For **WHO's announcement on Aug 14, 2024** see https://www.who.int/news/item/14-08-2024-who-director-general-declares-mpox-outbreak-a-public-health-emergency-of-international-concern

For the **GISAID website** see https://gisaid.org/

collected from Africa since October, 2023 (the date of the initial outbreak in the Democratic Republic of the Congo) have been made publicly available. They all belong to clade I and account for 2·8% of 2219 confirmed cases in Africa during this period. This proportion is much lower than that during the last PHEIC of clade IIb monkeypox virus (6581 genome sequences [7·5%] from 87 329 confirmed cases; figure A). Furthermore, all complete genomes for the ongoing PHEIC are from three countries, with 59 from the Democratic Republic of the Congo (with 5160 confirmed cases), and two from Uganda (with ten confirmed cases) and one from Kenya (with five confirmed cases), despite 15 African countries having reported confirmed or suspected cases of mpox since 2024.[8] Additionally, we identified a clear gap in data from Africa between February and June, 2024 (figure A), despite onward transmission of mpox during that time. The lack of adequate reporting of data during this period could be due to several reasons, for instance, insufficient awareness regarding the importance of timely data sharing, even if genomic surveillance has been conducted and relevant data have been generated. Another reason might be limited funding and related resources (eg, infrastructures and technical personnel) required for sequencing and data sharing. Yet, the few sequenced monkeypox virus genomes from Africa makes the determination of whether novel variants have emerged among these countries impossible. Despite these challenges, efforts made by clinicians, researchers, and health-care professionals in Africa on rapid sequencing and prompt data sharing merit great recognition. The median interval between sample collection and genome submission for monkeypox virus samples collected after October, 2023 in Africa is 88 days, which is even faster than the median 90-day interval observed for clade IIb monkeypox virus samples up to the end of the last PHEIC (figure B); indicative of the rapid response to the epidemic in Africa.

Given the pivotal role of the first 100 days in establishing scalable mechanisms for disease management and containment,[4] more publicly available data about epidemics could enable the scientific community to evaluate the epidemic situation in real time and thereby adjust prevention and control policies accordingly to control the epidemic and end this PHEIC as soon as possible. Failure to fill these gaps might exacerbate the risk of undetected or hidden viral transmission and the emergence of novel variants, thereby complicating efforts to mitigate the spread of mpox. Considering the numerous challenges faced by Africa (eg, large-scale infections and limited funding and infrastructure for genomic surveillance), multifaceted international support, such as funding and technical infrastructure and platforms for sequencing and data sharing, as well as professional training, are necessary. Moreover, streamlining policy barriers on timely data sharing should be prioritised where feasible.

GFG and LW designed and coordinated the study. LW collected data, performed analysis, designed the figure, and wrote the first draft of the manuscript. GFG and LW reviewed and revised the manuscript. GFG and LW accessed and verified the underlying study data and had final responsibility for the decision to submit for publication. We declare no competing interests. All data used in this study are publicly available from the Global Initiative on Sharing All Influenza Data (GISAID) database. We thank researchers from the originating laboratories and the submitting laboratories where genetic sequence data were generated and shared via the Global Initiative on Sharing All Influenza Data and National Center for Biotechnology Information, enabling this research. This work was supported by the National Key R&D Program of China (2022YFF1203203), and the Strategic Priority Research Program of the Chinese Academy of Sciences (XDB29010202).

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For more on the **2024 high-level meeting on AMR** see https://www.who.int/news-room/events/detail/2024/09/26/default-calendar/un-general-assembly-high-level-meeting-on-antimicrobial-resistance-2024

Antimicrobial resistance: now is the time to revisit global commitments

Antimicrobial resistance (AMR) and the inability to treat infections affects everyone, especially individuals in low-income and middle-income countries (LMICs) and the most vulnerable groups, such as very young children, older adults, and refugees. Effective antimicrobials are key for human and animal health and should be viewed as common global goods.

The 2024 high-level meeting on AMR in the UN General Assembly is a timely opportunity to revisit global commitments to curb the increasing resistance. We must do our best to ensure that world leaders maintain political attention on this issue and increase their efforts to counteract AMR, in response to the UN General Assembly political declaration.

A shared vision and common goals are essential to unite us in counteracting resistance; ensuring reliable access to, and responsible use of, effective antimicrobials for humans and animals; exercising accountability; and monitoring global progress. Aligning with this vision and global goals, countries now commit to set and monitor progress towards national targets adapted to their contexts, with the aim to accelerate action on the ground and support priority setting and budgeting at the national level.

However, a few issues must be considered. First, resilient health systems at the country level, supported by universal health coverage, including reliable access to antibiotics, hygiene measures, clean water, and proper sanitation, are crucial. Second, monitoring goals and targets requires robust surveillance to generate reliable and representative data. The unavailability and fragmentation of relevant data are common, especially in LMICs with insufficient laboratory capacity, and prevent data from being used for evidence-based policy making and follow-up. Third, the focus on targets needs to go beyond deaths to also include avertable infections, which substantially affect hospital length of stay and patient outcomes. Finally, improving the responsible use of antibiotics in human and animal health is crucial to slowing the emergence of AMR, but this will never be sufficient without substantial improvements in prevention of both infections and dissemination of resistant bacteria.

High-income and upper-middle-income countries need to ensure domestic resource allocations for the work to mitigate the effects of AMR; resource-constrained countries need support in their implementation of National Action Plans to contain AMR. Resource mobilisation must be promoted at national and global levels and political commitment is a good start to garner the adequate support and resources needed.

When the UN General Assembly meets in New York City (NY, USA), its decisions will affect AMR and the possibility to treat infections, in humans and animals, both now and in the future.

I am the Minster for Social Affairs and Public Health.

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August, 2024 Bangladesh floods: emerging health risks

The floods in August, 2024 in Bangladesh triggered an unprecedented public health emergency, exposing the incipient fragility of the nation's health-care system under such catastrophic natural disasters. Relentless monsoon rains, coupled with an irreversible deluge from upstream, have inundated vast swathes of Bangladesh, particularly in the southeastern and northeastern districts, displacing millions and incapacitating vital infrastructure.[1,2] The unparalleled flooding has given rise to a multifaceted public health emergency that requires immediate, strategic, and multifarious intervention.

The flooding has compromised water and sanitation services, rendering previously potable water sources lethal vehicles for pervasive waterborne diseases. As the floodwaters combine with an array of contaminants, including human excreta and agricultural and industrial runoff, the probability of an outbreak of cholera, dysentery, hepatitis A, and other enteric diseases is large. The densely crowded makeshift shelters have made the risk of a contagion outbreak particularly alarming, especially in the absence of any semblance of clean water and adequate sanitation facilities.[3] Simultaneously, the stagnant waters pervade the submerged facilities, providing a breeding ground for mosquitoes. The escalating threat of mosquito-borne diseases, such as dengue fever, malaria, and chikungunya, is magnified by the high water table, which is set to be sustained well into the future. Bangladesh has already had an alarming outbreak of dengue cases, and the ongoing flood confluence is set to exacerbate the already intractable challenge. The irremediable destruction of agriculture and livestock means a food security crisis of unprecedented magnitude is all but inevitable. The obliteration of food sources and the economic immolation of rural communities portend a soon-to-be-nutritional catastrophe, particularly for vulnerable demographics such as children, pregnant women, and older adults.

Besides being an evident physical health disaster, the floods exert an equally dangerous yet less observable effect on the psychological health of the victims. Displacement, disruption of livelihoods, and the pervasive uncertainty towards the future are likely to prompt a surge in the rates of mental health disorders, including anxiety, depression, and post-traumatic stress disorder.[4] Since the existing mental health infrastructure in Bangladesh is already fragile, the flooding crisis requires the inclusion of mental health services as part of the disaster–response cycle.

The solution will need to be complex and address the moderate rise towards disaster resilience accordingly: responses in the short, middle, and long term need to be defined. In the short term, people in the flood-affected areas need to gain access to uncontaminated water and proper sanitation. In addition, drastic vector control measures need to be implemented immediately to start reducing mosquito-borne diseases. Furthermore, the distribution of emergency food supplies should be commenced without delay, with special attention to pregnant women,

For more on **dengue cases** see https://dashboard.dghs.gov.bd/pages/heoc_dengue_v1.php

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