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**Global health and humanitarian issues**

**Virtual press conference of 28 November 2024**

Speaker key:

MH Margaret Harris

TAG Dr Tedros Adhanom Ghebreyesus

MR Dr Mike Ryan

MY Dr Michel Yao

NT Mr Nabil Tabal

MVK Dr Maria Van Kerkhove

DT Mr Daniel Thornton

AA Dr Abdinasir Abubakar

RP Dr Rik Peeperkorn

MH Hello everybody, this is Margaret Harris at WHO Headquarters Geneva welcoming you to this virtual briefing on global health issues. With apologies for the late start, it's been a really busy time. We have with us in the room as always the WHO Director Dr Tedros Adhanom Ghebreyesus and to his right is Dr Michael Ryan, our Executive Director for the WHO Health Emergencies Programme. Next to Dr Ryan is Dr Michel Yao, who is our Director for Strategic Health Operations and also the Incident Manager for the mpox emergency. And next to Dr Michel Yao is Mr Nabil Tabal, our Deputy Incident Manager for the Conflict Escalation in Israel and Occupied Palestinian Territory. On Dr Tedros' left is Dr Maria Van Kerkhove, our Director at Interim for Epidemic and Pandemic Preparedness and Prevention, and next to her we have Mr Daniel Thornton, our WHO Director for Coordinated Resource Mobilization. We also have online both our representatives from Lebanon and from the occupied Palestine territory, and we have many other experts online, so do not hesitate to ask your questions on all relevant matters. Now, as I said, apologies for the late start and we will of course as usual only be able to devote an hour at most so without further ado I'll hand over to Dr Tedros for his opening remarks.

TAG Thank you Margaret, good morning, good afternoon and good evening. Yesterday, WHO was shocked and saddened by the passing of Dr Faustin Ndugulile, Regional Director-elect for Africa at the age of 55. He survived by his wife and three children. Dr Ndugulile of the United Republic of Tanzania was nominated for the post of the Regional Director by the Regional Committee for Africa in August this year. His appointment was due to be considered by the WHO Executive Board at its meeting in February next year. I offer my deepest condolences to Dr Ndugulila's family and friends and to the Parliament and People of the United Republic of Tanzania.

At the G20 Leaders’ Summit in Brazil last week, I had the honour of announcing the outcome of the first WHO Investment Round alongside His Excellency President Lula da Silva of Brazil. The Investment Round is about mobilizing the resources to implement WHO's Global Strategy to help keep the world safe and save 40 million lives over the next four years.

Through a series of events, WHO has received 70 pledges worth US$ 1.7 billion. Of these pledges, 39 are first-time voluntary contributors to WHO, including 21 from middle-income countries. Some of the world's poorest countries have contributed because they see the value that WHO makes on the ground. Along with other funding agreements and partnerships, we can now count on at least US$ 3.8 billion, or 53% of the voluntary contributions needed for the next four years. This is truly significant, because for decades, only a small portion of WHO's total budget was predictable. The funding from the Investment Round gives us more predictability and flexibility and the ability to respond rapidly to continually evolving health threats around the world. I thank all countries and partners who have contributed.

Now to mpox. Last Friday, the Emergency Committee met and advised me that the outbreaks of mpox in Africa continue to represent a public health emergency of international concern. I accepted that advice.

Yesterday, the Emergency Committee issued updated temporary recommendations, adding some new recommendations and extending or modifying others. As we have said many times, we are not dealing with one outbreak of one virus, but several simultaneous and overlapping outbreaks of different strains or clades of the virus affecting different groups in different places.

So far this year, 20 countries in Africa have reported more than 14 000 confirmed cases including 55 deaths. More than 75% of all confirmed cases and deaths in Africa this year have been in the Democratic Republic of the Congo, where the outbreak of Clade 1B has now spread to six provinces including the capital Kinshasa. COVID-1b has also spread to four neighbouring countries. In Burundi, more than 2000 cases have been reported, largely in urban areas. In Uganda, there are 649 cases and a fast-expanding epidemic. In Rwanda, 37 cases have been confirmed and in Kenya, there are 19 cases. And cases have also been reported in at least eight other countries in Africa, the Americas and Europe. WHO, Africa CDC and our partners are continuing to support countries to respond to these outbreaks and prevent further ones under one joint Continental Preparedness and Response Plan.

Together, we're strengthening the five Cs of Outbreak Response: Coordination, Collaborative Surveillance and Detection, Community Protection, Care that's Safe and Scalable, and Countermeasures, including vaccines.

So far, six million vaccine doses have been pledged, of which 1.6 million are ready for distribution by the end of the year. Almost 56 000 people have been vaccinated in seven provinces of the DRC, and health officials are preparing to administer a second dose with vaccination starting in Kinshasa this week. We still face many challenges to bring these outbreaks under control.

To meet them, we need stronger political commitment to scale up responses, activities. We need fully resourced preparedness and response plans. We need further contributions of medical countermeasures, including diagnostics and vaccines, and we need continued transparency and collaboration between affected countries and partners.

WHO welcomes the ceasefire between Israel and Lebanon that took effect yesterday, and we very much hope it's respected and becomes a lasting peace. Although the fighting has stopped for now, the health needs are huge and will only increase. Those needs are more acute now that winter has arrived. In Gaza a year ago almost all those displaced by the conflict were sheltered in public buildings or by family members. Now 90% are living in tents. This leaves them vulnerable to respiratory and other diseases. Cold weather, rain and flooding are expected to exacerbate food insecurity and malnutrition.

At the same time, the ongoing blockade of northern Gaza is limiting the entry of essential resources, including blankets, fuel and food, all of which are already in short supply. This week, WHO and our partners conducted a three-day visit to the north of Gaza. The team visited 13 health facilities, including five hospitals. They saw a high number of trauma patients and increasing number of patients with chronic diseases needing treatment. There are critical shortages of essential medicines and significant psychological stress among health workers. WHO and our partners are doing everything we can – everything Israel allows us to do – to deliver health services and supplies.

One of the most important ways that happens is through emergency medical teams made up of health professionals from around the world who have volunteered to serve. So far, WHO has supported the deployment of 45 teams from 25 partner organizations. Since January this year, they have delivered more than 2 million consultations.

But once again, the ultimate solution to this suffering is not aid, but peace. As we always say, the best medicine is peace.

Monday this week marked the start of WHO's annual 16-day campaign to draw attention to gender-based violence, which affects at least one in three women and girls globally.

It harms women in all countries and cultures, but some are more at risk, especially those living through wars, conflicts, and other humanitarian emergencies. Often, sexual violence is used as a weapon of war, as it has been in Sudan.

Armed groups terrorize women and girls in their homes, on displacement routes, in temporary shelters, or at border crossings. There are reports of kidnapping, trafficking, sexual slavery, genital mutilation, and child marriage. Many survivors face immense hurdles to access essential health and support services because of destruction of infrastructure, the danger of moving through conflict zones, or fear of stigma and reprisals.

For the past six years, WHO has been working to address gender-based violence in 30 countries with humanitarian emergencies, with guidelines and training for health workers to manage rape and domestic violence. We have also supported ministries of health and partners to train at least 10 000 health workers in survivor-centered clinical care. All parties to a conflict have a responsibility to prevent and end violence against women and girls. It's preventable and never inevitable.

Finally, this Sunday marks World AIDS Day. This year's theme is Take the Rights Path, reminding us of the critical importance of human rights in the response to HIV. Since the First World AIDS Day in 1988, we have come a long way in expanding access to prevention, diagnosis, and treatment for HIV. But these gains are at real risk, and reductions in new infections and deaths have stalled.

While nearly 30 million people are now on antiretroviral treatment, another 9 million need treatment and are not getting it. More than half of those, nearly 5 million, are still unaware that they are living with HIV. Many of these gaps are among key populations who are marginalized, criminalized, or discriminated against: men who have sex with men, people who inject drugs, transgender people, sex workers, and prisoners.

The most effective way to close these gaps and reach these populations is by recognizing and respecting their human rights. Together, this World AIDS Day, let's take the right path. Let's take the rights path.

Margaret, back to you.

MH Thank you, Dr Tedros. So now I'll open the floor to questions from journalists, but before that, just to give you a reminder, please use the raise your hand icon to get in the queue. And if you've joined by Zoom, please make sure you've given your full name and your media outlet. We will only give the floor to bona fide journalists. And speaking of excellent journalists we have Nina Larson on the line from AFP, Nina the first question goes to you please ask your question… unmute yourself and ask your question.

JOURNALIST Thank you Margaret, thank you very much for taking my question, I would… I wanted to ask about um about H5N1- Bird flu and how concerned you are about the growing number of human cases in the United States, the detection in raw milk, and fears that this could potentially spark a new pandemic. I mean, there's been a lot of criticism of U.S. authorities for not doing enough testing. Do you think there is enough testing being done to give an accurate picture of what's happening on the ground? Thank you.

MH Thank you, Nina. I'll hand that question to Dr Maria Van Kerkhove.

MVK Thanks very much, Nina, for the question. So yes, as you've pointed out, we've seen a large number, well, still small, relatively speaking, but a growing number of human infections of H5N1 around the world, not only in the U.S. but around the world over the last several years. What is concerning to us is that in the last five years or so, we've seen a massive epizootic of avian influenza, including H5N1, not just H5N1, but in wild birds, in poultry, expanding to other animals, livestock, dairy cattle in the United States, but also land mammals, marine mammals.

And over the last couple of years, this expansion of H5N1, of avian influenza, is putting more people at risk. We have had about 55 human infections in the U.S. this year. All of two have had exposure, known exposure to infected animals.

There are many investigations that are underway looking at the exposures of each of these cases to determine how people have been infected. But what we really need globally in the U.S. and abroad is much stronger surveillance in animals, in wild birds, in poultry, in animals that are known to be susceptible to infection, which includes swine, which include dairy cattle, to better understand the circulation in these animals.

We need much stronger efforts in terms of reducing the risk of infection between animals to new species and to humans. And to do that, we need to protect people who are at risk, people who are exposed. So these are occupationally exposed persons making sure that they have the right personal protective equipment, that it's worn appropriately and properly when they are handling infected animals or even suspected infected animals. We need to make sure that they have testing, that they have access to care, so that we can mitigate any potential spread.

We have not seen evidence of human-to-human infection. But again, for each of these human detected cases, we want to see a very thorough investigation taking place, including further testing of contacts.

Excuse me, I've been a little unwell over the last couple of days, so it's hard to speak.

We need serology to be done among the contacts so that we can really understand the extent of exposure. We've reached out to our partner agencies at WHOA and FAO to try to increase the urgency as it relates to surveillance and animals to make sure that we are all working towards a common goal of preventing you know the next pandemic.

For us at WHO we are always in a constant state of readiness as it relates to influenza because it isn't a matter of if it's a matter of when and so the work that we do through the Global Influenza Surveillance and Response system, but also our PIP framework, our Pandemic Influenza Preparedness Framework, and looking at access to medical countermeasures like vaccines, diagnostics, therapeutics, gets us ready for when or if we will be in a situation where we are in a flu pandemic. We're not in that situation yet, but we do need more vigilance. We need more collaboration, more transparency across the human health sector, the animal sector, the environmental sector, so that the risk assessments that we do can be regular, can be robust, and that we could do them on a regular basis.

But globally, the risk to the general population for avian influenza is low, but it's low to moderate for occupationally exposed people. And that moderate level depends on the level of protection that they have. I do want to just comment on the work related to milk. We recommend and we've always recommended drinking pasteurized milk for a number of different health benefits. This is just as important for H5N1 as it is for other pathogens, other bacteria. So that continues to be a recommendation from us.

MH Thank you very much, Dr Van Kerkhove. The next question goes to Mohamed from Andalou. Mohamed, please unmute yourself and ask your question.

JOURNALIST Margaret, thank you so much for taking my question. As Mr Tedros mentioned, ceasefire started yesterday between Israel and Lebanon, there were Israeli attacks on Lebanon from end of September until yesterday. My question is, in this process, how many health-care workers were killed and how much health-care system affected in Lebanon? Thank you.

MH Thank you. Mr Nabil Tabal will take your question.

NT Thank you, Margaret. So, in WHO, we have the Surveillance System for Attacks on Healthcare, which is a reporting and monitoring system that uses a robust methodology to verify the attacks on healthcare. And that was established during the start of the escalation last year on October 8. And since that, we have recorded 160 attacks that led to the killing of 241 people and injuring close to 300.

And that has really affected also the operational status and the structural damage also to the hospitals and primary health care centers. Almost 10% of the hospitals were affected, whether completely, became completely unoperational or partially operating at a partial capacity, prioritizing only emergency care. And several hospitals and PSCs have also suffered structural damage so this is up until the ceasefire and work is also now ongoing on especially with the start of the ceasefire to re-operationalize the hospitals that were affected in all across the countries and especially in the conflict-affected areas, so especially with the return of IDPs to the conflict-affected zones in the south, in the Bekaa, so that we can ensure also the continuity of essential healthcare to the returnees. Thank you.

MH Thank you. And we also have our representative in Lebanon who's joined. Oh, yeah. He has not joined yet, maybe Dr Michael Ryan will just make an intervention while we're waiting.

MR I just, whatever what Nabil said was great, I just want to add that it's fantastic to see the prospect of people returning to their homes on both sides of this conflict, there's been displacement for many and disruption for many and it's really important that peace is maintained because civilians are returning already it's very important that their return is respected by all sides and they get to re-establish their communities, um so we welcome that as Tedros always said peace is the best medicine so let's hope this holds but it doesn't take away in a sense that's really important and Tedros again said this in the speech, the horror that's unfolding in Gaza and what has happened in Lebanon has been a terrible tragedy and this peace is fantastic. The attention must now move urgently to Gaza. We have to stop the fighting in Gaza. Situation is catastrophic, the system is under huge pressure. And on the health side the hugely brave health workers, international emergency medical teams, WHO and other UN staff keeping that system going in an incredible way. So I think it's really important that whatever has been achieved now is secured and in the Lebanon-Israel conflict but that we have the same process achieved as quickly as possible for Gaza. Maybe Rick from oPt wants to speak.

MH I think we have both so maybe we'll start with Dr Abdi from Lebanon and then move to Dr Peeperkorn as well.

AA Thank you very much Margaret. I think you know Nabil have already shared some of the figures but you know first we welcome the ceasefire and I think the ceasefire provides an opportunity and it's a critical window to address the urgent humanitarian needs. And I think what's more important is that the scale of the health-care challenge remains enormous and I think from now until the next few months I think we have to try to re-establish the health services in the conflict affected areas.

You know almost a million people now are moving back to the south and the east and some of those returnees and some of those displaced people might not have homes because some of the villages have been destroyed. Primary health care facilities need to be re-established, renovated, you know, medicine should be provided. But also as WHO we are working closely with the Minister of Health how to facilitate the return of health-care workers as well. As you know that many health-care workers were also displaced from the south and from the east and also we need to facilitate that. I think the most critical aspect is how to re-establish the health-care services in those conflict affected areas. Of course it will take some time but I think we are working with the partners with the Minister of Health to make sure that health services are available for those people who are returning to the conflict affected areas.

But again you know of course we welcome the opportunity that this might lead to the long-lasting peace and we are very hopeful for that. I think that you know all the displaced people you know they are very happy to see the ceasefire and I'm sure, you know, all of us are very happy to see that the prospect of this peace will prevail, not only short term, but in the long term into that. Thank you.

MH Thank you very much, Dr. Abubakar. And now we'll also have, hear from Dr Rik Peeperkorn. As Dr Ryan mentioned, there is a great deal to add.

RP Thank you very much Margaret and colleagues. I just want to refer to the introduction by the DG and maybe even not start about health, but let's say with winter approaching and being more than close to 40 months in this horrific crisis, we are back that we are discussing the basics of humanitarian support.

The first top priority is actually fuel at the moment, again. So we're talking again about the lack of regular supplies of fuel. Without fuel, no humanitarian operation at all. We also, again, are back in discussing food. There's again massive food shortages in Gaza, both in the south, with skyrocketing prices for whatever is available, and in the north. The third area is shelter, deeply concerned about shelter or what they call they have also the shelter kits to make sure that even the ad hoc tents are better, more waterproof etc to get them in no food items tarpaulins and everything related to that for me and just having been more than almost four weeks in Gaza and go next week again these are the top priorities links to unfortunately what we have seen a huge increase in insecurity, crime and looting. So this is an absolutely topic.

Now going back to specifically on health and I'm glad that Mike mentioned I often get the question how health service completely collapsed in Gaza, that's not true i want to make that very clearly and i think it's the incredible resilience of the health workers, Ministry of Health, WHO and partners who've kept a system, I call it partly functional, and we all know that in February, for example, WHO had to assist getting the last patients out of national medical complex and the staff out, evacuate, the same happened in Shifa, European Gaza, etc. All those hospitals are again working as referral hospital, not as we want them, but partly functional, and we are even referring patients there for better treatments.

However in the extreme, in the north of Gaza and we've raised this many times, there's only two hospitals left for approximately 70 80 000 people left and those hospitals there I would call, I cannot call them partly functioning; they're minimally functional, and one has one or two specialists and the director, Dr Hussam, pediatrician, who, by the way, was recently injured through an attack on the hospital, run by a few doctors and 70 nurses, still has 55 inpatients among 30 children and five in the ICU. The hospital has fuel for one or two days and is in dire need for an emergency medical team, blood units, medical supplies, food, and fuel.

Now, a lot of hospitals where I've been also many times, even they have, if their fuel stock is zero, they get a lot of obstetrics and trauma. It's one of the only hospitals with actually a surgeon, the only one, a surgeon north of Gaza, and so are in need for everything. So in November, WHO planned 22 missions. Only nine were facilitated. The last five, in the same time, five missions were denied to provide supply fuel and bring an EMT to Kamal Adwan. Only a few, and one of the few you heard about, you know, we managed. Coming Saturday, we plan another mission, and we hope everybody is listening, and this mission will go. And it should go not only to Kamal Adwan, it should also go to a lot of. The cluster mission under leadership who I think was a success critical supplies to where supplies to chief hospital the patient-friendly hospital UNRWA primary health care center and MSF primary health care all in Gaza city there's a need to expand the service in Gaza city because Gaza city actually there's another between 100 150 000 people from the north are now actually camping in Gaza city where they assess huge need for mental health, psychosocial support especially also for the health workers and of course the shortages in supplies to the staffing but also the high influx of trauma patients and the shortages remain in the key area energetics, antibiotic, surgical supplies, etc so we have that. The same applied for the primary health care, assessments, where you see similar shortages, more basic diagnostic equipment and chronic disease medication, etc.

Again, I want to stress WHO is ready to do more missions to bring some of those much-needed supplies and fuel, including emergency medical teams. That should always be allowed, it's weird that we continuously discuss these topics in pressers like this, so we hope that we will make inroads, but I want to stress the other key humanitarianized areas which I mentioned, I'm currently even more concerned about. Maybe a last positive, just the day before yesterday, WHO facilitated another medevac 17 patients to Jordan for special medical treatment, 12 will receive care in the US, and 6 of the patients require cancer treatment and 11 need a treatment for injuries. So since Rafah crossing closed, we have been assisting almost 300 patients moving to better places. What we of course ask for is consistent medical corridors, and first of all a restoration the medical corridor to West Bank and East Jerusalem but also into Egypt etc because approximately 12 000 patients need to be referred out of Gaza and if we continue in this pace we will be busy for the next 10 years. Over to you.

MH Thank you very very much for that really comprehensive summary of the situation Dr Peeperkorn and also thank you Dr Abubakar. The next question goes to Yuri from RII Novosti. Yuri please unmute yourself and ask your question

JOURNALIST Yes thank you Margaret and thank you for the briefing I just wanted to know if you have more information on the possibilities that have who in Lebanon during these 60 days to I don't know to work in the hospitals that were closed during the conflict to provide everything that is needed in the south of the country in order to close the gap in the humanitarian reaction during the hot period of the conflict.

MH Thank you, I think we did answer some of that but perhaps we'll go over it a little. Would you be happy to start Nabil? Sorry, WR is still online. Sorry, I thought he'd left. So that's great. Is he still online?

AA Yes, I'm online.

MH Brilliant.

AA Yes, actually. Yes, we are trying to take advantage of this. And I think one of the first that we have decided, you know, for the last two days, together with the Minister of Health, as well as other partners, is to do a quick assessment of the hospitals and primary health-care facilities. You know, the extent of the damage. Because some of those hospitals, they have a very extensive damage, which cannot be repaired, which cannot be renovated within 60 days, within even six months. There are some hospitals which requires a minor renovation, but also some minor equipment. Same thing with the primary health-care facilities. So I think we decided to do a quick assessment together with the Minister of Health and also the local authorities.

And then we will take some action to renovate and also, you know, procure some of those equipment. Probably some of our hospitals will take some time, but some hospitals probably will be able to restart very quickly. For example, there are four hospitals, two in Beirut, two outside Beirut, that probably will be able to operationalize for the next four weeks. If the situation, if the ceasefire remains intact, and also if the security allows us to move around, there is no restrictions. So we are very hopeful. But at the same time, also, we do have a backup plan where we are trying to increase the mobile clinics that probably that will be serving for the, you know, the displaced people who are returning to the conflict affected area. So at least they will have access to services overall.

So overall, I think we have a master plan for us to help all the hospitals and primary health-care facilities and all the health services to restart most of the conflict areas. But I'm sure to kickstart all the services 100%, it will take some time. But definitely, we do have a backup plan to at least provide the critical health services for those areas and those displaced people who already tend to conflict-affected areas, especially the hospitals.

MH Thank you very much for that, for that really comprehensive answer again. We now have a question from John Zaracostas. John, please unmute yourself and ask a question.

JOURNALIST Yes, good afternoon. My question is to Dr Tedros and Dr Ryan. Some of the humanitarian agencies have already put out what their ask will be for 2025. The World Food Programme have mentioned their figures, and the UNHCR. I was wondering what will be the ask from donors for humanitarian relief and support in the health area in 2025? Thank you.

MH Thank you. Over to Dr Ryan.

MR John, yeah, that's where we're currently finalizing with the country officers and with our partners the ask from both WHO and also from the health cluster partners as part of the humanitarian health appeal and that's feeding into the global humanitarian overview which I’m sure you'll be awaiting with bated breath. I think it's thank you, I think it's a good question to ask. I think the question is less what are the humanitarian community going to ask for because it is very clear that the needs are growing and the needs are growing exponentially in some situations and the complexity of the crises we're all collectively facing the interface now between conflict displacements climate and epidemics, sometimes I call it the climate contagion and conflict have just finally ripped through so many countries.

The countries are just not recovering and what we're seeing is a new pattern John and you you've seen this yourself over the years we've moved from a series of acute humanitarian crises where there's a beginning a middle and the end of a crisis be it a natural disaster be it a conflict. What we're seeing is countries rolling over in crises going from one crisis to the next, be it from a political to economic to a climate to conflict to an epidemic and countries are just not pulling out of that.

And we're seeing the length and of these crises increasing the duration of these crises, is not measured in weeks anymore it's not measured in months it's measured in years and in some cases measured in decades and therefore humanitarians have to stay on in the ground on the field, this move between humanitarian intervention and development has been interrupted and disrupted in country after country it's very impossible, it's nearly impossible in some situations to reignite development activities in many geographies.

So the humanitarian needs are growing, but the real question is, how much money does the international community have to give? Because that's been falling. So while the rate of crisis and the depth and intensity of crisis has grown, the appetite of the international community to fund those has fallen away. And we're seeing that in crisis after crisis last year and many of the humanitarian health appeals last year were less than 50% funded. Some of them were less than 20% funded. There are a couple that are less than 10% funded. It is very, very hard for WHO and its health partners to deliver on any of the ambition that we have with those kinds of funding numbers. Last year, I think the overall ask was in excess of $1.5 billion to deal with all of the crises. That doesn't take into account the operational costs that WHO has to have our offices on the ground in countries and all of the infrastructure that goes with that. That is an extra cost on us.

So what are we asking? And Tedros keeps saying this. We can keep asking for money. We can keep asking for resources. But when you look at it, the realities on the ground are we keep asking for more money. The number and depth and intensity of crisis grows. Then we ask for more money and then it goes around and around. What has to happen is something has to be done politically to interrupt these crises. We have got to have a much more fundamental intervention that prevents countries going from fragility to collapse, that prevents populations going from being in homes to being displaced, that prevents communities that are well protected with vaccines going to massive epidemics.

We're shifting huge elements of our societies from stability to instability. And while we continue to do that and leave hundreds of millions of people outside what is the developed world standards, and this is no longer a developed world to developing equation, there are many, many developing countries or so-called developing countries making great progress. They're stable. Their vaccination rates are rising. Their education rates are rising. Women's rights are being addressed. It's not perfect. No country is perfect, but we're seeing progress.

But there is a group of countries where they seem to be separating from the rest of the planet geopolitically, where they're having these permanent states of crisis and literally we're going every year we're nearly doubling the number of people who exist in those settings. We believe by the end of the decade that that up to 80-85 % of the world's poorest people will live in these fragile, conflict-affected and vulnerable settings. We think that two-thirds of women are over half of women over half of children who die in before five over half of women who die in childbirth will die in these settings – 70% of high impact epidemics will die in these settings. That's what's driving migration. That's what's driving desperation. That's what's driving global epidemic risk. And we don't seem to be able to get to grips with that.

So John, while I respect the question, I really appreciate the opportunity to reach out to our donors to ask for more money. More money is great and we need it, but more money is not the solution to what we're all facing right now.

MH Thank you very much, Dr Ryan. And I think, oh, Dr Tedros has something to add on. No? I was going to say, well, I was going to say I'd like to ask Dr Tedros to end the press conference because on that note, I think that's the note on which we end.

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