COVID-19 & Other Global Health Issues

Virtual Press Conference
14 June 2022

Speaker key:
CL Christian Lindmeier
TAG Dr Tedros Adhanom Ghebreyesus
SF Dr Ibrahima Socé Fall
MK Dr Maria Van Kerkhove
RL Dr Rosamund Lewis
MD Dr Meg Doherty
SA Simon Ateba
CP Carmen Paun
CO Christiane Oelrich
DL Daniel Lawler
HB Helen Branswell
JK Jamie Keaton

00:00:00
CL Hello and welcome to WHO and today’s virtual press conference on COVID-19 and other health emergencies. My name is Christian Lindmeier and it is Tuesday, 14 June 2022. Today, we have simultaneous interpretation provided in the six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, as well as in Portuguese and Hindi.

Let me now introduce the participants. First and foremost, we have Dr Tedros Adhanom Ghebreyesus, WHO Director-General. Then, from left to right, we have Dr Mariângela Simão, Assistant Director-General, Access to Medicines and Health Products, Dr Rosamund Lewis, Technical Lead on Monkeypox, Dr Ibrahima Socé Fall, Assistant Director-General for Emergency Response at WHO, and Dr Maria Van Kerkhove, Technical Lead on COVID-19. Welcome. We also have online with us Dr Meg Doherty, Director for Global HIV, Hepatitis and
STI Programmes. With this, let me hand over to the Director-General for the opening remarks. Dr Tedros.

00:01:00
TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. Today is World Blood Donor Day. Blood donations are a lifeline in emergencies, disasters, humanitarian crises and for people who need regular transfusions, and yet, around the world, many communities do not have access to safe blood. Women and children are the most at risk. So, please give blood if you can and give regularly. And to the millions of blood donors around the world, thank you. You are literally lifesavers. Thank you so much.

A few hours ago, WHO published a new technical brief on Parkinson’s disease. Globally, disability and death due to Parkinson’s disease are increasing faster than for any other neurological disorder. The prevalence of Parkinson’s has doubled in the past 25 years and yet, around the world, the resources needed to manage the disease are lacking, especially in low and middle-income countries.

Our new brief outlines the global burden and treatment gaps, and provides considerations for policies, implementation and research, especially in low and middle-income countries. It outlines key actions for policymakers and healthcare providers to prevent and treat Parkinson’s disease, raise awareness, and support people with the disease and their carers.

The global decline in reported COVID-19 cases and deaths is continuing. Reported cases and deaths have now both fallen more than 90% from their peaks earlier this year. This is a very welcome trend.

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Still, more than three million cases were reported to WHO last week and, because many countries have reduced surveillance and testing, we know this number is under-reported. And 8,737 deaths were reported, 8,737 deaths too many. We cannot allow ourselves to become numb to these numbers. There is no acceptable level of deaths from COVID-19 when we have the tools to prevent, detect and treat this disease.

Many of us who live in high-income countries have easy access to these tools. We now take them for granted. But for many people around the world, these tools remain scarce commodities. It’s now more than two years since WHO and our partners launched the COVID-19 Technology Access Pool or C-TAP. C-TAP was proposed by former President Carlos Alvarado of Costa Rica, to promote voluntary mechanisms to share intellectual property, know-how, and data.

The licences C-TAP has received, for tests, vaccines and therapeutics, are making a real difference and show that this innovative mechanism can work. However, the licences we have received are too few and only from government research institutes. Manufacturers have not contributed to a single licence. This highlights why the world needs a more effective mechanism for sharing licences in an emergency, and why governments that fund so much research
must retain licensing rights for products that are needed in emergency situations.

WHO is aware that countries are discussing a temporary waiver on intellectual property rights for COVID-19 tools at the World Trade Organization’s Ministerial Conference this week. As I have said many times, the TRIPS waiver was created for use in emergencies. So, if not now, then when? I hope countries will come to an agreement on a waiver, not just for vaccines, but for diagnostics and therapeutics as well.

As you know, last week the Scientific Advisory Group for the Origins of Novel Pathogens, or SAGO, published its first report. Understanding the origins of SARS-CoV-2 is very important for preventing future epidemics and pandemics. All hypotheses must remain on the table until we have evidence that enables us to rule certain hypotheses in or out. We continue to call on China to collaborate with this process and carry out the studies that SAGO has recommended.

Now to the Horn of Africa, where the worst drought in 40 years has pushed over 30 million people in eight countries into acute food insecurity, Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, and Uganda. Many families have left their homes in search of food, water and pasture. The implications for health are severe. Malnourishment can have a life-long impact on health, and makes people increasingly vulnerable to disease. Severely malnourished children are nine times more likely to die of diseases such as cholera and measles.

WHO has now graded this crisis as a grade 3 emergency, the highest level in our internal system. A grade 3 emergency means that we are coordinating the response across all three levels of the organisation, country offices, regional offices and headquarters. Our priorities are supporting countries to fight outbreaks and to make sure people have access to the essential health services they need.

Finally, to monkeypox. So far this year, more than 1,600 confirmed cases and almost 1,500 suspected cases of monkeypox have been reported to WHO from 39 countries, including seven countries where monkeypox has been detected for years, and 32 newly-affected countries.

So far this year, 72 deaths have been reported from previously-affected countries. No deaths have been reported so far from the newly-affected countries, although WHO is seeking to verify news reports from Brazil of a monkeypox-related death there.

WHO’s goal is to support countries to contain transmission and stop the outbreak with tried-and-tested public health tools including surveillance, contact tracing and isolation of infected patients. It’s also essential to increase awareness of risks and actions to reduce onward transmission for the most at-risk groups, including men who have sex with men and their close contacts.
Today, we have also published interim guidance on the use of smallpox vaccines for monkeypox. WHO does not recommend mass vaccination against monkeypox. While smallpox vaccines are expected to provide some protection against monkeypox, there is limited clinical data and limited supply.

Any decision about whether to use vaccines should be made jointly by individuals who may be at risk and their healthcare provider, based on an assessment of risks and benefits on a case-by-case basis. It’s also essential that vaccines are available equitably wherever needed.

To that end, WHO is working closely with our Member States and partners to develop a mechanism for fair access to vaccines and treatments. WHO is also working with partners and experts from around the world on changing the name of monkeypox virus, its clades and the disease it causes. We will make announcements about the new names as soon as possible.

The global outbreak of monkeypox is clearly unusual and concerning. It’s for that reason that I have decided to convene the Emergency Committee under the International Health Regulations next week, to assess whether this outbreak represents a Public Health Emergency of International Concern. Christian, back to you.

CL Thank you very much, Dr Tedros. Let me now open the floor to questions from the media. To get into the queue to ask questions, you need to raise your hand using the Raise Your Hand icon, and do not forget to unmute yourself when it is time. We’ll start with the first on my list, and that’s Simon Ateba from Today News Africa. Simon, please unmute yourself.

SA Thank you, Christian, for taking my question. This is Simon Ateba, with Today News Africa in Washington. To the DG, you have spoken a lot about the blockade in Ethiopia’s Tigray region that has left millions of people on the brink of a humanitarian disaster, but things seem to have changed last week with the UN announcing that it was able to deliver more than 300 trucks loaded with food. Do you have any update? Does the WHO now have access to the Tigray region?

Also, I was wondering if you have a reaction to the US government announcement that it was lifting the COVID-19 negative test requirement for all US-bound passengers. Thank you.

CL Thank you very much, Simon. For the Horn of Africa, we’ll start with Dr Socé Fall, the Assistant Director-General for Emergency Response.

SF Thank you, Simon, for this very important question. We are still monitoring the situation in Tigray, which is still very difficult. According to our last assessment, approximately more than 5% of the needs in terms of medicine have been covered but we know that in the main hospitals, the head hospital covering more than 300,000, they had to stop many priority interventions including surgery.

With the lack of fuel also, we know that a lot of the medicine we are supplying cannot be distributed to all the health facilities and more than 80% of the
health workers are not reporting on duty, so the situation is still very bad. We continue to raise the alarm. We need to do more and we need full access to Tigray in terms of fuel, cash, medical supplies and all the commodities a population needs. If you don’t have full access, it will be very difficult to have any sustainable outcome.

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I think it’s also important to have a proper analysis of the consequences of the blockade in terms of excess mortality, to have a proper understanding of the situation and to make sure that this will never happen again.

CL      Thank you very much, and for the COVID-related question to Dr Van Kerkhove.

MK      Thanks, Simon, for the question. I don’t have a particular comment about any one country’s rules about testing for travel but I will use this an opportunity to talk about the fact that we still have the pandemic raging globally, and the DG pointed out 3.2 million cases reported in the last seven days alone under the backdrop of the fact that testing has dropped significantly around the world.

So, this virus is circulating at a pretty intense level three years into a pandemic and, if we look at the global numbers, while we’ve seen a steady state at a global level, there’s a 13% increase in cases in the Americas. We have a 58% increase in cases in the Eastern Mediterranean region, 33% increase in Southeast Asia. So, it’s far from over.

And 8,737 deaths in the last week, as the DG just said, is 8,737 deaths too many. And it really is, it’s a tragedy, given that we have tools and could prevent that. So, it is important that we still take measures to keep ourselves safe and reduce the circulation of this virus with these proven public health tools, distancing and masks, and using tests appropriately.

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We still need to be able to track the virus. We need to track the trends in at-risk groups. We need to track the trends of the variants of concern that are circulating, of variants of concern that may emerge. And without testing, without sequencing, without these public health measures in place, we’re really playing with fire because we know that this virus continues to evolve.

BA.2 is dominant worldwide. We have increasing numbers of BA.4, BA.5 around the world. We have more sublineages that are being tracked. BA.2.12.1, which is dominant in the United States now. So, this is far from over from a virus evolution point of view.

The good news is that the vaccines continue to work, these vaccines that are based on the ancestral strain, that are significantly reducing hospitalisations, admission to ICUs and deaths. This is why we continue to need to push for vaccination coverage around the world and, in particular, among those who are most at risk.

I’m a bit of a broken record here but I’ll continue to be that broken record, as well as with the Director-General and other colleagues here because we know these tools work. And for us to become complacent this far into a pandemic,
when we have so many tools that actually work, we really need to fight against that.

So, for those of you who are out there who are travelling, travel as safely as possible. I know everyone is eager to see family and friends. Know what your risk is, where you live and where you’re going and take measures to lower your risk. We’re not saying to stop travel or to stop socialising but do it as safely as possible with the tools that exist today.

00:16:58
CL Thank you very much, Dr Fall and Dr Van Kerkhove. Next question goes to Carmen Paun, from Politico. Carmen, please unmute yourself.

CP Thank you so much for giving me the floor. I just wanted to ask Dr Tedros if there’s a date already for the committee meeting next week and whether him or any of the other experts present can give us a bit more details about this equitable share mechanism for monkeypox vaccines. I know it’s still being worked out but do you have a timeline for when it should be ready by? We see announcements almost every day now of countries or regional groups buying monkeypox vaccine, so I was wondering whether you have a timeline for then that will come up.

And, if you allow me, a question on the acute hepatitis cases, since we didn’t hear about it today. I’m not sure if Dr Easterbrook is on the line but I remember she was mentioning a study in the UK about a month ago comparing infection with adenovirus in kids who are hospitalised with acute hepatitis and in kids who are hospitalised for other causes.

At the time she mentioning something like results in the next few weeks and I was wondering if there have been already any sort of results on those studies and getting anywhere closer to finding the cause of that disease. Thank you so much.

00:18:25
CL Thank you very much, Carmen. That gives me a good opportunity to remind everyone to please stick to one question if possible because now we have already a lot. Dr Tedros, please.

TAG I think she asked about when, and it will be next week, Thursday, the EC meeting.

CL The Emergency Committee scheduled for next week, Thursday, and we will definitely send out the invitation, the alert to media, well in advance. Now, for the other parts, first Dr Lewis, please.

RL Thank you. As you have just heard, WHO has just released interim guidance on the use of vaccines and immunisation for monkeypox. There are some smallpox vaccines that may be protective against monkeypox. Much of the data that we have is from years gone by and/or from animal studies.

There is not a lot of clinical data and so WHO is calling on countries to work together to collaborate in the use of these vaccines, to use standard usage research protocols with standard data collection tools so that we can learn about the effectiveness of the vaccines as they are deployed in this situation.
For countries seeking access to the vaccine a lot of work is ongoing right now, working with Member States as well as vaccine manufacturers to determine what supplies are available, what supplies may be made available in the coming weeks to months, and how those can be coordinated to deploy them on a needs basis, in other words, on a public health needs basis.

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Where vaccines are needed, that would be where we would ideally work with countries, Member States, and manufacturers to deploy them. This mechanism is being developed at the moment and it will be ready in the coming weeks or days.

CL Thank you very much. I’ll hand to Dr Van Kerkhove for the hepatitis part.

MK I can give a brief update on this. I don’t have the latest data as of today, so we can come back if those numbers have changed. But, as of the 6th of June, we have at least 704 probable cases of acute hepatitis of unknown cause that have been reported, and we have an additional 112 cases that are under investigation. These come from 34 countries across five WHO regions and we do have an additional four countries that are pending classification.

So, there’s a lot of work that is still being undertaken related to these hepatitis cases in these children, some of whom have experienced severe disease, some of whom have died. There are several hypotheses that are being studied to understand the cause of this hepatitis in these children. We don’t have the complete answers yet.

I know that that is quite frustrating to many of you that are out there, as is to us, but countries are working on this and they’re looking at several different potential links with some of the known causes of hepatitis and some of the unknown causes of hepatitis. So, will have to get back to you as those studies are carried out and as some of those answers are being addressed.

00:21:45
CL Thank you very much. For those who tuned in a little bit later, let me just clarify that. The Emergency Committee convened by the Director-General on monkeypox is next Thursday. We’re talking 23 June, 2022, not that there’s any confusion. So, Thursday, 23 June. With this, we go to the next question and that’s for Christiane Oelrich, from DPA. Christiane, please unmute yourself.

CO Thank you for taking my question. I was going to ask about hepatitis but that question was answered. Thank you very much. My question is can Dr Tedros or someone else give us a bit more of flavour what makes you convene the Emergency Committee? What exactly are you afraid of? And what should countries do at this moment or what do you hope they will be doing once the Emergency Committee comes to the conclusion to declare this as a PHEIC? Thank you very much.

CL For Dr Fall, please.
Thank you very much. I think the Emergency Committee is part of the International Health Regulations and it’s very important for the Director-General, when we have an unexpected event, to make sure that we get all the analysis and right advice to be able to guide Member States on the best way to prevent and to control the situation.

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We have done a rapid risk assessment and assess the risk as high at regional level in Europe and moderate in other regions, but you can see that every day we have additional cases and we have many gaps in terms of knowledge of the dynamic of the transmission, both the countries where we used to have transmission but also in new countries where we are having transmission, understanding the dynamics of the transmission.

Also, filling the knowledge gap, making sure that we advise the countries the best way to prevent and control the situation are made aware. We need also advice from a broad range of experts. Also, we are all working in our domain with a network of experts. We need to make sure that we come together and provide to the world in an appropriate manner, a rapid way of controlling the situation.

We believe that with advice from the Emergency Committee, we can be in a better position to control the situation, but it does not mean we are going straight to a Public Health Emergency of International Concern. We don’t want to wait until the situation is out of control to start calling the Emergency Committee. I think this is reason why the Director-General is pro-active in calling the Emergency Committee.

CL  And, Dr Lewis.

RL  Thanks very much. Just to add on the second question that was there. What should countries do? This Emergency Committee will allow us to hear directly from some of the countries affected, which is important for our in-depth understanding of their experiences but also the solutions that they are finding locally in how to address the situation.

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In the meantime, WHO has put out quite a set of interim guidance documents now. There are several on surveillance, contact tracing and one on laboratory investigation, one on clinical care and infection prevention control, and then the recent one today on immunisation and use of vaccines.

So, the guidance for countries is there in the Disease Outbreak News, as well as in these other documents which are technical guidance documents. The most important thing that countries can do is raise awareness in a way that supports people to understand their own level of risk and to appreciate how to manage their own risk so that people can understand under which situations, which circumstances they may be at risk of contracting monkeypox which, just as a reminder, is contracted by skin-to-skin contact primarily, close proximity, prolonged close contact.

There are situations in which there may be this type of contact where people are at risk. Family members of cases may also be at risk. There are
recommendations on how to protect close contacts in family members. Those are in the documents that we’ve just mentioned.

So, raising awareness, communicating with those who need to know their risk and how to protect themselves and working together as countries because this is now in 39 countries, and so we really need to work together with our Member States and with all parties and stakeholders, from national to community level, to help address the situation now.

**00:26:40**
CL Thank you very much both. The next question goes to, I believe somebody who we haven’t had here before, and that’s Daniel Lawler, from the AFP, Agence France-Presse. Daniel, please unmute yourself.

DL Thank you. I just wanted to ask. The CDC has said that some of these new monkeypox cases are not displaying the usual symptoms. It is milder, only in certain parts of the body, making it more difficult to diagnose. I was wondering, are you seeing the same thing? And do you have any insight into why this might be happening?

CL Dr Lewis, on the symptoms.

RL Thank you, Agence France-Presse, for the question. Indeed, the classic presentation of monkeypox, it has several names in French. Sometimes we just put monkeypox too. It’s been known about and written about for decades and in the epidemic, as we’re seeing it at the moment, we have a lot of cases, a high proportion, more than usual, that are more severe than usual.

There are skin effects that are limited to certain areas of the body, the genital region for example, which is different to the classical description of the disease on the hands, for example. We’re also seeing issues with it being present on the mouth where there is contact between people who have monkeypox, perhaps family contacts or sexual contact or a healthcare worker, for example, who is working closely diagnosing or caring for the patient.

**00:28:33**
So, we need to be very aware of the fact that despite the fact that this illness can be less severe, it’s very contagious and contact cases need to be ensure that they are careful until the skin effects heal, dry, heal over. It can last between two to four weeks actually.

We know that this is very difficult for people to have to isolate for so long when they are diagnosed with this disease but it’s very important in order to protect other people. Family members and close contacts also need to isolate, mainly at home, very rarely at hospitals for different reasons and that way this can be contained in order to protect the local populations.

CL Thank you very much, Dr Lewis. Dr Fall, please.

SF Thank you. I’d just like to add a few points. There can be a lot of different manifestations of the disease and these are the clinical forms, and these are the most classic forms, but there can also be improbable forms which can cause different problems.
This is why it’s important within the definition of cases from the beginning of an epidemic to keep the broadest definition possible so that we don’t forget these atypical cases. We should exclude the possibility of having a number of different diseases at the same time, so we shouldn’t just concentrate on monkeypox but we should also be able to diagnose other diseases, particularly among vulnerable populations.

Thank you very much, Dr Fall. We have Dr Meg Doherty also coming in. She’s Director for Global HIV, Hepatitis and STI Programmes. Dr Doherty, please.

Thank you and merci, but I’m going to speak in English. I think the only other thing I’d like to add to all of this is that we are seeing some cases that are also presenting potentially, as you might see, as sexually transmitted infection with lesions in the genital area. So, I do think that high view on making sure that even subtle lesions are considered in the differential diagnosis and consider that as clients and people who potentially could be infected come forward and are requesting evaluations. Thank you.

Thank you very much to all. Next question goes to Helen Branswell, from STAT News. Helen, please unmute yourself.

Thank you very much for taking my question, Christian. I’d like to circle back to the question that was asked by the woman from DPA about why now. Why convene the Emergency Committee now? I believe it was looked at earlier and decided that an Emergency Committee was not needed. So, if Dr Tedros would be willing to answer this question, I would like to know what made him think that now it’s important to have an Emergency Committee. Thank you.

Thank you. Thank you, Helen. As you have been following this virus, I think it’s now clear that there is an unusual situation, meaning even the virus is behaving unusually from how it used to behave in the past. But, not only that, it’s also affecting more and more countries and we believe that it needs also some coordinated response because of the geographic spread.

Plus, at the same time, having an Executive Committee would help us to discuss about this issue, these are experts, external experts, to understand the virus better. The declaration of a PHEIC may or may not be there but we believe that a meeting of the Executive Committee, the external experts, could expand the understanding and the knowledge we have about this virus.

But, the three are very, very clear now. The unusual behaviour, the more countries being affected and also the need for a coordinated response. Of course, while holding the Emergency Committee next week, since the start we have been working on improving the awareness and the risks and the actions that should be taken and we’re encouraging countries to do surveillance, contact tracing and other public health measures.

As I said in my speech, we’re also preparing for the equitable distribution of the vaccines we have in stock. One of the elements, while doing the comprehensive approach to manage monkeypox, is having a discussion at the
Executive Committee level that will shed light on any issues that can help to respond even more, in a more organised way. So, that’s why we’ll be holding it next week and we will see whether the experts will suggest or maybe not but we will see. Helen, I don’t know if that’s enough.

00:35:09
CL  It better be because we have hard stop today and we try to get as many questions as possible. We have to go soon, hopefully getting in two questions, but at least one we will try still, and that goes to Jamie Keaton from the AP, please. Jamie, please unmute yourself.

JK  Good afternoon, Christian. Good afternoon, everyone. Thanks for taking my question. I just wanted to talk. Helen’s question was actually going to be mine but I do have another. You mentioned the mechanism, Dr Tedros, that’s being considered.

Can you tell us a little bit more about the latest developments with that? For example, which countries will have access to the smallpox vaccines and how will those be prioritised, whether it is the European countries or the countries that are endemic that have endemic cases? Why was a smallpox vaccine not considered in previous outbreaks in Africa? Thanks.

CL  Thank you very much, Jamie. Let’s keep this as short as possible. Dr Lewis, please.

RL  Thanks very much. There are several steps that we need to go through to try to address this need, this issue, and answer these questions. The first is the vaccines, themselves. As you know, some of them are smallpox vaccines. Only one has actually been approved for monkeypox, and that’s only in two national jurisdictions.

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The regulatory issues become quite complex when we’re talking about vaccines that are approved or not approved for monkeypox. They’re used off-label in most of the instances that are mentioned in the guidance today and then whether they’re procured by countries, whether they’re procured through WHO, whether they’re procured through contributions from Member States, all of them present legal and regulatory issues.

This is not to slow things down. It’s just that WHO needs to do its due diligence to make sure that there’s a full understanding of the steps required for countries to access eventual countermeasures as they become available.

The second point you ask is why were smallpox vaccines not used in the past in countries which have experienced monkeypox in the past. In the past, there were primarily smallpox vaccines. They were held in national stockpiles. They are called first generation vaccines and they are from the smallpox eradication programme era, which ended in 1980.

These vaccines are tested on a regular basis but they are the original vaccines and their use in monkeypox has not been recommended at any time and is not presently recommended.

Since then, there’s been an extensive programme of research overseen by WHO. This is mandated by the World Health Assembly, overseen by WHO, with
the advice of the WHO Advisory Committee on Variola Virus Research, and these products were primarily developed in the context of health security preparedness in the event of re-emergence of smallpox. That research programme has yielded, over the years, different, newer products and safer smallpox vaccines of which several are mentioned in the guidance you can look at today.

So, these products, again, they’re new and the one that’s approved for monkeypox is the newest and so production capacity has not yet scaled up and the regulatory work had not be done. And, as mentioned earlier, because there was no smallpox for the last 40 years and because there was limited investment in research, we’ve mentioned this before as a challenge, limited investment and support for research where it is most needed, there have really been very limited studies to date of the use of countermeasures in the setting where this virus is already present.

We hope this will change. We hope there will be support and coordination for investment in research and this will actually support ongoing work towards access for the vaccines as well.

CL    Thank you so much, Dr Lewis. This brings us to the end of our press conference today. Apologies to all journalists, and we have quite a list still, who didn’t make it to their questions, but thank you again very much for your participation.

We will be sending the audio file and Dr Tedros’ remarks right after the press conference, and the full transcript will be posted on the WHO website tomorrow morning. Otherwise, Dr Tedros, over to you.

TAG    Thank you. To Jamie’s question, maybe one part. He wanted to know how we’re trying to prepare for the distribution of vaccines. We’re working closely with Member States and partners to design a mechanism for the fair distribution of the vaccines.

As Rosamund said, we have the first generation, of course, and there is a new one. We will consider both the first generation and the new vaccines that have been approved recently for this purpose. That’s just what I would like to add to that.

Then, to what Helen said, I think that one part I didn’t comment on. We have been monitoring the monkeypox movement but we have been always throughout, been open on calling the Executive Committee if needed. I don’t remember before saying there is no need for EC, for Emergency Committee.

We have been doing internal discussions whether there will be a need and then, when it started to expand its geographic reach and the unusual behaviour was already there, then said, okay, with the expansion we may need to coordinate a response.

So, that’s why we wanted to have the meeting of the Emergency Committee. We have been monitoring the situation from the start and that’s why we need to call an Emergency Committee next week, June 23. With that, to all
members of the media, the members of the press. Thank you so much for joining us and see you next time.

00:41:47