

Mpox: interdependence and inequity

The concept of Ubuntu, which originated in South Africa, implies the interdependence of human beings and can be captured by the phrase: I am because you are.¹ Mpox (formerly known as monkeypox) has reached high-income countries after it emerged in central Africa; indeed, with the increase in international travel, cases of mpox have been reported outside Africa in recent years, leading to the recent pandemic that caused 88 122 infections and 148 deaths worldwide.² However, there is little published information on what has happened to mpox in African countries, or whether these patients have received the care they deserve as human beings.

In this issue of *The Lancet Infectious Diseases*, Ogoina and colleagues³ present the results of the largest African study of 160 patients with mpox in Nigeria, describing the clinical characteristics and treatment outcomes of the disease during the 2022–23 global epidemic.

Although mpox cases in high-income countries during the pandemic were almost exclusively among gay, bisexual, and other men who have sex with men, in Ogoina's study this group comprised only 5.6% of infections, although some participants might not have disclosed their sexual orientation because Nigeria criminalises same-sex relationships. This disparity highlights the fact that the same virus (ie, monkeypox virus) can manifest differently depending on the environment and culture of the exposed population. In Africa, most infections were associated with contact with infected animal reservoir (probably rodents and squirrels), followed by human-to-human transmission, whereas in high-income countries infections were exclusively human-to-human transmission.⁴

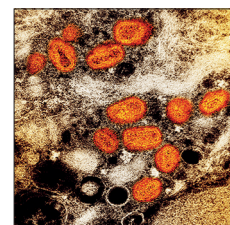
The authors found that a high number of rashes and a confluent distribution of rashes were independently associated with severe mpox. In this cohort, 29% of patients had mpox-varicella zoster virus co-infection, which was an independent predictor of severe disease in patients, as was HIV co-infection. This study recorded higher rates of hospitalisation, rash burden, varicella zoster virus co-infection, and more frequent secondary bacterial infections, which draws more attention to the severity of mpox in Africa compared with high-income countries.⁴ In addition, a case fatality rate of 6% was reported, which is much higher than that seen

in high-income countries (<1%) during the mpox pandemic.⁵ The investigators also reported that patients in Nigeria were treated only with antimicrobials, analgesics, and antihistamines; none received an mpox-specific treatment (eg, tecovirimat) or an mpox vaccine (eg, Modified vaccinia Ankara) because these medical countermeasures were not available in Nigeria. These treatments highlight the inequity in the treatment of patients in Africa compared with high-income countries where the patients usually have access to vaccines and appropriate treatment.

According to this Article and others from affected countries including the Democratic Republic of the Congo, Central African Republic, and Cameroon, the main challenges of mpox are surveillance and diagnosis, low awareness and education, insufficient health-care infrastructure in rural areas where mpox cases occur, high-risk populations, and low vaccination coverage.^{5,6} To address these challenges, it is essential to strengthen disease surveillance; improve laboratory capacity; intensify risk communication and community engagement, education, and public awareness campaigns; and ensure access to appropriate health services in affected areas. Interinstitutional collaboration is essential to effectively manage and control the spread of mpox in Africa. At the national level, Ministries of Health could integrate mpox into national AIDS and STI control programmes. Partnerships with international health organisations and local communities are also crucial to implement adequate prevention and response measures including targeted communication to sensitise the population.

The study was done by Nigerian scientists and sends an important message to African leaders to invest more in research, in line with the Abuja Declaration.⁷ This investment will help African scientists to strengthen subregional collaborations to enhance cross-border epidemic control, optimise the collection and analysis of epidemiological data, understand the patterns and characteristics of different pathogens within their populations, and therefore find local solutions to the continent's health problems, rather than adopting one approach to suit all, which doesn't work in most cases.⁸

A final lesson from the mpox pandemic is that infectious diseases are everyone's concern no matter



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appendix

where they arise. Investment in research and disease surveillance is crucial in low-income countries, because the world is interconnected. What happens in Bangui, Central African Republic, can scale-up in San Francisco, CA, USA.

We declare no competing interests.

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