Hello, everybody. This is Margaret Harris in WHO Headquarters, Geneva, welcoming you today, September 7 to a press briefing on major global health issues including monkeypox and COVID-19.

As always, we will open with remarks by our WHO Director General Dr Tedros Adhanom Ghebreyesus. After which we will open the floor to questions from media representatives. We will have this as always simultaneously translated in the six UN languages plus Portuguese and Hindi, and I thank the interpreters for your work on this.

Joining Dr Tedros in the room from his left side are Dr Mike Ryan, Executive Director at WHO Health Emergencies; Dr Mariangela Simao, our Assistant Director General for Access to Medicines and Health Products; and Dr Rosamund Lewis, our Technical Lead on monkeypox. And of course on the right side of Dr Tedros we have Dr Maria Van Kerkhove, Technical Lead on COVID-19. They will be there to answer questions and I will open the floor to questions after Dr Tedros’ remarks. But now, without further ado, I will hand over to Dr Tedros. Dr Tedros, you have the floor.
Thank you. Thank you, Margaret, and welcome. Good morning, good afternoon, and good evening. First, to the COVID-19 pandemic. The global decline in reported cases and deaths is continuing. This is very encouraging but there is no guarantee these trends will persist. The most dangerous thing is to assume they will.

The number of weekly reported deaths may have dropped by more than 80% since February but even so, last week one person died with COVID-19 every 44 seconds. Most of those deaths are avoidable. You might be tired of hearing me say the pandemic is not over but I will keep saying it until it is. This virus will not just fade away.

We understand that many governments are dealing with multiple challenges and competing priorities. To support them, WHO will next week publish a set of six short policy briefs outlining the essential actions that all governments can take to reduce transmission and save lives. The briefs will cover the essential elements of testing, clinical management, vaccination, infection prevention and control, risk communication, and community engagement, and managing the infodemic. We hope countries will use these briefs to reassess and readjust their policies to protect those most at risk, treat those who need it, and save lives.

The pandemic is always evolving and so must the response in every country. Even as we continue to respond to the pandemic, work is progressing to put in place the measures to keep the world safer from future epidemics and pandemics. In November last year, WHO’s member states made a historic decision to negotiate a new international accord on pandemic preparedness and response. Just as countries have come together before to agree on treaties on the threats posed by tobacco, nuclear weapons, and climate change, so now countries are coming together to agree on a common approach to the common threat of epidemics and pandemics. The final outcome will be a legal instrument negotiated by sovereign states and implemented by sovereign states in accordance with their own laws.

But this is not a discussion for governments alone. Pandemics threaten every single person on earth so it’s important that everyone can have their say on what this landmark international agreement looks like. To enable that to happen, WHO is holding public hearings to give as many people as possible the opportunity to have input into the negotiating process. The first round of public hearings was in April and second round will be held later this month.

We invite everyone everywhere to have their say by submitting a video statement between the 9th and 15th of September, responding to this question: based on your experience with the COVID-19 pandemic, what do you believe should be addressed at the international level to better protect against future pandemics? We look forward to receiving many suggestions and ideas from as many countries as possible.

Now to monkeypox where we’re continuing to see a downward trend in Europe. While reported cases from the Americas also declined last week, it’s
harder to draw firm conclusions about the epidemic in that region. Some countries in the Americas continue to report increasing number of cases and in some there is likely to be underreporting due to stigma and discrimination, or a lack of information for those who need it most.

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But as I said earlier, a downward trend can be the most dangerous time if it opens the door to complacency. WHO continues to recommend that all countries persist with a tailored combination of public health measures, testing, research, and target vaccination where vaccines are available.

Community engagement is vital. Last week, WHO held a consultation with community leaders from all over the world to listen to their views and concerns and to emphasise the importance of responding to monkeypox using existing services and infrastructure, including those for HIV and sexual health.

Now to Pakistan where almost 1,500 health facilities have been affected by flooding. There are limited stocks of emergency medicines and other health supplies. WHO has delivered medicines, water purification kits, tents, and other supplies. And together with our partners, we have set up more than 4,500 medical camps to provide essential health services. The challenge is huge.

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Finally, we remain deeply concerned about the situation in the Sahel and the Greater Horn of Africa, and particularly in Somalia. Parts of Somalia are projected to fall into famine in the very near future unless there is an urgent scale-up in humanitarian assistance. Millions more people in the other parts of the country are facing extreme hunger and it’s likely that many people already starved to death.

A rapid scale-up in the humanitarian assistance since early this year has saved many lives, but the resources that WHO and our partners have to respond to the crisis are outstripped by the explosion in needs. Somalia and its neighbours in the Greater Horn of Africa as well as the countries of the Sahel region need the world’s help and they need it now. Margaret, back to you.

MH Thank you so much, Dr Tedros. So I will now open the floor to your questions. I’ll remind you again that we have a simultaneous translation in the six UN languages plus Hindi and Portuguese so please make the opportunity, you may ask your question in any of those languages. Please use the raise your hand function. And when you ask the question, please indicate to whom you think the question should be directed but also indicate your name and your outlet, even though I do have that.

Now we have the first question. We go to India for that, to Banjot Kaur. Banjot, please unmute yourself and ask your question.

BK Hi, can you listen to me?

MH I can hear you very well. Please go ahead.

BK My name is Banjot and I work for The Wire Science from India. A country’s drug regulator yesterday gave the go-ahead to the first intranasal
vaccine against COVID-19. It was first in India the intranasal vaccine. Is WHO aware of any safety efficacy or immunogenicity data? And what are your views about the importance of this vaccine considering more than 90% of the country’s population is already inoculated with the first two doses? Thank you.

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MH   Thank you for that question. Dr Simao will answer.
MS   I’ll start, thank you, Margaret. And thank you for the question and maybe Maria or another colleague is going to add. We are aware of this. Actually, two vaccines for nasal use were introduced, were approved by national regulatory authorities. We have not seen the data yet. We are in touch with regulatory authorities of the two countries to get more data in this. Let me say that these two companies, they have also not reached out to WHO yet for the emergency use listing.
MR   If I just might add on the general question around the use of nasal vaccines and the prospects. And again, using potentially those vaccines in highly vaccinated populations. We do this for a lot of diseases like polio where we see the benefit of getting mucosal immunity. The advantage that nasal vaccines bring is that you’re generating the immune response on the surfaces of the respiratory mucosa in the lungs. So in effect, you’re generating the first line of defence at where the virus enters and causes a lot of damage.

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Linking both the mucosal vaccine with an injectable vaccine allows you to give full protection to the human internal systems but also that potentially preventing a person being infected and passing the disease on to somebody else and I think that’s the prospect that mucosal vaccines bring. Not only an opportunity to reduce the severity of infection, but an opportunity to reduce onward transmission of the virus. And that may offer us a much stronger prospect for control of COVID in the long run.
But that remains to be seen because a lot of work needs to be done. We don’t have access to that data yet but we do look forward to that and we encourage the kind of work that develops new innovative vaccines that allows us to go to the second and third generation of vaccines. And we may need ultimately to deal with the end of COVID and to deal with future respiratory virus threats.
MK   If I could just add to that because I think...
MS   Let me just add, sorry, that we do actually have other manufacturers working on intranasal vaccines which is extremely welcomed for the reasons that Mike just reflected.
MK   Sorry, Mariangela, I jumped in on top of you there. I just wanted to comment on the innovation aspect of it so this is really critical as we are in this third year of this pandemic. So, continuing to invest and spend on research and development for advanced vaccines, particularly on inhaled vaccines like have just been discussed, looking at not only preventing severe disease and death but also potentially preventing infection, is really critical.
But we also need investment in the whole full spectrum of research related to COVID-19. There are still many unanswered questions that we have about this particular virus, how it evolves, its impact on the body, particularly looking at the long-term effects of infection in post-COVID-19 condition or long COVID. Looking at innovation around personal protective equipment, making sure that we have the right types of PPE for health workers’ bodies and in particular women. So there’s a lot we want to see in investments as it relates to COVID-19 but across the spectrum for emerging diseases with epidemic and pandemic potential.

So not only do we want to see a sustained response to deal with the outbreak itself, the pandemic itself, but also on the research side. And we thank those who are working in this area. We thank the funders who are continuing to invest in this but this is something for the long term. So we welcome this news, we welcome this innovation, we look forward to seeing the data to see how this could be incorporated into the response for COVID-19.

MH Thank you very much all of our experts for those excellent answers. The next question comes from Helen Branswell from STAT News. Helen, could you please unmute yourself and ask your question?

HB Hi, thanks very much, Margaret. I’m not sure who my question would go to, perhaps Dr Simao or perhaps Maria. Does the WHO have a position yet on whether annual COVID boosters are going to be needed? Has the SAGE opined on this issue yet? Thank you.

MR You picked the short straw, you got me. The SAGE will consider a lot of this in their upcoming meeting in the autumn. And we’ll be looking at the issue of not only boosters but the issue of varying specific vaccines and the use of monovalent, bivalent and other potential uses of that. So I do think it’s an important issue because as you’ve seen in many countries now are offering people third and fourth doses of vaccine. And we will have to come to a point where there’s some kind of schedule created that’s beyond the idea of a primary schedule.

So it’s an important consideration because obviously it’s tough for countries to deal with ad hoc policy where you’re adding an extra booster on for certain people after so many months and it’s very easy to become incoherent. I think governments are making the best decisions they can based on the data that they have but ultimately, we need to settle down into what we consider to be some accepted pattern of vaccination boosting.

And whether you call those boosters or whether you consider that these are part of a primary course of vaccination for certain people is another reconsideration. But yes, the SAGE will be considering all of that I think in this upcoming meeting. Kate is not here today or Joachim. They could explain more. I don’t know, Maria, if you have more information on that.

MK I wanted to comment on the seasonality aspect of it so I think a lot of people are expecting that SARS-CoV-2 COVID-19 to fall into some kind of a seasonal pattern like we see with influenza. And that very well may be the
case as this virus continues to circulate but right now we don’t have that predictability.

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And the reason for that is because we’re seeing this virus continue to evolve quite rapidly. It’s expected as you’ve heard us say many, many times. We have BA.5 that is dominant. This is Omicron, this is part of Omicron but even of the subvariant BA.5, there are dozens of subvariants of BA.5 that are circulating. So, more than 90% of the sequences that have been shared in the last week alone are BA.5 but in some countries, we have a predominance of BA.275 for example. So we don’t have that level of predictability. And that will impact how we look at vaccines going forward.

And there’s a lot of discussion with our TAGVE, our Technical Advisory Group for Virus Evolution. Our technical advisory group that decides and advises WHO on vaccine composition, SAGE as you’ve just heard about in terms of looking at that. But we don’t yet have that predictability so the short answer is we don’t know yet but we do know that there will be vaccines that are needed.

And just a plug here that these vaccines continue to work incredibly well against preventing severe disease and death. The vaccines that were developed on the ancestral strain, the original virus that was circulating, continue to work. So getting vaccinated, making sure you receive all of the doses that you have, remains critically important. As you heard the DG say today, most of the deaths that are being reported are avoidable and this is because we have these vaccines that exist.

But if you look in country after country, the people who are dying are people who are of older age. These are people who have not received the full course of vaccines that are required or even a single dose. And so this is what remains fundamental to reducing morbidity and mortality to COVID-19. But we also have to take measures to reduce the spread because the virus is changing.

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So, there will be a predictability coming forward. We hope there will be a pattern that we’ll settle into but this virus keeps surprising us and that’s why we have to remain vigilant, we can’t be complacent to keep track of this. But a lot of people around the world are working on this and we call upon surveillance to be strengthened, sequences to continue to be conducted and shared so that the advisory groups around the world that help advise us have the data to make those proper assessments on the variance for transmission, for severity, but importantly, on the impact of our interventions and in particular the impact on the use of diagnostics, therapeutics, and vaccines.

MH Thank you very much for those answers, Dr Van Kerkhove and Dr Ryan. Now the next question comes from Denise Roland from the Wall Street Journal. And Denise, I understand you’re having connection issues. I have got your question here and I’ll read it if you can’t get through but let’s try you asking it first. So, Denise? No, she can’t. I’ll read it, okay, sorry.

So the question is does the fall in monkeypox cases in many places in the world give reason for optimism that countries outside of western and central
Africa can avoid monkeypox becoming endemic or is this virus here to stay? I think that’s a question for Dr Lewis.

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RS   Sure, thank you very much. Well, the virus is here to stay because it is a zoonotic disease and we’ve known that for many decades. So monkeypox in and of itself will not disappear completely. And we need to do many more studies on animal health on one health approach to learn more about where this virus actually circulates, incidental hosts, reservoir animals, and so on. Of course, we want to prevent further animal infections in other parts of the world.

So regarding human-to-human transmission in this current multi-country outbreak, we have seen good signs of early reduction in the number of cases on a weekly basis. We usually are very careful about interpreting cases over the last two weeks because there’s always a bit of a reporting lag. We’re beginning to see that in several European countries there certainly is a trend downwards that looks like it’s well, we can’t predict the future, but it looks like that downward trend is being maintained at the moment.

These are countries that were early in the outbreak. They are countries that had strong public health and social measures as well as some access to vaccines and limited access to treatment. So the important thing here is really ensuring that all public health measures are applied and that there is hope, as was mentioned by our director general last week, that the virus could be eliminated in certain countries if all public health measures are applied.

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So this includes information to those who need it most, in other words, those who are most at risk at the moment, include gay and bisexual men who have sex with men and others who have multiple sexual partners. And there are many ways to approach this. We’ve discussed this before so reducing number of sexual partners, reducing casual sex, reducing group sex, at least for the time being. Being aware of the venues, events, and festivities where frequent sexual physical contact may occur. And of course, if you have monkeypox, isolating yourself to protect others in your family or in your circles and networks.

So there are a number of approaches that can be used. These are all important. It’s not one or the other. It’s a package and applying that package individually at the community level and at the national level are all important interventions.

With these elements, we continue to be hopeful that we will see a downward trajectory of number of cases, particularly in countries as the outbreak matures. But we remain very concerned for countries where the trajectory continues upwards and also for countries where there remains a significant amount of stigma and discrimination and it may be difficult to know whether cases are actually being reported. So, enhancing surveillance is really critically important as well. Thank you.
MH  Thank you so much, Dr Lewis. And I think that was a very complete answer so no more adds. Now our next question goes to Jennifer Rigby from Reuters. Jen, please unmute yourself and ask your question.

JR  Hello, thanks for taking the question. I just wanted to ask, talking about monkeypox again, with the decline in cases, I know you said in the past that this is due to a lot of things but largely probably behaviour change and public health measures. What impact do you think vaccines have had and can the behaviour changes be sustained?

MH  Dr Lewis again.

RL  When it comes to behaviour change, there are studies that are beginning to show that there has been a change in activities, individual choices being made, lots of information campaigns increasingly being provided to those who need the information most. And so we are starting to see studies that are showing that people are reporting a change in behaviour, a change in the activities they choose to participate in.

Whether this is sustainable and whether it needs to be sustainable is a question we can't answer yet. It's of course understood that there are many different factors that contribute to infection and being in the midst of an outbreak is of course one of them. So as the outbreak does wane, then people collectively will be at lower risk and so public health and social measures can and should be adjusted according to the level of risk in any outbreak.

With respect to the vaccine, as we have been saying from the beginning of the outbreak, there's every reason to think these vaccines may be effective to some extent in preventing monkeypox but we still need solid data on their actual efficacy in this outbreak and with this mode of transmission.

So we are looking to countries still and scientists and academics still to continue to design studies and promote participation in studies so that we can learn more about vaccine effectiveness. And then we'll be able to answer your question in the future, but right now, we don't have the information to be able to do that. Thanks.

MH  Thank you very much, Dr Lewis. And now we'll go to Mexico for a question from Manuel Lino of EJE. Manuel, please unmute yourself and ask your question.

ML  Thank you. I was wondering do you have any comments on the use of the Abdala COVID vaccine on children, this vaccine from Cuba. It was announced that it's going to be used in Mexico and I wonder if it is being evaluated by WHO. Thank you.

MH  Mariangela, Dr Simao will answer but otherwise you can email the question, we'll try to get you more detail.

MS  Thank you, Manuel, and let me say that there are two Cuban vaccines that are being assessed by WHO for an emergency use listing but it's still at early stages so we have not assessed the vaccine for adults yet. But we understand that Cuba is already using it under the national regulatory
authority for children. WHO doesn’t have a position yet because the assessment has not finished. Thank you.

MH Thank you, Dr Simao. We’ve now come to the end of our questions but we’ve had questions from all around the world so I do appreciate your questions and the content and the value of your interest. So I’ll now hand over to Dr Tedros for final remarks.

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

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