OPINION

As monkeypox cases rise, US health officials are failing again

The CDC needs to move swiftly to expand testing and increase awareness.

By **Shan Soe-Lin and Robert Hecht** Updated July 14, 2022, 3:00 a.m.

A medical writer in San Francisco found it took two weeks to confirm that a blister was caused by monkeypox. Longstanding weaknesses in the public health system are giving the virus a chance to become entrenched. ANASTASIIA SAPON/NYT

The United States is making the same mistake in its response to the monkeypox

outbreak, led by the Centers for Disease Control and Prevention, as it did with the start of the COVID-19 pandemic, by not moving swiftly enough to expand testing and increase awareness.

There have been more than 900 confirmed cases in the United States and more than 10,000 worldwide. Because of testing and reporting problems, however, the actual number of cases in the United States is undoubtedly much higher.

Symptoms include fever, headache, chills, and exhaustion before the emergence of a rash and painful blisters and lesions that can last for two to four weeks. While the virus is usually not fatal, it can cause serious illness or death from infections of the brain, bloodstream, or lungs. Reported long-term complications include bronchopneumonia, sepsis, encephalitis, and infection of the cornea with possible loss of vision.

To fight the virus, health officials have good tools available, including tests capable of detecting monkeypox infection and a vaccine, originally developed for smallpox, which is 85 percent effective. They also need to apply the lessons that should have been learned from COVID-19 and from earlier epidemics like HIV/AIDS. Health officials need to:

▪ Communicate the threat of monkeypox without stigmatizing the communities most at-risk.

Similar to HIV, the current monkeypox outbreak was originally concentrated mainly among men who have sex with men, and public health officials have been struggling with how to appropriately message the dangers of monkeypox without stigmatizing the communities most at-risk.

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HIV was originally named GRID for "gay-related immune deficiency" and routinely referred to as the "gay plague" in the 1980s. Yet health officials found ways both to work with gay communities to put in place strong prevention and AIDS treatment programs, and to motivate the general population since HIV was also transmitted among heterosexuals. The existing experience and infrastructure managing HIV/AIDS should be used to accelerate our response to monkeypox, (which can also be spread not only sexually but by close contact).

▪ Make testing widely available.

Almost 2 months after monkeypox was first detected in the United Kingdom, CDC guidelines to state public health agencies still restrict testing narrowly to those with specific symptoms — as was the case in the early days of COVID-19. As of a week ago, the CDC had tested only 300 people, with about 100 of them coming back positive. With a case detection rate this high, the CDC is clearly missing a large number of monkeypox infections. These bottlenecks in testing are causing public health officials to fly blind and allowing the virus to spread, just as happened two years ago with COVID-19. The CDC needs to move faster to educate health care providers and the public about monkeypox, encourage testing, and make access to tests much more widely available.

▪ Improve vaccine supply and access.

The majority of the stockpiled doses of smallpox vaccine was mainly reserved to deter bioterrorism threats, not to manage a monkeypox outbreak. Most of the stockpiled vaccine is a live virus vaccine that cannot be used in pregnant women, the immunocompromised, or infants — those who are most vulnerable — and also carries a risk for myocarditis, inflammation of the heart muscle, affecting its ability to beat properly. Only 200,000 doses of the safer vaccine, Jynneos, are available immediately — and while efforts are under way to procure a million doses by the fall, this will still not

be enough if a wider campaign is needed.

Currently available vaccine doses are being distributed to states on the basis of their reported monkeypox case rates, but because of significant under-testing many people will be missed, and the doses are not going to states on the basis of expected risk (i.e. Florida has received no doses). The CDC and the Federal and Drug Administration need to solve not only the vaccine manufacturing piece of the puzzle but also overcome the same hurdles to distribution of vaccines for monkeypox that negatively affected the early rollout of COVID-19 vaccines.

▪ Provide effective global leadership.

Monkeypox has been circulating in a number of African countries for decades and attracted little research funding or political attention until outbreaks spread to high-income countries this year. Yet the World Health Organization late last month declined to declare monkeypox a Public Health Emergency of International Concern, a legal mechanism that triggers intensified global coordination, increased funding, and accelerated development of vaccines, diagnostic tests, and treatments. Even without being routinely fatal, monkeypox is still a pathogen worth containing to minimize the number of people afflicted with a painful illness, protect those most at-risk for serious complications, and reduce the risk of the emergence of more lethal mutants. The US government should step up to fill the void, working with likeminded countries to coordinate resources and efforts.

With every emerging pathogen, there is always a narrow window of opportunity to stop small clusters of infections from spreading more widely. The United States failed to do this for past epidemics, including HIV and COVID-19. Monkeypox should be a relatively easier virus to control, but only if the United States takes the needed steps now.

Shan Soe-Lin is managing director of the *Boston-based Pharos Global Health Advisors and a lecturer in global health at the Jackson Institute for Global Affairs at Yale*

University. Robert Hecht is the *president of Pharos Global Health Advisors and a clinical professor of epidemiology at the Yale School of Public Health.*