue or the biggest issue.

Certainly, the risk of infectious disease in flooding events goes up. It's usually due to lack of access to clean water and the fact that sanitation, sewage, toilet systems are overwhelmed and you end up with a lot of contamination of the environment, so the risk of that is very high.

You also see in groups of people who are on the move, particularly migrants, refugees, the people pouring into Armenia right now in the cold, especially children, when people are packed closely together in those situations acute respiratory diseases are very common.

This is all very commonsense, it's very logical. If you pack people together who are stressed, who are cold, who are on the move, the chances are respiratory viruses will emerge in groups like that and we have to be very careful. Measles

would be another disease that emerges, diseases of overcrowding, diseases associated with stressful, overcrowded conditions.

00:21:50

So, there is no question that conflict and instability drive the incidence of epidemic disease and other diseases but it's also important to remember that those situations also reduce access to TB therapy, reduce access to mental health.

In Libya right now, one of the biggest issues we're dealing with is a mental health crisis. People are absolutely psychologically traumatised by what has happened to them.

We can't just deal with their physical needs. We have to support their psychological needs. Equally, if you're a person arriving in Armenia today across a border, destitute and you've lost your home, the impacts of that are as equally psychological as they are physical.

So, yes, there is this link between conflict and instability and disease in humans. It has always been there. It has been amplified currently by the number of conflicts and the number of unstable situations, and if we add in climate change and climate instability.

Dr Tedros spoke in his speech about cholera and the risks. We currently have so many cholera outbreaks around the world and many of them very severe. They're all sensitive to climatic variability and climate change, and that's adding another dimension to this already very complex interaction. That's the downside.

The upside is that we can do something about that, that we can address these issues. And, actually, some of the interventions to prevent these epidemics and prevent these problems are very straightforward, they're very cost-effective. It does not cost that much to save a life. It does not cost that much to protect a child with vaccination. It does not cost that much to get someone on TB therapy.

00:23:33

The fact is probably we have never before had the opportunity we've had to treat and prevent disease in a cost-effective way and especially to deliver that to those people who are in the situations that many people find themselves in today. So, we have to balance our concern with what is happening with the opportunity we have to do something about it, and never has that opportunity been greater.

The question is whether we're going to do that and Dr Tedros speaks about the high-level announcements, the high-level declarations in New York. It's one thing to talk about it, it's another thing to go do it, and he's calling on the world to go do it.

MH Thank you very much, Dr Ryan. I think that really says it all. We'll now go to Muhammet, from Anadolu. Muhammet, please unmute yourself and ask your question.

MA Thank you, Margaret. As you know very well COVID-19 cases are on the rise recently. Can we say that new variants are more contagious and

dangerous and new vaccination programmes will be needed for new variants?
Thank you so much.

MH Thank you very much. I think Dr Van Kerkhove is ready to answer that question.

00:24:55

MK Thanks very much for the question. As DG pointed out, we have seen some worrying trends for COVID in recent months and in the countries that are continuing to report to us we do see increases in case detection in some countries. More worrying is that we're seeing some increases in hospitalisations and admissions to ICU.

The data that we have globally to assess the circulation of this virus, monitoring the known variants that are in circulation, the ability to detect new ones is reducing because surveillance is declining.

This is one of the points the DG made in his speech today. Sustaining the gains that have been made for COVID-19 across collaborative surveillance, across all of the different elements of response are needed for now but also for those future threats that we face that Mike just mentioned.

But I think what we can say is that the variants that are in circulation, we're still dealing with Omicron and many of the sublineages. We have three variants of interest that we're tracking, XBB.1.5, XBB.1.16 and EG.5. EG.5 is on the rise around the world and other two XBBs are starting to decline, but we don't have any one variant that is dominant worldwide.

The SARS-CoV-2 virus, all of these viruses that are in circulation can cause the full range of disease. We have not detected a change in severity. If you are infected with this virus, whatever variant is circulating, it can cause either asymptomatic infection, all the way to severe disease and death.

00:26:27

The good news is that our countermeasures work. We have many countermeasures that can prevent infection and this ranges from improving ventilation where we live, where we work, where we study, wearing of masks, respirators, personal protective equipment, distancing, the use of vaccinations.

COVID-19 vaccines remain safe and effective and prevent severe disease and death. Advanced therapeutics can prevent the development of disease and can prevent, if you are diseased, from going on to develop severe disease. There's so much that we can do now.

We have not detected a change in severity. What we are working on with our Member States, with everyone around the world, is to have good surveillance so that we can track these viruses, that we can track the variants, we can conduct risk assessments as quickly as possible.

One of the elements of this is not only testing and reporting of cases, hospitalisations, ICU, but reporting of the sequences themselves. We've had a decline in the number of sequences that are available from around the world but we've also had a decline from where those sequences are coming from. We need good representation of sequences from around the world.

Again, the good news is that the capacities for PCR-based testing, the capacities for genomic sequencing around the world have expanded dramatically.

00:27:46

We love to give the example of Somalia. I'm looking at Mike. We were just talking about this before. A country that didn't have PCR-based capacity or sequencing before the pandemic and now has across the country. We can give examples across many countries around the world that now can do the sequencing.

These are gains that need to be sustained, not just for the current threats but for all future threats that we face. So, yes, COVID is still circulating, it's still circulating in countries, and there's a lot that we can do to prevent infections, prevent severe disease and prevent death.

MH Thank you, Dr Van Kerkhove. Dr Briand, would you like to add on the vaccine composition work that has been going on?

SB Yes, sure. I think what is important to understand, as Maria alluded to, is that we have different lineages of viruses. Even if no one is dominant, I think this is an important characteristic of COVID-19 virus, that it is evolving, it is changing.

So, we need to constantly assess what those changes mean on the effectiveness of the vaccine. This is why, when we see that the effectiveness of the vaccine is reducing, then we have called a group of experts called TAG-CO-VAC to look at the composition of the vaccines and see if we change the composition of the vaccine, meaning the antigen that we put in the vaccine, would this allow vaccinated people to have better immunity against the virus.

The group has met in May and has provided recommendations, and will meet again in a few weeks' time to look again at the data and see if we can have a better vaccine by changing the composition.

00:29:42

The current vaccines that are available are really good vaccines, so they protect people, depending also on the epidemiology in each country, each context. That's why countries are recommending new vaccination, so that the people who are at highest risk to have severe disease, hospitalisation or death could be protected better should the virus be circulating heavily in these populations.

So, it's a context-based decision, of course, but we are working to monitor the evolution of the virus and its dynamic so that we can provide the best recommendations possible regarding the composition of the vaccine. Thank you.

MR Margaret, can I just add because I think it's important just for the public to understand that WHO has been doing this kind of activity for over a half a century in terms of constantly surveilling that viral world for influenza, looking at the evolution of hundreds of thousands, if not millions of viruses within those families over the last 50-plus years, 70 years.

This is one of the real contributions, one of those global goods that WHO brings to the world with the support of our Member States and the WHO collaborating centres and the hundreds of laboratories who contribute to that system.

00:31:13

This is about collective security. We protect ourselves by collecting data, by bringing samples to reference labs, by sequencing, by characterising these viruses, by tracking the severity of disease in hospitals, by tracking the impact and the epidemiology of these respiratory viruses in communities.

Putting all that information together we're able to decide twice a year for the northern and southern hemispheres what should be in the influenza vaccine every year. The COVID work is an extension of that. It brings a different group of experts with expertise in COVID but many similar and many experts from that same community.

So, I think it's a real example of the added value that the World Health Organization brings to the service that we can deliver, a platform we can deliver for our Member States that allows Member States to communicate, to work together, to come up with the right solutions so we can protect our communities from influenza and, now, from COVID-19.

MH Thank you very much for all those answers. Now, we'll move on to Helen Branswell, from STAT. Helen, please unmute yourself and ask your question.

HB Thank you very much, Margaret. My question is about Ebola and DRC. I've read that DRC is vaccinating in Butembo, I think as a precaution, I guess to prevent a resurgence there. Does WHO know about this programme? Can you tell us anything about the scope of the programme and which vaccine is being deployed? Thank you.

00:32:52

MH Thank you, Helen. I'll hand that over to Dr Ryan.

MR Helen, I don't have any direct information on that but I know that the authorities in DR Congo were looking at using a two-dose vaccine for health workers and using that more extensively from a prevention point of view as, to my knowledge, there is no active outbreak in Congo and there is no outbreak response underway as such.

We will check and get back to you. Really, there's only two vaccines that could possibly be used. There's a Merck vaccine and there's a J&J vaccine. One is a single-dose, one is a double-dose.

Doses of the single-dose vaccine have been pre-stockpiled in Congo and we'll have to check whether or not they're being used as part of a study to look at longer-term protection or whether it's the J&J vaccine being deployed for the purposes of protecting health workers. I just haven't got that micro-knowledge to hand right now, so we'll get back to you, Helen, directly after this presser.

MH Thank you very much, Dr Ryan. The next question goes to Gabriela Sotomayor, from Proceso. Gabriela, please unmute yourself and ask your question.

GS Thank you. Thank you very much. Hola to everybody. One clarification and one question, if I may. The clarification is where can we check the list of countries that are giving you the data on COVID-19 deaths, hospitalisations, etc., because it looks like that not all the Member States are collaborating with WHO, so I just want to know where is the list or where can we access that?

00:34:41

Now, my question. According to a report in Mexico published by CONEVAL, a highly respected institution, from 2018 to 2022, 50 million Mexicans do not have access to health services. This is 30 million more people since the last report in 2018. Furthermore, the number of children without measles vaccine and the shortage of medicines increases as well.

We are talking about Mexico, that is a country of the G20. So, the government is not investing in the health system. I would like to hear Dr Tedros' comments on this very worrying situation because even High Commissioner, Volker Türk, High Commissioner for Human Rights referred to this problem at the opening of the Human Rights Council here, in Geneva. So, if you have comments on this. Thank you so much.

MH Thank you, Gabriella. As you know, we don't normally make country-specific responses but I think Dr Tedros has something to say.

TAG Sorry, I don't have the figures you have. Maybe the best we can do is we can come back to you after checking what you have just said because, as you know, it will be difficult to know the figures by country and response. We would be happy to get back to you though.

MH Thanks, Gabriella. If you could send the questions and all those numbers that you've mentioned to Media Inquiries, we'll sort it out for you. And the first part?

00:36:28

MK Number of countries.

MH Yes. Please go ahead, sorry.

MK Just the first part of the question, I can clarify. The question was around which countries are providing data to WHO on COVID. Us mentioning how many countries are providing this information is not an attempt to name and shame. It's really an attempt to plea with governments who are continuing to collect this information to continue to report it to us.

You can look on our dashboard and you can see which countries are providing information on cases and death. This is a dashboard that we are updating regularly based on the information we receive from the Member States through our regional offices.

But many countries are integrating COVID-19 with influenza, for example, in the GISRS dashboard. So, that's a good thing, that we see data coming in from sentinel base sites and non-sentinel base sites, from hospitals, for example.

And that information that comes in includes information on the numbers of tests that are being performed for influenza and for SARS-CoV-2, the percent

positivity. There's data that countries report through reports on their websites, and this is very helpful for us.

00:37:36

What is really challenging right now is in this transition phase, where we're out of a crisis but we're actually dealing with COVID, we're managing COVID as part of respiratory disease management, as part of infectious disease management. It's a bit of a messy period.

And what our teams are trying to do in countries and regions and here, in HQ, is to troll the web and to find this information where it exists, and we need Member States' help.

We need help particularly with impact data, looking at hospitalisations, ICU, death, looking at uptake of vaccines and, importantly, how much of the population that are in the at-risk groups have received an additional dose within the last year, for example, and that's where we need help.

Our dashboard is currently being updated as much as we can. We're looking at revising our dashboard, how we can integrate different information, looking at impact, looking at wastewater surveillance, looking at data on variants so that you can look all in one place. So, we don't say this to really name and shame. It's really just a plea to help us do a better evaluation of what is in circulation and what threat it continues to pose.

I wanted to make one clarification as well on the vaccine question. To be very clear, the COVID-19 vaccines that are currently in use are protective against the variants that are in circulation, including the variants of interest that are in circulation and the variants under monitoring. This one where we have less than 200 sequences worldwide, the variant under monitoring, BA.2.86.

00:39:08

SAGE is meeting this week to look at updated policy recommendations but let's be very clear, if it is your time to receive an additional dose, especially if you are in an at-risk group, don't wait. Get a vaccine because vaccines protect against severe disease and death.

MH Thank you very much and thank you for that clarification, Dr Van Kerkhove. Now, the next question goes to Nina Larson, of Agence France-Presse. Nina, please unmute yourself and ask your question.

NL Thank you for taking my question. I was hoping you could say a little bit more about the health concerns about the exodus from Nagorno-Karabakh and what your main health concerns.

I understand it's nearly half the population that has fled by now, so I assume the housing issue and also coming cold is a problem. And if you have any insight into the level of injuries from the fuel depot blast earlier this week that would be also helpful. Thank you.

MH Thanks, Nina. I think for the numbers and so on we don't have that. I think Dr Michael Ryan already did cover this, but I'll let him say some more about the health concerns.

MR I was just dealing with something else there. You've all seen the images, you've all seen the people fleeing across the border, you've seen the older persons and the young children and it reminds me of so many other times in our careers, just watching people fleeing from violence and fleeing in fear.

00:40:57

It has significant public health implications for people who move in the conditions they're moving. First of all, people are moving are very slowly. They're stuck on roads. It's cold. Children are getting cold. There's a lot of risk of exposure.

A lot of people, possibly up to one third of Nagorno-Karabakh's ethnic Armenian population has moved in a very short time and the health needs in that situation are always immense because people come with nothing. They don't have their normal meds with them, they haven't eaten, they're thirsty, there's a risk of dehydration, there's a risk of exposure to disease and there are the psychological traumas that go along with that.

I think, right now, given the cold temperatures at night, emergency shelter is absolutely crucial. People that are arriving are exhausted. They need urgent assistance, as I say, as well as that psychological support. There's a need that people get back on their medications if they don't have them with them and that, again, is easy said, it's not as easy done.

But people with diabetes, hypertension, HIV, TB, we forget these things in these situations. When people move, they don't always move with the things they need to support them when they get there.

We have offices in both countries and we're very much supporting the ICRC in their efforts and all the other partners on the ground. We don't have independent verification of what's happening on the Nagorno-Karabakh side but what we are doing right now is focusing on supporting the Armenian authorities in supporting those people who are fleeing across the border.

00:42:46

The explosion is another disaster within a disaster and that means we have lots of people with burns, in particular blast injuries and burns. They are being treated inside the area. I've seen the images myself. There are many people with what look like really severe burns that are going to require very extensive medical and surgical interventions.

Again, we stand ready to support with the emergency medical teams' support. I know there are other emergency medical teams there and I know this is something that the ICRC will manage and will coordinate and we stand ready to support them in that. So, once again in the world we have innocent people fleeing conflict, leaving everything behind them and all of the risk that brings to their life, their health and their psychological well-being.

MH Dr Tedros, please.

TAG Thank you. I think Mike had already said it but one thing I would like to underline is those who are fleeing are actually the vulnerable ones and I think

all parties should really protect the civilians who are fleeing because they're very vulnerable as well.

00:44:03

But at the same time international law should be respected and from WHO's side we will do everything to support. The number is increasing. I think the estimate now is even more than 40,000. We will mobilise in order to support but with the increasing number we understand it is going to be difficult to catch up. Thank you.

MH Thank you very much for those comments, Dr Ryan and Dr Tedros. We've gone past the hour, so we've only got time for one more question and that will go to Donato Mancini, from the Financial Times. Donato, please unmute yourself and ask your question.

DM Hi. Good afternoon. Thanks for taking my question. I think you may have seen the Nature study on molnupiravir that appeared a couple of days ago showing that it increases mutations in the coronavirus and that these can be passed on between patients, even though no variant of concern is currently linked to the signature associated with molnupiravir.

What do you say about these findings in general? Are you considering changing your guidelines for use of this drug? Obviously, I know there's a big access deal in place. Is molnupiravir even necessary anymore? Any comment would be helpful. Thank you.

MH Thank you very much, Donato. We may need to get the clinical team to provide you with advice and information but Dr Van Kerkhove is going to start answering the question.

MK Thanks, Donato, for the question. We welcome all new evidence that is coming out on treatments. This is something that needs to continue as we learn more about the use of treatments in the fourth year of this pandemic.

00:45:55

You mentioned its link to variants. One of the things I want to highlight, and we will get the clinical team to come back on the specifics of molnupiravir, but one of things is there may be a misunderstanding of where variants emerge from and there's only one or two possible ways in which we can see the emergence of new variants.

Variants can emerge from anywhere. This virus is circulating in every country. We've already talked about the limited visibility that we have on tracking the known variants and the ability to detect new ones. We have very limited surveillance in animal populations, looking at spillback, spill-forward and the potential mutations. We saw that Cluster 5 variant in September 2020.

But we do need to evaluate the use of therapeutics and the benefits, the wonderful benefits that we actually see in preventing severe disease. So, we are aware of the studies that have come out but I did just want to highlight that variants can emerge anywhere.

It's not one particular population, it's not one particular country or one particular region, which is why we need good surveillance in all countries associated with its circulation, associated with the use of therapeutics,

associated with people working at the animal-human interface and immunocompromised individuals, etc, so that we can do these robust and rapid risk assessments to evaluate what's actually happening out there and determine whether or not we need to update our therapeutic guidance.

00:47:24

I will say that our therapeutic guidance is a living guidance and it's updated regularly. It's in its 14th version. We continue to rely on experts in our guideline development groups, who assess all available information and make updates as necessary.

And we do have a range of therapeutics that are out there. We don't only rely on one particular medicine, and that's a good thing, so that we have options for people around the world. We do need to continue to work on access, affordability of these treatments, so that people who require this clinical care, regardless of the therapeutic, get it in a timely manner, and that is a problem, still, around the world.

MH Thank you very much, Dr Van Kerkhove and on that note...

MR Margaret, can I just take the floor?

MH Oh, Dr Ryan has got something to add.

MR I just want to pass back some information to Helen on the Ebola vaccine. Yes, Helen, there is a campaign underway for vaccinating frontline workers. It's in North Kivu and Ituri and it's aimed at utilising vaccines that would otherwise go beyond their shelf life.

These vaccines are stockpiled for the purpose of outbreak response and as is standard practice in many of the stockpiles we use, we can then use those vaccines. We don't want to waste those vaccines. We want to use them public health purposes.

00:48:44

So, we would use them in protecting frontline workers in the very area where that virus emerged. To my knowledge, our target population is approximately 7,000 frontline workers, of which about 70% have been vaccinated. That's my current information related to your question.

MH Thank you very much, Dr Michael Ryan. So, there you are. You've got really fresh information. Now, we're going to close but first of all I'll ask Prof. Parham if he's got some final remarks because it's a privilege to have you with us, sir.

GP Final remarks? I have so many remarks. I would just like to say that I am a gynaecologic oncologist, a cancer surgeon, and I have been living and working fulltime in Lusaka, Zambia, for the past 20 years. That was a passion I had and I just decided to give up my work in the United States and move to Africa.

And now, because of support from the DG, I've been able to move around Sub-Saharan Africa, I know that people are not using that term anymore, to various countries, and I have been singularly impressed with the commitment of frontline workers, doctors, nurses who have very little to work with but who are

inspired to do their best to try to eliminate cervical cancer with vinegar, putting vinegar on the cervix and trying to visualise abnormal lesions.

00:50:35

We now have this more sophisticated test called the HPV test, but they have just taken the things that they have, surgical equipment that's not nearly what you would expect to be in an operating room, but trying to do their very best and to advocate and to educate.

So, this elimination initiative, when the DG made the call, it's just amazing how it switched everybody on, how it has energised workers in these countries where there are very few resources and they really want to do it. They really are trying.

And i think that your expert group was spot on when they talked about the necessity of now focusing resources on the front line, putting resources on the front line to give a boost to this innate effort, organic effort that is already going on inside the countries.

And I'm convinced that this disease can be eliminated. I never thought it could but, just from what I've seen over the past four or five years, I'm convinced that it can be if we focus on the frontline workers in the countries and help them get the things that they need in order to implement HPV vaccination, cervical cancer screening and treatment.

I think your pillars, you were right on target. I could go on and on and on but you don't want me to preach the gospel about cervical cancer. I want to thank the DG for making the move that he did to make the call to eliminate this disease. Again, if we help people to get what they need, I'm pretty sure we can eliminate this disease.

00:52:44

TAG Thank you. Thank you, Professor, and to that is, sure we can. I think I've said it many times, cervical cancer is a major killer, a leading cause of death in women, especially in Africa, and it's sad that it's a major killer despite the effective tools that we have at hand.

When you don't have the tools and women are dying or people are dying then, of course, still it's tragic but it's more tragic when you have the tools and you cannot save them and they're still dying. And we have the tools, we have the vaccines, and we have the treatments and the tests. I think the only thing left is the action.

And, as I said earlier, we're now even moving from two doses to one dose because that's enough. We can cover more people, actually, more women and girls, and save more women and girls. I call on all who can contribute to really take cervical cancer seriously and join the elimination effort.

Again, thank you, Professor, for your leadership. And to our members of the press, thank you for joining us and I hope, although there was no question on cervical cancer today, you will highlight that and you will continue to add your voice to save women. Thank you for joining us and see you next time.