World Health Organization

Global Health & Humanitarian Issues

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Speaker key:

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TZ	Dr Teresa Zakaria
AM	Dr Adelheid Marschang
SS	Steve Solomon
PG	Dr Peter Graaff
BG	Belisa Godinho
AB	Ashvin Barshinge
JK	Jamey Keaten
BK	Banjot Kaur
CK	Constantine Kanakis
JZ	John Zarocostas
KB	Keren Betzalel
KC	Kerry Cullinan

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FC Hello, all. I am Fadéla Chaib, speaking to you from the WHO headquarters in Geneva and welcoming you to our virtual press conference today, Wednesday, 21st February, on global and humanitarian issues.

Let me introduce to you our experts and participants present in the room, Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Dr Mike Ryan, Executive Director for the WHO Emergencies Programme, Dr Maria Van Kerkhove, Director ad interim for Epidemic and Pandemic Preparedness and Prevention.

We have also Dr Teresa Zakaria, Incident Manager for Conflict Escalation in Israel and the Palestinian occupied territory, we have also Dr Adelheid Marschang, Senior Emergency Officer, and we have also Mr Steve Solomon, Principal Legal Officer.

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We have also several colleagues online. Let me tell you who they are. We have Dr Peter Graaff, who is the Acting WHO Representative in Sudan. We have also Dr Abdirahman Mahamud, who is Director ad interim for the Alert and Response Coordination, and Dr Philippe Barboza, who is the Team Lead for Cholera and Epidemic Diarrhoeal Diseases.

And we have also the privilege to have our dear friend and colleague, Chris Black, who is in Gaza. He's a Senior Communication Officer, currently in Gaza. Now, without more delay, I would like to hand over to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Fadéla. Apologies for the delay. It's because of technical problems and I hope you understand, but apologies again. Good morning, good afternoon and good evening.

This week, Member States from around the world are meeting in Geneva to discuss the new pandemic accord. This agreement is being developed, shaped and decided by the 194 Member States that make up the World Health Organization.

Building on the lessons of COVID-19, I broadly see three key benefits. The agreement would help countries drive a more equitable response, it will boost collective health safeguarding and it will enhance cooperation. First, the agreement would ensure access and equity so that collectively we better share tests, treatments and vaccines to save both lives and livelihoods.

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Second, on safeguarding health systems, the agreement would improve information sharing about pathogens with pandemic potential, as well as protecting health workers and the most vulnerable in all societies. And, finally, the agreement will boost cooperation between Member States, preparing them for a common response.

Strengthening and clarifying international cooperation now will give all of humanity a better chance of taking on the disease threats of the future, and when the next pandemic does happen it takes a whole of society approach to tackle it. That's why Member States are designing an agreement to support countries to mobilise all sectors in a coherent response, including across governments, multilateral agencies, the private sector and civil society.

There's a rich discussion going on about the agreement, which will happen for several more months to come. There is progress and I maintain confidence that by the World Health Assembly in May this year countries will have agreed on a new pandemic agreement that sets out a better set of parameters than we had during COVID-19. Ultimately, it will save lives and livelihoods while protecting national security and sovereignty.

Now to Gaza. The health and humanitarian situation in Gaza is inhumane and continues to deteriorate. Over the past three days, WHO and partners have carried out several emergency missions to Nasser Medical Complex in Southern Gaza. Around 130 sick and injured patients and at least 15 doctors and nurses remain in the hospital. With the intensive care unit no longer working, WHO has helped move patients, many of whom cannot even walk.

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On a broader level, Gaza has become a death zone. Much of the territory has been destroyed, more than 29,000 people are dead, many more are missing presumed dead and many, many more are injured. Severe malnutrition has shot up dramatically since the war started, from under 1% to more than 15% in some areas, putting more lives at risk. This figure will rise, the longer the war goes on and supplies are interrupted.

We note with apprehension that the World Food Programme cannot get into northern Gaza with supplies. What type of world do we live when people cannot get food and water or when people who cannot even walk are not able to receive care?

What type of world do we live in when health workers are at risk of being bombed as they carry out their lifesaving work? What type of world do we live in when hospitals must close because there's no more power or medicines to help save patients and they're being targeted by military force?

We need a ceasefire now, we need hostages to be released, we need the bombs to stop dropping and we need unfettered humanitarian access. Humanity must prevail.

Sudan, while not receiving much international media attention, is witnessing a humanitarian catastrophe. More than ten months of conflict have had a deadly impact on the lives, livelihoods and health of the people.

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Over six million people have been displaced internally and nearly two million people have gone to neighbouring countries. This is the largest displacement of people in the world. Half the population needs humanitarian aid but partners cannot reach most of them.

Already, more than 14,000 people have been killed and, if the world turns a blind eye to the suffering in Sudan, many more will die. About three quarters of hospitals in conflict-affected states are not working. The remaining ones are overwhelmed by the number of people seeking care, many of whom are internally displaced.

People are dying from a lack of access to basic and essential health care and medication. Critical services, including maternal and child health care, the management of severe acute malnutrition, and treatment of patients with chronic conditions, have been discontinued in many areas.

A health system that was already struggling is now facing conflict, disease outbreaks and a relentless drought that has led to spiking hunger. Since the start of the war, WHO has verified 62 attacks on health care, with 38 deaths and 45 injuries.

WHO is scaling up on-the-ground efforts to deliver health emergency response, respond to disease outbreaks, sustain disease surveillance and provide life-saving medical supplies and equipment. This includes embarking on a strong cross-border operation to reach previously unreachable areas in Darfur and Kordofan, where the need is greatest.

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WHO condemns, in the strongest terms, the continued attacks on health care in Sudan, and the occupation of health facilities. Like in Gaza, peace is desperately needed in Sudan to protect lives and rebuild the health system.

After years of progress against cholera, the deadly disease has come roaring back in 30 countries, spurred on by conflict, poverty, the climate crisis and global socio-economic inequality. Along with Sudan, the countries with the most concerning outbreaks right now include Ethiopia, Haiti, Zimbabwe and Zambia.

In October 2022, the International Coordinating Group that manages the emergency stockpile of cholera vaccines suspended the standard two-dose vaccination regimen in favour of a single dose only in response to outbreaks, to stretch supplies. Despite this extreme measure, at the start of this year the stockpile was empty. Zero doses are left, while 15 countries are reporting active outbreaks.

So, what do we need? We need the world to wake up to the rapidly growing threat represented by cholera. First, it is important to ensure people have safe water and access to toilets that don't contaminate their surroundings. This means investing in major infrastructure projects and working directly with affected communities.

Second, as cholera spreads so rapidly, honing a surveillance system that can detect outbreaks quickly is key to delivering effective treatment and rolling out vaccines to those in need. Third, it remains important that global vaccine production is incentivised, increased and nurtured regionally. This is a critical element as the trend toward more and bigger cholera outbreaks continues.

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For immediate needs, WHO has released over US $16 million from the WHO Contingency Fund for Emergencies but to tackle cholera outbreaks around the world, WHO has issued an appeal for US $50 million for 2024.

In emergency situations noted above, it's often infectious disease that is highlighted. However, people living with noncommunicable diseases such as diabetes, heart and lung disease and cancer are facing an even more precarious situation, especially those who depend upon lifesaving commodities like insulin, dialysis and cancer medicines.

Without these essential services, it's a death sentence. Early next week, leaders are meeting in Copenhagen to discuss how to include and integrate noncommunicable diseases into the preparation and response to emergencies.

These are difficult times but we must not forget that these challenges can be overcome. As we speak, countries and communities and organisations,

including WHO and so many partners, are working to alleviate the suffering. There is hope but it must be nurtured and supported, and we must do more. The health of all depends on that. Fadéla, back to you.

00:13:28

FC Thank you, Dr Tedros. Now, I would like to open the floor to journalists' questions. If you want to ask a question, please raise your hand using the raise your hand icon and unmute yourself. Now, I would like to invite Belisa Godinho, from W Magazine, to ask the first question. Belisa, can you hear me? Belisa?

BG Yes. Thank you, Fadéla. Thank you very much to all. Recently, the European Centre for Disease Prevention issued an alert for an expanding hypervirulent bacteria, Klebsiella pneumoniae. My question is, is this matter under control? What measures should be taken? Thank you.

MR I think you're referring to Klebsiella pneumoniae as the pathogen, which is a common cause of pneumonia in people. We don't have specific data on the incidence outside Europe, so we will come back to you with some specific data but one of the issues with Klebsiella and others is antimicrobial resistance. So, it's not just the organism, itself, it's the association of that organism with antimicrobial resistance. We will check on our data and come back to you before the end of the teleconference or the video conference with some updated figures from WHO.

FC Thank you, Dr Ryan. I would like now to invite Ashvin, to ask the next question. Ashvin, can you hear me?

AB Thank you. Thank you for considering my question. This is Ashvin Barshinge, Observer Times, India. My question is in Gaza Strip, Rafah Border and Israel is their occurring ambiguity and highly limited independent decision-making and operational space for both local and international medical and humanitarian aid response, as actors? How are these situations coped with by WHO teams on the ground? Thank you.

00:16:00

FC Thank you, Ashvin. Dr Zakaria, please.

TZ Thank you very much for the question. First of all, I think the operational space is very clear. We don't have sufficient operational space across Gaza. Now, when it comes to the delivery and the transportation of supplies from Egypt into Gaza, there is a coordination mechanism established. I think it needs to be acknowledged as such.

The prioritisation, as well, of supplies getting into Gaza is also organised to the extent possible. There are challenges, of course. For example, we have less visibility on bilateral shipments of supplies but I think the coordination is there.

The biggest challenge at the moment is then what happens after supplies get inside Gaza, and this is where things get extremely challenging because of road damage, lack of security. Many of the missions, actually, that we are jointly planning with other humanitarian partners are being denied or not facilitated.

So, that's a major challenge and that's just one among many other operational challenges as well that renders our current humanitarian response really not sufficient. It's really just a tiny drop in the ocean.

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Now, on the objectivity, because of that coordination structure that exists, there is a collective agreement as to what supplies need to get in. There's agreement on, then, what needs to be put in the first truck, in the second truck queueing to get inside Gaza.

The intention is really to make sure that the most important and most urgently needed supplies needed by the population are those that get in first but then, again, that's really just one part of the overall chain of transportation and delivery of humanitarian assistance and, once again, we're only delivering one tiny portion of what is truly needed by the population. Thank you.

FC Thank you, Dr Zakaria. I would like now to invite Jamey Keaten, from Associated Press, to ask the next question. Jamey.

JK Thank you, Fadéla. My question is for Dr Tedros. Dr Tedros, what contact have you had with Prime Minister Netanyahu, himself, either by phone or in person over the last few months to try to ensure that the needed medical supplies reach the people in Gaza and that the hospitals and other medical facilities remain protected? And if you have not had any contact, what has been the response from the Israeli authorities? Thank you so much.

TAG Thank you. I think we haven't had a contact. The last time we had contact was actually in 2014, when I was Foreign Minister. So, probably, I will take that as a recommendation and make contact.

Of course, the contacts we have, we have contacts, especially through our office, the country office and most of the requests from our side actually go through our country office and I hope our WR can maybe explain about the contact we make based on the issues of joint concern. Do we have Rik online? Okay.

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FC Thank you, Jamey. We can ask the WHO representative in oPt to provide you with an answer. Thank you, Jamey. Now, I would like to invite a journalist from Channel 12 News to ask the next question. You have the floor. Can you hear me? If yes, can you unmute yourself and ask your question? For the time being we have another journalist raising hand. It's Banjot Kaur, from The Wire, from India. Banjot, you have the floor.

BK Thanks for taking my question, Fadéla. I do not know whether there are experts on the panel immediately to answer this but if there are, are there any WHO guidelines or any broader UN guidelines as to how law enforcement agencies should treat protestors, especially from the health point of view? What are things that they are supposed to use and not supposed to use? Also, if you could say if things like tear gas shells are allowed or not?

FC Thank you so much. I think we will come back to you with a written answer just after this press briefing. Thank you. Coming back to Channel 12.

Please, if you can ask your question. We cannot hear you. So, I would like to ask Kanakis, from ABC News, to ask the next question.

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CK Thank you very much. Thank you for speaking with us today. I would just like to ask if there are any objectives or future planning for some of the emergency considerations for the noncommunicable diseases in essential services that you discussed? This question can go to anybody.

FC Can you please clarify your question? You were very, very fast. Mr Kanakis, can you just repeat your question, please?

CK Yes, of course. Thank you. You spoke briefly on future planning for noncommunicable disease as essential services in planning for emergency responses. Can you speak more about some of those objectives? Thank you very much.

FC Thank you. Dr Ryan.

MR Sorry for misunderstanding your question. It's very clear. We're preparing for a major meeting next week in Copenhagen, in which we'll be getting together with partners from around the world to really discuss how we can increase the focus on these noncommunicable diseases in emergency situations because historically, as you know, when we talk about emergencies or disasters, we assume we're going to be dealing with injured people and people understand that.

We assume that there may be epidemic risk because people understand that, but what's often forgotten is that displaced or refugee populations or populations who have lost access to their homes and their medicines or lost access to health care also lose access to care for long-term diseases like diabetes, like hypertension, people with disabilities, people with mental health conditions.

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So, in a disrupted system, particularly where that disruption lasts for a long time and, again, historically with a short-term emergency people very often have enough medicine, they have enough to help carry them over. It's when these conflicts or when these disasters last for months and even years, where the system becomes incapable of delivering for those individuals or where the health care, itself, becomes inaccessible to the community, where the health care system is being attacked and where the community are afraid to access that health care.

And this is something that's often forgotten and when we look at the actual death toll, it's interesting, even in the recent analysis we've seen from our colleagues at Johns Hopkins and the London School of Hygiene when they've been looking at estimates of mortality and morbidity projections going forward for the impact of the crisis in Gaza.

They're adding into that, not just the impact of injuries or the potential impact of epidemics, they're actually looking at the impact of untreated chronic diseases. And it takes a terrible, terrible toll and it also is a huge reason for the continued fragility at community level.

When a community loses a primary health care centre, when a community loses its hospital, when it loses its immunisation programme, there's more than just a loss of health. There's a loss of hope, there's a loss of community confidence. And that often forces people to move and migrate and to move away from where they are, where they can't get services, to somewhere else, which then deepens the problem because the community that ends up hosting them is now providing care for more than the number of people they can care for.

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So, it triggers a whole series of negative things. Adelheid may wish to comment on this as well. But getting the focus, and Dr Tedros is very keen to get that focus on what we need, strong primary health care services everywhere in the world.

And in countries where we have fragility and conflict, it doesn't mean there can't be health care. Health care can be delivered in any situation. If health care is protected, if health care is funded, if the partners who were delivering health care are supported we, with our partners, can deliver health care almost anywhere and we do it almost anywhere in the world, and we can deliver both acute care and we can deliver care for chronic diseases.

And I think it's an important realisation and an important point for the world to get, is that diabetes doesn't stop when there's an emergency, hypertension doesn't stop when there's an emergency, cancer doesn't stop when there's an emergency, and we must be able to continue those services.

Again, we saw the impact of this in COVID. We saw what happened in COVID when the system had to move and give its attention to COVID patients, which was correct. In many countries that attention was taken away from immunisation programmes, it was taken away from cancer treatment, it was taken away from elective surgery.

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And we need health systems that are capable of both responding to acute emergency and being resilient and being able to have continuity of services for all of the other diseases. So, that's what we mean when we talk about noncommunicable diseases in emergencies. We can't forget them and we must provide for them. But Adelheid is more of an expert than me, so maybe you wish to speak to this.

AM Thank you, Mike. In this meeting, that you have kindly asked about, we're going to really look in to the operational challenges that Mike has just mentioned to look how we can, in a more predictable way, build NCDs into existing systems.

We're going to look if there are systems that are missing, if there are tools that are lacking and if there are strategies that we need to incorporate the work on NCDs throughout the whole emergency management cycle, so that is prevention, preparedness, response and risk mitigation.

We're going to look into issues of displacement and how that can be tackled or how that influences the work on NCDs in emergencies and the mechanisms

that we can strengthen to strength health systems addressing NCDs in emergencies.

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Often, at the beginning of an emergency, even if there is preparedness, even if things are supposed to be in place, we find out and we see that through operational reviews that we have done in the field in actually emergency settings, that something is lacking, that there are not dialysis products available that we can get to the patients or that the logistical set-up may have flaws.

So, we're going to look into all of that to be sure that the increasing burden of NCDs that affects, also, the mortality in emergencies, increasingly can be tackled in a more predictable and better way. Thank you. Back to you, Fadéla.

FC Thank you so much. I would like now to give the floor to John Zarocostas, from France 24 and The Lancet. John, you have the floor.

JZ Good afternoon. It's a follow-up question to my colleague's. The experts around the table, if you can elaborate a little bit more this initiative to incorporate NCDs in preparedness and response in emergencies. What's the state of play at the moment in some of your big, protracted emergencies, for instance in the oPt, in Yemen, and in our countries? What is the case load and especially with reference to cancer, which is not easy in these settings? Thank you.

MR John, you always ask a very detailed question and we can certainly get into that with you. Adelheid will maybe be able to provide some specific information but please don't get us wrong. We're not about to incorporate the care for noncommunicable diseases into emergency management. We've been doing this for years.

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What we're highlighting is that providing emergency care is important but part of providing care in emergencies is providing care for noncommunicable, long-term chronic diseases and we've seen a huge case load in places like Gaza for cancer, untreated cancer patients, people who have lost access to their hypertension and diabetes medications, people who don't have access to dialysis anymore. We can give you the numbers on that.

We saw exactly the same pattern in Yemen. We saw exactly the same pattern in Syria. We're seeing exactly the same pattern in Sudan. When you displace six million people in an already fragile situation and you move two million across the border and you scatter four million of them across the country in the middle of an open war and you attack health care facilities and you occupy those facilities and they're used for military purposes, then people will continue to get sick, they will stay sick and they will ultimately die from diseases that they don't need to die from. That's the reality. We can bring the metrics and the numbers to that.

So, when we're talking more today, again John, you know this. You go back a long way. I'm not saying you're old, John. If you go back to the classic emergency, as we might have had 20 years ago, was very often short. The time was measured in weeks and months.

We're talking about emergencies now lasting decades. And you cannot deal with a chronic emergency situation by just dealing with the threat of an acute epidemic or purely dealing with injuries. You've got to deal with people's lives. You've got to deal with birth. You've got to deal with death. You've got to deal with cancer. You've got to deal with hypertension. You've got to deal with diabetes. Because this is what's killing people in many of these situations now.

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And that means it's a new complexity because the package of care we have to bring is more complex. The diagnostic process. How do you diagnose hypertension and diagnose cancer in a situation where you don't have access to CT scanners, you don't have access to proper laboratory tests? How do you do that? And we have to find ways to adapt our care, to adapt our diagnostic and care process, so that it does the best it can in those situations.

It doesn't mean dumbing down care, it means providing basic care to people for chronic diseases and being able to scale up those services. And, most importantly, when peace does come and when you get an opportunity to rebuild those health services by ensuring that the health service incorporates chronic diseases from the very beginning and not coming very late.

What very often happens is that the return of services for noncommunicable diseases ends up being the last thing to return when, in fact, it should often be the first thing to return because it's the thing that people have missed most. Again, I'll defer to Adelheid on some of the numbers.

But you're absolutely correct, John, this has been our collective experience over the las number years. And we have to commend partners and, again, we also have to commend some host governments and host communities. If you look at the likes of Chad and South Sudan, both countries experiencing their own problems. They've absorbed literally millions of refugees from the Sudan conflict and those host communities are hosting those refugees across the border.

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That system is still trying to provide care to both of those communities when it was already struggling to provide basic care to its own community. And I think we have to take our hats off to those governments and those communities who continue to share care and effectively share what is a limited health service with others who arrive by no choice of their own. And I think that's to the credit.

Those countries like Chad, those countries like South Sudan, deserve the support of the international community in order to be able to continue providing basic health services to all of those people who cross international borders.

FC Thank you, Dr Ryan. John, we will be sending journalists some information about the upcoming meeting of NCDs in emergency settings, taking place in Copenhagen next week. So, you will have more details about the summit, the agenda, the list of participants and also what we are planning for journalist. So, stay tuned.

I'm inviting journalists to raise hands if they want to ask a question to our experts. In the meantime, I would like to invite Keren Betzalel to ask the next the next question. Keren, you have the floor.

00:35:45

KB Hi. Do you hear us?

FC Very well.

KB Hello?

FC Yes, we can. Go ahead, please.

KB Thank you. I apologise for the technical issue. I would like to ask Dr Tedros, sir, you have said in your opening remarks, you have asked what world are we living in when hospitals need to shut down because of lack of electricity or fuel?

And many people here, in Israel, are asking what world are we living in when every medical facility in Gaza has been used as a military base, when Hamas has placed ammunition inside hospitals, dug tunnels beneath? What do you have to say about these things that have been revealed by the IDF?

And I would like to also ask you if, by acting like this, these hospitals hadn't lost their protected entity status under international humanitarian law and actually allow the IDF to operate inside while evacuating patients and medical staff? Thank you, sir.

FC Thank you, Keren. I believe you work for TV 12. Where are you based? Just for us to know. That's okay. Steve?

SS Hi. Let me thank, Keren, for the question and let me address the very important issue she mentioned, humanitarian law. Let me address this once again because it's very important to convey that humanitarian law is very clear.

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Health care workers and health care facilities are off limits. They must not be attacked. They must not be used for military purposes. They must be protected at all times. The point is both to protect civilians, as well as to protect the health systems and infrastructure that communities depend on for lifegiving care and continuity of services, care and services that are denied or degraded when, for example, hospitals are attacked or militarised.

This compound harm is why the safeguarding of health care is treated so seriously in international law. Failure to protect and respect health care devastates twice. First, in the initial harm and then, again, for the months or years it takes to rebuild the health systems.

The protection of health care also includes the prohibition against combatants using health facilities for military purposes but IHL is also clear that, even if health care facilities are being used for military purposes, there are stringent conditions which apply to taking action against them, including a duty to warn and to wait after warning and, even then, disproportionate attacks are strictly prohibited.

In sum, all combatants should understand that health facilities and health workers are off limits. Targeting them or militarising them are both prohibited. Health care depends on the facilities and the workers that deliver it. Attacking them or militarising them destroys lives, degrades health systems and diminishes pathways that can lead to post-war peace a reconciliation. Thank you. Fadéla, back to you.

00:39:45

FC Thank you, Mr Solomon. I would like now to invite Kerry Cullinan, from Health Policy Watch, to ask the next question. Kerry, can you hear me?

KC Yes, Fadéla. Thank you so much. Earlier in the week there was a press release from a number of UN experts concerned about the attacks on Palestinian women. They reported that there extrajudicial killings. There were multiple reports of sexual assault of Palestinian women in detention, etc.

I just wondered whether any of the WHO people on the ground had come across similar such incidents and whether you would support their call for there to be an investigation into these allegations. Thank you.

FC Thank you, Kerry. I would like to ask Dr Ryan to start.

MR Thanks, Kerry. We have no specific awareness of these specific allegations but the use of sexualised violence in conflict is well recognised and increasingly used and we've certainly had the reports of sexual violence against female hostages in Gaza, Israeli hostages in Gaza. We now have accusations or, at least, allegations of sexual violence and extrajudicial killings and others on the other side.

I think all of these require investigation by the appropriate authorities. Steve spoke to this. Even war has rules. And what we're seeing increasingly, and we were discussing it before we came online today, the number of situations in which the basic rights of people, of civilians in war are not being respected.

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Civilians have a right in war not to be attacked. They have a right not to be denied health care. They have right not to be raped. They have right not to be denied food. They have a right not to be besieged. They have a right to free movement. They have a right to congregate.

They have all these rights. These are rights we all have. These are inalienable rights and in conflict after conflict after conflict they are being ignored and, to a point, weaponised. In fact, it's not even that they're being ignored. They're actually being actively used as weapons to prosecute war and that's happening on all sides of conflict and it's particularly happening, we've seen it now in conflict after conflict after conflict.

So, WHO's position on this, we have no specific information related to these allegations. We believe that all allegations should be investigated by the appropriate authorities, especially those that involve sexual violence because, again, we're continuing to witness an ever-expanding use of this as a tool of war. But, again, we have no specific knowledge regarding these specific allegations.

FC Thank you, Dr Ryan. I would like to invite Dr Peter Graaff, who is patiently listening to this press conference, to say a few words about the situation in Sudan. Peter, can you hear me?

00:43:05

PG Yes, Fadéla. Can you hear me?

FC Very well. Go ahead, please.

PG My intervention is based on John's question about numbers and about noncommunicable diseases. I would like to start by saying we heard Dr Tedros talk about the 25 million people, half the population of Sudan now needing humanitarian assistance.

The 2024 Humanitarian Needs and Response Plan only targets 15 out of the 25 million and only five million in terms of health care provision. That has to do with access, that has to do with investments and available funding, that has to do with capacity on the ground, and it means that all of us who are acting in and for Sudan need to focus. We need to focus on the direct lifesaving interventions. We need to focus on outbreak disease control.

The other figure that I would like to share is a much smaller one. Not so long ago, I was asked, Peter, can you please help? Out of the 43 patients in this particular area of Darfur that need renal dialysis there's only one still alive and, unless we provide the necessary fluids, this patient will die very soon.

And we were not able to provide those fluids, and I've not heard back and I assume that this patient has died. So, when Dr Tedros asked about unfettered access for the humanitarians, that patient is on my mind. Thank you very much.

00:45:00

FC Thank you so much, Dr Graaff. I think we come to an end of our press conference. As soon as we finish here, you will receive the audio and video files of this press conference and Dr Tedros' opening remarks. The transcript of the press conference will be available on the WHO website tomorrow morning. Now, I would like to invite Dr Tedros for his closing remarks and thank you, journalists, for your presence and patience.

TAG Thank you. Thank you, Fadéla. I was just going to say the thank you part to the members of the press. Thank you so much for joining us today and see you next time.