

Over 100 monkeypox infections detected in 10 countries as unprecedented outbreak spreads globally

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An unprecedented outbreak of monkeypox virus has officially spread to 10 countries outside of Africa, with 107 confirmed or suspected cases reported as of this writing, in the United Kingdom (9 cases), Portugal (34), Spain (32), France (1), Belgium (2), Sweden (1), Italy (3), Canada (22), the United States (2), and Australia (1).

Much remains unknown about what is causing the outbreak, which is the most geographically dispersed and rapidly spreading monkeypox outbreak since the virus was first discovered in 1958. In the coming days and weeks, more data and scientific understanding will emerge, but already there is profound concern within the scientific community and among the public, which has found wide expression on social media.

In preliminary posts, scientists speculate that the virus, which is endemic in parts of Africa, could have evolved to become more contagious and better suited to human-to-human transmission. In addition, nearly all people under 42 years old have not received a smallpox vaccine (which is 85 percent effective at preventing monkeypox infection) since smallpox was eradicated in 1980. As a result, they have no immunity, and younger adults can be infected as easily as children. Since 2017, annual monkeypox cases have been steadily rising in Africa.

The fact that this monkeypox outbreak takes place amid the deepening COVID-19 pandemic has caused unease among a growing number of people, particularly those who have been alerted to threats to public health by the COVID pandemic. Over the past two years, the criminal negligence and policies of deliberate mass infection by the majority of world governments have needlessly killed over 20 million people worldwide. If capitalist society has disastrously failed to stop the preventable spread of COVID-19, what will transpire in the coming weeks and months with new or previously rare infections?

Since the peak of the global Omicron BA.1 surge in January, nearly every government outside China has scrapped all mitigation measures to slow the spread of COVID-19, falsely claiming that the virus has become “endemic.”

In the US, the Biden administration is presently doing nothing to stop the growing surge of the highly infectious Omicron BA.2 and BA.2.12.1 subvariants, which have once again driven the 7-day average of daily new cases above 100,000.

Due to the deliberate undermining of public health during the

COVID-19 pandemic, world society is deeply unprepared for this latest infectious disease outbreak, which could potentially develop into another parallel global pandemic.

On May 13, the World Health Organization (WHO) was first notified of two confirmed and one probable case of monkeypox in the same household in the UK. A British citizen who traveled to Nigeria developed a classic monkeypox rash on April 29, and subsequently returned to the UK on May 4, is considered a likely index case. Upon his return, he was immediately isolated and contact tracing identified chains of transmission, though health authorities indicated that onward risk of infections from this case is minimal. The source of infection in Nigeria has not been determined.

Regarding the UK cases, the WHO has stated, “In contrast to sporadic cases with travel links to endemic countries, no source of infection has been confirmed yet. Based on currently available information, infection seems to have been locally acquired in the United Kingdom.”

The emergence of multiple cases across different countries is deeply problematic. Dr. Jennifer McQuiston, the Deputy Director of the US Centers for Disease Control and Prevention (CDC) division of high consequences pathogens and pathology, told *STAT News*, “Given that we have seen now confirmed cases out of Portugal, suspected cases out of Spain, we’re seeing this expansion of confirmed and suspect cases globally, we have a sense that no one has their arms around this to know how large and expansive it might be. And given how much travel there is between the United States and Europe, I am very confident we’re going to see cases in the United States.”

Michael Osterholm, director of the University of Minnesota’s Center for Infectious Disease Research and Policy, added his concerns, stating, “There could be dynamic transmission here that we just haven’t appreciated because of the potential number of contacts.”

In nearly every public statement by epidemiologists, they have all admitted to being bewildered by how entrenched the virus already is in communities, given that it is normally extremely rare. Tom Inglesby, director of the Johns Hopkins Center for Health Security, told *STAT News*, “this is starting off with much more of a foothold, in a much more distributed way, and we don’t understand how it got into those networks.”

The monkeypox virus was first identified by Danish virologist Preben von Magnus in 1958 from crab-eating macaque monkeys used as laboratory animals, hence the name of the disease and the virus that causes it. Unlike the single-stranded RNA-based SARS-CoV-2, the virus that causes COVID-19, the monkeypox virus is a double-stranded DNA zoonotic virus, one of the human orthopoxviruses that includes the variola virus which causes smallpox.

The incubation period lasts about one to two weeks and symptoms of overt infection begin with fever, headache, fatigue, muscle aches and swollen glands. After a few days of high fever, distinct lesions appear, first on the face before spreading to other parts of the body. The lesions begin flat, then raise, containing fluid and pus. The lesions then scab over and can leave scars. The course of illness usually takes two to four weeks.

According to the WHO, human-to-human transmission is normally limited, requiring close contact with respiratory secretions or skin lesions of an infected person or recently contaminated objects. Saliva and respiratory droplet transmission are possible, placing health care workers and their family members at risk of infection. Some studies have shown that monkeypox could potentially be airborne, similar to SARS-CoV-2, although this has not been definitively proven.

Asymptomatic transmission is theoretically possible. Patients with monkeypox can suffer from secondary infections, respiratory distress, gastrointestinal disturbances, vision problems, and brain inflammation. Treatment is supportive.

The number of severe side-effects of the smallpox vaccine makes its use in a mass vaccination campaign problematic. However, due to the long incubation period for monkeypox, the smallpox vaccine can work as a post-exposure prophylaxis in a “ring vaccination” model.

Monkeypox is endemic to Central and West Africa and found mainly in the rainforest regions. There are two natural groups of viruses split into clades (groups with common ancestry) from the Congo Basin and West Africa. The first human transmission was reported in 1970 in the Democratic Republic of the Congo (DRC, then known as Zaire) in a nine-year-old boy in a region where smallpox had been eliminated two years earlier.

Since its emergence in human populations, monkeypox outbreaks have been primarily limited to the African continent. In a World Health Organization (WHO) surveillance between 1981 and 1986 in the DRC, 338 confirmed cases and 33 deaths gave the Congo Basin clade a case fatality ratio of roughly 10 percent, similar to SARS-CoV-1. The clade that has caused the current outbreak in Europe and North America is the milder West African clade, with a fatality rate comparable to SARS-CoV-2.

The first monkeypox outbreak outside Africa occurred in the Midwest of the US in the spring of 2003. The zoonotic source was pet prairie dogs that had been infected by African rodents brought in from Ghana. Since then, there have been more frequent reports of cases across the globe.

An outbreak in Nigeria that started in 2017 has been ongoing. The UK reported its first case of monkeypox in September of 2018 from a Nigerian national, and three additional cases were identified that winter. In May 2019, a middle-aged man traveling

from Nigeria was hospitalized with monkeypox in Singapore.

Amid the COVID-19 pandemic, three cases in a UK household with connection to Nigeria were identified on May 24, 2021. On July 16, 2021, an American traveling from Nigeria was hospitalized.

A report published in the CDC’s Emerging Infectious Diseases in April 2021, by Dr. Raina MacIntyre of the Kirby Institute in New South Wales, Australia, detailed the emergence of monkeypox in Nigeria, noting, “[t]he effect of a decline in individual-level immunity among vaccinated persons, as well as population growth in the [smallpox] postvaccination era, has substantially reduced the overall population immunity level within the past 45 years.”

Critical to the current global outbreak of monkeypox was the ending of the mass vaccination program for smallpox after it was eradicated in 1980, leaving the youngest in the population susceptible to monkeypox.

MacIntyre et al. wrote, “This contemporary susceptible population is composed mainly of working adults who maintain wider social contact and are more likely to engage in activities that include risk of animal exposures, such as hunting, farming, or trading bush meat. In addition, the expanding unvaccinated population means that entire households are now susceptible to monkeypox instead of just children, which enhances the risk of human-to-human transmission. In fact, the index case in 2017 was part of a five-member family cluster of cases.”

These observations for the Nigerian population are just as applicable to the global population. In a world deeply interconnected by travel and commerce, local outbreaks in one country are no longer isolated events.

As with COVID-19, the emergence of monkeypox and the lack of any internationally coordinated response by health authorities to address the crisis speaks to a much broader decay of public health precautions under the impact of the deepening crisis of capitalism.

The past two years of the COVID-19 pandemic and the deepening propaganda campaign that workers must “learn to live the virus” underscores the inability of capitalism to protect the lives and livelihood of the world’s population against any such threat.

It is both possible and necessary to eliminate monkeypox, SARS-CoV-2 and myriad other infectious diseases worldwide, but this will only happen through the development of a mass revolutionary movement of the international working class, the overthrow of capitalism, and the building of a world socialist society which prioritizes social needs over private profit.



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