Monkeypox: What are we Waiting for to Act?

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On May 7, 2022, the World Health Organization (WHO) was informed of a confirmed case of Monkeypox, caused by the Monkeypox virus (MPXV), in the United Kingdom, in a patient who had traveled to Nigeria. Since then, several cases have been reported in countries where the disease is not endemic, with rapid spread: on July 24, 2022, there were 16,000 cases confirmed in 75 countries. On July 23, 2022, The WHO established the disease as a public health emergency of international interest.

Monkeypox is an endemic zoonosis in Central and West Africa caused by an orthopoxvirus, hitherto largely ignored globally. Although it is still called Monkeypox, the name is not adequate, since monkeys are not its main vector. It is, therefore, urgent that the disease and the virus have their names reclassified to avoid stigmatizing and discriminatory labels, as well as animal extermination actions with no effect in combating the disease.

The number of cases has increased over the years in endemic regions, with outbreaks in non-endemic countries related to travel and animal imports since 2003. It is usually a self-limiting disease and its case fatality ratio varies from 1 to 10% between the West Africa and Congo Basin in Central Africa, respectively. Although there is a similarity between the genomic sequence of recent cases of 2022 (Europe and the Americas) and the West African clade, more than 40 mutations have already been reported in the viral genome, possibly related to increased inter-human transmissibility. Since 2017, the few reported deaths were associated with young age and immunosuppressed patients. Data indicate that person-to-person transmission occurs through direct contact with skin lesions, body fluids, respiratory droplets, during close physical contact such as sexual intercourse and crowds. Transmission also occurs through contact with contaminated animals, surfaces or personal objects such as clothing, glasses, plates, cutlery or bed and bath linen. An analysis of a series of cases reported between April and June 2022 in 16 countries found that 98% of infected people were men who have sex with men (MSM) or bisexuals, with a median age of 38 years. Systemic features such as fever, lethargy, myalgia, headache and lymphadenopathy have been reported before the rash, which occurred in 95% of cases, with no deaths reported. However, there are still gaps in knowledge regarding transmission, risk factors and clinical characteristics.

The first case imported into Brazil was confirmed on June 9, 2022. In less than a month, on July 25, there were already 813 cases confirmed and community transmission registered in the country. This escalation of cases occurs amid the scenario of COVID-19 pandemic, which remains a significant health challenge that sustains the importance of the Unified Health System (SUS) and puts the country’s fragility in facing a health emergency in the spotlight.

However, negligence and slowness in responding to disease are worrisome. There is a lack of laboratory structure for the rapid diagnosis of Monkeypox, as well as a breakdown of surveillance services, which have low capacity to identify cases and difficulties in isolating cases in a timely manner. There are also the limitations of establishing a transparent, agile health information system capable of recording and disseminating data in real time, limited training actions for health workers, and insufficient communication initiatives for the population and to combat stigma. Quick and coordinated actions are urgent and essential.

In this scenario, efforts are needed to:

- define clinical protocols and therapeutic guidelines for the health care network;
- implement a unified information system to record confirmed and suspected cases, considering clinical, epidemiological and sociodemographic aspects, ensuring the transparency of health information for the population and health professionals, as well as its decentralization to the three federated entities;
- expand resources for structuring, qualification and decentralization of epidemiological and laboratory surveillance services. Case investigation and contact tracing are essential to provide necessary clinical care, isolate cases (to stop transmission), and monitor contacts. Despite the increase in diagnostic capacity during the COVID-19 pandemic, laboratory diagnosis of Monkeypox is performed in only four reference institutions in the Southeast Region, which makes it difficult to identify cases in a timely manner, especially in historically neglected locations such as the vast Brazilian Amazon;
- invest in MPXV genomic surveillance and integration with epidemiological surveillance. Increase and articulate partnerships to systematically organize orthopoxvirus genomic surveillance in the country;
- train and educate health professionals on epidemiological and clinical profile of the disease, as well as to establish devices for monitoring scientific evidence;
- design and organize communication campaigns and actions aimed at health risks for the population addressing the disease, its signs, symptoms, preventive measures and the fight against stigma, with the active participation of communities; to incorporate these actions aiming at the public at greater risk in this initial stage of disease spread, basing actions on rights and scientific evidence that can avoid stigmatization;
- continuously monitor, plan and evaluate prevention measures, incorporate vaccines and existing medicines, their use and define priority groups while planning actions to the population as a whole;
- with proactivity of the Ministry of Health, approve and acquire medicines and vaccines and/or investments in the national production of the immunobiological agent; and
- invest in research on epidemiological diagnosis, monitoring and evaluation of social impacts.

Although initially the disease is mild in healthy patients and the risk of complications is greater in children, preg-
nant women and immunocompromised patients, the lack of coordinated and planned measures is very worrying in a country marked by social inequalities. Brazil, immersed in a health, economic and political crisis, keeps making the same mistakes while managing this new health emergency—mistakes that produced dramatic impacts on the health of Brazilians and resulted in hundreds of thousands of preventable deaths associated with COVID-19.

As in the fight against COVID-19, the distribution of medicines and vaccines already approved and administered in European countries and the United States is unequal, and developing regions suffer without access to these resources. Thus, in addition to national, there are also international inequalities.

Measures are urgently needed to adequately address this health emergency, with the coordination of multilateral agencies such as the WHO, so that all countries with cases of community transmission can respond to it. The lessons of the COVID-19 pandemic cannot be neglected, nor should the same mistakes be made, both nationally and internationally. Ensuring equal access to available resources to fight the disease is essential in the face of yet another public health emergency due to a communicable disease.

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