Elsevier has created a Monkeypox Information Center in response to the declared public health emergency of international concern, with free information in English on the monkeypox virus. The Monkeypox Information Center is hosted on Elsevier Connect, the company's public news and information website.

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Diagnostic capacity is a key part of public and global health preparedness for newly emerging or spreading infections, and the recent global spread of monkeypox virus illustrates the consequences of inadequate diagnostic capacity. Monkeypox virus infection has a syndromic diversity—from asymptomatic infection, to isolated skin lesions, to fever and disseminated rash. Many recent monkeypox virus infections presented with lesions in the genital area alone, inconsistent with previous syndromic diagnoses in sub-Saharan Africa and the USA. Therefore, relying on syndromic cluster investigation could misclassify these infections as other genital ulcer diseases, allowing monkeypox virus transmission to continue unchecked. Furthermore, inadequacies in diagnostic access have contributed to our collective failure to identify, understand, and control monkeypox in sub-Saharan Africa over the past 50 years, long before it was declared a Public Health Emergency of International Concern after spreading to high-income countries.

Diagnostic tests are essential tools that safeguard health security by identifying the cause and helping mitigate the impact of public health events. Diagnostic testing alleviates the effect of such events by permitting early disease detection, strengthening and focusing outbreak response, improving health-system surge capacity, and increasing community resilience. Delays in pathogen identification postpone targeted infection prevention and control measures, and diagnostic scarcity interferes with early outbreak recognition. If monkeypox diagnostic capacity had been widely available throughout central and western Africa, preferably with a point-of-care rapid diagnostic test, monkeypox outbreaks would possibly have been easier to detect and control locally, thus preventing human sickness and death, and decreasing the risk of international spread.

Diagnostic paucity interferes with the surge capacity of health systems. Preparation cannot be accomplished in a data void. Early diagnosis allows leadership to predict when medical demand will exceed the capacity of the existing infrastructure, if there has not been time to effectively respond. Real-time diagnostic information allows incident command to monitor the outcome of interventions. Commitment to early diagnosis of monkeypox, preferably at a local level, would cause an increase in demand of diagnostics, thus enabling accelerated production and distribution of monkeypox diagnostics, vaccines, and antivirals.

Bolstering diagnostic capacity at the local level improves community resilience to public health events by allowing a decentralised response. Using six tracer conditions, the Lancet Commission on diagnostics describes the sobering need for diagnostics: 47% of the world’s population does not have adequate access to testing of these six tracer conditions, the single largest gap in the care pathway. Although local communities are often capable of responding to emergencies more easily than large bureaucracies, a dearth of local information interferes with their ability to analyse their own situation. Substantial investment is needed to develop, evaluate, and adapt existing tools to address diseases of epidemic potential. This investment cannot be accomplished by the private sector alone, as there is no viable market for diseases of epidemic potential such as monkeypox. Private–public partnerships between clinicians, researchers, regulators, policy makers, and companies might provide a way forward by determining a background need for surveillance of designated diseases, thus creating demand for initial diagnostic development for which production could be increased when an outbreak is detected. The Biomedical Advanced Research and Development Authority is an example of such a partnership. By providing technical and financial support for the late stages of product development, the Biomedical Advanced Research and Development Authority connects public and private spheres to respond to emerging infections, including monkeypox.

Additional international programmes for diagnostics are needed.

The scarcity of diagnostic access at the community level is an equity issue with disproportionate effects in low-income and middle-income countries. Diagnostic capacity in primary care clinics in low-income and middle-income countries could be as low as 1% (based on the WHO service readiness index). It is often said...
that pandemics do not create new problems, they merely make us face problems that we have long ignored. Poor diagnostic access for laboratory services is one such problem that has been raised as the Achilles’ heel of global health since 2006, and yet here we are again facing this inequity with the uneven ability to detect and control monkeypox outbreaks worldwide. Previous monkeypox outbreaks in sub-Saharan Africa and multistate outbreaks in the USA in 2003, would have been an ideal time to strengthen monkeypox diagnostic surveillance. By improving outbreak response, surge capacity, and community resilience, diagnostic access is essential to improving global health security and necessitates sustainable support from diverse organisations to keep the global population safe. We cannot continue to sleep through the alarm.

We declare no competing interests.

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HPV vaccination and cervical cancer screening in Afghanistan threatened

War-torn Afghanistan remains in the spotlight because of political unrest, violations of humanitarian conventions, budgetary constraints, and an overwhelmed health sector, which compels us to highlight barriers to the eradication of vaccine-type human papillomavirus (HPV). Alarming, there has been an upsurge in cervical cancer incidence in 2020, with 1200 new cases and 15–44 years. Under the Taliban’s discriminatory policy, women are prohibited from leaving their homes without a Mahram (adult male family member or husband), which restricts their access to health-care facilities. Furthermore, when considering sexual transmission as a possible route of HPV transmission, sexual norms in Afghanistan differ from those in European countries, and sex education is considered a social taboo. Afghanistan also does not meet standards to eliminate sex trafficking and the Taliban have prevented efforts to protect vulnerable populations.

A modelling study showed that adopting HPV vaccination in low-income and middle-income countries might prevent 12.5–13.4 million cervical cancer cases by 2069. Some south Asian countries have launched nationwide HPV vaccination programmes. Bhutan was the first in the region to do so in 2010, followed by Thailand in 2017, Sri Lanka in 2017, and the Maldives in 2019, and pilot projects have been done in Bangladesh and India. However, to date, HPV vaccination has not been included in Afghanistan’s national immunisation programmes, and the country has no immediate plans to do so in the near future.

Alongside policy making, we must not overlook the diverse challenges faced during polio and COVID-19 immunisation drives in Afghanistan, as well as low vaccination coverage, poor vaccine logistics, geographical barriers, vaccine illiteracy, human resource capacity, the killing of health workers, the rapid migration of refugees, inadequate surveillance methods, and hesitancy towards vaccination due to religious beliefs. The economy of...