Global Health Issues

Virtual Press Conference
29 November 2023

Speaker key:

MH	Dr Margaret Harris
TAG	Dr Tedros Adhanom Ghebreyesus
MK	Dr Maria Van Kerkhove
RP	Dr Rik Peeperkorn
MR	Dr Mike Ryan
IN	Dr Ilham Abdelhai Nour
HB	Helen Branswell
AT	Alexander Tin
CV	Christophe Vogt
AD	Ari Daniel
MA	Muhammet Ikbal Arslan
OA	Omar Abdel-Baqui
IF	Imogen Foulkes

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MH Hello, everybody. This is Margaret Harris in WHO Headquarters, Geneva, welcoming you today, November 29, 2023, to our press briefing on current global health issues.

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

In the room we have a large panel. On Dr Tedros' right, we have Dr Mike Ryan, our Executive Director for our Emergencies Programme. Next to Dr Ryan we have Dr Ilham Nour, our Acting Incident Manager for the occupied Palestinian territory Israel escalation. Next to Dr Nour is Dr Maria Neira, Director of our Department for Environment, Climate Change and Health.

And next to Dr Neira is Mr Andy Seale, our Technical Officer for HIV, Hepatitis and Sexual Transmitted Infections. And next to Mr Seale is Mr Derek Walton, our Legal Counsel. And to Dr Tedros' left we have Dr Maria Van Kerkhove, Acting Director our Department for Epidemic and Pandemic Preparedness and Prevention.

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We also do have our usual large panel of experts online and we will call upon them whenever appropriate, when you ask your questions. But now, without further ado, we'll go to Dr Tedros for his opening remarks. Dr Tedros, you have the floor.

TAG Thank you. Thank you, Margaret. Good morning, good afternoon and good evening. WHO welcomes the extension of the humanitarian pause in the conflict in Gaza and the release of hostages and prisoners by both sides. The pause has enabled WHO to increase deliveries of medical supplies in Gaza and to transfer patients from Al-Shifa hospital to other hospitals south of the Wadi Gaza.

During the first three days of the pause, WHO received 121 pallets of supplies into our warehouse in Gaza, including IV fluids, medicines, lab supplies, medical disposables, and trauma and surgical supplies. This is enough to support about 90,000 people.

However, much more is needed. We continue to call for a sustained ceasefire so that aid can continue to be delivered to end further civilian suffering. And we call for the remaining Israeli hostages to be released and for those who are still being held to receive the medical care they need.

WHO's greatest concern remains supporting Gaza's health system and health workers to function. Only 15 of Gaza's 36 hospitals are still functioning at all but are completely overwhelmed. For example, European Gaza Hospital is currently operating at triple its capacity.

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Of the 25 hospitals north of the Wadi Gaza before the conflict began, only three are functioning at the most basic level but they lack fuel, water and food. The remaining health system capacity must be protected, supported and expanded.

The health needs of the population of Gaza have increased dramatically but they are now being serviced by one third of the hospitals and primary care clinics and, with severe overcrowding, the risks are increasing for epidemics of respiratory tract infections, acute watery diarrhoea, hepatitis, scabies, lice and other diseases.

WHO is working to support Gaza's health system and health workers in every way we can. Together, with partners, we're distributing supplies, coordinating emergency medical teams to provide extra clinical capacity for existing hospitals and establishing standalone field hospitals in strategic locations.

We thank those partners who are working with us but we repeat that emergency medical teams and field hospitals can only complement Gaza's

health system, not replace it. The priority must be to support Gaza's health workers, hospitals and clinics to do their jobs.

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This week, the world is converging in the United Arab Emirates for COP28, the United Nations Climate Change Conference. According to the Intergovernmental Panel on Climate Change about 3.5 billion people, nearly half of humanity, live in areas highly vulnerable to the climate crisis. This year alone catastrophic flooding in Libya and the Horn of Africa has cost lives and livelihoods, and just this week Brazil hit record temperatures.

An unhealthy planet means unhealthy people. Heat-related deaths among people aged over 65 years have climbed by 70% globally in two decades. Every year, seven million people die from air pollution. Changing weather patterns, driven by human activity and the burning of fossil fuels, is contributing to record numbers of cholera outbreaks. And our warming planet is expanding the range of mosquitoes, which carry dangerous pathogens like dengue, chikungunya, Zika and yellow fever into places that have never dealt with them before.

The climate crisis is a health crisis. So we're pleased that for the first time, this year's COP will include a day dedicated to health, with more than 50 health ministers attending from around the world. While at COP, I will make three specific calls. First, a climate-friendly world. WHO calls on leaders from government and industry to work together to phase out fossil fuels urgently, and accelerate the transition to clean energy.

Fossil fuels -- coal, oil and gas -- are by far the largest contributor to global climate change, accounting for over 75% of greenhouse gas emissions. Weaning the world off fossil fuels is therefore the only way for countries to meet their commitment to limit global warming to 1.5 degrees Celsius. This is a public health imperative.

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Second, climate-friendly health systems. While the health sector is affected by climate change, it also contributes to it, with about 5% of global emissions. We must focus on decarbonising health systems to reduce that.

At the same time, we must continue to strengthen health systems to be more climate-resilient. That means strengthening the health workforce and disease surveillance systems, building on investments that many countries made during the COVID-19 pandemic, and it means scaling up vector control and access to safe water and sanitation.

Third, finance. The health sector is at the frontline of the climate crisis but it receives just half of one percent of global climate financing. The world spends trillions of dollars of public moneys in fossil fuel subsidies every year.

We call on governments and investors to redirect those funds to protecting and promoting the health of our planet and the health of people. And we ask also for the international community to honour their pledge of US $100 billion for climate change annually.

Finally, this Friday marks World AIDS Day. This year's theme is Let Communities Lead. It affirms the vital role that affected communities play in leading the response to HIV. Thanks to decades of activism, advocacy and support from affected communities, millions of new infections have been averted and 30 million people are now receiving antiretroviral therapy.

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As prevention and treatment services for HIV are increasingly delivered in community and primary health care settings, communities and community health workers are even more critical. We must stand together to ensure communities have the funding and resources they need to stand up for human rights, to fight stigma, and to help us end AIDS for good. I thank you and, Margaret, back to you.

MH Thank you very much, Dr Tedros. We'll now open the floor to questions. As I should have mentioned, if you want to ask a question, please use the Raise Your Hand icon if you haven't done that already. There are a lot of you online and there a lot of you with hands raised, so please keep your questions short and clear. And if you know who it's addressed to, do mention this at well and give your name and outlet. The first question goes to Helen Branswell, from STAT. Helen, could you unmute yourself and ask your question.

HB Thank you very much, Margaret. I think this is probably for Maria. It's a follow-up to the situation in China. I'm wondering if WHO is hearing of other places that are seeing an increase in mycoplasma pneumonia in children as well as the Chinese authorities have. Thank you.

MK Thanks, Helen, for the question. Yes, we are seeing, in general, an increase in respiratory infections around the world. We do tend to see increases in children because they're the school-age children, and in the northern hemisphere it's the autumn already and we're entering the winter months. So, we are expecting to see increases in acute respiratory infections.

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Mycoplasma pneumonia is not a reportable disease to WHO, so we tend to track this information through reporting systems and through discussions with our Member States. As you and I had discussed earlier or last week, we are following-up with the situation in China and, again, they have seen overall an increase in acute respiratory infections due to a number of different pathogens, including influenza, which is on the rise. Mycoplasma pneumonia was on the rise for the last couple of months and now seems to be a little bit on the decline.

We're following-up through our clinical networks and working with clinicians in China to better understand resistance to antibiotics, which is a problem across the world but is a particular problem in the Western Pacific and South-East Asia region.

One of things we are following-up on in terms of the acute respiratory infections is looking at burden in health care systems. It's one thing to see a rise in these types of infections, particularly in school-age children, but also to monitor the severity and looking at the health care capacities around the world to be able to deal with these types of infections, looking at what are

treatment options that are there, and there are many antibiotics that are available for mycoplasma pneumonia.

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I don't have the specifics on the rates around the world for this particular bacteria but we have seen outbreaks of mycoplasma pneumonia in a number of countries over the course of many different years. So, I can follow-up with you on some specifics on that and specifically in China and elsewhere.

MH Thank you very much, Dr Van Kerkhove. The next question goes to Alicia Sánchez, from Europa Press News Agency, Spain. Alicia, could you unmute yourself and ask your question. Alicia, we're not hearing you. Are you having problems? We'll go to the next question. The next question goes to Alexander Tin, of CBS. Alexander, please unmute yourself and ask your question.

AT Hi. Thanks for taking my question. I just wanted to follow-up on the report last week about BA.2.86. I was wondering if you could clarify what you think the role of JN.1 is in BA.2.86's growth and if you have any updates to share on what you've heard about its comparative severity. Thank you.

MH Thank you. I think that's another one for Dr Van Kerkhove.

MK Thanks very much. We are continuing to track the variants around the world and BA.2.86 was recently classified as a variant of interest. It was formerly a variant under monitoring. Within BA.2.86 includes this further sublineage of JN.1. Globally, about 10% of the sequences that are reported to public platforms are BA.2.86 and its sublineages.

They're still very small numbers. I don't have the exact number of sequences in this grouping but it's just over 4,000 sequences globally. It has a growth advantage but this is what we expect from variants that are classified as variants of interest.

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In terms of severity, we don't see a change in the disease profile of people infected with BA.2.86 and its sublineages, including JN.1, but it is one, of course, to watch. When we look at severity, we are looking at any changes in hospitalisations, we're looking at any changes in disease presentation, and we don't see that for this particular variant of interest and its sublineages.

So, again, anyone who is infected with SARS-CoV-2, including BA.2.86 and its sublineages can cause a full range of disease, anything from asymptomatic infection, all the way to severe disease and death.

Our vaccines are still working very well protecting against severe disease and death and it remains really critical that those of you who are due for an update vaccine of COVID-19 get that vaccine, whether it's based on the new XBB.1 monovalent vaccines or the vaccines based on the ancestral strain. So, if you in an at-risk group, if you're of older age, if you have underlying conditions, please make sure that you are up to date on your vaccines.

MH Thank you very much, Dr Van Kerkhove. The next question goes to Christophe Vogt, from Agence France-Presse. Christophe, please unmute yourself and ask your question.

CV Hello. Thank you for taking my question. It's about Gaza. I was just wondering if you had teams on the ground doing the assessment of what is going to be needed to bring the health system back up to pre-war quality, so to speak, and if you have any idea of how much money that would cost. Thank you.

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MH Thank you. I think we have Dr Rik Peeperkorn online, who can answer that question, and we may have supplemented answers in the room. Dr Peeperkorn, are you online?

RP Yes, I'm online. Thank you very much for the question. Let me start with Gaza had 36 hospitals before this war and 3,500 hospital beds. Currently, we talk about 15 hospitals which are functional or we call partly or barely functional. It's important to be specific. I think the DG referred already a bit to this.

There's 12 in the south, which are currently all overwhelmed and partly to fully functional. There's three to the north, Al-Awda, Al-Ahli, and Al-Sahaba, which are working more on minimal levels, more like almost first aid centres, and three others ones, the well-known, Al-Shifa, Indonesian and Kamal Adwan. They have some patients left but they don't accept any patients anymore. Al-Shifa is again having some dialysis patients but it is really minimal.

So, we had 3,500 beds. Currently, 1,500 beds. And this may be the first thing we are focusing on. You ask what is needed? First of all, the bed capacity needs to be expanded as quickly as possible with the functional hospitals and that's part of the WHO Operational Plan. So, first how do we restore the health sector and the referral pathway, primary care, secondary care and, third, referral care.

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And linked to these hospitals, we need to strategically position emergency medical teams, which is currently ongoing in very few places, to help expand the needed bed capacity. So, how do we bring the bed capacity from 1,500 to 2,000 and 2,500? We estimate there is a need of 5,000 beds, so we have really a long way to go.

And, as Dr Tedros says, complementary to that there is a need for a strategically-located field hospitals but, again, we all have to focus on making sure that crippled and very much vulnerable health system which we have now is becoming fully functional.

There are Gaza health workers. We have more than 20,000 Gaza health workers, very good health workers. We need to make sure that they get the right supplies and medical equipment, we have some of these emergency medical teams linked to that and we get these hospitals ticking again and, secondly, that we get the primary health systems working again or referral.

We talk always about trauma. We have to focus as well on maternal and child health, think about reproductive health, emergency obstetric care, mental health and psychosocial support, non-communicable diseases and the whole referral system linked to that.

The last point I want to make is we are very concerned. The health system at the moment is extremely vulnerable and when we talk about the 12 hospitals in the south, they are currently the backbone of the health infrastructure.

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I would like to say I am on my way on at the moment to Gaza. I'm in Ismailia. And I will probably, hopefully tomorrow enter Gaza and discuss. We have a team there, a very strong team, which are doing all the things I just mentioned. But any resumption of violence could damage the health facilities and make more health facilities dysfunctional.

I want to stress the point. Gaza can absolutely not afford to lose more hospital beds. We need to expand the number of hospital beds. We need to make the vulnerable system work again. Over to you.

MH Thank you very much, Dr Peeperkorn. I'm just looking in the room. Any supplements? Yes, Dr Ryan.

MR Just to add to what Rik has said. Dr Tedros expressed our gratitude to those other agencies who are providing emergency medical team support and extra bed capacity, particularly to those structures south of the Wadi Gaza. That requires the deployment of up to 750 beds that have been requested or more.

It is a huge ask to get to that level. We do thank our colleagues working in the ICRC and MSF, the UAE Government, the Jordanian Government, the Turkish Government and other colleagues, IMC and others who are working with us to try and coordinate the process of deployment.

I think you'll understand that deploying international teams into a setting as complex as this is a big logistic operation, given the restrictions and the siege and the difficulties in getting material and equipment supplied, transported and located in Gaza.

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There is also the added challenge of maintaining security for these individuals when they do go to Gaza. We don't know what's going to happen tomorrow. Many of these hospitals that we're supporting are potentially in harm's way again within the next 24 hours, and we need to recognise that.

Right now, as far as we can see and as much as we would like this, we're not dealing with a permanent pause or a long-scale ceasefire. Many of these facilities lie in very strategic locations, along highways and, as would be in any major urban conurbation, you put your hospitals in strategic locations that are accessible to people.

But because of that we really do need to get reliable deconfliction of these facilities so that we can continue to support them and that we won't end up in the same situation again in two or three weeks' time where what we've seen in the north, the collapse of health system from 25 hospitals down to three barely functioning, that we don't repeat that again south of the Wadi Gaza.

There are now almost two million people internally displaced, so many people living within shelters, living within family homes, three, four or five families now per apartment, living in other types of shelter, mosques and schools,

community halls. Everywhere is packed. The weather has deteriorated. The rain is falling. Children is getting colder. Nutritional status is dropping rapidly.

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Maybe calorific count is being supported but when we talk about a nutritious diet for children, I don't think anyone can claim that children of Gaza are receiving a nutritious diet. At most, they're getting barely enough calories to survive. So, all of the conditions are there for a deterioration in the situation, as Tedros has laid out.

As our colleague has asked, rightly, what are the longer-term plans for reconstruction in Gaza? I think it's very hard for people there right now to think about reconstruction, to think about where we go next because we don't even know where we're going to be in 24 hours' time. We don't know where the situation is going to be in 72 hours' time.

It is important to think about how this can be rebuilt but, as Rik has said, our primary focus is to support the system that still remains, to support the doctors and nurses and health professionals that are still on the ground in the best way we can so they can support their own citizens and their own people, and that is the primary strategy that WHO has.

As I said, we are being assisted in that hugely but the emergency medical teams who are deploying. Some are deploying directly into facilities to provide extra hands, extra clinical capability, as Dr Tedros has said. Some of them are deploying with extra bed capacity that they can add and those bed are being added to the hospital. And some are able to come in and bring in standalone facilities which are then being put in strategic locations.

When we combine all that together, as Rik has said, we've lost from 3,500, I think, beds down to less than 1,500 beds. We've lost so much capacity. Even with that wonderful effort by many, many countries and many organisations, there is no way that EMT capacity can replace the existing capacity.

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So, therefore, the single most precious thing right now is to preserve the existing capacity in the health system in Gaza and particularly for the two million displaced people who are mainly displaced to the south. We then need to build from there. The costs of reconstruction, given the destruction, are massive. Reconstructing the health system, rebuilding the health workforce, rebuilding the surveillance systems, rebuilding everything is going to be very hard.

The one thing I will say is that if we use as a marker, and this is often used as a marker of the effectiveness of health systems, the immunisation rates in Gaza prior to the conflict were some of the highest in the world, which means regardless of the government situation the reality is that primary prevention and basic care to individuals was being carried out beforehand and in fact we're in many ways relying on that residual protection that exists for that population.

So, I do think that Gaza has the health workers. It has the previous experience to deliver health and plan health and deliver health. The question is going to be when you see the scale of the destruction of the system, how long it's going

to take to rebuild, and not only the shattered infrastructure but to rebuild the shattered confidence and the shattered psychology of a very brave and very effective health workforce?

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MH Thank you, Dr Ryan. Dr Peeperkorn has got a couple of things he also wants to add, I understand.

RP Thank you very much. I just want to add because we were asked questions about our plans. I just want to say, first of all, there's an overall flash appeal for these 90 days, a 90-day flash appeal for 1.2 billion covering all the areas and all the sectors.

And I want to make also a plea for UNRWA, for the fantastic work they're doing in all these shelters and the absolutely needed work they are doing and, of course, we talk about food security, we talk about wash, we talk about shelter, etc.

On health, WHO leads and coordinates with partners the 90-day appeal was 220 million. Based on that WHO, on the request from our partners and donors, focused on what can WHO then do specifically besides coordinating and leading the partners. So, came with the 90-day plan for 108 million and that is actually outlined by the DG and Mike.

Focus on the existing system, the crippled system but still the resilient system, to expand and to make it work again. Make sure that we link the EMTs to it and a few field hospitals but also very much restore the public health intelligence and the early warning disease prevention and control. As a third pillar, ensure that we have a sustained supply for health and logistics and that we focus on the emergency coordination and for that, of course, there's a need for flexible funding. Over to you.

MH Thank you very much, Dr Peeperkorn. The next question will go to Ari Daniel, from NPR, USA. Ari, please unmute yourself and ask your question.

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AD Hi there, everyone. Thank so much for taking my question. For the last several weeks we've known that there's been concern around the possible spread of infectious diseases, diarrhoeal diseases, other types of disease within Gaza. And I'm just wondering if you've actually seen that starting to materialise or if it's just that the threat remains ever present and more concerning than ever.

MH Dr Ryan, did you want to start and then we could go to Dr Peeperkorn?

MR I think we could start with Rik. All I can say is that, as you said, Ari, the risks are clear. We've been tracking the various diseases over a number of weeks now, both through the medical system but also within the UNRWA displacement camps, and Rik can give a sense of that.

I do know that we've picked up some very serious signals around acute jaundice syndrome in a particular part south of the Wadi Gaza. Acute jaundice syndrome is a very, very serious disease, particularly in the context of if someone is pregnant, and it can spread extremely rapidly. Once you've seen those first cases, there are many, many more.

So, there have been a number of signals around acute jaundice syndrome and that would be a harbinger for other epidemic diarrhoeal disease. The main cause of acute jaundice in this context is hepatitis E, and we've seen large-scale outbreaks of hepatitis E in the past in refugee situations and situations of population displacement. It's a very worrying indicator of the underlying risk and it is particularly impactful on the health of pregnant women. But Rik can give more details or other information.

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MH Over to you, Dr Peeperkorn.

RP Thank you very much. Can you hear me? Let me just give some figures and I think it's not easy to get these figures because, of course, the surveillance system and the existing system is not working as it should work but I think with the technical staff from the Ministry of Health, UNRWA and WHO, since mid-October.

Let me give you, first, some figures. We've seen 111,000 cases of acute respiratory infections, 12,000 cases of scabies, lice 11,000. Diarrhoea under five, 36,000. Diarrhoea over five, 40,000. Skin rash 24,000. What Mike just mentioned, jaundice 1,100. Chickenpox 2,500. And also meningitis, 111 cases of which 74 in the last two weeks, an upward trend.

Now, what does this say? It's difficult. Diarrhoea increased, if you compare it to last year, 45 times, 31 times when you look at under five and over 100 times when you look at above five years when you compare it to 2022. So, yes, it is deeply alarming.

We just had a team meeting with our team in Gaza and one of our colleagues had visited, just as an example, an UNRWA school with 19,000 people with eight toilets, with enormous lack of water, etc. This describes, a little bit, the situation, the enormous need for wash, etc.

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Also, the lab capacity. Normally, those samples would go to Al-Shifa and to the Turkish Hospital, where you had the central lab. Those are not functional anymore, as we know. So, we are looking into can we bring in mobile labs? Can we get samples out to Egypt, etc? We have to really quickly start going on it. It's a very concerning situation.

One other point I want to raise, routine vaccination in Gaza. Gaza and the West Bank had one of the best routine immunisations globally, close to 100% for most vaccine base. Now, we struggle. Together, within the UN team, UNICEF and WHO we got some of the vaccines from the warehouse, from the north over the last couple of days back to the south, etc., but we need to get going to make sure that children are getting vaccinated.

And, as Mike said, the system, despite all the challenges of Gaza and the West Bank, East Jerusalem, oPt's health system produced health indicators at par or I would say even better than its neighbours. So, it is possible and we should back to that level. Over to you.

MR Margaret, can I just supplement because it think it's important again to recognise too that there was a very good system of surveillance before the

conflict and it was linked to a laboratory confirmation system that was based in a central public health laboratory that was housed in Al-Shifa and the Turkish Friendship Hospital in Northern Gaza. So, not only has Gaza lost its hospital capability, it has lost its ability to confirm even the most basic of diseases in that context, in terms of infectious diseases.

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This creates a blind spot where we have huge risk of epidemic diseases in a context where we have limited capacity to diagnose those diseases right now. Historically, many of those samples that might have been processed at the central public laboratory would also have gone to the West Bank or been sent to reference labs in Israel. That is no longer possible. So, we're trying to work out how can we get samples to move from Gaza back into Egypt and get reference facilities in order to be able to do that.

But, right now, not only is the potential for epidemics a risk for the people of Gaza, but not knowing what's happening, not being able to confirm, having disease potentially spread is a risk that we don't want to currently leave in place. We're blind at the moment to what is actually going on.

That's why we have very good syndromic surveillance on the ground. That means health workers going around and filling in tally sheets for what they're seeing in the camps. But what we don't have right now is the capability to do on-the-ground diagnostics and being able to tell exactly what we're looking at.

For example, in the case of acute jaundice syndrome or meningitis it's very important to work out what the causative agents are because the routes of transmission are different, the agents are different. Meningitis can be a mild viral meningitis that doesn't need to be treated except with antipyretics and IV fluids, but it could be bacterial meningitis that requires immediate treatment of a child to prevent death. So, knowing that the diagnoses are becomes extremely important.

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So, this is something we do need to focus on in the coming weeks but, again, it's not that we have to provide this capacity to Gaza. This capacity existed before. It has been put beyond use of the system in Gaza and we need to restore it.

MH Thank you very much, Dr Ryan and Dr Peeperkorn. The next question goes to Muhammet Aslan of Anadolu. Muhammet, please unmute yourself and ask your question.

MA Thank you so much, Margaret, for taking my question. There is information and it says no fuel reached the hospitals in the north of Gaza since the humanitarian pause started. Does WHO's aid reach all parts of Gaza? If not, what is the obstacle to this? Thank you so much.

MH Thank you. I think that's one for Dr Peeperkorn.

RP Thank you very much. I think over the last couple of days, and I really want to stress it's really One UN together with UNRWA and OCHA, WHO-led. We had a mission, for example, today to the north to deliver fuel and medical supplies to Al-Ahli and Al-Sahaba hospitals and it was 7,000 litres of fuel to Al-

Ahli covering their minimum requirements for the next seven days, and 3,500 litres for Al-Sahaba, covering the minimum requirements for the next seven days as well. We also had some medications and surgical supplies delivered to those two hospitals.

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There's also plans to bring fuel to Kamal Adwan and Al-Awda Hospital. We are planning that for tomorrow. We hope that that will continue. It is, of course, absolutely needed that those four remaining hospitals which are, I would say, barely partly functional, that they keep on going.

We know there are still a number of patients in Al-Shifa and they opened again for the dialysis, as well as in Indonesian there are still some patients and they will need fuel as well. And we hope that we can also bring some fuel and some additional medication in the future there as well. But, yes, over the last couple of days we have managed to bring a certain level of fuel and essential medicine and equipment. Over to you.

MH Thank you very much, Dr Peeperkorn. The next question goes to Omar Abdel-Baqui, of The Wall Street Journal. Omar, can you please unmute yourself and ask your question.

OA Hi, there. Thanks for taking the time. What countries have taken injured and sick Gazans for treatment? How many Gazans have left the Strip for treatment? And is the World Health Organization helping facilitate this effort?

MH Thank you. I'll start with Dr Peeperkorn but maybe Dr Nour can help as well, but we'll start with Dr Peeperkorn.

RP Thank you very much. First of all WHO, as you know, has been assisting over the last week actually, and I think the DG was referring to this as well, over the last ten days now almost, what we call to transfer the most vulnerable, complex patients, trauma patients but also very sick, critical injured and sick, from some of the hospitals in the north to the south in Gaza and specifically to the larger hospitals in the south, European Gaza Hospital and Nasser Medical Complex, etc. That's one.

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There have been a number of patients transferred. We've reported on the stories, of course, of the neonates and when I count roughly I think there's at least 40-50 more patients transferred. It's led by the traffic cop, that's the Ministry of Health and the respective hospitals, to triage their patients, to make sure which patients need to be referred outside Gaza and which are the most critical patients over the next weeks and months.

And what we really want to help facilitate is a more orderly transfer of these patients into Egypt. First of all, it's absolutely needed and patients deserve that, that they get the treatment which they need but it will also, of course, relieve the completely overwhelmed health system in Gaza.

I want to make one point on that. One of the hospitals we work closely with, the European Gaza Hospital, which is having 370-bed capacity which included

already a field hospital which was established during the COVID period, they have more than 900 patients currently, so more than triple.

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Now, what is needed is this orderly transfer and then, yes, there's a number of countries and maybe Mike wants to refer to that as well. A number of countries have actually offered their services. They welcome the idea to actually get some of those referral patients for treatment in their country.

But, first and foremost, they need to be orderly transferred into Egypt, get the treatment there and what happens from there, well, wherever they can get the best treatment they should be able to go there including, of course, their families and companions. Over to you.

MH Thank you, Dr Peeperkorn. Dr Ryan will add something.

MR First of all, we thank all of our Member States for their intention to support people affected by this crisis. There's no question that all help is welcome and primarily, as Rik said, we need to help the people of Gaza in Gaza, where they are, and we need to shore up that medical system.

There has been a process of medical evacuation to Egypt and I'd just like to recognise the Government of Egypt and the Ministry of Health in particular. They have put 11,000 beds at the disposal of medical evacuation, 1,700 ICU beds, 150 ambulances, 38,000 physicians, 25,000 nurses. They really have stepped up, not just in Al-Arish and around in terms of triage and stabilisation but in terms of onward referral within the Egyptian system. So, there's an incredibly powerful capability within Egypt to do that.

We have encouraged third parties, other countries, to work with Egypt to ensure that we have the transfer of patients to Egypt, their proper triage and assessment and clinical assessment and then, as needed, a discussion with third party countries to transfer maybe more complicated patients, patients that need more intensive interventions for burns, repatriating nationals. There are various other reasons why. And in that sense we think this is a useful enterprise.

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But, again, the cost of doing this versus the actual cost of investing in the system and investing, as Rik said, in the ability to support people where they are, we have to balance those two things. We'd also like to recognise the Government of France for deploying a medial ship with special surgical capacities, and they're working very closely with our Egyptian colleagues to base that at Al-Arish and they will be working in close collaboration with the Egyptian authorities on exactly the basis I explained earlier.

In situations like this, and I think this is something that we really all need to redouble down on, in a crisis everybody wants to help and that's fantastic. The real trick is to be coordinated and organised and deploy in a meaningful and targeted way.

If we look at EMTs, we're now beginning to see more coordination, more direction, more strategic placement of these, and I think that's really beginning to help. The problem is when everyone rushes in to help then we

lose the directionality of the response. It's the same when you bring people out. It's got to be done in an orderly fashion, like we facilitated in Ukraine and we facilitated in other situations.

00:46:01

And I think we would point our third countries really to work with Egypt to ensure that the patients that are being selected for onward referral can truly benefit from the process of international referral and in particular too, that they be accompanied by companions in a way that the person doesn't lose entire contact with their social network.

So, it's very important that we don't just take patients out of the system. They need to come with companions and the necessary social and psychological support. Their medical condition is only one part of what those people are suffering. Thank you.

MH Thank you very much, Dr Ryan. Dr Nour is going to add something as well.

IN Just to add one thing, that the system is not new, of medevac. Before this crisis medevac existed between Gaza and West Bank and Israel actually, which is now is not possible, but also existed before with Egypt for cases like cancer and other chronic diseases, only that the needs have increased manyfold, just to add that as a background. Thanks.

MH Thank you very much, Dr Nour. We're running out of time but we've got time for one more question and that goes to Imogen Foulkes, of the BBC. Imogen, please unmute yourself and ask your question.

IF Hi. Thanks very much. It's also about Gaza. I'm really interested. There's almost this note of optimism or planning for the future in what you're saying. You talk about a crippled but resilient health service. What you're talking about seems to be based on the premise that fighting won't start again. I'm just wondering if you fear that's over-optimistic.

00:47:52

MH I think I'll start with Dr Ryan on this one.

MR Thanks, Imogen. I don't know if we've communicated too much optimism but I don't think myself or Rik or Ilham or Tedros before were speaking in optimistic terms. You're absolutely right. Any resumption of the violence is going to greatly affect what's happening now.

If, and we all hope, if there can be an extension of a pause, if we can get to a place even with that happening tomorrow, even if peace was declared, we have a massive challenge ahead of us, an absolutely gargantuan public health and health delivery challenge ahead of us.

If fighting resumes and particularly if that fighting pushes into Deir Al-Balah, pushes into Khan Yunis, pushes into Rafah, we're going to see further displacement of people to the west, concentrating people on the western side of Khan Yunis where there are very little in the way of services.

Many people have been directed again and again to the area of Al-Muazi, which has no infrastructure whatsoever in place. To continue to concentrate

people and push them through there with the promise that when they get there, there will be services for them, because again that has been repeated again and again. Go there because that's where you'll get the necessary assistance. I think there's a very troubling narrative associated with that push of people.

00:49:23

If the violence starts again then, Imogen, that is a real scenario and I really don't know what to say to you about that scenario because it is truly horrific in terms of the impact of so many people out in the open. We're not talking about people in tented cities here. We're talking about open ground onto which we could have up to two million people approaching into the depths of winter with their underlying nutrition status, with the overcrowding, with the stress and with the wounded and the old and the disabled and the mentally and psychologically damaged and suffering.

I really don't know and maybe Rik will speak to this, but if we go to that scenario and we see that happen, then I shudder to think, quite frankly I shudder to think what will happen. The numbers we've seen up to now of deaths and casualties may be a distant memory in weeks to come.

It really depends what happens on the side of the forces that are combatting each other, and particularly the occupying force, as to what its intentions are. And so the military and security intentions right now will determine life and health in Gaza in the coming weeks. Maybe if Rik wants to supplement and Tedros may want to come in on that too.

MH Over to you, Dr Peeperkorn.

RP Thank you very much. I want to be very clear and if I have not been clear enough, then let me state again. We are extremely concerned about the vulnerability of what I call a crippled health system. And we are extremely concerned about these 12 hospitals of which some of them are more important than the other ones, which are currently the backbone of the health services of more than two million people.

00:51:32

Now, I think have made it clear, when we would see a resumption of violence, which potentially would also damage health facilities or make them even dysfunctional, we have a further humanitarian disaster, an increasing humanitarian disaster.

Again, I say the health system can absolutely not afford to lose more hospital beds. We need to expand. But also the resumption of violence would mean a resumption of violence in an even more densely populated area. Gaza is the most densely populated area in the world or almost. Now, we see 1.7 million people displaced it is extremely densely populated.

We have seen many, many, many deaths and injuries, so we would expect many more from a resumption of violence. Besides that, you will get more IDPs and IDP flows, etc., everything related to that, overcrowded shelters with what we just described, where were are very concerned in the increase of communicable diseases and the chance for outbreaks. So, we have that combination.

I think we are all extremely concerned and it should not happen. The health system should remain as intact as possible. We should be able to expand the capacity and it simply should not happen. So, if we didn't express that enough, extremely concerned. Over to you.

00:53:20

MH Thank you very much and on that note I'll end the Q&A session and hand it back to Dr Tedros for any final remarks.

TAG Thank you. Maybe I'll touch the last question. Are you optimistic? Maybe I wouldn't use the optimism and pessimism category but if you read the reality on the situation, the chance of resumption of the conflict is very, very high. That means the health system is already broken.

Less than a third of the health facilities are providing service and very difficult to say providing service, actually. They're overcrowded and beyond their capacity and the way they take care of their patients or the service is really, really bad. So, you cannot say there is service anyway but for what it is at least there is a small proportion compared to what Gaza had providing service.

But, as you rightly said, based on the situation, a resumption of the conflict, there is a high chance, but at the same time I really believe that the humanitarian pause or even a ceasefire is possible if those with influence can take it seriously. I believe it's possible.

So, the question is will those who have the influence do everything to stop it, I mean to sustain the pause, then ultimately have a ceasefire and a political solution to this problem? So, it's possible except those with influence are not doing it. That's the situation. It can happen. It's a matter of will, to be honest. With that, thank you so much for joining, to the press who joined us today, and see you next time.

00:56:16