Global Health Issues

Virtual Press Conference
8 May 2024

Speaker key:

FC	Fadéla Chaib
TAG	Dr Tedros Adhanom Ghebreyesus
MK	Dr Maria Van Kerkhove
WZ	Dr Wenqing Zhang
MR	Dr Mike Ryan
RP	Dr Rik Peeperkorn
AR	Dr Abdirahman Mahamud
LP	Lauren Pelley
MA	Muhammet İkbal Arslan
CO	Christiane Oelrich
HB	Helen Branswell
FV	Frances Vinall
AT	Alexander Tin
PA	Paul Adepoju
JR	Jennifer Rigby

00:00:37

FC Good afternoon. I am Fadéla Chaib, speaking to you from WHO headquarters and welcoming you to the virtual press briefing of WHO on global health and humanitarian issues.

Today, we have several people online and in the room. Let me introduce people who are in the room; Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Dr Mike Ryan, Executive Director, Health Emergencies Programme, Dr Maria Van Kerkhove, Director ad interim for Epidemic and Pandemic Preparedness and Prevention, Dr Abdirahman Mahamud, Director ad interim for Alert and Response Coordination, Dr Wenqing Zhang, Unit Head, Global Influenza Programme.

We have also several experts joining online that I will introduce in due time but let me just tell you that we have two WHO representatives online, Dr Rik Peeperkorn, WHO Representative, occupied Palestinian territory and Dr Shible Sahbani, who is the WHO Representative in Sudan. If I may, I would like to ask journalists to address their first question on Gaza and Sudan to take advantage of the presence of the two WHO representatives online, one from Jerusalem, another one from Khartoum. Thank you so much and now, without delay, I would like Dr Tedros to address this press conference in his opening remarks. Dr Tedros, you have the floor.

00:02:18

TAG Thank you. Thank you, Fadéla. Good morning, good afternoon and good evening. First, to Gaza, where we are deeply concerned about Israel's increased military activities in Rafah, where most of Gaza's people have fled for safety. An estimated 30,000-40,000 people have left Rafah for Khan Younis and Deir al-Balah but more than 1.4 million people remain at risk in Rafah, including 600,000 children.

Already, one of Rafah's three hospitals, the Al-Najjar Hospital, has had to shut down and its patients have moved elsewhere and hospital staff are removing supplies and some equipment to safeguard them. The Rafah crossing from Egypt into Gaza remains closed, which is a major access points for supplies into Gaza. Fuel that we expected to be allowed in today has not been allowed in, meaning we only have enough fuel to run health services in the south for three more days.

WHO has pre-positioned some supplies in warehouses and hospitals but without more aid flowing into Gaza, we cannot sustain our lifesaving support to hospitals. WHO has no intention of withdrawing from Rafah and will stay and deliver alongside our partners.

00:04:01

WHO is coordinating the work of 20 Emergency Medical Teams in Gaza, comprising 179 internationals from 30 countries, working alongside 800 local staff. These teams are embedded in ten existing hospitals and have established five field hospitals. They have provided almost 400,000 consultations, performed more than 18,000 surgeries, and added more than 500 additional hospital beds.

They are working at all levels of care in the north and south, providing trauma stabilisation, delivering babies, supporting early warning for disease outbreaks and so much more. With support from WHO and hospital staff, Emergency Medical Teams have cleaned up Nasser Medical Complex in Khan Younis following an attack and siege earlier this year.

They have recruited health workers and the hospital is ready to start receiving dialysis patients today. A ceasefire is needed urgently for the sake of humanity. WHO calls for the removal of all obstacles to the delivery of urgent humanitarian assistance into and across Gaza at the scale that is required.

Now to Sudan, where more than a year of fighting has left the country facing a humanitarian disaster. More than 15,000 deaths and 33,000 injuries have been reported since the conflict began in April last year. 15 million people are

in need of urgent humanitarian health assistance. Almost nine million people are displaced, half of them children, with extremely limited access to health services.

00:06:08

More than 70% of hospitals in conflict-affected states and almost half of health facilities in the rest of the country are not functioning. Those that are functioning are overwhelmed by people seeking care, many of whom are internally displaced.

Health facilities, ambulances, health workers and patients continue to be attacked, depriving entire communities of essential health services. Just last week, two of our colleagues from the International Committee of the Red Cross were killed in South Darfur.

The conflict has led to a devastating deterioration in food security. More than one third of the population is facing acute hunger and there is a risk of famine in Darfur and Khartoum. Humanitarian partners have released a famine prevention plan.

WHO's priority is to ensure continuity of health services to prevent and respond to outbreaks, and to provide care for those most in need, including pregnant and breastfeeding women and children under five. Access to the most vulnerable remains highly constrained. It is imperative that all sides to the conflict provide unhindered humanitarian access to those in need, including through cross-border routes.

In neighbouring Chad, an outbreak of hepatitis E has been declared, with more than 2,000 cases and seven deaths, mainly among Sudanese refugees. WHO has deployed a team to support the response. Most of all, we call for a ceasefire and a comprehensive peace process for Sudan. It's time to silence the guns and raise the volume for peace. The best medicine is peace.

00:08:19

Now, to the United States, and the outbreak of H5N1 avian influenza among dairy cattle. So far, 36 dairy herds have been infected in nine states. Only one human case has been reported, at least 220 people are being monitored and at least 30 have been tested.

However, many more people have been exposed to infected animals and it is important that all those exposed are tested or monitored and receive care if needed. So far, the virus does not show signs of having adapted to spread among humans but more surveillance is needed. The virus has been detected in raw milk in the US but preliminary tests show that pasteurisation kills the virus. WHO's standing advice in all countries is that people should consume pasteurised milk.

Based on the available information, WHO continues to assess the public health risk posed by H5N1 avian influenza to be low and low-to-moderate for people exposed to infected animals. In recent years, H5N1 has spread widely among wild birds, poultry, land and marine mammals, and now among dairy cattle. Since 2021, there have been 28 reported cases in humans, although no human-to-human transmission has been documented in that time.

WHO has a strong system for monitoring influenza around the world through a network of influenza centres in 130 countries, seven collaborating centres and 12 reference laboratories with the capacities and biosafety requirements to deal with H5 viruses.

00:10:34

We also have the Pandemic Influenza Preparedness Framework to support the rapid development and equitable distribution of vaccines in case of an influenza pandemic. However, no similar system exists for other pathogens, a gap that WHO Member States are now seeking to close through the pandemic agreement.

The outbreak of H5N1 in dairy cattle also demonstrates the importance of a One Health approach that recognises the intimate links between the health of humans, animals and our environment. These two systems, one to prevent outbreaks and pandemics through a One Health approach and another to respond to them by sharing vaccines, are two vital elements of the pandemic agreement that WHO Member States are negotiating as we speak.

I am encouraged that all 194 Member States are strongly committed to finalising the agreement in time for the World Health Assembly. They are working long hours to find common ground in good faith for the people of the world.

Finally, yesterday we launched the 2023 WHO Results Report, summarising our work over the past two years. This interactive, comprehensive report, available on the WHO website, shows the depth and breadth of our work with 174 dedicated country pages, 100 country impact stories and more. It also provides transparency on where our funding comes from, where it's going, and what it's doing.

00:12:35

The report paints a mixed picture of the state of global health. We have many reasons to celebrate. For example, since the turn of the century, child mortality has fallen by half, thanks largely to vaccines, but due to the disruptions of the COVID-19 pandemic, vaccination rates fell and we are seeing a resurgence of diseases like measles.

We have seven years remaining until 2030, the deadline for achieving the Sustainable Development Goals. Some are on track, many are not. WHO will continue supporting all countries to strengthen their health systems in pursuit of our founding vision, the highest attainable standard of health for all people, as a fundamental right. Fadéla, back to you.

FC Thank you, Dr Tedros. I would like now to open the floor to journalists' questions, staring with Lauren Pelley, from CBC. Lauren, do you hear me?

LP Hi, there. I can hear you. Thank you. It's Lauren Pelley, with CBC. On the H5N1 front, there are many countries that don't have access to vaccines for this virus, let alone stockpiles, and I'm just wondering if the WHO has any major concerns over if we did see human-to-human transmission of this virus how prepared would countries and drug makers be to scale up and provide vaccines if they were needed?

MK Perhaps I'll start and I think Wenqing should come in on this. I just want to contextualise the question that you have. You did add this into your question but I want to contextualise the situation that we're in. As the DG has said there's been 28 human cases of H5N1 since 2021. There's been one human case of H5N1 in the US associated with contact with dairy cattle.

00:14:43

There's a lot of ongoing work that is happening. We are asking for more surveillance to be conducted in animals, in poultry, in wild birds, now in dairy cattle, not just in the US but globally and, of course, people that are occupationally exposed to infected herds need to be tested, they need to be provided care.

All of that type of work helps us do these risk assessments to understand the virus, its circulation and if there are any changes in the virus. As you pointed out in your question, we have not seen human-to-human transmission of this particular virus, this H5N1. However, we do have a system that is in place. It's based on the Global Influenza Surveillance and Response System or GISRS and also the PIP Framework that we have, the Pandemic Influenza Preparedness Framework that came into effect in 2021. GISRS has been in operation for 70 years.

And through those systems, there's an ongoing risk assessment of the viruses, looking at the viruses themselves, the different mutations, the characteristics of those viruses, and through that system there are candidate vaccine viruses that are recommended to be considered for production.

And within that system we have two that are H5N1 viruses that could be used to ramp up vaccine production. We have not triggered that system yet. We do not need to trigger that system yet. And through the PIP Framework, through the relationships that we have with manufacturers, we have access to real-time production of H5N1 vaccines should those start to be produced. And so there's a lot of work that's in place in terms of the production, in terms of ramping up those capacities, but again we haven't done that. We haven't triggered that in place.

00:16:20

There are billions of vaccines that could be produced within the first year if necessary based on the manufacturing technologies that we have. And WHO has worked on agreements with the manufacturers to have approximately 10-12% of those vaccines in real-time production should we need, to be distributed based on risk and based on need.

So, I just want to highlight that there is a system that is in place. It has not been triggered. We don't need to trigger that system, but that's based on a lot of work, a lot of relationships that are in place and, as the DG has said, we have the system in place for flu and we don't yet have that for other pathogens.

WZ Just to add to what Maria said is that to ensure that we do have a system in place, if human-to-human transmission occurs and if a pandemic starts, the system will be triggered to take a serious response. As Maria said, there's ongoing risk assessment and an update of candidate vaccine viruses.

For the current H5N1 in cows, we have two. What you will also need to bear in mind is that are also other clades of H5 virus circulating and we also candidates for these other clades of H5 virus. And it is not only H5. They could also be H7, H10. So, all these candidate viruses are being updated by the system and being distributed to vaccine developers.

00:17:54

Once the situation warrants, they will be triggered into action to scale up the production. Also to add that this system is also producing reagents to enable the release of the vaccines. To add that for the seasonal influenza, there's an influenza programme in place, so there's a deployment system also in place in countries that could be used for the pandemic response.

As Maria said, if we look at the seasonal vaccine production capacity, we would be able to, of course, on the assumption of a similar antigen dose as well as egg supply for example, all smooth, we would be able to have more than eight billion doses. That's the best scenario of estimate. This only takes into consideration the existing platform, licensed platform. There are also other novel platform under development and there are also vaccines in trials. So, this is something I want to add. Back to you.

MR Just to add very briefly to what Maria and Wenjing have said. First of all, this virus has been under very tight surveillance since 1996 and that global network of laboratories who work all around the world, including our colleagues at CDC Atlanta, are extremely vigilant in the way they've shared information and specimens through the PIP Framework and to have candidate vaccines in place and to have manufacturers in place ready to produce vaccine.

And you may ask out there, well, why don't we just produce the vaccine now? Well, first of all, we've got to make sure it works against this clade, which we believe it does. And, again, I think our colleagues at CDC in Atlanta are testing human sera of people previously vaccinated with H5 vaccines to look for that cross-reactivity and make sure that the candidate vaccines would work.

00:19:52

And secondly, we produce hundreds of millions of seasonal flu vaccines every year and we would have to switch production. You can't just press the button and begin producing pandemic H5 vaccines. You have to stop producing your seasonal vaccine and all of you out there know how lifesaving that vaccine is, both in the northern and southern hemispheres. So, this requires a very careful consideration, as Wenqing said, to determine whether this virus does switch.

Again, the virus spread very rapidly around the world, this time not in humans but this particular clade, the 8.3.4.4b is that it? No? Not quite. 2.3.4.4b. It spread around the world very, very quickly and that is what has, in a sense, concerned us, that this virus did spread very, very quickly around the world and it has moved from avian species into mammals in different settings and in particular, in this case, in the US but the fact that we know that, the fact that we're observing that and working with our colleagues in the agricultural sector.

Again, on a day-to-day basis, we're working with our colleagues at the Center for Disease Control in Atlanta and we thank them for the wonderful work they're doing. But they also have to work with the state-based system in the US and that requires states and there are eight states involved here.

00:21:18

Again, more than WHO working with Member States, the US federal system has to work with the states who have their state public health architecture and they, in turn, have to work with agricultural authorities across all of those states. That requires very smooth, efficient and standardised work across many sectors, and that's the trick with One Health approaches.

We speak about One Health approaches and we talk about that process but when the reality hits, the fact that we have to work across sectors, we have to work between federal and state-based systems, we have to work between national systems and global systems, that's the trick of cooperation, getting all of these systems that are inherently designed to work by themselves to work together.

And I think the Global Influenza Surveillance and Response System, to me, is one of the greatest examples of how the world has overcome that inefficiency in how we do business and actually created a very efficient, very, very strong system for managing this and many other avian viruses over the last 75 years. Wenqing, is it 70? I'm getting all my numbers wrong today. 71 years. Thank you.

FC Thank you. Now, I would like to invite Muhammet Arslan, from Anadolu, to ask the next question. Muhammet?

MA Thank you so much, Fadéla. As Mr Tedros mentioned, Rafah border crossing remains closed since yesterday, Kerem Shalom crossing also closed. My question is if this process got longer, do you have an alternative plan to deliver aid to Gaza as WHO? Thank you.

00:23:06

FC Thank you, Muhammet. Dr Peeperkorn may take this question.

RP Thank you very much. I didn't get the last part of the question. Can you repeat the last part of the question?

MA I said if this process got longer, do you have any alternative plan to deliver aid to Gaza as WHO? Thank you.

RP Thank you very much. As we all know, this process should not get longer. I'm just actually describing as the DG did. Currently the border crossing, Rafah crossing is closed. Maybe the most important element, what we all need, humans there, is fuel, fuel, fuel. Then, of course, also for humanitarian aid but also staff movement and medevac. I want to stress again, without fuel all the humanitarian operations, including hospital operations, they come to a halt.

In the south, our estimation is that the hospitals only have fuel for two to three days left and we should talk about expanding the humanitarian operation because of this escalation on top of an escalation and with this insecurity and lack of fuel. So, it's not only that nothing comes into Gaza but also there will

not be movement in Gaza. We, at WHO, we have suspended our missions to the north now for the coming week because of the lack of availability of fuel. We cannot move the EMTs, etc.

00:24:56

And I want to stress a few important points. At the moment, today the UN sent an assessment mission to Kerem Shalom, which took almost a whole day. Currently, there is no fuel. There were discussions that fuel would come in through Kerem Shalom. The current status is that there is no fuel coming in today. So, anyone with influence on that, that is the biggest. It is absolutely needed. Think about food and food distribution but think about the fuel for bakeries, fuel for hospitals – we discussed that – fuel for any operations.

I want to maybe add a little bit on this. Al-Najjar Hospital, and the DG was referring to that, it has become a non-functional hospital and we have seen this constantly. When hostilities increase, when military incursion takes place, and Al-Najjar was right on that line, the patients cannot reach the hospital, staff cannot reach it, ambulances cannot reach it. We, as WHO and partners, cannot bring supplies. So, very quickly that hospital becomes, from partly function, non-functional.

We've seen this in the north. We've seen this in Khan Younis. We've seen it in middle area and we see this, now, in the south. There are three hospitals in Rafah. Al-Najjar, non-functional. In my last lengthy mission, I was there from 8-23 April for three weeks and this hospital had more than 200 inpatients. It provided services. It was the main dialysis services for serving Gaza. It provided dialysis to 700 patients. Before the crisis only 60. During the crisis expanded to 700 patients. Some of the equipment has been moved from Al-Najjar to other field hospitals and to Nasser Medical Complex.

So, what is WHO doing, and partners? I want to stress that again with this military incursion which is now taking place – people talk about restricted military incursion now -- when it would be a full military incursion, we have a contingency plan, WHO and partners.

00:27:31

At that stage, we expect that the other two hospitals, there is one other mother and child hospital, the Emirati Hospital in Rafah and the Kuwaiti Hospital, that they will become dysfunctional as well. So, then we are only left with a few field hospitals along the coast, in Al-Mawasi area and in Khan Younis.

There was a referral hospital, Al-Aqsa, that is in the middle area, and you have the European Gaza Hospital. Unfortunately, the European Gaza Hospital will not be reachable then. It will be isolated. So, WHO and health workers, partners like, I want to mention UK-Med, MSF, UNFPA and UNICEF, we revived Nasser Medical Complex, which was non-functional a couple of weeks ago and at least, now, it has an emergency department, a surgery with nine operating theatres and maternity and paediatric ICU and some dialysis.

WHO provided medical supplies and now also 15 dialysis machines to Nasser Medical Complex. That hospital will be opening today, Well, one of these days it will open. It's actually already partly opened. Then, expanded field hospitals,

but I want to stress the point and maybe one point is important. This contingency plan is like a Band-Aid. When there's a full incursion, it will not avoid the excess mortality and morbidity we expect. Over to you. Apologies for my long reply.

00:29:11

FC Thank you. Dr Ryan?

MR Thanks, Rik. And just to follow-up because the journalist asked what are the alternatives and really and truly the Kerem Shalom crossing, which is now closed, and the Rafah crossing were the two main lifelines for supplies getting into Gaza. There is a crossing in Erez, to the north but to my knowledge, Rik, you can confirm this, that's not fully functional and it's certainly not fully functional for humanitarians and it's certainly not providing supplies into the south.

And there is a pontoon-based solution that has been proposed that is being built by the US military but that is not functional yet. So, it's very hard. When Rik uses words like this has been characterised as a restricted military incursion or a limited offensive, the first act of that offensive is to cut off the two lifelines to 2.5 million in Gaza, the first act is to stop the fuel, stop the food, stop the medicine at source, at the border.

I don't call that limited and I don't call that restricted. I call that a reimposition of total blockade on nearly 2.5 million civilians who are already starving, who are already dying from preventable diseases and who need our protection. So, while it may be characterised by others as a limited offensive in order to appease the political views or interpretations of others, this is not limited if you don't have food, this is not limited if you don't have fuel to run generators in hospitals, and this is certainly not limited if the whole humanitarian system effectively collapses in the face of this. Thank you.

00:31:00

RP Maybe I can confirm what Mike said. The entries in the north, it will not work for the south, where the majority of the populations are and, as you heard, the maritime corridor is not yet functional. So, the Rafah crossing and Kerem Shalom crossing have to open as quickly as possible. WHO did as well, for ourselves we had, as you know, warehouses in Khan Younis which were destroyed.

Then, we had opened three warehouses in Rafah, which are functional. We opened also a huge warehouse in Deir al-Balah. Most of our supplies we moved from Rafah to Deir al-Balah and we started to pre-position supplies at the still functional hospitals. But, again, this is what I call Band-Aids. It will not be enough. It will not help avoid the substantial additional mortality and morbidity we expect when a full-scale military operation will take place. So, that is, of course, the most urgent request, is a ceasefire. Over to you.

FC Thank you, Dr Peeperkorn. I would like now to invite Christiane Oelrich, from dpa, to ask the next question. Christiane, you have the floor.

CO Thank you very much, Fadéla. I'm sorry to contribute to the jump in here but I'm going back to H5N1. Can you help us a bit with the risk assessment? Is it only a question of when not if there will be human-to-human

transmission? How do you rate the possibility that this will not ever happen? And if it does happen, isn't it also a possibility that the virus will be totally harmless in people and people will just have mild symptoms? And that's it. Thank you.

00:33:05

MR Nobody is suggesting that this virus will be the new pandemic virus. I said before, we've been tracking this since 1996 and everyone thought H5N1 would be the next pandemic and it turned out to be H1N1, which was a totally different reassortment that emerged in a different part of the world. So, the idea that you can predict based on this, the reality is though, and this is the reason why, this particular virus, this highly pathogenic virus spreads very easily amongst birds.

It is thought that, in general, pandemic viruses emerge through reassortment of avian, human, swine strains of viruses. In other words, these viruses exchange genetic material and at some point along the way a virus emerges that can cause transmission from human-to-human with either high mortality or low mortality.

Nobody is suggesting that H5N1 is the new, next pandemic. I don't believe anybody can predict that, but it's certainly concerning when a virus like this begins to infect multiple mammalian species, which means the virus is adapting to mammalian species which are more like us than birds, and therefore there's a higher level of alert. A higher level of alert does not mean a prediction that this will become a pandemic but we must remain vigilant. Maria, Wenqing?

MK On the risk assessment part, it's a good question because these risk assessments are ongoing. They are many different things we take into consideration. The latest risk assessment that we published on H5N1 we did together, it was WHO, WOAH and FAO, our sister agencies that work on animal health, are focused a lot on animal health.

00:34:44

And so what we're looking at is how this virus is circulating in different species, whether these are animal species, as Mike has pointed out and Wenqing has pointed out, poultry, wild birds, domestic poultry, small mammals, marine mammals, land mammals, in humans.

And we're looking at those circulations. We're looking at the characteristics of the virus and we don't take anything for granted. We look at the genetic sequence of the virus. We look at the mutations that are there but also how the virus behaves, if you will; viruses are not alive but in terms of their severity, their transmissibility and how we need to prepare.

Wenjing may want speak specifically on flu but we, as WHO, we work in scenarios. We try to think through all of the different options that may happen to make sure that we have the preparedness plans in place, we have the readiness plans in place.

And many countries are now actually revising all of their pandemic preparedness work because of flu but also because of COVID. And so making sure not just surveillance is strong, not just vaccine pipeline systems are

strong, but clinical care, making sure that we have access to personal protective equipment, that we have evidence-based guidance around all of the different public health and social measures versus the medical countermeasures that we need.

00:36:01

So, there's a whole pipeline that's in place and we think through these scenarios to try to make sure that our Member States are ready for those different types or scenarios. We don't operate in fear. We don't operate in always a worst case scenario but we have to keep that in mind. I just wanted to highlight that these risk assessments are constantly ongoing. We do them regularly with partners around the world.

It's not just WHO that does this. We work with virologists and epidemiologists and clinicians and many different disciplines around the world to do this in real time. But it's based on the information that we have, which is why those partnerships in human health and animal health, environmental work are critical.

FC Dr Zhang, please.

WZ Just to add that when we are talking about risk assessment, we need to be very specific. Risk of what? Risk associated with what? Here, we are talking about that virus at the moment circulating detected in cows in the US, the risk of this virus to become human-to-human transmissible.

This is the risk assessment we were talking about and we assess that the risk is low. But at the moment this is the form of the virus and we know influenza virus is constantly changing. So, for this virus to become a pandemic virus, it will undergo a lot of changes so that it could transmit easily among human-to-human.

00:37:31

You also asked about whether the next pandemic could be harmless or basically whether it will be mild or severe. First, as I mentioned, for the pandemic influenza virus we really need to take one step back, not just to that particular clade at the moment in the US, B3.13. We also need to bear in mind there are also another clade, it's called 2.3.2.1c, also is circulating and infecting humans in South East Asia. That's H5.

In addition to H5, I already mentioned we have H7, we have H10. These are avian viruses. Aside from avian viruses, we also have swine viruses. It's called a variant, which caused the 2009 pandemic. So, the global system, we basically keep all these viruses under monitoring and continuing doing the risk assessment, continuing to update the candidate vaccine viruses, so that when the situation warrants the response could be triggered immediately.

FC Thank you so much. I would like now to invite the next journalist. CNN London, if you can just please identify yourself. Can you hear me? No. So, let's go to the next journalist and we will come back to our journalist from CNN London. Next journalist, Helen Branswell, from STAT. Helen, go ahead please.

HB Thank you, Fadéla. I think this question is for Dr Mahamud. Do you have word yet whether the suspected Ebola case in Burundi is actually Ebola

and any details about, I think there's a suspected second case? And while we're talking, can you tell me where is vaccine and can it be deployed quickly to the region if it's needed? Thank you.

00:39:44

FC Dr Abdi, please.

AM Thanks, Helen. We are aware of two suspected viral haemorrhagic fever cases from southern Kivu in the Democratic Republic of Congo that were referred to Burundi. The first case, sadly passed away, was a nine-year-old child who passed on 2nd May. Samples were collected from there and immediately the government started the investigation and collecting samples on 2nd May.

So far, we received a few challenges with the flight in transporting those samples and the team, the country office, the ministry were able to send samples to DRC in Goma to be tested. As we speak, the lab is conducting that test and hopefully the government will announce whether it is negative or not but, as you know, we have to also send the sample to a WHO reference lab for the final confirmation.

Because of the detection of the suspected viral haemorrhagic, the government increased the surveillance and improved surveillance led to detection of several cases. We had a second child suspected, an eight-year-old who is in a stable condition. Initial samples were also taken but that child, as we speak right now, is in a stable condition.

Contact tracing has started, almost 20 contacts for the first case, 25 contacts but more important is the situation in DRC. As you aware, DRC has been responding to multiple outbreaks of Ebola. They do have the response capacity and they've started the investigation, sent a multidisciplinary team there. Where the child came from, around 75 contacts have been traced and the team is out in the field.

00:41:34

In summary, there is close collaboration between the two countries, our team there in the field office, regional office are supporting the government and once we have, we will share with you and we would really like to state our appreciation for the Ministry of Health Burundi, which came out with all the information in a transparent way, and all the teams that have been supporting this investigation. Thank you.

FC Dr Ryan.

MR I'd just like to reiterate Dr Mahamud's acknowledgement to the three governments, the government of Burundi, who very speedily reported this case before confirmation. Some of the delays that have occurred in transporting samples have been logistic, they have not been political in any way and we really do commend the government for that openness and transparency. To DR Congo for immediately on being notified by Burundi, sending a team to the field and immediately beginning to pre-emptively identify contacts.

And also, on the Burundi side, the identification of contacts at the community level but also the health care workers and the IPC measures put in place on

both sides. So, we're seeing really standard textbook activity occurring in an area of difficult logistics, and that's where we need to provide more support so these teams have the support they need to do the job they're doing. And then to Uganda, UVRI in Uganda, the Virus Research Institute of Uganda, which provides an excellent service, not only in Uganda but across the region and has multiple platforms for making diagnoses of viral haemorrhagic fevers and other dangerous pathogens.

00:43:11

Again, we're seeing sub-regional and mutual support, transparency between countries, sharing of information, sharing of samples and vaccines are available and are ready to dispatch should there need be, and we have plenty of vaccines in stock to be able to deal with this.

But remember, we only have a vaccine for Ebola. We don't have a vaccine for Marburg virus. We don't have a vaccine for Sudan virus. So, we will have to wait and see whether this turns out to be really a VHF. If it is a VHF, does it turn out to be an Ebola, and if it's Ebola, is it one of the two most common strains, Sudan or Zaire?

We wait to see but, again, the right actions are being taken and sometimes you can take the appropriate actions long before you know what the final diagnosis is, and that's what we really like and we'd just like to commend the governments of the three countries for doing that because that's what saves lives, is taking immediate and decisive action.

FC Thank you so much. I would like now to invite Frances Vinall, from Washington Post, to ask the next question. Frances?

FV Good afternoon. Thank you. My question is on Gaza. We're looking at hospital capacity throughout the strip and I was hoping you'd be able to share the names of the hospitals that are currently functional. I think the last update was that there were 12 but with what the Director-General was just saying about Al-Najjar, maybe it's now 11. But, yes, it would be great if you were able to share specifically which hospitals, not including the field hospitals in Gaza, are currently at least partially functioning.

00:45:00

FC Dr Peeperkorn, are you still with us?

RP Yes, I'm still with you. I was also actually wondering. Is it 12 out of 36 hospitals which are what we call partly functional or 11. We can provide you the whole list. But when it comes to the south, in Rafah, as the DG mentioned, Al-Najjar Hospital is not functional. Then, there's two other hospitals which we fear when the military incursion would be proceeding and that is the Emirati, a maternal and child hospital, and the Kuwaiti Hospital.

Currently, the hospitals which are functional, we call them partly functional, none of them are fully functional. In the north you talk about Kamal Adwan, Indonesian Hospital, Al-Awda, Jabalia, Al-Ahli Arab Hosi and Al-Sahaba Hospital, and Al-Helou International Hospital, All of them relatively small hospitals, I can tell you, because as you know Al-Shifa Hospital was the main hospital there and it's non-functional.

In the south Al-Amal, Kuwait, also European Gaza, Al-Aqsa, and Al-Helal and Emirati. That's the Emirati. We call it a mother and child health hospital. And we hope that will definitely happen, Nasser Medical Complex will be partly functional as well. Over to you.

00:46:37

FC Thank you, Dr Peeperkorn. Frances, we will also send you by email the list of hospitals this afternoon. This will be helpful for you, I think. Thanks so much. I would like now to ask Alexander Tin, from CBS, to ask the next question.

AT Hi. Thanks for the time. On SARS-CoV-2 can you tell us more about KP.2 and vaccines? Is anything being done to look at KP.2's mutations against antibodies or in vivo? And then on H5N1, can you expand a little bit on that production ultimatum you were talking about earlier? Why is it not possible simply just to fold that CBV into a new seasonal quadrivalent? Thanks so much.

MK Sorry, I have to look up my notes on the KP.2. We're trying to pull this together. All right, Wenjing, you go first.

WZ With regards why we cannot just click a button and change the virus itself. There are a couple of reasons here. First, is that, as probably you'll know, at the moment all the vaccine production is ongoing to produce seasonal vaccines and there should be situations that warrants that there is a need to stop the seasonal vaccine production, switch to the pandemic vaccine production. And also in the vaccine production, the plants, they would need to clean out or they need to take certain procedures in order to start replacing with the pandemic CVVs itself.

So, this is the reason. There's a process in place and also associated with that is a risk assessment, whether the situation really warrants a stop of seasonal vaccine production and switch to the pandemic just to end up with, every year. Seasonal influenza also kills, kills more than 620,000 at least every year.

00:48:58

FC Thank you.

MK The first part of the question asking about KP.2. KP.2 is a descendant lineage of JN.1. JN.1 is dominant worldwide based on all of the sequences that are shared with online platforms like GISAID. These are analysed by our Technical Advisory Group for Virus Evolution.

KP.2 is a descendant of JN.1 and has additional mutations in the spike protein. I won't read them out. And there are other emerging SARS-CoV-2 variants and it continues to evolve. So, we're going to keep seeing these other variants in circulation.

Based on the information that we have and the sequences that have been shared there's about 8% of the sequences globally that are this variant, this KP.2, and the prevalence varies by region for lots of different reasons, based on the other waves of infection that have happened, the other variants that have circulated and the amount of circulation of this virus. The first sequences

that were reported were in January this year, so it's been circulating for some time and we expect these percentages to change.

00:50:12

I just wanted to highlight that our Technical Advisory Group for COVID-19 Vaccine Composition recommended that future formulations of vaccine do include JN.1 but also we state that countries should be using all available safe and effective COVID-19 vaccines according to SAGE recommendations, primarily focusing on people who are most at risk for developing severe disease.

So, it's one that we are watching, it's one that we are monitoring and, again, reiterate the need for continued surveillance of SARS-CoV-2 in people around the world so that we can monitor the evolution of this virus. The virus is circulating in all countries, it continues to evolve, and for us to do risk assessments on SARS-CoV-2 remains critically important.

FC Thank you so much. I would like now to invite Paul Adepoju, from The Lancet, to ask the next question. Paul?

PA Hello and thank you very much for taking my question. I would like to ask a question. With the focus gradually shifting away in Africa from COVID as an urgent response what is being done to ensure that the continent continues to do genomic surveillance and keep track of these new strains as they're emerging? And what is also being done to ensure that these capacities that the continent has in various aspects of responding to infectious diseases are also being channelled to supporting the response to noncommunicable diseases also? Thank you very much.

MK Thanks very much for the question. It's an excellent one and really appreciate you mentioning this because what we are trying to do as WHO through our regions and through country offices is to support the capacities, especially during the last four years, that have been expanded for COVID-19, to deal with COVID but also to deal with the current threats that we face and the future threats that we expect.

00:52:27

PCR-based capacity and testing capacity across the continent of Africa has increased dramatically over the last four years. The question now is how is that sustained? How do we sustain the workforce? How do we sustain the financing of these systems?

Genomic sequencing across the continent has expanded massively in the last four years and, again, how do we sustain this? As demand for SARS-CoV-2 may go down there's demand for other pathogens for testing and for sequencing and for risk assessment. The capacities on the continent are truly impressive and there are so many countries right now that have capacities in-house, in-country that can do this assessment, can do the testing, can do the sequencing, can do the bioinformatics and are actively contributing across the continent and globally to our understanding of SARS-CoV-2.

So, we are supporting through our regional offices, through our country offices, trying to ensure that we have the financing to be able to support this ongoing activity. It's very difficult at the moment. I think we need to be very

realistic about this. The fiscal space for dealing with COVID has shrunk. There are so many challenges that every country is facing. Our press conferences used to just be about COVID and now they're about war, they're about displacement, they're about Ebola, they're about mpox, they're about earthquakes, they're about floods.

00:53:46

And so governments have to make some very, very difficult choices about what they can continue to do but for us we are trying as best we can with all of our partners to ensure that we don't lose these capacities. COVID is not gone but the legacy of the crisis of COVID needs to be that we have these strengthened systems.

Our Member States are downstairs negotiating how to keep up these activities for pandemic preparedness, for better responses as we go forward but there's a lot that we have learned. There's a lot that the entire continent of Africa has taught the world, not just for COVID, not just for early detection of SARS-CoV-2 variants and the timely sharing of that information but how to deal with outbreaks, outbreak response, and you've heard some of these examples today. So, thanks so much that question. It's a really critical one with a very, very difficult answer.

FC Thank you. We are almost at the end of our press conference but I will take one last question and this goes to Jenn Rigby, from Reuters. Jenn, you have the floor.

JR Hi, there. Thanks for taking the question. The UNFPA says that Emirati Hospital in Gaza has stopped accepting patients and our question is just, probably if Rik Peeperkorn is still there, where can women in Rafah go now to give birth? What are their options?

00:55:07

FC A question about the Emirati Hospital in Gaza. Dr Peeperkorn are you online?

RP I'm online. I didn't get the last point of the question. Do you mean where patients flow to?

MR No, Rik, the journalist is saying that the Emirati Hospital is closed and we know that's the MCH hospital, the one you referred to in the south of Rafah, so it's a mother and child health specialist centre. Where do women go now to give birth?

RP Emirati Hospital is not yet closed. I want to make that point. It's not closed. It is not yet closed and, of course, we hope it will not have to be closed. But where will patients go? First, there is, as I said, a number of field hospitals, IMC, UK-Med, etc., which have maternity. And IMC definitely have expanded their maternity services with, again, assistance from WHO and partners, UNFPA. UNFPA actually brought in a very good mobile maternity service. We should have had two more of these mobile maternity services but they are stuck at the border. I think I want to make it clear on that one as well.

Then, in Nuseirat, a little bit further north, IMC are setting up currently and actually it's already set up, another field hospital specifically focused on MCH.

Again, WHO supported with a number of beds, 30 beds and other medical supplies and equipment.

00:56:50

And thirdly, at Nasser Medical Complex, as I said, there's not just an emergency ward, there is also a maternity ward, which will be open, maternity and neonatal ward, ICUs, operating theatres and a bit of OPD. Of course, it will be a big blow if that hospital, which is currently the largest maternity hospital in the south, if that would be non-functional but there is some contingency planning done. Thank you.

FC Thank you so much. We are coming to closing this press conference. You will be receiving the DG's remarks this evening, plus the audio and video files of this press conference. The transcript will be available to you tomorrow morning on the WHO website. With this, I would like to hand over to Dr Tedros for his closing remarks. Thank you.

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