COVID-19 & Other Global Health Issues

Virtual Press Conference
17 May 2022

Speaker key:

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MR	Dr Mike Ryan
PE	Dr Philippa Easterbrook
SS	Dr Soumya Swaminathan
SF	Dr Ibrahima Socé Fall
ST	Steve Solomon
EF	Emma Farge
BH	Bodi Hugger
DR	Denise Roland
SA	Simon Ateba
JZ	John Zarocostas
CP	Carmen Paun
NL	Nina Larson
HB	Helen Branswell
GH	Gunilla von Hall

00:00:00

FC This is Fadéla Chaib, from WHO, and I am terribly sorry for the delay in starting this press conference. I am pleased to welcome you to this virtual press briefing on COVID-19 and other global health issues. Today is Tuesday, 17 May. Simultaneous interpretation is provided in six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus Portuguese and Hindi.

Let me introduce to you the participants. Present in the room are Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Dr Mike Ryan, Executive Director, Health Emergencies Programme, Dr Maria Van Kerkhove, Technical Lead on COVID-19, Dr Socé Fall, Assistant Director-General, Emergencies Response, Dr Mariângela Simão, Assistant Director-General, Access to Medicines and Health Products.

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Joining remotely are Dr Soumya Swaminathan, Chief Scientist, and Dr Kate O'Brien, Director, Immunisation, Vaccines and Biologicals. Now, let me to hand over to Dr Tedros for his opening remarks. Over to you, DG.

TAG Thank you. Thank you, Fadéla. Good morning, good afternoon and good evening. Over the last week COVID-19 cases have risen in four out of six WHO regions. Due to testing and sequencing reducing in many countries, it is increasingly difficult to know where the virus is and how it's mutating.

The Democratic People's Republic of Korea, DPRK, has announced, through their state media, their first outbreak of COVID-19, with more than 1.4 million suspected cases since late April. WHO is deeply concerned at the risk of further spread of COVID-19 in the country, particularly because the population is unvaccinated and many have underlying conditions putting them at risk of severe disease and death.

We are also concerned about Eritrea, another country that has not started vaccinating its populations. WHO have requested that the Democratic People's Republic of Korea share data and information, and WHO has offered to provide a package of technical support and supplies, including diagnostic tests, essential medicines, and vaccines ready to be deployed to the country.

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After three years, I will be so glad to meet many health leaders face-to-face in Geneva on Sunday for the start of a critically important World Health Assembly. There is a lot to discuss in health and there are a series of crises that are fundamentally stretching health workers, resources and systems to the limits, which risks lives, livelihoods and overarching security. The pandemic will be discussed, including how to end the emergency, including increasing access to vaccines, antivirals and other life-saving tools.

Last week, I welcomed President Biden's announcement about the sharing of health technologies between the United States National Institutes of Health, WHO's COVID-19 Technology Access Pool and the Medicines Patent Pool regarding the development of innovative therapeutics, early-stage vaccines and diagnostic tools for COVID-19.

As you know, equity is one of the key principles behind the proposed pandemic preparedness accord. During this pandemic we faced many challenges, including a lack of sharing information, a lack of sharing biological materials, and a lack of sharing technology, among others. This hampered the response, cost lives and revealed the limitations of the global preparedness.

For the world to respond quickly and more effectively at the next outbreak or pandemic, the world must prepare now. At the World Health Assembly Special Session in November 2021 all Member States agreed that COVID-19 reflected

the need for all countries to share information and strengthen systems more effectively together.

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WHO's job is to support countries, our Member States, as they negotiate and agree on an accord to commit to protecting future generations from pandemics. Our mandate is 100% determined by Member States and what they agree.

The accord process is led by Member States with their own Intergovernmental Negotiating Body, called INB, representing all regions of the world. The INB has now started a two-year process that includes global public hearings with all stakeholders. This represents the world's opportunity to plan together, detect pathogens quicker, share data broadly and collectively to respond more effectively to the next disease X or known pathogens.

Unfortunately, there has been a small minority of groups making misleading statements and purposefully distorting facts. I want to be crystal clear. WHO's agenda is public, open and transparent. WHO stands strongly for individual rights. We passionately support everyone's right to health and we will do everything we can to ensure that the right is realised.

The first ever World Health Assembly, which took place soon after the WHO Constitution entered into force in 1948, was a watershed event in global public health and, like the proposed pandemic preparedness accord, this did not mean WHO usurped nations' sovereignty, in fact it strengthened countries' ability to fight diseases together.

WHO is an expression of Member States' own sovereignty and WHO is entirely what the sovereign 194 Member States want WHO to be. Every year, the sovereign governments come together at the World Health Assembly to set the health agenda for the world. Individually we can't beat pandemics. Our best chance is together.

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It was via the assembly, in the last century, that the seeds of smallpox eradication were sowed as countries agreed to work collectively to consign the disease, smallpox, to the history books. In 1988, the assembly agreed to focus on tackling polio. At the same time there were 350,000 cases every year in more than 100 countries. Last year, we saw the lowest number of cases of wild poliovirus with just two countries still endemic.

Many people have sight today exclusively because they received treatment for river blindness and because of increasing access to antiretrovirals, 15 countries have eliminated mother-to-child transmission of HIV and syphilis.

All the achievements go back to that founding accord, which promoted the individual right to health and enshrined those rights in a collective responsibility to work together against deadly diseases. The world faces serious challenges with disrupted ecosystems, new conflicts and the climate crisis, and this convergence demands a collective response and an accord will be a critical element of that.

WHO is not just fighting COVID-19. There is an Ebola outbreak in the Democratic Republic of the Congo, an unknown hepatitis affecting children around the world and monkeypox affecting a number of countries. WHO is working with national authorities to respond quickly and effectively to these outbreaks.

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The last few years have taught us about our own collective fragility and the threat to economies and security of not working together. The accord process is at the very beginning of a multi-year Member State-led negotiation, which will only be finalised in 2024 after multiple public hearings around the world, and all voices will be heard.

The essence of the proposed pandemic preparedness accord is to improve cooperation, coordination, and the sharing of data, biological materials, information and life-saving tools. Fadéla, back to you.

FC Thank you, Dr Tedros. Now, I will open the floor to questions from members of the media. I remind you, you will need to raise your hand using the Raise Your Hand function in order to get in the queue. Now, I would like to invite Emma Farge, from Reuters, to ask the first question. Emma, over to you.

EF Good afternoon. A question on North Korea, please. I'd be interested in the WHO's feedback on the approach that the government is currently taking, relying on painkillers, antibiotics, home remedies. Are you concerned about this? And given the apparent lack of responsiveness from Pyongyang to the WHO what can, if anything, the WHO do about the situation there? Thank you.

MK Thank you for the question. With regards to the outbreak of COVID-19 in the Democratic People's Republic of Korea, as the DG has mentioned, we're deeply concerned about the increase in cases that have been reported there and the fact that it is an unvaccinated population, a population that has underlying conditions.

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We do know that BA.2 had been reported and with Omicron, Omicron is a highly transmissible virus as you know, a variant of concern, and people who have underlying conditions, who are not vaccinated, are at risk for severe disease. As the World Health Organization and with our regional office, we have been offering support and we have a number of recommended priority actions with regards to surveillance, with regards to the use of testing and, importantly, increasing vaccination.

We have offered support in the form of technical assistance, in the form of medical supplies, tests, vaccines, and we are ready to deploy those. So, it's a matter of using a comprehensive approach, as we've talked about, with all countries using the tools at hand to be able to detect the virus, to be able to support populations who are at risk, particularly for severe disease, and we have those tools that are ready to be used.

There are antivirals that are available, there are diagnostic tests that can get patients into that clinical care pathway and, of course, we have several safe and effective vaccines that are very effective at preventing severe disease and

death. We will continue to offer that support and we stand ready to be able to deploy that.

FC Thank you so much, Dr Van Kerkhove. I would like now to invite Bodi Hugger, from Phoenix TV, to ask the next question. Bodi?

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BH Thank you. Thank you for taking my question. Hi, Dr Tedros. Regarding your statement last Tuesday that China's zero COVID strategy will not be sustainable, I would like to know whether the WHO has made a specific shift to the plan for China. If not, how does WHO evaluate preventive measures for COVID in a country? Do we have a standard for assessment? Thank you.

FC Thank you, Bodi. Dr Tedros?

TAG Thank you so much. I think I have said last week that the zero COVID strategy is not sustainable and the reason behind that is the virus has changed significantly and the change of the behaviour of the virus needs a shift. In addition to that, I have also said we know the virus better and we have better tools, including vaccines. So, that's why the handling of the virus should actually be different from what we used to do at the start of the pandemic.

With regard to what we do with China, of course we have given them the advice, both at expert level and high level, but with regard to the choice of policies, I think it will be up to each and every country to make that choice. Thank you. Fadéla, back to you.

FC Thank you, Dr Tedros. Dr Mike Ryan.

MR In supporting Dr Tedros from last week as well, we do recognise that China faced a difficult situation with the rapid rise in deaths that occurred. China has been successful in keeping deaths to a very low level. We understand why the initial response of China was to try and suppress infection to the maximum level but what Dr Tedros has said and repeated is that strategy alone is not sustainable and other elements of the strategic approach need to be amplified.

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China is vaccinating many, many people, ensuring that vaccination gets to everybody who is vulnerable and the efforts that are made in that laudable, but that needs to continue. We've said since the beginning of the pandemic that a comprehensive strategy is needed.

The existence of tools that we have at our disposal means we have to apply all of the tools in order to have a sustainable step by step exit for each and every country. Dr Tedros' statement was clear in that a suppression-only strategy is not a sustainable way to exit the pandemic for any country and, therefore, was only commenting on the sustainability of a zero COVID approach.

FC Thank you. I would like now to invite Denise Roland, from Wall Street Journal, to ask the next question. Denise, over to you.

DR Hi. Thanks for taking my question. I just wondered if you could provide an update on the latest global figures for the hepatitis cases in children. What are the latest numbers of cases, deaths and the number of countries that this

is occurring in? Are there updates on the leading hypotheses as to why it is happening? Thank you.

FC Thank you, Denise. I believe Dr Philippa Easterbrook, Scientist, Global HIV, Hepatitis and STI is online. Dr Easterbrook, can you hear me?

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PE Yes, I can hear you. Thank you. In terms of the update on the numbers first, and then I'll just quickly summarise the WHO response and updates on the etiology. As of 15 May, there are at least 429 probable cases of the acute hepatitis of unknown origin from 22 countries, and there are now 12 countries compared to six countries the previous week, that have reported more than five probable cases and the majority, nine of those countries, are in the Euro region.

The remaining ten countries are reporting less than five cases and there are at least 40 additional cases pending classification. Of course, the numbers are changing almost daily as we wait for cases to be investigated and verified. No changes from last week. There are at least six children who have died, 26 children requiring transplants and overall around 75% in those less than five years of age. Hospitalisation in the majority. Intensive care, based on Euro data, in about 15%.

In terms of the priority activities for WHO, we're obviously continuing to encourage Member States to investigate and report cases but a big focus of our work at the moment is working both with our colleagues in the region as well as partners on three key tools to help support countries in harmonising the reporting and managing of cases.

It's clearly very important to have a common approach to the way we capture information so that we can compare across countries. First of all, there is a diagnostic algorithm. This is really a simple plan or flow chart of how to investigate cases.

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So, what are the most important tests to do, what type of samples should be collected, when they should collected and how they should be stored? We're obviously taking into account the fact that some countries can't access these tests and establishing a laboratory network to support this.

Secondly, a clinical case report form which will capture all the clinical information on the cases, their test results and the outcomes. Thirdly, clinical guidelines on how to manage acute liver failure in children and adapt it for use across different settings.

Then, finally, because as I've mentioned previously these cases of unexplained hepatitis in children have always occurred and some causing severe liver disease, although they were rare. So, we're working with establishing a survey across multiple countries to collect better information on what that background rate of unexplained hepatitis was, so we can really help establish whether across the range of reports we're seeing from different countries, it's an uptick.

Then, finally, just briefly finishing on the etiology, which obviously is going to remain under investigation and I think this may continue to take some time to really establish the pathways of causation, the mechanisms. I think it's good to reiterate again that the hepatitis A to E, these have largely been excluded, but reiterating the importance of excluding hepatitis A because we know that is not uncommonly reported in outbreaks as a cause of jaundice in both adults and children, and that the toxins, common exposures, medications, COVID vaccination have not been identified as causal.

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We're aware of some additional hypotheses about mechanisms emerging in the literature because the key working hypotheses remain that of the links to adenovirus and/or SARS-CoV-2 and, importantly now, how these two infections may be working together as co-factors either by enhancing susceptibility or creating an abnormal response.

I think there is some interesting communications in the scientific literature, raising a bit more about those mechanisms and about whether a previous COVID infection in children, perhaps some time ago, may have persisted and stayed around in the gut and then a subsequent adenovirus infection may have resulted in the immune system being activated and causing inflammation.

This was just a hypothesis. There was no data based on the studies in children to support this. That's why it's so important that the CoV-2 test, among the other tests, is done systematically both for past and current infection in all the children, so we can make comparisons across the cases being reported in different countries. We know that CoV-2 in adults can be associated with hepatitis but much less is known about what happens in children.

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We're very much relying on the UK, that is doing a lot of the detailed investigations, both immunological in children, host genetics as well as the viral sequences. I think as the findings start to emerge from those studies, that will give us pointers as to where across the global network and cases we may need to investigate further. Thank you.

FC Thanks so much, Dr Easterbrook. I would like now to invite Simon Ateba, from Today News Africa, to ask the next question. Simon, over to you.

SA Thank you, Fadéla, for taking my question. This is Simon Ateba with Today News Africa, in Washington. As you know, the FDA has limited the use of Johnson & Johnson's COVID-19 vaccine here, in the US, because of the risk of blood clots. Since the Johnson & Johnson vaccine is still widely in use in Africa, I was wondering if the WHO still recommends it there, especially for people who can't take the mRNA vaccines. Also, can you give us an update on the humanitarian situation in Ethiopia's Tigray region? Thank you.

FC Thanks, Simon. Dr O'Brien?

SS Fadéla, I can come in. I think Kate had to leave.

FC Okay. Dr Swaminathan, over to you. Thank you.

SS And Dr Simão may want to add. Thank you for that question, Simon. Our committees, the SAGE committee as well as the committee that reviews the safety of vaccines, as you know is constantly reviewing the information on both effectiveness and safety of all of the vaccines that have received Emergency Use Listing.

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The SAGE Working Group has discussed the J&J vaccine in the light of the FDA's recent announcement. We also have discussed with the company in detail and reviewed all of the data that they have on the TTS, the thrombocytopenic syndrome, which has been reported now. Most of the cases have been reported from US but the rate is only about two to three per million. It's the same in Europe. There were two cases reported from South Africa and two from one of the Latin American countries at a rate of about 0.2 per million people who have been administered the vaccine.

Overall, it's a very robust safety record and the WHO committees believe that the benefits of the J&J vaccine clearly outweigh the small risks and that more studies need to be done to investigate what are the risk factors. But the fact that very low rates have been reported also means we also need to strengthen the systems for reporting adverse events in these countries but it appears that it is very safe and, of course, the advantage of the vaccine is that it is still licensed to be used as a single dose, that vaccine.

Many countries are opting to do that, particularly in situations where it is very difficult to reach people, and on the background of a lot of natural infection it is possible that even a single dose offers high protection. Of course, the WHO recommends that the second dose also be administered. So, as of now, our guidance on the J&J has not changed and, Mariângela, you may want to add.

FC Thank you so much for this detailed answer, Dr Swaminathan. Dr Socé will take the second question. Thank you.

00:26:49

SF Thank you, Fadéla, and thank you for your question. It's clear that we do not meet the conditions to improve the health of populations in the Tigray region. The systematic blockage of aid continues. Since the announcement of the opening to humanitarian aid, we have had roughly 5% of humanitarian needs covered. Convoys are often turned back. It's very difficult to ensure that health products and food and nutrition needs are met.

When we look at the health system functioning there, less than 20% of the system is functioning, so obviously access to basic healthcare, because of a lack of medicines, because of a lack of access, and the health workers have not been paid for more than ten months. So this, combined with the lack of nutrition, mortality will continue to increase in Tigray.

I think that it is important, then, when we talk about the population health in these regions to take into account all the activities of prevention and the treatment of common illnesses, that is not taking place. Even routine services like vaccination for children, healthcare for pregnant women, chronic illnesses, people suffering from HIV and tuberculosis and other diseases that require long-term treatment, this is simply not being done.

We can only sound the alarm to say that there is a risk of this situation worsening in Eritrea, and other regions have been pointed out. I think the situation is dire. Drought, furthermore, is progressing throughout the Horn of Africa, and this will only worsen the existing situation. This is a terrifying situation and we must do something otherwise it will soon be too late.

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FC Thank you, Dr Socé Fall. Dr Tedros?

TAG Just to add a little bit, I think Socé had covered it, maybe very, very briefly. This is close to seven million population, call it between six and seven million population, under siege for more than 18 months now. There is no telecom, no banking services, no electricity, no medicine.

Now, there is but a trickle of food and fuel. Food is about 5% now delivered since the truce was agreed. It's already 50 days and the expected number of trucks was more than 3,000 but we have only 5% of the trucks. So, you can imagine people with all these difficulties, what kind of situation they're living in. It's really, really, dreadful.

One thing I want the world to imagine is this is a population, the same as the population of Denmark or Singapore, which is fully sealed off from the rest of the world and starving to death or dying due to treatable diseases. This complete siege is imposed by Eritrea since it invaded in November 2020 when Eritrea invaded Tigray and also by the Ethiopian forces. So, we urge again for this blockade to stop and also for the basic services to start. Fadéla, back to you.

FC Thank you, Dr Tedros. I would like now to invite John Zarocostas to ask the next question. John, you have the floor.

JZ Good afternoon. Can you hear me there?

FC Very well, John. Go ahead, please.

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JZ My question is with the forthcoming World Health Assembly, what are the expectations and what would the Secretariat like to see in the amendments to the International Health Regulations? What have we learnt in the last two years of what did not go right in the IHR and what, with some of the amendments that the Member States will work on, could improve it going forward? Thank you.

FC Thank you, John. I would like to invite Steve Solomon, Principal Legal Officer, to take this question. He is online.

ST Thank you. Thank you for the question about the International Health Regulations at the upcoming Health Assembly. There have been a significant number of targeted amendments that have been offered by the US for consideration. They will be considered at this Health Assembly. There is informal work going on now among Member States on how that work might be taken forward at the Health Assembly next week.

One of key areas of focus is on how the IHRs, themselves, are amended. When the IHRs were concluded in 2005, it was agreed that amendments

could be adopted and then enter into force in 24 months or two years after adoption and, indeed, the IHRs have been amended but just once, and that was a two-year long waiting period, even following the negotiations, a two-year waiting period before they enter into force.

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One of the amendments that has been proposed would streamline that process. Instead of having to wait two years for an amendment to enter into force, if agreed this amendment would change it so that it could be a waiting period of half that time, just one year.

This is one of the areas that is being focused on. It's an area that the DG supports as helping to streamline and make more effective and more agile this important international legal instrument, the IHRs. That's an area to watch. That will be taking place probably in the early part of the week and, if agreed, it would represent the second time that the IHRs have been amended. Thank you. I am happy to answer any follow-up questions on that.

FC Dr Ryan?

MR As the Director-General outlined in his speech with regards to these matters, the accord and resolution, regulations are entirely within the purview of the Member States. This is the means by which Member States shift and move on global health policy. They move through various articles of the Constitution by creating regulations or by having resolutions under different articles of that Constitution, but this is wholly and solely the landscape within which our Member States operate. We are the Secretariat to the Member States.

As Dr Tedros outlined in his speech, the sovereignty of individual Member States is represented as a collective approach to setting global health policy, setting global health targets, and the Secretariat implements those policies and targets in collaboration with national institutions, with civil society, with organisations around the world.

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So, again, reflecting the democratic nature of the World Health Assembly and the collective means by which WHO, as a Member State organisation, reaches consensus regarding health policies, regarding health legislation.

FC Thank you, Dr Ryan. I would like now to invite Ari Daniel, from NPR, to ask the next question. Ari, can you hear me? Ari, can you please unmute yourself? I will come back to you later. Let's invite Carmen Paun, from Politico, to ask the next question. Carmen, can you hear me?

CP Yes. Thank you, Fadéla. I just wanted to ask one more question on North Korea. There's been reports that they've expressed interest in receiving mRNA vaccines and I wanted to see if you can confirm that or give us an update on the status of talks of providing vaccines through COVAX or through some other ways.

Also, given that them and Eritrea are the only two countries in the world that haven't started vaccinations, can you tell us what is the status in Eritrea? Why haven't they started vaccination? Thank you.

FC Thank you. Dr Swaminathan?

SS Thank you for that question. As you know, the COVAX facility and the teams have been in touch and are working with all of the AMC countries, right from the beginning of 2021, in order to deploy vaccines according to the prioritisation framework and, except for Eritrea and DPRK, all countries are vaccinating their populations, though still quite a few are off-track.

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About 65-odd countries have not yet vaccinated 40% of their populations and, as you know, a 70% target was set for all countries by the end of June. So, there is still a lot of work to be done.

As far as the reasons are concerned, this is a governmental decision and of course we've done our best, including outreach, to the highest political leadership. We are ready to work with the DPR Korea now. We have, as you know, a variety of vaccines to offer through COVAX. There is absolutely no shortage and we have enough supplies, and we will be able to send them into the country as soon as possible, and we can offer a choice of vaccines, mRNA platforms, viral vectored platforms, as well as inactivated vaccines.

We are having this conversation and I hope that in the days to come, as was mentioned by the Director-General, that it would be a whole package, which they will need now, because it's not only vaccination that will be needed but also the clinical care and interventions for people who are already infected to make sure that we can reduce mortality and that we can prevent people from getting really sick.

So, we stand ready to work with the governments of both Eritrea and DPRK to ensure that people have access to the tools that are now available all over the world. Thank you.

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FC Thank you, Dr Swaminathan. I would like now to invite, Nina Larson, from AFP, to ask the next question but, before that, Dr Tedros would like to say something. Over to you.

TAG The one question about Eritrea. They haven't started vaccination because they haven't still accepted our offer that we made some ago to get vaccines. So, we haven't heard from them. I have written to the President stating that we're ready to help and we have vaccines in stock that can go to Eritrea, but we haven't heard from him either.

FC Thank you, Dr Tedros. Now, over to you Nina, from AFP. Nina, can you hear me?

NL Yes. Thank you for taking my question. I wanted to follow-up on that and also on Emma's question earlier. What choices do you have? You've offered a lot of support to both North Korea and Eritrea. What choices do you have to help address the situation? If they don't respond, is there anything you can do? If left unchecked, how worried are you that North Korea or Eritrea could become incubators for new variants? Thank you.

FC Thank you, Nina. Dr Ryan?

MR I think WHO has repeatedly said that where you have unchecked transmission there's always a higher risk of new variants emerging and part of that strategy of suppressing infection and vaccinating is, yes, to save lives, in terms of reducing hospitalisation and deaths but also to keep pressure on the virus so we don't see the same rate of evolution of the virus around the world.

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Certainly, it's worrying if countries, as the DG has said many times, are not using the tools that are now available. The tools are available and they're ready to be used and, as such, WHO stands ready to support both North Korea and Eritrea with our partners in doing that. But, beyond that, WHO has no special powers to intervene in a sovereign state.

It would be clearly of interest to surrounding states and other states to work with both countries to encourage them to take the action necessary to protect their population and, by extension, protect populations in countries around them but WHO bears no particular power and would not and cannot intervene in a sovereign state without the express wish and intent and invitation of that state. But other states may wish to work with the two countries to encourage them to participate in this global effort.

FC Thank you, Dr Ryan. I would like now to invite Helen Branswell, from STAT, to ask the next question. Helen, over to you.

HB Thank you, Fadéla. I wanted to ask about monkeypox, please, probably Dr Fall. Is there a good sense of what is happening in Nigeria, why there seems to be such an increase in exportation of cases? Are people in Nigeria contracting monkeypox in urban settings now as opposed to more rural places?

The first recent case that went to the UK, that person travelled internationally whilst symptomatic. Is WHO working with countries to try to find people who might have been on the flight or flights that that person was on? Thank you.

FC Thank you. Dr Socé Fall.

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SF Thank you, Helen. This is a very important question. We have spent the last days and weeks discussing about monkeypox in general and what needs to be done. As you know, we have a number of countries in Africa where monkeypox is endemic, mainly in West and Central Africa, and clearly the number of cases we have seen in Nigeria and Democratic Republic of Congo are the most important ones.

For example, in 2020 we have seen more than 6,000 cases in DR Congo and more than 3,000 cases in 2021. In Nigeria, also, we are seeing an increased number of cases this year and it is mainly in rural areas, mostly in Nigeria and Democratic Republic of Congo and Central African Republic. But the most important thing is we really need to invest in understanding the development of monkeypox because we have so many unknowns in terms of the dynamics of transmission, the clinical features, the epidemiology. In terms of therapeutics and diagnostics also, we still have important gaps.

With regard to the cases reported in the UK, we are working very closely with our regional office, the UK, Public Health England and partners to monitor the people who have been in contact with not only the case that travelled from Nigeria but also the local cases. We are seeing transmission among men having sex with men. This is new information we need to investigate properly to understand better the dynamic of local transmission in the UK and some other countries.

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But, clearly, the main problem we need to investigate is really knowing the real extent of monkeypox transmission in Africa and making sure that we invest in tools for prevention and treatment for people who are the most exposed in Africa. Maria?

MK Thank you. I'd like to comment also on the recent cases that have been identified in the UK. Since the beginning of May there have been seven confirmed cases of monkeypox and one additional probable case reported from the UK.

As Socé has said, we are working very closely with our regional office, with European Centre for Disease Control and primarily the UK Health Security Agency to evaluate each of these cases, the source of their infection, forward contact tracing to ensure that there isn't further human-to-human transmission, as well as back contract tracing to better understand the source of their infection.

These are separate incidents. There is one case with recent travel, as you mentioned, Helen, that came from Nigeria and, of course, there's contact tracing that is ongoing with that case. In addition to that, there is a family cluster with two confirmed cases and one probable case that was recently reported from the UK.

Following that, the UK Health Security Agency reached out to a number of health clinics and, in doing so, identified an additional lab confirmed cases that were identified through sexual health services, in some of the services across London and in Newcastle among men who have sex with men.

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What we looking at here is a number of studies that are ongoing to better understand, number one, the extent of circulation if monkeypox in London among communities with men who have sex with men and making sure that testing is occurring, that people who are suspected of having monkeypox are isolated and that they receive the appropriate clinical care.

As Socé has mentioned, what we really need to understand is the basic epidemiology of monkeypox. This, once again, highlights the threat of viruses like this. This is an orthopox virus. This is one that is one that is on our radar, of course, but we really need to better understand the extent of monkeypox in endemic countries like in DRC and in Nigeria, Central African Republic and others to really understand how much is circulating and the risk that it poses for people who are living there, as well as the risk of exportation.

We are working with a number of partners to pull together advancing our understanding on the epidemiology in terms of transmission and especially

the use of antivirals, the use of vaccines to help prevent this. As you've heard the Director-General talk about many times, COVID-19 is just one of the viruses, one of the diseases that WHO is looking at. Monkeypox, of course, is another, Ebola is another, and there are many others. Those, we cannot afford to take our eye off the ball on.

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There are many people that are working on this but at the present time it is seven confirmed cases in the UK with an additional one probable case. So, there's a number of key actions that are underway in the UK, as well as in countries across Africa. We'll update you as more information becomes available.

Just last point is to mention that we have reached out through our European regional office to raise awareness about monkeypox, looking at people with unexplained rash, particularly in communities of men who have sex with men, just to add monkeypox as a potential diagnosis to make sure that we have the right testing underway. So, there's a lot that is going in this space.

FC Dr Ryan?

MR As Maria said and Socé said, understanding the ecology of this varies in situ. The cases imported to other countries imported to other countries are signals that something is happening elsewhere. There's been a shift in the last number of years in the epidemiology of monkeypox, extending ranges where the disease appears.

We see, also, the fact that that the protection offered by previous smallpox vaccination also has reduced, so we're seeing a shift in the age distribution of cases, we're seeing a shift in the geographic distribution of cases and we also see that environmental pressure that's on the ecosystem.

Dr Tedros has spoken to converging threats. It's not a surprise that we're in a zone in the Sahel in West and Central Africa of increasing climate stress, of changing agriculture practices, of humans trying to survive in many cases, having to adapt.

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But also, at the same time, the small animals and rodents are adapting. They're in the same crisis, they're in the same droughts, they're seeking the same food sources, and that's bringing the animal population and the human population into ever closer proximity as we all compete, sometimes for those same food resources.

We have to really understand that deep ecology, we have to understand human behaviour in those regions, and we have to try and prevent the disease reaching humans in the first place. That may not be necessarily with scientific interventions like vaccines. That may be in changing social and agricultural practice, food storage practice but engaging and empowering communities to understand how this disease spreads and then trying to stop the disease at its sources, which are coming from nature.

We have to be able to work all the way from the communities and the land, all the way through to developing longer-term prevention solutions for this virus

and, again, it demonstrates that there isn't just one risk. When you have fragility, when you have climate stress, when you're driving changes in the environment, driving changes in the ecosystem, human and animal behaviour changes and it is generally in that situation that we see breaches of the species barrier.

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We are seeing that, I think I can say with confidence, on an ever more frequent nature with monkeypox. We're seeing it in a broader geographic distribution. So, getting answers isn't just about getting answers about the virus. We've got to get answers about the hosts, we've got to get answers about human behaviour and practice and we've got to operate at all levels to try and ensure that human populations are protected.

MK I just have one more point to add. With regards to the seven cases reported in the UK, with the exception of the first case that was reported by the UK on 7 May, that case had a travel history to Nigeria, the other six confirmed cases and one probable case in the UK are believed to have acquired infection in the UK.

The source of their infection is ongoing. The UK is highly capable of carrying out these type of investigations. We are in regular contact with them about the ongoing work that they are doing in the forward contact tracing as well as the backward contact tracing.

As soon as we have more information and as soon as they have more information, they will make that available but, with the exception of the first case, we believe that the six confirmed cases and the one probable case acquired infection in the UK.

MR Just to add, we will be convening a major research meeting to bring together researchers across that whole spectrum, from the animal-human side, all the way through to what Maria has been speaking about as well. So, there will be a convening of experts on a global basis to look at this issue just as soon as it is possible to pull it together.

00:52:35

FC Thank you. I would like now to invite Gunilla von Hall to ask the next question. Gunilla, over to you.

GH Hi. Thanks for taking my question. It is on North Korea. I'd just like to understand when Omicron hits basically a completely unvaccinated population, it would still give milder infection than the original strain?

Then, I would like to ask a question I think Nina was also alluding to. If we have now pandemics flaring up in unvaccinated countries, North Korea, Eritrea, they're isolated but what does that do for the risk of new mutations that can then spread back into the rest of the world? Thank you.

MK I could start on the first part of that question. I think you were asking about Omicron causing mild infection. Let's please correct the record here that Omicron is a variant of concern and if somebody is infected with the Omicron variant, any of the sublineages, it can cause anything from asymptomatic infection, all the way through severe disease and death.

This notion that Omicron is mild is false. What we are seeing is that people who are vaccinated have a much reduced risk of developing severe disease and death and this is why vaccines are so critically important around the world, particularly among those who are vulnerable, those who are over the age of 60, those who have underlying conditions of any age and our frontline workers who are most exposed to this virus through their occupational exposures.

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But Omicron, itself, and all the sublineages. We are tracking BA.2, which is dominant worldwide, and this is the variant that had been detected in DPRK. We are seeing an increase of some of the other sublineages that are circulating, particularly BA.4 and BA.5 but all of these are variants of concern.

Again, we need to correct this narrative that Omicron is mild. That narrative is really deadly because people think that they're not at risk. We know consistently across countries that people with underlying conditions are at increased risk of severe disease but we have solutions for this because we have vaccines. Those vaccines have to be accessible to people so that they can be administered and save people's lives.

We also have access to tests and early clinical care and all of these tools are saving lives. So, please, help us correct this narrative that Omicron is mild because it's not. It can cause anything from asymptomatic infection, all the way to severe disease and death, and what we want to do is prevent infections.

Not only do vaccines prevent against severe disease and death, they also reduce the risk of developing post-COVID-19 condition. We cannot forget about the long-term consequences following infection and this is something that all countries need to consider in going forward. So, increasing vaccination coverage is key but also we have to take steps to reduce the spread and we have tools that can do that.

00:55:45

FC Thank you. This was the last question. We are coming to the end of our press conference. Thank you, all, for your participation. A special thanks to our interpreters' team. You will be receiving the DG remarks and the audio file of this press conference right after the end of this press conference, and the transcript will be available to you tomorrow morning on the WHO website. Now, I am inviting Dr Tedros for his closing remarks.

TAG Thank you. Thank you, Fadéla, and thank you to the members of the press who have joined us today. See you in our next presser. Thank you.