Hello, everybody. This is Margaret Harris in WHO Headquarters, Geneva, welcoming you today on a cloudy but still pleasant day at WHO Headquarters on 2nd December 2022. This is our WHO global press briefing on global health emergencies and other current health issues.

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

In the room, with us, we have Dr Michael Ryan, Executive Director of our Health Emergencies Programme, Dr Meg Doherty, who is Director of our HIV, Hepatitis and Sexually Transmitted Infections Programme, Dr Rogério Gaspar, Director of Regulations and Prequalification, Dr Maria Van Kerkhove, who is our WHO Technical Lead on COVID-19. And who has joined us is Dr Ana Maria Henao-Restrepo, our Co-Lead for Research and Development Blueprint for epidemics, and Dr Abdi Mahamud, Director Ad Interim for Alert and Response Coordination Department.

We also have our usual panel of experts online and we have full simultaneous translation services. Thank you to all our interpreters. And now, without further
ado, we will go to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

00:02:00
TAG  Thank you. Thank you, Margaret. Good morning, good afternoon, and good evening. This week, I had the privilege of travelling to Brussels for the launch of the European Union’s Global Health Strategy. The EU is a key partner for WHO and has played a leading role in global health. It was a driving force behind the creation of the ACT-Accelerator and has been one of the largest funders of COVAX.

The European Union’s new global health strategy is closely aligned with WHO’s priorities and will help to tackle many of the most pressing challenges in global health, from addressing the root causes of disease, to supporting countries on the road to universal health coverage, to making our world safer, and the final eradication of polio.

I was also very grateful to sign an agreement with Commissioner Urplilainen for a contribution from the European Union of €125 million to support WHO’s UHC Partnership, which is supporting 115 countries to progress towards universal health coverage. My deep thanks to the European Union, its Member States, and the people of Europe. This support comes at a critical time.

Our world is facing a deadly combination of war, starvation and disease. Yesterday, the United Nations Office for the Coordination of Humanitarian Affairs launched its Global Humanitarian Overview for 2023, appealing for US$51.5 billion to meet humanitarian needs around the world next year, an unprecedented amount to meet unprecedented needs. A record 339 million people will require humanitarian aid in 2023, one in every 23 people on the planet.

Humanitarian crises affect people in all aspects of their lives, including reducing their access to health care, often at the exact time when they need it most. Those fleeing conflict or drought, or living in poverty and facing hunger, are also those whose health is the most threatened. In humanitarian crises, health interventions like immunisation, disease surveillance and the treatment of malnourished children can be the difference between life and death.

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Last Saturday marked one year since WHO announced a new variant of concern in the COVID-19 pandemic, the Omicron variant. Omicron has proved to be significantly more transmissible than its predecessor, Delta, and continues to cause significant mortality due to the intensity of transmission.

The number of weekly deaths reported to WHO has declined slightly over the past five weeks but more than 8,500 people lost their lives last week, which is not acceptable three years into the pandemic when we have so many tools to prevent infections and save lives.

Since the emergence of Omicron, the virus has continued to evolve. Today, there are over 500 sublineages of Omicron circulating. They are all highly transmissible. They replicate in the upper respiratory tract and tend to cause
less severe disease than previous variants of concern, and they all have mutations that enable them to escape built-up immunity more easily.

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WHO estimates that at least 90% of the world’s population now has some level of immunity to SARS-CoV-2 due to prior infection or vaccination. We are much closer to being able to say that the emergency phase of the pandemic is over, but we’re not there yet.

Gaps in surveillance, testing, sequencing and vaccination are continuing to create the perfect conditions for a new variant of concern to emerge that could cause significant mortality. WHO continues to urge all countries to take a risk-based approach that protects both public health and human rights.

Earlier this week, WHO announced that we will begin using mpox as a synonym for monkeypox. Both names will be used for one year while the name monkeypox is phased out. Meanwhile, the global mpox outbreak continues to decline, with 620 cases reported last week, more than 90% less than the peak in August. Most cases are being reported from Latin America.

Finally, yesterday was World AIDS Day, an opportunity to re-affirm and refocus on our shared commitment to end AIDS as a public health threat by 2030. We have just eight years left and we’re not where we need to be. The pandemic badly disrupted access to treatment and services for HIV in many countries, while in others like Tigray, conflict, displacement and other humanitarian emergencies are depriving people of access to the care they need.

While more than 28 million people are on life-saving antiretroviral therapy, new infections and deaths are not decreasing fast enough and severe inequalities and inequities prevent people from getting the care they need. More than 650,000 people died of AIDS-related causes last year and 1.5 million people were infected with HIV.

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Nearly six million people who are living with HIV are not receiving treatment, a further four million people have contracted HIV but have not been diagnosed, and nearly half of the children who need treatment cannot access it. Key populations, men who have sex with men, transgender people, sex workers, people who inject drugs or are in prison, continue to face many barriers to care. With their partners, these populations make up 70% of all new infections globally.

While transmission has declined in Africa, there has been no significant decline in HIV among men who have sex with men in Africa over the past ten years. The outbreak of mpox shows that infections can move quickly in sexual networks but with community-led responses and open attitudes to address stigma, transmission can be prevented and lives can be saved. So, on World AIDS Day, and every day, WHO is calling on all countries to equalise the response to HIV. Margaret, back to you.

MH Thank you, Dr Tedros. So, now I’ll open the floor to questions. We’ve got a lot of people online and many hands raised, so please try to keep your question short and simple, one question per journalist. Please, also give your full name and your organisation, and indicate with your question who it should
be addressed to. As you can see, we have a lot of expertise here today. And
the first question goes to Erin, from Fortune. Erin, could you please unmute
yourself and ask your question. We’re not hearing from you, Erin. So, I know
that we’ve also got Helen Branswell on the line. Helen, if you’re ready, can you
unmute yourself and ask your question.

00:11:08
HB  Thanks very much, Margaret. I’m Helen Branswell, from STAT. I think
this question would be for Ana Maria. I’m wondering what the status of the
effort to test Ebola Sudan vaccines in Uganda is at this point. Are there any
doses in-country? When will that work start? And is Uganda still willing to
proceed with this given the decline in cases there? Thank you.

MH  Over to you, Dr Ana Maria.

MR  Let me begin. Ana Maria will follow. I think a tremendous amount of
global preparation has been underway for the last 70 days or so, an incredible
collaboration between developers, some of our key Member States,
particularly in the US and the United Kingdom. The manufacturers, regulators,
so many others have come together in a global coalition to pull together
potentially the three products that can be tested first.

Ana Maria and her team in the Research and Development Blueprint and
others around the house have also created and managed that platform. I
believe we’re right on the cusp but I’ll leave it Ana Maria to estimate the time.
But, again, under the leadership of the Ugandan authorities, with Bruce
Kirenga as the Principal Investigator, from Makerere University, this is a
Ugandan-led enterprise with WHO, I hope, bringing with other partners again,
as I said, organisations like CEPI, Gavi. UNICEF and others working with us to
bring these products to the field.

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Helen, as you know, the number of cases has dropped, which is a wonderful
thing to see the control measures working, but we will continue to pursue the
trials platform. We will get the vaccines in-country and we will begin the
process because you know more than most that Ebola always has a sting in its
tail, and while control measures have really improved on the ground there are
still significant gaps in tracing some of the chains of transmission and
following up on some of the contacts.

So, we need to be prepared and having this vaccine coming on stream and
being able to test these vaccines in a regulated and ethical fashion under the
leadership of the Ugandan authority is a great honour for WHO and all of the
partners involved, but Ana Maria can give more detail.

AH  Thank you for the question, Helen. As Mike says, we have a team on
the ground under Makerere University, Prof Bruce Kirenga, ready to start the
trial with all the preparations. We also have the developers who have really,
against the clock, prepared the vaccines and two of them have already
received import permit approval by the national regulatory authority in
Uganda, who also have provided all the approvals for the trial.

And, third, we are working with the developers and their funders on the
shipment of the vaccine. There are last-minute discussions with the shipping
agencies, etc., so this is why I cannot give you a firm date but I can say it is imminent, the arrival of the vaccines in Uganda. Probably next week we will have the first ring organised but it’s not that we are trying to be cagey. It’s that we really have a lot of logistics being addressed as we speak.

**00:14:51**
But, I just want to say that what Mike mentioned is really important. We started 70 days ago with no vaccines in vials, with no vaccines being developed, and we are sitting today discussing when the vaccines are going to be put in a plane to Uganda for a protocol that has been already approved, with a research team of Ugandans ready to do the trial. And I think it will be important to underline that because this is remarkable and it’s faster than anything we have done before. Thank you.

MH Thank you very much, Dr Ana Maria Restrepo and Dr Ryan, for those answers. Erin, from Fortune, tells us that her mic is now fixed, so we’ll go to you again, Erin. Please, unmute yourself and ask your question.

EP Thank you so much for your patience. I appreciate it. This question is for whoever is interested in taking it. Regarding China’s zero-COVID policy, there has been some talk of the country potentially loosening restrictions. Should China open up again and, if so, what should that reopening look like, and should the country allow in outside mRNA vaccines? Thank you.

MH Thank you, Erin. Dr Ryan will take that question.

MR And I’m sure Maria will supplement. We’re pleased to learn that the Chinese authorities are adjusting their current strategies and really trying to calibrate, now, the control measures that they need for this virus with the lives, the livelihoods and the human rights of people in communities who, like all over the world everyone has suffered.

**00:16:40**
We’ve all had to deal with restrictions of movement. We’ve all had to deal with having our lives changed and, frankly, it’s exhausting. It has been exhausting for all of us. So, there are natural frustrations, there are natural issues with that, and it’s really important that governments listen to their people when the people are in pain. And that we really want to see that adjustment happen and accelerate but recognise that each country has to deal with an infectious disease based on their risk assessment, based on the tools they have at their disposal.

We’re also pleased to see that vaccination rates are improving and have been improved and there’s been a big attempt to do that. One of the issues in China, and this is something maybe the rest of the world needs to understand, that vaccination coverage, there were difficulties in covering certain age groups with vaccination, again using the locally-made vaccines. They’re effective but their effectiveness is based on having at least two doses of vaccine.

There are limitations in the length of that protection against severe disease and booster doses are needed, and that push to increase vaccination in those vulnerable and older groups I think is gaining momentum and that creates
more choices for governments then, when they have more confidence that their health system will not be overwhelmed by a surge in cases.

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I think we’ve also seen, and Maria will speak to this, Omicron is very transmissible and whatever chance we may have had with previous variants in containing or stopping or having that zero-COVID-type approach, I think Omicron has been at the Olympics of virus evolution in terms of its transmissibility.

It’s really hard to stop and it gets through your fingers very, very quickly. So, you have to recognise those realities and you have to seek to protect the most vulnerable. When you can’t stop a fire, you get the people in danger out of the way, and the way to get people out of the way of the fire in this case is to vaccinate people and I think that’s a focus we’re pleased to see. But, it requires that to continue.

In terms of mRNA vaccines, certainly mRNA vaccines produce a very effective form of immunity and some countries have used mRNA vaccines as a booster methodology. I know the Chinese authorities were looking at developing their own mRNA vaccines and I don’t think there’s any restriction on China accessing those. I'm not 100% sure. I would ask Maria or Kate, if she was here, whether or not China is importing mRNA vaccines.

But, certainly, it’s a very solid option for a country, especially in highly vulnerable groups, whether you can target boosters using other vaccines that may provide a better pattern or a better breadth and depth and length of protection but, again, they’re choices that sovereign governments need to make based on the best benefit of their population against the cost of doing that. But, with that in mind, we hope this progresses and we see that coherent, calibrated strategy emerge that balances the control of the virus with the lives, the livelihoods and wellbeing and human rights of the people of China.

00:20:03

MK Thanks, Mike. I fully agree, obviously, on all of that. I think what we’re trying to do is we’re trying to work with all countries, all over the world, to be able to absorb the circulation of this virus worldwide. We’ve had at least 2.5 million cases reported to us in the last week alone globally but that number is a gross underestimate of the circulation of this virus. Around the world there are some wastewater estimates suggesting that number could be as much as five times higher in some countries.

So, this virus is circulating rampantly around the world and we need to be able to absorb COVID circulation, COVID cases in the context of everything else that is circulating, including flu, including RSV and other pathogens that are out there.

We’re working with countries to adjust their strategies, as Mike has said, to calibrate the response, because we have so many tools that are available, taking into context what is circulating, how much is circulating, what are the capacities to respond, the access to tools, and the way that those could be utilised for those who are most at risk in every single country.
And we’re working with countries to accelerate the use of these life-saving tools. Vaccines have been mentioned over and over. This is one of many tools that exist. Vaccines are absolutely critical to reach those who are most at risk in the population, so people over the age of 60, people with underlying conditions, immunocompromised and our frontline workers.

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We have not yet reached that target of 100% of at-risk people around the world in every country, including in China, and this what we want governments to focus on. But, again, there are other tools that exist too, the use of testing that could get patients into the clinical care pathway early, so that we can save lives. We are in, as you heard the Director-General say, a much better position than we have ever been in, in dealing with COVID and managing COVID in the context of all of these other global crises that we face.

The last point is on Omicron, itself. Omicron has been circulating for more than a year now. There’s actually really excellent paper that just came out recently that I just read today, suggesting that it was even circulating before it was first detected and reported to WHO, which is to be expected if you look back. But, there are more than 500 subvariants of Omicron that are in circulation right now. Most of these are the BA.5 sublineage but there are a number of other sublineages and the dynamics of this virus are very different around the world.

We need to be able to track this. We need to be able to assess this with our technical partners around the world, so that we can look at how these variants behave in terms of transmission, in terms of immune escape, in terms of severity, and to make sure that our interventions work.

And my last point is that the interventions do work. I’ll mention vaccines again but the other tools that we have at our disposal, distancing, improving ventilation, those will be beneficial no matter what variant is circulating but our vaccines are holding up incredibly well against severe disease and death.

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So, when you have access to this vaccine, if you’re recommended to get an additional dose, please get that dose because this is the balance between how we go about living our lives and doing that as safely as possible. The vaccines are working against preventing severe disease and death.

MH Thank you very much, Dr Van Kerkhove and Dr Ryan. The next question goes to Priti Patnaik of Geneva Files. Priti, unmute yourself and ask your question.

PP Good afternoon. Thanks for taking my question. This is about the appointment of the leadership team. We understand that announcements have been made for interim appointments. Can you tell us whether this will be further finalised and, if not, can we understand this ostensible delay as a result of parallel discussions on financing that are happening? And if I may just add another one on the EB retreat. The discussions around the EB retreat, is this something we will already witness in the next EB in January? Thanks a lot.
Thanks, Priti. I don’t know about the EB retreat, so please send that message to Media Inquiries, your question, and we’ll ask that for you and get that answered for you later. On the senior staff, we’d very much like to thank the distinguished departing members of the senior leadership team for their service to WHO, and they’ll always be part of the WHO family.

And while the Director-General considers the future configuration of the senior leadership team in his second term, he’s asked a number of colleagues to lead divisions on an ad interim basis and the Director-General, I’m speaking on his behalf, thanks these valued colleagues. And any further announcements we’ll make in due course. Thank you. So, I’ll move on. The next question goes to Simon Ateba. Simon, please unmute yourself and ask your question.

Thank you, Margaret, for taking my question and thank you for continuing these press briefings, even as attentions shift away from COVID. This is Simon Ateba with Today News Africa, in Washington.

My question is to Dr Tedros. Dr, it’s exactly one month today since the Ethiopia-Tigray peace agreement was signed in South Africa and several weeks since the Nairobi declaration in Kenya on the implementation. As far as the access to Tigray is concerned, can you please give us an update? Does the WHO now have access? Has the peace agreement changed anything on the ground for the people suffering there? Thank you.

I think Dr Ryan will answer that initially.

Thanks, Simon, and thanks for your continued focus on really desperate situations in sometimes forgotten parts of the world. The announcement of the negotiations on ceasefires and peace processes are obviously welcome. The Director-General has always said that we need peace to have health, we need health to have peace, so any cessation of hostilities that allows us to address the health concerns and needs of the population must always be welcomed.

But, that peace process has not yet resulted in the kinds of full access, unfettered access and in the massive scale-up of medical and health assistance that the people of Tigray need. There are issues in Tigray, particularly with militias in the west who control parts of the territory. There are still significant parts of the country that are occupied by Eritrean forces, for which there is no access and very disturbing reports emerging around the experiences of the people there.

There are areas, certainly in Tigray now, in which the Ethiopian defence forces are, but other areas in which other Tigrayan forces are. So, it’s a very mixed bag and certainly we are seeing some increase in access in terms of getting some of our staff in. We’ve had a small allocation of fuel that will allow us to do some operations and we’re starting to see a small trickle, and would say it’s a trickle.

We have a tiny percentage of the need that’s there, potentially, we can meet. There are some areas from which there is access for assessment teams but
as regards bringing back online the health system, as regards resupplying primary health care and secondary health care facilities with essential medical equipment, as regards paying health staff, as regards communicating and being able to effectively use their banking system, which is still completely offline.

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Without mobile communications, without a banking system, it’s horrific for the people there not to have that, so many years in, not to have access to your own money, not to have access to communications with loved ones. But, it is critical, in an emergency operation, to have those systems.

So much of the success of humanitarian response depends on logistics, depends on communication, depends on banking systems. If they don’t exist, you don’t have the means. Now, we are tying directly with bringing cash in. I think the last cash allocation we wanted to bring in, we were only allowed to bring in half of that cash, so it’s half of this, a quarter or that, a tenth of the other.

So, it’s really hard to plan a scale-up when at every moment you can have your ambitions curtailed. The UN system, I believe, is really anxious to scale-up our operations. We welcome, and let me say that again, we welcome any cessation of violence, we welcome any access that’s given but the people in Tigray are desperate. They’ve been years now without access to proper healthcare, without access to proper nutrition and they need our help now, not next week, not next month. They need it now and I still, personally, and my team, do not see evidence of unfettered access to the people in need in Tigray. That needs to change and that needs to change soon.

We hope that some of this is just beginning to wind up, the aid system again, but I have to admit I remain cynical on that front because we’ve been a long time waiting to get access to these desperate people. So, I hope, I still live in hope but I can’t report good news on that. But, we will continue to try and we will continue to try and do our jobs on behalf of all the people of Ethiopia and those in Tigray. Thank you.

00:30:13
MH  Thank you very much, Dr Ryan. Now, we’ve got a number of competing events, so even though we’ve still got a lot of interest I’ll have to wrap here. Thank you all very much for joining. Please send any questions, any outstanding questions to you have to mediainquires@who.int. And now over to Dr Tedros for final remarks.

TAG  Thank you. Thank you, Margaret, and maybe, as Mike had already said on the situation in Tigray, but I would just like to add a few lines. First of all, we welcome peace. The agreement is important and I hope all parties will continue to commit to peace and, at the same time, the agreement should be implemented in full.

And, as Mike said, of course, there is some food aid and medicine being delivered but unfettered access is what we expect because the need is massive. The second part is the services, banking services, because six
million people still are not having access to their bank accounts and starving as a result.

And the third part is the ongoing massacre by Eritrean forces in the areas they occupied and massacring civilians, reports coming every day, and that could undermine the peace process, not only massacring civilians but looting, destroying infrastructure and all sorts of activities that could really undermine the peace process. But, again, I repeat, the only solution to this conflict is through political dialogue that’s happening now and through peaceful settlement. We encourage that but civilians should be at the centre.

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Even when there is conflict, even in the middle of war, food aid and medical supplies should be delivered, and it should not be even a condition and should not be attached with the political or military dialogue which is happening. It should be unconditional and unfettered medical and food aid to those who need it. So, with that, to all media colleagues who have joined, thank you so much and see you next time.