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Monkeypox—*not doing enough is not an option*

The covid-19 pandemic should have taught us that there's no time to lose when it comes to responding to emerging disease threats, writes Boghuma K Titanji

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Outbreaks of monkeypox virus (MPXV) in non-endemic countries have grown steadily in recent weeks, causing increasing international concern. Since the first cases were reported in the UK in early May, more than 5000 cases have been recorded in 52 countries and territories.¹ MPXV is an old pathogen, which has caused human outbreaks in countries across west and central Africa for more than 50 years and has mostly been ignored by the rest of the world.² The situation we are witnessing is unusual because of the large number of cases occurring simultaneously outside endemic locations; local human-to-human transmission in non-endemic settings; and the clustering of cases in specific social networks of primarily gay, bisexual, and other men who have sex with men.² This has drawn global attention to the once neglected disease, leaving many wondering how big this outbreak will become and what its impact will be.

As we weather a third year of the global covid-19 pandemic, these uncertainties about MPXV are amplified by the fear of another infectious disease outbreak that might lead to loss of health, social disruption, and economic crisis. The situation with MPXV is worrying but different from what we have witnessed with covid-19. We have more existing knowledge, from historical outbreaks, about how this virus is transmitted, and vaccines and antiviral drugs are available as potential tools to contain it.² Although this should be reassuring, the many missteps of the covid-19 pandemic response prompt valid concerns about whether the world is better prepared to respond to emerging disease threats.

A response characterised by complacency

The systems for outbreak response developed and optimised during covid-19 could rapidly be engaged for scaling up key elements of MPXV containment, such as testing, contact tracing, and deployment of vaccination and therapeutics. In reality, however, the response in many countries has been more muted and plagued by complacency and outbreak fatigue. The US, for example, has so far recorded 395 confirmed cases of MPXV,¹ yet testing has been abysmally slow and access to vaccination for pre-exposure and post-exposure prophylaxis is limited, despite existing national stockpiles of smallpox vaccines,³ which are effective in preventing monkeypox.

As outbreaks in non-endemic countries have dominated the news, countries in west and central Africa that are also dealing with MPXV outbreaks, such as Nigeria, Cameroon, and Democratic Republic of Congo, have once again been excluded from the conversation about access to vaccines, testing, and

antiviral treatments. Just this week South Africa reported its first case of MPXV with no link to travel to any of the countries with ongoing outbreaks.⁴ There is growing unease that we are seeing only the tip of the iceberg, the scale of which remains to be clearly defined. Yet a concerted global response once again appears sadly severely lacking, with mistakes of the recent past playing out in real time.

The reasons behind the lack of urgency in the response to MPXV are multifaceted and complex. The estimated mortality of the west African clade of MPXV responsible for the ongoing outbreak⁵ (based on previous outbreaks) is around 3-6%⁶; in 2022 so far, one death has been recorded in a non-endemic country and 72 deaths in endemic countries.⁷ This makes MPXV infection less deadly than Ebola virus disease, for example. The notion of “disease mildness” has unfortunately translated into MPXV outbreaks not being prioritised in the same way as other outbreaks in recent history. The concentration of cases in gay, bisexual, and men who have sex with men has engendered narratives of stigma and blame reminiscent of the early days of the HIV epidemic, during which infection with HIV was blamed on sexual orientation and entire communities were ostracised and abandoned. It also gives the broader population a false sense of security, and with geopolitical unrest in eastern Europe, ongoing conflicts in Africa and the Middle East, an impending economic recession threatening the world, and a covid-19 pandemic that is far from over, MPXV outbreaks couldn't have come at a worse time.

Failure to declare an emergency

On 23 June 2022, the World Health Organization convened an emergency committee meeting to discuss whether the current MPXV situation constituted a public health emergency of international concern (PHEIC).⁸ In a surprising turn of events, WHO declined to make that determination based on expert advice.⁸ What happened to acting quickly, acting decisively, and having no regrets? The stringent criteria for declaring a PHEIC require “an extraordinary event which constitutes a public health risk to other states through the international spread of disease and potentially requires a coordinated international response.”⁹ A PHEIC is formulated when the situation is deemed to be “serious, sudden, unusual, or unexpected,” with implications beyond the borders of the affected countries.⁹

Certainly, the current monkeypox outbreak checks a lot of these boxes and the failure to pull the PHEIC lever now has a sense of *déjà vu*, running the risk of making an already bad situation worse. Historically,

PHEICs have been fraught with controversy and many commentators have debated whether they make a difference in outbreak response.¹⁰ However, these declarations draw the attention of the public and raise the priority level of the problem. PHEIC declarations also have the potential to mobilise international coordination, streamline funding, and accelerate research towards development of vaccines, therapeutics, and diagnostics under emergency use authorisation.¹⁰ Whether this always translates into an organised global response centred on equity is a whole other question.

Inequalities persist

After initial hesitation, covid-19 was declared a PHEIC on 30 January 2020¹¹ and a global pandemic six weeks later. Soon thereafter, a global collaboration to accelerate development, production, and equitable access to covid-19 tests, treatments, and vaccines was launched in the Access to Covid-19 Tools Accelerator.¹² This initiative and others played an important part in getting vaccines and therapeutic access to lower resourced countries but were limited in achieving their full potential because of the failure of wealthy countries to honour their commitments. As a result, Africa remains the continent with the lowest covid-19 vaccination coverage and limited access to covid-19 therapeutics.¹³

Also important to consider are the ethical undertones of declaring an infectious disease outbreak a PHEIC only when high income countries are affected, thereby reinforcing a double standard that sees diseases affecting poor people afforded less importance. This is a valid interpretation of what has happened with MPXV, which has plagued countries in Africa for decades, yet struggled for attention and research funding to tackle it. Before the Ebola outbreak in west Africa, Ebola virus disease suffered the same fate; it was an obscure disease that nobody cared about, primarily causing deadly outbreaks in the Democratic Republic of Congo. When the west African outbreak was declared a PHEIC in July 2014¹⁰ (albeit after a much criticised four month delay by WHO), it moved forward more than 10 years of stalled progress on vaccines and therapeutics research for the disease, which had been neglected for years, putting the world in a better position to respond to outbreaks that have come since.

Covid-19 revealed the many shortfalls of the existing systems designed to respond to global threats from infectious diseases. Coming out of the pandemic, these systemic issues have been compounded by an erosion of public trust, polarisation in the public health discourse, and the flood of misinformation and disinformation. This creates a very challenging landscape for navigating future outbreaks, but seeking perfection in the response to MPXV would be losing precious time and giving this virus more chances to spread, adapt, and become more deeply entrenched globally. Whether our next move comes through a PHEIC declaration in the future for MPXV or other mechanisms is beside the point if the response continues to be defined by inertia and hesitation. MPXV deserves more urgency; we are simply not doing enough and this is unacceptable, especially for a disease which has made its way to centre stage as a direct result of decades of inaction and neglect.

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