IHR Emergency Committee stops short of declaring the monkeypox epidemic a global emergency

Benjamin Mateus
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Two days after the International Health Regulations (IHR) Emergency Committee deliberated on the current multi-country monkeypox outbreak, the World Health Organization (WHO) issued a statement on June 25, 2022. They wrote on the Committee's advice that the monkeypox epidemic does not constitute a Public Health Emergency of International Concern (PHEIC).

After the meeting, WHO Director-General Dr. Tedros Adhanom Ghebreyesus issued his own carefully crafted contributory remarks, writing, “I am deeply concerned by the spread of monkeypox, which has now been identified in more than 50 countries, across five WHO regions, with 3,000 cases since early May. The Emergency Committee shared serious concerns about the scale and speed of the current outbreak, noted many unknowns, gaps in current data, and prepared a consensus report that reflects differing views among the Committee.”

Under the IHR provisions, a PHEIC is “an extraordinary event, which constitutes a public health risk to other states through international transmission, and which potentially requires a coordinated international response.” Under such a declaration, countries have a legal obligation to respond promptly to the threat posed by the infectious pathogen or, for that matter, chemical agents and radioactive material that threaten populations of multiple geographic regions.

Since the first case of monkeypox was confirmed on May 6, 2022, in a British citizen flying back from Nigeria, the number of confirmed and suspected cases has climbed to 4,229, according to Our World in Data. The seven-day rolling average of new cases has been steadily rising; the latest figure is around 230 cases per day.

In all, 66 countries and territories have detected monkeypox infections. In Europe, Germany, Britain, Spain, France and Portugal are the epicenters of the monkeypox outbreak, and the US and Canada have each reported more than 200 monkeypox cases.

The Emergency Committee was briefed on the current assessment, including concerns raised on the lack of any epidemiological links to areas, mainly in west and central Africa, that are endemic for monkeypox, underscoring the undetected transmission that may have been proceeding for some time in the more impacted countries.

Under the present circumstances, why then didn’t the IHR Emergency Committee declare a PHEIC?

In their deliberations, the Committee remarked that most cases were among male patients, and “most of these cases occurred among gay, bisexual and other men who had sex with men in urban areas and are clustered social and sexual networks.” Also, there were challenges related to contact tracing because many of these cases arose through anonymous sexual contact. The Committee highlighted that many of these cases were linked to “international gatherings and LGBTQI+ Pride events” that facilitated exposure to monkeypox.

At the crux of their “differences” and hesitancy, as the WHO statement noted, “The Committee was concerned about the potential for exacerbation of the stigmatization and infringement of human rights, including the rights to privacy, non-discrimination, physical and mental health, of affected population groups, which would further impede response efforts. Additionally, for the protection of public health, some members of the Committee expressed the view that laws, policies, and practices that criminalize or stigmatize consensual same-sex behavior by state or non-state actors create barriers to accessing health services and may also hamper response interventions.”

This raises critical issues about balancing the public health safety of the general population through the

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declaration of a PHEIC, which would mobilize resources to contain the global outbreak, on the one hand, and the potential impact in exposing vulnerable people to state scrutiny and impeding public health efforts under way, as those potentially infected or exposed shy way from medical services and attention, on the other.

In other words, the social backwardness and ideological reaction expressed in hostile attitudes towards LGBTQ populations are actively impeding a more aggressive public health effort to suppress a potentially deadly disease.

Monkeypox has been endemic in Africa for several decades. Since January 2022, more than 1,450 people have been infected in endemic African countries, and 66 have died, predominately in the Democratic Republic of Congo.

However, the wealthy countries have neglected to provide any funding and resources for research and infectious disease control in these regions, let alone access to vaccines and antiviral treatments. The consequences of this neglect have been predicted, and since 2018 the emergence of human-to-human transmission should have prompted a thorough international collaboration.

Director-General Ghebreyesus accurately noted in his remarks, “What makes the current outbreak especially concerning is the rapid, continuing spread into new countries and regions and the risk of further, sustained transmission into vulnerable populations including people that are immunocompromised, pregnant women, and children.”

Instead of a PHEIC, the Committee insisted that there is a need to engage these communities and identify critical activities that place individuals at risk. The Committee said it would be essential to work “in close partnership with affected communities to raise awareness about personal protective measures and behaviors during upcoming events and gatherings.”

They added that knowledge gaps about the outbreak's nature must be closed quickly to “support a more comprehensive assessment of the public health risk of this event.” These include “transmission modes, the full spectrum of clinical presentation, infectious period, reservoir species and potential reverse zoonoses [human to animal transmission].” An accounting of access to vaccines and antivirals and their efficacy needs to be made to public health authorities.

Though the Committee finally decided that at the current stage, the outbreak did not yet constitute a PHEIC, they acknowledged the emergency nature of the epidemic and planned to readdress the issue in the next three weeks based on reevaluating the rate of growth of cases, “both among and beyond the population groups currently affected.”

Dr. Jay K Varma, an epidemiologist with experience in epidemic responses to infectious diseases who teaches at Weill Cornell Medical Schools, raised concerns that in the United States there are many more cases going undetected, as compared to Europe. In particular, he raised concerns that such infections may be more severe among people with HIV.

The Centers for Disease Control and Prevention (CDC) has acknowledged unrecognized community transmission. According to Varma, many emergency room physicians, inexperienced with the signs and symptoms of monkeypox, are misdiagnosing cases.

Varma wrote in his guest opinion piece in the *New York Times*, “Why are cases being missed? One reason is that the United States lacks a sufficient number of clinics that specialize in sexual health, including family planning, sexual dysfunction, gender-affirming services, and STIs [Sexually Transmitted Infections]. Historically, most of these clinics have been affiliated with local health departments with public funding.”

There are serious concerns that allowing the monkeypox virus to entrench itself in human populations will have severe consequences for the most vulnerable, including the poor. The erroneous association with sexual transmission will further the social stigma that will only hamper the already beleaguered public health infrastructure.

And in the current era where democratic rights are being felled left and right, and funding for any social programs completely gutted, unscientific religious bigotry and backwardness will deem those with monkeypox as sinners deserving of the ravages of the plagues.

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