Global Health Issues

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Speaker key:

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AM	Dr Abdirahman Mahamud
MR	Dr Mike Ryan
DL	Daniel Lawler
HB	Helen Branswell
BG	Belisa Godinho
EP	Erin Prater
AD	Ari Daniel
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BK	Banjot Kaur

00:00:48

TJ Hello to everyone from Geneva, Switzerland. My name is Tarik and I welcome you to our regular WHO press briefing on global health issues. We will start, as always, by introducing our speakers here, in the room.

With us, we have Dr Tedros, WHO Director-General, Dr Mike Ryan, Executive Director of WHO Health Emergencies Programme. Also with us is Dr Maria Van Kerkhove, Technical Lead for COVID-19. Also, Dr Teresa Zakaria, Technical Officer within the Health Emergencies Programme. And with us is also, today, Dr Walter Kazadi Mulombo, who is WHO Representative in Nigeria.

Online we have several WHO experts who may also answer some of your questions a bit later, when we come to that section. Journalists who are online can click the icon Raise Hand, so you will be put in a queue for questions a bit later. With this, I will hand over directly to Dr Tedros for his opening remarks. Dr Tedros.

TAG Thank you. Thank you, Tarik. Good morning, good afternoon and good evening. We continue to see concerning trends for COVID-19 ahead of the winter season in the northern hemisphere. Deaths are increasing in some parts of the Middle East and Asia, ICU admissions are increasing in Europe and hospitalisations are increasing in several regions.

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Still, data are limited. Only 43 countries, less than a quarter of WHO Member States, are reporting deaths to WHO, and only 20 provide information on hospitalisations. Globally, there is not one variant that is dominant. The variant of interest, EG.5, is on the rise, while the XBB subvariants are declining. The BA.2.86 variant has been detected in small numbers in 11 countries.

WHO is monitoring this variant closely to assess its transmissibility and potential impact. One of WHO's biggest concerns is the low level of at-risk people who have received a dose of COVID-19 vaccine recently. Our message is not to wait to get an additional dose if it is recommended for you.

Yesterday, WHO published an annex to our global Strategic Preparedness and Response Plan for COVID-19, which further supports countries in five critical areas, collaborative surveillance, community protection, safe and scalable care, access to countermeasures and coordination.

The increase in hospitalisations and deaths shows that COVID is here to stay, and that we will continue to need tools to fight it. Over three years ago, WHO and our partners launched the COVID-19 Technology Access Pool, or C-TAP, to facilitate sharing of intellectual property, knowledge and innovations for vaccines, tests, treatments and other tools.

Last week, C-TAP announced three new licensing agreements acquired through the Medicines Patent Pool. Medigen Vaccine Biologics Corp. offered its patent and know-how for its COVID-19 vaccine, the Spanish National Research Council shared a second license for a vaccine prototype, and the University of Chile shared its technology for a COVID-19 assay for quantifying neutralising antibodies.

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I thank the three institutions for sharing their technology and expertise with C-TAP, which demonstrates proof of concept of the model. WHO is now reviewing the C-TAP model with a view to developing a new, broader access model for technologies, which we plan to announce by the end of the year.

Now, a few words about the various emergencies to which WHO is responding around the world. First to Sudan, where the humanitarian situation is continuing to deteriorate. About 65% of the population has no access to health services and more than 70% of health facilities in conflict areas are not functioning.

The implications are horrific. Every day, nine patients with renal dialysis die, and dialysis centres in four states have closed due to lack of supplies. In addition to supporting 11 hospitals, WHO is now rolling out 12 mobile health clinics to provide life-saving and essential health services to people with no access. An additional 12 mobile clinics will be launched later this month.

Meanwhile, attacks on health have continued to increase. So far, WHO has verified 56 attacks on health care, leading to 11 deaths and 38 injuries. WHO condemns in the strongest terms the increasing attacks on health care in Sudan, and the occupation of health facilities.

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The Sudan crisis has displaced close to five million people, including one million who have fled to neighbouring countries. The health situation at Sudan's borders is dire, with a combination of disease outbreaks, impact of extreme weather events, hunger and malnutrition.

WHO personnel and Emergency Medical Teams are on the ground, treating patients, delivering medical supplies, training health workers, and ensuring health facilities are functioning.

Now, to Bangladesh, which is experiencing its most severe outbreak of dengue on record. Since the outbreak began in April, more than 135,000 cases and 650 deaths have been reported, including 300 deaths reported in August alone. The outbreak is putting huge pressure on the health system. Cases are starting to decline in the capital, Dhaka, but are increasing in other parts of the country.

WHO is supporting the authorities to strengthen surveillance, laboratory capacity, clinical management, vector control, risk communication and community engagement. We have trained doctors and deployed experts on the ground. We have also provided supplies to test for dengue and to support care for patients.

Finally, to Nigeria, which is experiencing a severe outbreak of diphtheria. So far, more than 9,000 suspected cases have been reported across 17 states, with 307 deaths. This is the second wave of diphtheria this year.

Diphtheria is a highly contagious but vaccine-preventable disease caused by a bacterium which can be fatal in 5-10% of cases, with a higher mortality rate in young children. In response, WHO is supporting the government to improve vaccination, surveillance, case management and risk communication.

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We are also working with partners to increase access to vaccines and antitoxin. This outbreak and others highlight the need to increase routine vaccination to stop these outbreaks before they start. Tarik, back to you.

TJ Thank you, Dr Tedros. Now, we will open the floor to questions. Again, just to remind journalists, please identify yourself and click the icon Raise Hand and, if possible, limit your questions to one, maximum two. We will start with Agence France-Presse, and we have Daniel Lawler online. Daniel, could you please unmute yourself.

DL Hi. This is Daniel Lawler, from AFP. As we move into the fall and winter of the year, how big of a threat is COVID now to public health? For example, how would you compare the danger posed by COVID with other respiratory infections such as the flu, RSV or the common cold? Thank you.

TJ Thank you, Daniel. Maybe Dr Van Kerkhove to start.

MK Thanks very much for the question. As the DG pointed out, we're seeing some continued concerning trends ahead of the autumn and the winter in the northern hemisphere and we are seeing increases globally in case reporting, and this is in the backdrop of a significant decline in surveillance and reporting.

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But more worrisome, we're really seeing several countries, several regions reporting increases in hospitalisations. We have data from a limited number of countries, about 20 countries right now, providing information on hospitalisations, and 18 countries providing information on ICU admissions.

But hospitalisations are increasing in the Americas, in Europe, in what we call our South-East Asia Region, and that is of worry given that when we get to colder months in some countries people tend to spend more times indoors aggregated together and viruses that transmit through the air like COVID will take advantage of that, even more so than it is taking advantage now. So, we are concerned seeing these increasing trends of COVID right now.

Flu circulation, particularly in the southern hemisphere, is going down, they're finishing their winter months, but we will expect seasonal influenza to circulate, as it does every year. RSV is circulating as well. So, the backdrop of health facilities to deal with patients, they have to deal with COVID, they have to deal with flu, they have to deal with RSV.

COVID, right now, is infecting and reinfecting millions. We estimate that there are hundreds of thousands of people in hospital now for COVID and that can be prevented with lifesaving tools like vaccination. And, as the DG pointed out in his comments, what is really important is that those who are most at risk for developing severe disease receive a booster, receive an additional dose.

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Certainly, if you're in an older age group within 12 months, if you're in the oldest age group, over 75, if you have multiple underlying conditions, the current SAGE recommendations are to be boosted within six months. And the vaccines that are in use continue to prevent severe disease and death even with the new subvariants, the new variants that are being detected, including EG.5, and some preliminary data coming out suggesting that the vaccines will be protective against this new variant, BA.2.86. So, this is encouraging news.

But it is really important that we continue to use all available tools. It's not just the vaccines that are there. It's really critical that we utilise testing for patients, so when they show up at a health care facility, if they have influenza or if they have COVID, they get into the right clinical care pathway and receive antivirals quickly so that infection does not progress to develop severe disease. And, of course, we have the other tools that are in our possession, like masks, like improving ventilation, distancing where possible.

So, we are concerned about COVID but we're also concerned about influenza and RSV. What we don't want to see are actions that only focus on one particular pathogen at the expense of others and what we're doing for COVID is beneficial for flu, is beneficial for RSV.

There was a recent study that had come out looking at mortality and it's very difficult when you start comparing these pathogens, but the important message here is that these viruses, flu can kill, so can COVID, so can RSV, but there's a lot that we can do to actually prevent infections and there's a lot that we can do to prevent severe disease, prevent long COVID in the case of SARS-CoV-2, and prevent death.

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TJ Thank you very much, Dr Van Kerkhove. We will move on to the next question and we have Helen Branswell, from STAT. Helen.

HB Thank you for taking my question, Tarik. It's also on COVID. It follows-up a bit on Maria's answer just now. You mentioned that emerging evidence suggests that the current vaccines will protect against BA.2.86. I know Moderna released some data last evening or maybe earlier this morning.

What are you learning about BA.2.86 at this point? Is the picture becoming any clearer in terms of whether or not it is much more of a threat than what it is taking over from, if it takes over? Thank you.

MK Thanks, Helen, for this. We have very limited information on this variant under monitoring, BA.2.86, and the numbers are going to change. Because it's a variant under monitoring there is active search for this particular sequence around the world. Right now, we know that there are about 42 sequences that have been shared with GISAID from 11 countries. That number will likely change but it's small numbers across 11 countries. These have either been detected from patients or they've been detected in wastewater.

Our Technical Advisory Group for Virus Evolution, TAG-VE, is meeting every week to discuss this particular variant. We have invited many of the researchers that have been sharing their preprint material publicly to discuss with us. And what we're looking at is if we can estimate a growth advantage. What can we say about transmissibility?

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We don't have enough information to actually estimate that growth rate, however, given that it has been detected in 11 countries since July, since late July, that indicates to us that it is circulating. But this is in the backdrop of three variants of interest, EG.5 and two of the XBB sublineages. EG.5 is about 30% of the sequences that are globally. This variant is not outcompeting any of the variants of interest right now or other variants that are in circulation and this is what we're looking out for.

It is quite a complex picture globally, in terms of how these variants behave because different variants circulated in different countries at different times. What we're trying to do is look at transmissibility and right now we have very limited information.

But we're also looking at immune escape and there is some preliminary data that has come from three different groups suggestive that our vaccines protect against, the current vaccines and the monovalent XBB will protect against these, protect against severe disease and death but the data is quite limited so far.

This is why the surveillance is so important, why these studies and the collaborative way in which these studies are being done. It's being shared with us in real-time. We're so grateful for the researchers on that. But we don't have a completely clear picture. This is why it's a variant under monitoring, this is why we're tracking it so closely and so grateful for our TAG-VE and those who are sharing information with us directly.

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TJ Thank you, again, Dr Van Kerkhove. Next question is Belisa Godinho, from W Magazine, Portugal. Belisa, the floor is yours.

BG My name is Belisa Godinho, from W Magazine, in Portugal. Thank you for taking my question. In a conversation, the Minister of Health of my country said something that suggested that WHO will have an office in Portugal next year. I would like to know if it's true and, if so, is there any particular reason for this happening? Thank you.

TJ Belisa, can you just repeat the question?

TAG It's okay.

TJ Oh, Dr Tedros.

TAG Thank you for that question. Of course, we're discussing about opening an office in Portugal but that has not been decided yet. It's in the process and we're in touch with the Minister. Thank you.

TJ Thank you, Dr Tedros, and thank you, Belisa. Sorry for mispronouncing your name. We will go now to Erin Prater, from Fortune. Erin.

EP Can you hear me?

TJ Yes.

EP Great. Wonderful. Thank you so much for taking my question. I have heard from some experts that BA.2.86 may not be the black swan event that some had feared it might be and they're more concerned about variants that evolve from it, that may pick up additional transmissibility and/or virulence. Any thoughts on this? Thank you.

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TJ I guess it's again for Dr Van Kerkhove.

MK It's a great question. The way that we have been working since the start of this pandemic is looking at different types of scenarios of how the pandemic may unfold, how the virus may evolve, to be prepared for different types of situations.

What we are looking at with virus evolution, we can't predict with certainty how the virus will evolve. We've brought together incredible scientists and public health professionals from around the world to make educated guesses on what we might think but, as an organisation and with our Member States, what we're preparing for are variants that have increased transmissibility because they have to outcompete with each other.

But what our worry is variants that will have a change in severity and be more severe compared to what is already circulating. So, we have to be ready for

that. We look at a number of different characteristics. We look at transmissibility, we look at severity and we look at our interventions. Will our interventions, like our diagnostics, like our clinical management, like our vaccines, will they continue to work?

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And so that's what we're prepared for, which is why the surveillance, the reporting, the assessment, tracking of these trends remains so critical. And we're in a worse position than we were six months or a year ago to do those rapid, robust assessments for each of those variants because there's a delay.

Not only has surveillance declined but the amount of sequencing around the world has declined, the number of countries that are providing sequences of these variants has declined, and the time from when a sample was collected to when the sequence was made available, to when it is shared publicly, that delay is actually getting longer.

So, that's making our job, the job of the Technical Advisory Group for Virus Evolution more difficult. But we, as an organisation, have to prepare for all of those different scenarios and each of the variants that are being detected, that are circulating are undergoing this type of assessment.

Each of the variants that we detect in circulation, whether they have a large number of mutations or not, if they're increasing in detection around the world, we do these types of risk evaluations and we publish those online.

That is something that will continue, that process will continue. It will be advised also by our Technical Advisory Group for COVID-19 Vaccine Composition, TAG-CO-VAC, which will assess whether or not we need to make a recommendation for a change in the vaccine composition.

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This is something that will happen periodically and we see this happening for the foreseeable future. Something similar happens for influenza but this is something that we do in our convening power, to bring the world together to discuss available data.

TJ Thank you, Dr Van Kerkhove. We will now move to National Public Radio. Ari Daniel. Ari, please go ahead.

AD Hi, there. Thanks so much, Tarik. My question is related to Bangladesh and the dengue outbreak. I'm wondering why is the outbreak so bad there. We know it has been bad in other places but why in Bangladesh in particular? And how does it compare to other countries where malaria is endemic?

TJ Thank you very much, Ari. I think online we have Dr Abdi Mahamud. Dr Mahamud, can you hear us? Can you take this question?

AM Thank you so much. Can you hear me, Tarik?

TJ Yes, we hear you Dr Mahamud. Please, go ahead.

AM Thanks. I think to reflect on, not Bangladesh, but the upsurge of cases of dengue we have seen earlier on in South American countries and several other countries, the climate change is impacting a lot of diseases and we have seen an upsurge in countries of that.

To go back to Bangladesh, it's an endemic disease and Bangladesh has one of the best systems designed to deal with it. But earlier, what we have noticed, even before the pre-monsoon season there was an upsurge in the mosquito, the Aedes mosquito, that had been picked up.

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I think we are seeing more and countries that are going to experience a heavy burden of these diseases, what we call arboviral diseases, dengue, chikungunya, yellow fever and Zika. Globally, around one billion people are at risk, so it requires an integrated approach and countries alone, with their economic struggle, and coming out of the pandemic, may not be able to handle it on their own.

So, it requires global solidarity to deal with this as a canary in the coal mine of the climate crisis we are facing. For us, we believe Bangladesh requires support and, as the DG mentioned, WHO has been supporting and standing with the government of Bangladesh. But what we are seeing and we are predicting more is the burden of these arboviruses will increase more.

Then, the main challenge an endemic country faces is the switch between the serotypes. Right now, all the serotypes of dengue are co-circulating in Bangladesh and we know very well if you get infected with one type, the second time when you get infection with a different one, the antibody enhances it and the severity of the disease is increased.

So, multilayer levels of complication that the country is dealing with but in the global context of global warming, and then add to it right now the El Niño factor that is even becoming worse. I think it is convergence of multiple factors, one the upsurge we having been seeing in the last decade, an increase in arboviruses, and more severely right now, what is making it more difficulty responding is the El Niño factor.

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We saw it in South America, we are seeing it now in Bangladesh and we, now, our surveillance system is picking it up in Sub-Saharan African countries, like Chad, which having experience with it there too. So, the world is preparing as we go into this new climate crisis, diseases that are mosquito-borne may be the next challenges.

TJ Thank you very much, Dr Mahamud. Dr Mahamud is Director ad interim of Alert and Response Coordination within the Health Emergencies Programme. Next question comes from Amalie Mersh, from Euractiv. Amalie, if you can unmute yourself. Please, go ahead.

AH Can you hear me?

TJ Yes, very well.

AH Thank you very much for taking my question. It's about the pandemic treaty negotiations. I was wondering if you could share anything about the meetings this week and whether there is any progress made. Thank you.

TJ Thank you, Amalie. Dr Ryan.

MR Thank you for the question. As you know, the discussions around a global accord, treaty or agreement are ongoing. The Member States are here this week and they're in active discussions. This is a process that is led by the Member States, driven by the Member States, so as Secretariat I would not like to comment on the progress as such.

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What I can say is that there is very positive engagement, lots and lots of meetings, briefings, discussions and I believe there's a very positive attitude from everybody to try and find the best possible platform or the best possible treaty or accord for the future.

It's really, really important. I think it's an important time, as Maria outlined so well, in terms of the continued risk of COVID, as was asked by yourselves, of the threat of dengue, the pressure of climate change. As we've seen in so many countries now, the pressure of conflict and displacement, the threat of infectious diseases, the threat of pandemics, the threat of major health emergencies has never been higher.

So, from the Secretariat's point of view and Dr Tedros has spoken to this so many times, the need for an agreement like this has never been greater. It is great testament to our Member States and their negotiators that they're coming together on the most regular basis, engaged in intersessional processes, involved in working groups managed by the co-facilitators of the bureau.

There's a tremendous amount of engagement. The issue now is to find solutions. The issue is to find the agreement needed to take us forward, an agreement needed that will protect future generations and, as Dr Tedros has said many times, a generational agreement. It will be huge tragedy if this opportunity is lost against the backdrop of the threats that we collectively face on this planet.

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TJ Thank you, Dr Ryan. I think we have Banjot Kaur, from The Wire, Indian outlet. Banjot, can you hear us? Please, go ahead.

BK Yes, I can hear you. Thanks for taking my question, Tarik. My question is regarding genome sequencing. Frequently, it has been raised as a concern from WHO that we need to do more. Is there any threshold, considering the threat that we face now, any minimum threshold that the nations must do in terms of genome sequencing so that they don't miss out on what is circulating in their respective territories? Is there any minimum threshold that you can suggest? Thank you.

TJ Thank you, Banjot. Dr Van Kerkhove.

MK This is an excellent question. We get this question probably at least once or twice a week of how much is enough for sequencing? I'm going to give a broader answer than that because I can't give an actual number of how much sequencing because it depends. It depends on your objective.

There are some thresholds that have been put out for influenza, for example, from the sentinel-based systems, a certain percentage of those samples, of

people who are hospitalised to be sequenced for influenza, for example. We have put out some recommendations in the past for SARS-CoV-2 but the demand, it's different now.

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We're not asking for more, more, more. What we're asking for is good geographic representation of sequences for SARS-CoV-2 as an example, but we could use other pathogens as examples for this as well, so that we have a good idea of what is in circulation around the world. We don't want all of the sequences to come from one country or a handful of countries or only high-income countries.

What is really astonishing to me is that in the last three and a half years the capacities for genomic sequencing around the world have expanded massively. This started before the pandemic but it was accelerated greatly in the last three and half years. These are capacities that were built and developed, building on the shoulders of influenza, on polio, on HIV, on many other diseases but really expanded, and this is capacities that could be used for other pathogens.

It could be used for the current threats, plus the ones that we will face in the future, and that's a positive. This is something that we are working on with Member States to sustain and to maintain so that workforce, the systems that are in place, that knowledge can be utilised for COVID, plus as we go forward.

But, specific to your question, we are working across different technical groups to provide specific answers like that to countries, to say this is a threshold, try to test this much or sequence this much so that we have good representation from around the world. But your question is a very poignant one and an extremely difficult one to answer. It's not just more, more, more. It's about intelligent sequencing, it's about using this type of information, the metadata, the bioinformatics to take action.

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And we are seeing countries utilise this. Sequencing has been a game-changer in terms of our ability to early detect, to characterise pathogens, to be able to take decisions about what needs to be done related to transmission, severity, variant assessment, etc. So, it's a capacity we want to see maintained going into the future.

MR If I could briefly add in a more general context. Sequencing represents a major, major opportunity. It's an evolving and extremely useful tool of public health decision-making. We have issued a genomic sequencing strategy for our Member States with relation to epidemic-prone diseases which takes the discussion much broader.

As Maria previously outlined, we're looking at how can we integrate the surveillance and sequencing for both all of the respiratory viruses within the GISRS system and we've initiated an international pathogen surveillance network for expanding genomic work for epidemic pathogens around the world and that's operating out of our Berlin hub, and that has been with the support of many, many of our Member States.

So, there is a real need to organise. Just sequencing for the sake of it, as Maria said, doesn't really give us what we need. What we need to be able to do is do sequencing of a standardised set of samples where we have the metadata, and the metadata is the information regarding the patient, severity, epidemiologic information, clinical information.

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If you have that information and you have the sequencing data for a defined proportion of the population, what you can do then is build up a picture of what's happening, a picture of the virus, a picture of its transmission, a picture of its evolution, a picture of its impact. And if you're going to make good decisions in public health, they're the pieces of information you need.

Doing more of one thing in one place is fine but really what you are doing is shining an even greater light on an area that you can already see. What we need to do is shine the light where the darkness is and be able to see everywhere and be able to see everything so we can make good decisions local, nationally and on an international basis.

So, sequencing has really joined that pantheon of the tools, that toolkit that you need at local, national and global level to understand and to manage infectious diseases in particular. It is also a major tool in the management of endemic infectious diseases such as TB, HIV, malaria and others. It's a fantastic tool.

In the context of epidemics, it's truly transformational but it must be linked to the other surveillance tools, as I said, and to the other initiatives that we have. And, as I say, WHO, we're working very closely with our Member States and partners to ensure that genetic sequencing becomes and remains a central pillar.

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It's very interesting. My colleague, Regional Emergency Director for the Eastern Mediterranean, Rick Brennan, has just returned from Somalia, and he was explaining to me yesterday just how impressive it is in Somalia to see a country that has expanded its genetic sequencing capacities right down to subnational level that didn't exist three years ago.

The danger now is that Somalia will lose that capacity because of the difficulties with development aid, with humanitarian assistance, with the lack of sustainability. Is it rational for the world to lose the light that is shone in that part of the world because that benefits not only people in Somalia, that benefits the region, that benefits the whole world.

So, we have a problem at the moment. We have greatly expanded genetic sequencing capacity all over the world and that's great, but what we don't have is sustainable infrastructure, sustainable financing for that capacity to be sustained and integrated into the broader system. It's a real challenge. It's a real problem. I could say the same for oxygen in Somalia the same way. Somalia has become self-sufficient in medical oxygen. Again, it could risk losing that infrastructure in the coming years.

So, we need to be very careful. When we get new opportunities and new ideas and new innovations we get a huge amount of interest and we roll them out.

The difficulty is sustaining them within the system and we continually have to refocus on how do we integrate these new innovations into the existing system, into the primary health care system, in the laboratory surveillance systems. I think we're getting there. COVID has offered us a huge opportunity to expand this capability. The challenge now is to sustain it.

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TJ Thank you, Dr Ryan and Dr Van Kerkhove. Last question is a follow-up from Helen Branswell. Helen.

HB Thanks very much, Tarik. I'm wondering if, Maria or Mike, you could talk about how much data is coming in for COVID vis-a-vis flu. Are you actually at a point where flu surveillance is better and, if so, how does that make sense? I know it's a long-standing programme but the pieces that are needed to both those things are the same, are they not?

MK Thanks. I can start. I am sure Mike will want to complement on this. The influenza system, the Global Influenza System is pretty incredible. It's been in operation for more than 70 years. This is GISRS, the Global Influenza Surveillance and Response System that we have.

There are labs around the world, sentinel-based labs, non-sentinel-based labs that are collecting information, not only on influenza but on RSV. And in many situations they're also collecting data on SARS-CoV-2. So, there is an integration of COVID into many of the flu-based systems that are in countries.

The response for COVID was built on the shoulders of influenza and other disease programmes like MERS, like polio, for example, but we are utilising the influenza system for COVID as well. We have an integrated dashboard. There are reports that come out from our Global Influenza Programme which outline the circulation of influenza, seasonal influenza, avian influenza regularly.

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Within that system, they also look at trends from data coming from those sentinel-based hospitals and other non-sentinel sites. They collect information on percent positivity, which we are utilising for COVID as well, percent positivity for influenza, as well as percent positivity for SARS-CoV-2. This is a really helpful gauge of how much is in circulation, especially because we're not getting systematic cases reports for COVID anymore because the focus on COVID is really on the hospital-based system.

But for COVID what we also need, similar to what we need for aviation influenza, is we need the animal component as well. These are pathogens that are zoonotic. They can pass between animals and humans. For avian influenza we work with the Quadripartite to look at circulation in wildlife, in poultry and small mammals and in humans for flu. We're doing the same thing for SARS-CoV-2. We need surveillance in animals as well. You remember the Cluster Five variant for SARS-CoV-2 in September 2020.

We're also utilising for COVID, wastewater surveillance. Some countries are adding wastewater surveillance as a component, an additional component to look at circulation. This has been a really fantastic tool that we've used for SARS-CoV-2. Polio has been using this for years. But there are many other

components that we have for SARS-CoV-2 in addition to GISRS, in addition to the Global Influenza Programme.

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So, yes, parts of this are integrated and there are additional elements of surveillance that we have been utilising for many different types of pathogens using a One Health approach, so in animals, looking at the environment, looking at animals.

And what we are working on right now in this transition period of COVID is where can we integrate the systems, integrate systems for surveillance, integrate systems for clinical care and clinical care pathways, and what needs to be standalone, and that's what countries are working on right now. We can't keep up the same systems with a COVID lens only. COVID needs to be dealt with in the context of all of these other circulating pathogens, including flu.

MR I think Maria has pretty much covered it all but I do think, when we look in the round, the single biggest pandemic threat comes from respiratory viruses because of the nature of their transmission and their ability to infect so many people over such a short period of time. We have other pandemic threats.

So, we have to look at respiratory viruses in particular as a common threat and the GISRS system, we're looking at how to expand that, and the advantage of GISRS is it does collect that other data I spoke about. The GISRS system doesn't just collect data on samples. It collects data on influenza-like illness at community level, on severe acute respiratory illness in hospitals, and on the lab samples. So, we're able to collect all of that data.

The historical reality, though, is the GISRS system was heavily oriented towards the northern hemisphere in terms of the surveillance that was carried out and had relatively few laboratories in the southern hemisphere. That's been changing over time.

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What's happened in COVID is that the capacity to do laboratory surveillance for SARS coronavirus has actually developed rapidly in the southern hemisphere. What we need to now is be able to link these two processes. We have the COVINet, which is the lab network for COVID. We have the GISRS, which is effectively the lab network for flu.

How you bring things together and integrate them, align them first. And I think that's going to be the challenge. It's the opportunity but you also have to be careful when you bring any two different systems or systems that work together, when you try to bring them together you have to make sure you don't break anything along the way.

I was taught that in public health school, that you should refer everything you do in public health policy to the Department of Unintended Consequences. GISRS is a highly-functional system. What we want to make sure is that we enhance GISRS and not overburden it, add in unnecessary elements to it but, at the same time, continue to build that COVID capacity.

The other thing I think that's very striking to me is that the Global Influenza Surveillance and Response System heavily relies on the national labs. It's not WHO, it's the national laboratories which are paid for by national governments, and the six WHO collaborating centres.

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Again, in a time globally when we have such difficulties at a global level, to see these WHO collaborating centres, who invest a huge amount of resources into supporting the national labs and into driving this system in South Africa, in Australia, in Japan, in the Russian Federation and in China, to see that collaboration going on across the geopolitical divides because everyone sees that influenza will spare nobody.

And I think we need to have the same view on COVID and I think we need to come back and have the same view when it comes to a pandemic treaty. The next pandemic will spare nobody. We need to work together and I think GISRS and the collaboration on COVID, and Maria referred to it, the TAG for Virus Evolution is an incredible group.

These are scientists who exist and work out in national labs all over the world. These aren't WHO staff. These are the experts of our Member States, the experts of your countries out there, the experts that come together and share their knowledge, share their expertise for the benefit of all.

That's the essence of what WHO does or what WHO attempts to do is to convene, to create platforms for countries, nation states to be successful in a common fight against common threats. That's what the pandemic treaty is about. That's what GISRS is about. That's what the WHO collaborating centre network is about. That's what our technical advisory groups are about.

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And pulling all of that together into a comprehensive strategic preparedness of the next pandemic, if we can pull together the technical, the operational, the financial, and the political aspects of dealing with pandemics. And we need to work at all those levels if we're to be successful in future.

TJ Thank you, Dr Ryan and Dr Van Kerkhove. This will conclude our press briefing for today. Reporters will receive, later today, an audio and video file of the briefing and the transcript will be available tomorrow on our website. Last word, as always, is for our Director-General, Dr Tedros.

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