Silence Can Be Damaging

How to talk about monkeypox without doing harm

PAHO Pan American Health Organization World Health Organization Americas

PAHO 120th ANNIVERSARY

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NOTE ON THE FIRST EDITION

This is the first version of this guide, based on existing information and evidence as of 20 August 2022. The dynamics and evolution of the monkeypox outbreak will be followed closely and there will be revisions and updates. The purpose of this guide is to provide resources so that people can work together to address the emergency created by the monkeypox outbreak, drawing on participation from civil society, communities, and in particular, organizations working with gay and bisexual men, and men who have sex with men.

1. INTRODUCTION

How to deal with a viral outbreak concentrated in a population

Several countries experienced outbreaks of monkeypox in May 2022. This disease mostly affects gay and bisexual men (98% of those infected according to the World Health Organization, WHO), although other men, primarily those who have sex with men, can also be infected. The question is what measures can be taken to help contain transmission without fomenting or increasing the stigma and discrimination associated with sexual orientation that already affects these populations.

It is important to note that anyone can contract monkeypox through contact with lesions or fluids from an infected person. Although the epidemiological profile of the disease is highly concentrated at this time, recommendations on care are applicable to the entire population.

In this outbreak, most cases are in gay and bisexual men who had more than one sexual partner in the three weeks prior to diagnosis. Monkeypox is not strictly considered a sexually transmitted infection; however, it should be borne in mind that transmission is mostly (95%) associated with sexual activity, and that the virus is found in skin lesions and mucous membranes, as well as in body fluids.

The epidemiological situation, the disease's forms of transmission, and the fact that most cases are concentrated among gay and bisexual men constitute a combination of factors that can intensify stigma, discrimination, and in some cases even criminalization. If it is not addressed with clear, targeted, and efficient communication strategies and interventions, and if health workers, communicators, journalists, and government workers are not adequately sensitized, this health crisis could reach a level comparable to the early years of the AIDS epidemic, when newspaper headlines called the new disease the "pink plague" or "gay cancer." A similar situation today could pose a risk of violence stemming from homophobic attitudes.

It is important to create positive narratives that emphasize that a community facing an outbreak can take care of itself and its environment, and to avoid pessimistic narratives that reinforce prejudices, leading, for example to the belief that people with symptoms are unlikely to seek medical consultation in order to avoid having to isolate, that they will not respect isolation periods, or that they will continue to transmit the infection through sexual intercourse during the acute phase of the disease.

In this connection, it must be clearly stated that contact tracing is not a mechanism for persecution, but rather, a reflection of people's right to know whether they have been exposed, so that they can take action accordingly. As a general rule, it is important never to use words or phrases associated with war or violence, such as fight, combat, attack, or invade.

The search for symptomatic cases can be included in activities to prevent human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and viral hepatitis in key populations. As part of such an approach, the comprehensive preventive actions shown in Table 1 are also recommended *(1)*.

Table 1. Comprehensive health intervention packages for gay men and men who have sex with men (MSM)

Essential for impact: Interventions that facilitate change
• Eliminate punitive laws, policies, and practices
• Reduce stigma and discrimination.
• Empower the community
• Address violence
Essential for impact: Health interventions
• Prevent HIV, viral hepatitis, and STIs
• Distribute free condoms and lubricants
• Post-exposure prophylaxis for HIV (PrEP)
• Post-exposure prophylaxis for HIV and STIs (PEP)
• Prevent vertical transmission of HIV, syphilis, and HBV
• Hepatitis B vaccination
• Address *chemsex*
Diagnosis
• Test for HIV
• Test for STIs
• Test for hepatitis B and C
Treatment
• Treat HIV
• Detect, diagnose, treat, and prevent tuberculosis associated with HIV
• Treat STIs
• Treat the hepatitis B virus (HBV) and hepatitis C virus (HCV)
Essential for overall health: Health interventions
• Protect anal health
• Protect mental health
• Detect and treat dangerous and harmful consumption of alcohol and other substances

Note: HIV: human immunodeficiency virus; STIs: sexually transmitted infections; HBV: hepatitis B virus;

What intensifies stigma and discrimination related to monkeypox

According to WHO, stigma and discrimination connected with any disease, including monkeypox, are never acceptable; they can seriously impact health outcomes, and undermine the response to the outbreak by making people reluctant to come forward or seek medical care. *(2)*

Silence, inappropriate communication, and a proliferation of inaccurate or false information create a vicious circle: despite lesions and discomfort, affected people may choose not to consult health professionals for fear of losing their anonymity or being subjected to stigma and discrimination. Meanwhile, promoting a discourse that puts blame and responsibility on a group of people for specific sexual practices fosters stigma.

Why we created this guide

For all these reasons, it is important that the various actors—LGBTQI+ communities, including especially gay groups and leaders; civil society organizations working with HIV issues; health professionals and their associations; government workers, and decision-makers—all assume responsibility for meeting the famous first principle of medical practice: primun non nocere, "first, do no harm." Achieving this means becoming informed: consulting scientific sources, drawing on evidence-based facts, and promoting active community participation to counteract the effects of stigma and discrimination. During the COVID-19 pandemic, we saw a parallel pandemic of disinformation—an "infodemic" that dampened demand and hindered access to preventive interventions in large sectors of the population (e.g., rejection of vaccines) *(3)*.

For all these reasons, the Pan American Health Organization (PAHO) considers it necessary to publish this guide, with the following objectives:

- **To reinforce what is known about monkeypox, its transmission, prevention, diagnosis, and treatment, including vaccines.**
- **To encourage, with communities, the bidirectional production and dissemination of information, educational content, and communication materials.**
- **To provide resources that facilitate dialogue among communities, with special emphasis on those most vulnerable.**

2. WHAT DO WE KNOW ABOUT MONKEYPOX?

What is monkeypox?

Monkeypox is characterized by rash or skin lesions traditionally described (prior to this outbreak) as being concentrated on the face, palms of the hands, and soles of the feet. The disease was first reported in Africa in 1970.

According to PAHO, monkeypox is a viral zoonosis (a virus from an animal that finds its way into human beings) caused by a virus of the genus Orthopoxvirus (to which the common smallpox virus also belongs) *(4)*. There are two genetically differentiated strains of the virus: the Congo Basin strain in central Africa (now renamed clade I) and the West African strain (clade II). Human clade II infections appear to cause less severe disease than the clade I strain.

In May 2022, cases were reported in several countries where monkeypox is not endemic, including countries in the Region of the Americas. On 23 July, the Director General of WHO declared the multi-country outbreak of monkeypox to be a Public Health Emergency of International Concern (PHEIC). The distinguishing feature of this outbreak is its high concentration in gay and bisexual men and in other men who have sex with men (MSM). Some differences in symptoms and clinical signs are also present: genital lesions as the primary symptom, greater frequency of proctitis and pharyngitis, a significant proportion of patients with only a small number of lesions, lesions at different stages of development, and appearance of lesions before the onset of general symptoms such as fever and general malaise.

How is monkeypox transmitted?

Monkeypox is transmitted by direct or indirect contact with blood, body fluids (including secretions from the respiratory tract), skin lesions, and mucous membranes of people with the infection, as well as by contact with contaminated objects.

The most frequent mechanism is contact with skin lesions (papules, blisters, pustules, and scabs). Transmission by respiratory droplets during close face-to-face contact with an infected person can also occur, but the risk of this type of transmission in the current outbreak is not yet known. A less frequent but possible route is skin contact with contaminated surfaces that have been in contact with lesions of an infected person (e.g., personal clothing, bedding, doorknobs, etc.). Infection is also transmitted through the placenta (congenital monkeypox) and can affect the fetus.

What are the symptoms of monkeypox?

The incubation period for monkeypox (time from infection to onset of symptoms) is usually between six and 13 days, but has consistently been under a week in this outbreak.

There are two stages:

1. **The acute period (up to five days) is characterized by fever, intense headache, lymphadenopathy (swelling of the lymph nodes), back pain, myalgia (muscle ache), and intense asthenia (lack of energy). Lymphadenopathy is a feature of monkeypox that distinguishes it from other diseases that may initially appear similar (chickenpox, measles, smallpox).**
2. **The rash usually begins within one to three days after onset of fever and is usually more abundant on the face and limbs than on the trunk. It affects the face in 95% of cases and the palms of the hands and soles of the feet in 75% of cases. Also affected are the oral mucous membranes (70% of cases), genitalia (30%), and conjunctivae (20%), as well as the cornea. In this outbreak, as noted above, there may be few lesions, and these may appear one or two days before fever and swollen glands.**

The rash evolves from macules (lesions with a flat base) to papules (slightly raised firm lesions), vesicles (lesions filled with clear fluid), pustules (lesions filled with yellowish fluid), and scabs, which dry up and fall off. The number of lesions can vary from a few to several thousand. Sometimes the lesions move directly from the papule stage to umbilical lesions and ulcers, which then become scabs. In severe cases, lesions can coalesce until large sections of skin slough off.

Monkeypox is usually a self-limiting disease with symptoms lasting between two and four weeks. Severe cases are related to the extent of virus exposure, the person's health, and nature of any complications. Pregnant women, children, and people with severe immunosuppression are considered to be at increased risk of serious complications.

The complications associated with monkeypox can include secondary infections, bronchopneumonia, sepsis, encephalitis, myocarditis, and infection of the cornea with ensuing loss of vision. It is not known to what extent asymptomatic infection can occur, but there are three described cases in which the virus was detected in rectal swabs taken for STIs, but no symptoms were identified in follow-up.

It is believed that people vaccinated against smallpox in the 1970s as part of a campaign to eradicate that disease may have some protection in this outbreak, but it is also possible that these people are no longer protected. It remains unknown whether the progression of the disease is better among vaccinated people than among the unvaccinated.

How is monkeypox diagnosed?

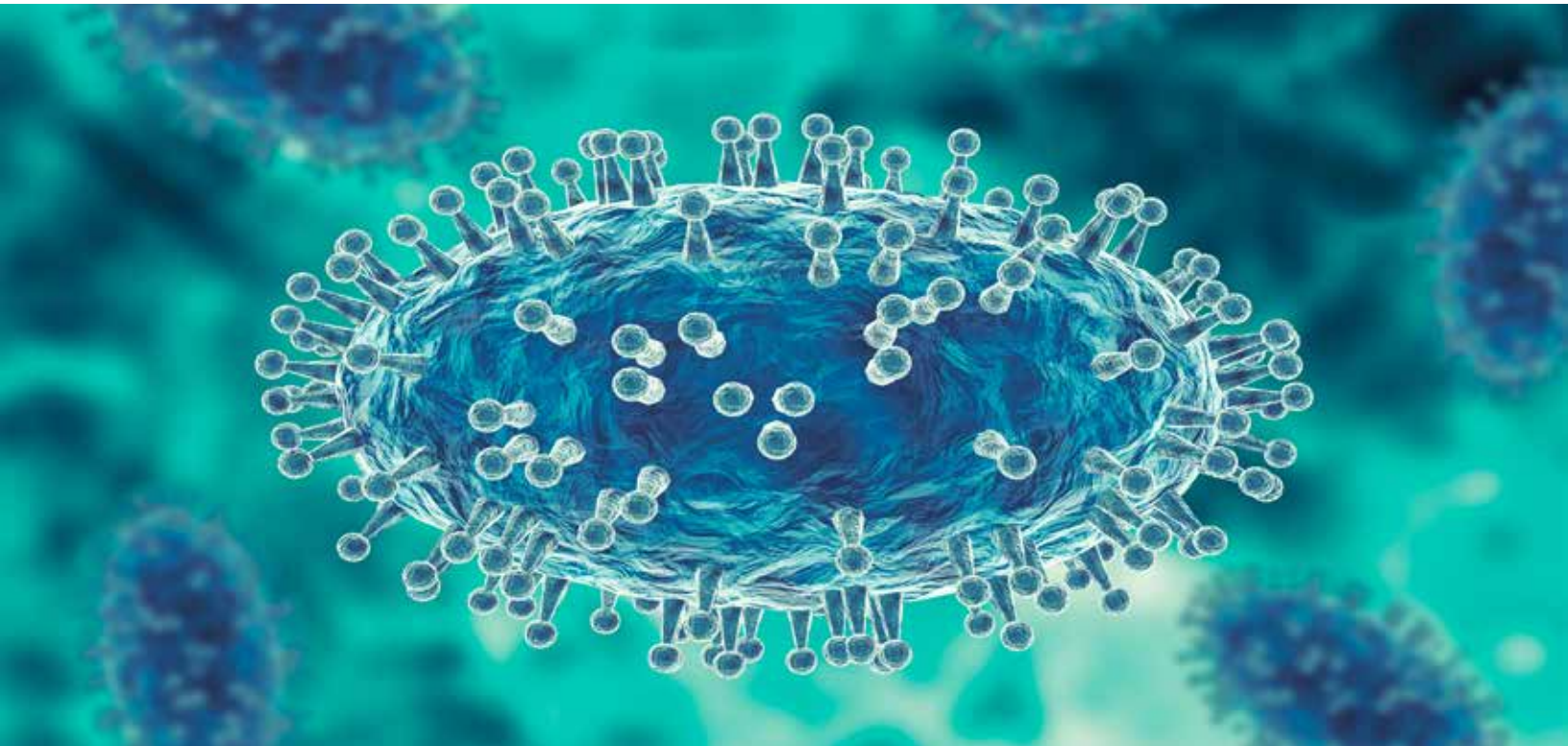
IInitial differential diagnosis must consider the elements (lesions and other symptoms) that differentiate it from other conditions involving rashes, such as chickenpox, measles, bacterial skin infections, scabies, syphilis, and medication-associated allergies. When lymphadenopathy is one of the first symptoms, this clinical manifestation may help distinguish monkeypox from chickenpox. In the context of this outbreak, however, suspicions of monkeypox are not to be lightly dismissed, especially in anyone exposed to a known case or to someone who has multiple sexual partners.

It should be noted that diagnosis of an STI does not rule out the presence of monkeypox since, in different studies, between 17% and 27% of monkeypox cases had an associated infection, especially syphilis *(5, 6, 7)*.

Confirmation of monkeypox depends on the type and quality of the sample and the type of laboratory test used. Where monkeypox is suspected, health professionals should obtain a well-preserved sample and send it to a laboratory in a dry, sterile, refrigerated tube. The best samples for diagnosing monkeypox are swabs from skin lesions, scabs, vesicles, or pustules.

Polymerase chain reaction (PCR) is the preferred laboratory test, due to its accuracy and sensitivity, but PCR blood tests are often inconclusive because the viral load (viremia) is not yet heavy enough to detect if the sample is taken too soon after the first appearance of symptoms. Thus, routine blood extraction is not recommended unless samples are meant to be saved for later serological studies.

In order to interpret test results, the following patient information must accompany samples: date of onset of fever; date of onset of rash; date sample was collected; patient's current health status (stage of rash); and patient's age.



What is the treatment for monkeypox?

There are no specific treatments for infection by the monkeypox virus. Symptoms usually resolve spontaneously. The best possible clinical care should be provided for monkeypox to alleviate symptoms, manage complications, and prevent long-term sequelae. It is important to take care of the rash by letting it dry if possible, or by covering it with a moist dressing to protect the area if necessary. The ulcers should not be touched. Mouthwashes and eye drops can be used.

The efficacy of some antivirals (tecovirimat, brincidofovir, cidofovir) has been documented in animals, but there are not yet clinical data demonstrating their efficacy in humans. Some countries have started using these antivirals under emergency use authorization. In this context, WHO recommends that if they are going to be used, it should be as part of a controlled clinical trial, and if clinical trial is not an option, as an expanded indication, with information recorded to establish the safety of the drug.

The figure shows the infographic of self-care recommendations issued by WHO for people with monkeypox *(8)*.

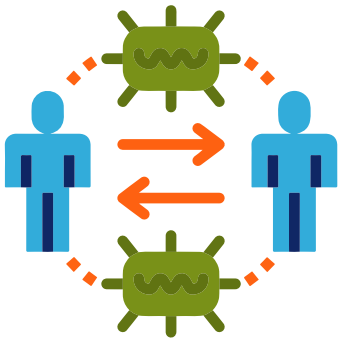
Figure. Self-care guidelines

Source: World Health Organization. Recovering from monkeypox at home Geneva: WHO; 2022. Available at: https://www.who.int/en/multi-media/details/recovering-from-monkeypox-at-home.

Recommendations for people at home with monkeypox include the following:

- **Isolate in a separate room, do not share a bed, and use a separate bathroom. If this is not possible, the person with monkeypox should be extremely careful, wearing a mask or chinstrap and gloves. If a bathroom is shared, it should be disinfected after each use[1].**
- **Bed clothes, sheets, and towels should be washed (in a washing machine or by hand) with hot water (above 60° C). For white clothes, bleach can be used (50–100 ml) in addition to soap.**
- **Glasses, plates, and cutlery should not be shared or reused without being washed with hot water and detergent.**
- **All areas can be disinfected with commercial products that have been used to prevent COVID, such as water with bleach (1:50 ratio), or a mixture of 70% ethyl alcohol and 30% water in a spray.**
- **Both patient and caregiver should wash their hands frequently with soap and water or use an alcohol-based gel.**
- **Good ventilation is very important where there are people with monkeypox: windows should be kept open, if possible, and brooms and vacuum cleaners should not be used to clean the floor.**

How we can reduce the risk of person-to-person transmission.



Rapid detection of new cases and contact tracing are critical to containing epidemic outbreaks. During human monkeypox outbreaks, close contact with an infected person is the most significant risk factor for infection. The risk of infection is highest for sexual partners, and next highest for people living with a person who has the disease. Health care workers may be at increased risk if they do not take the usual infection control precautions.

Samples taken from people and animals suspected of being infected with monkeypox virus should be handled by trained staff working in suitably equipped laboratories. Patient specimens must be safely prepared for transport, using triple packaging in accordance with WHO guidance for the transport of infectious substances.

[1] In many homes it is impossible to guarantee isolation. In these cases, it is recommended to contact the local health center or municipality to arrange accommodations for the symptomatic person in a nearby residential facility or hotel.

3. STIGMA AND DISCRIMINATION ASSOCIATED WITH MONKEYPOX

Understanding stigma and discrimination

The outbreak of a communicable disease can reactivate social stigma and discrimination, as well as fostering internalized stigma in the most vulnerable people.

In the case of monkeypox, as reported by WHO *(9)*, the highest proportion of cases is seen in gay and bisexual men—a fact that favors social stigma and discrimination, as well as institutional discrimination by health workers. Anyone can contract monkeypox, but social stigma is exacerbated by many people's perceptions, beliefs, and value judgments, in addition to the narratives that the media may construct and the information circulating on social networks.

In the health field, stigma consists of negative associations made between a specific disease and a person or a group of people who share certain characteristics *(10)*. Lack of information, prejudice, and fear increase discrimination, so that stigmatized people may be rejected, stereotyped, discriminated against or mistreated, or may be victims of violence because of their perceived or actual link to the disease. Stigma and discrimination affect not only the people suffering from a disease, but their entire families and social environments.

The problem of stigma and discrimination against certain populations cannot be solved in the course of an epidemic: it is an historical phenomenon that can intensify when there is an outbreak of a disease for which there is no proven treatment or effective vaccine, and this reaction is especially strong with communicable diseases.

While many people may not be aware that they discriminate or use discriminatory language, there are groups, including some political and religious groups, that see monkeypox as an opportunity to negatively single out affected communities and judge or punish specific practices. Nor must we ignore the fact that directly affected populations may, in addition to suffering the stigma and discrimination associated with their sexual orientation, live in a country with laws and regulations that criminalize homosexuality or related practices.

Stigma and discrimination have many negative impacts on efforts to control an outbreak and on the people affected. The most relevant structural barrier has to do with timely access to health services. If health services and professionals have not been trained or sensitized, they may be less friendly, resulting in lost opportunities for prevention, diagnosis, and treatment, as well as voluntary contact tracing with a human rights approach.

Many people in key positions for a response to the situation may not want to be associated with an outbreak associated with contradictory feelings and prejudices, and this can delay health decision-making. In contrast, a well-informed leader who speaks publicly about monkeypox will have a positive effect on mitigating stigma and discrimination.

Actions to combat stigma

The WHO guidelines *(11, 12)* include information about the impact of stigma on the response to monkeypox. WHO also provides guidance on appropriate language and ways to address stigmatizing attitudes and discriminatory behaviors that may be part of policies designed to respond to the monkeypox outbreak. Some of these guidelines are described below.

• Listening to the needs of those affected

The experience of stigma and discrimination can vary from one person to another, even within a community. Affected communities need to be consulted in order to understand what they are experiencing. Creating feedback systems or taking advantage of existing systems, overseeing online and other discourse, and dialoguing with the community can all help gather data to provide information on action to prevent, diagnose, and manage this outbreak.

• Draw on empathy

Empathy is the ability to understand and share other people's feelings. It can help you understand how painful it is to be stigmatized, shamed, or rejected. Empathy, more than sympathy, helps ensure the dignity of people affected by monkeypox. Empathic communication places more emphasis on listening than on speaking. It focuses on showing understanding and acknowledging the difficulties people face.

The way information about monkeypox is communicated is essential to help those suffering from the disease to respond effectively, and to avoid fueling fear and stigma. An environment must be created where the disease and its impact are discussed and addressed in an open, honest, and effective way.

• Engaging social influencers

Leaders can inform people about monkeypox and raise awareness of the dangers of stigmatization. Influencers can urge people to recognize and avoid stigma, and can bring messages that reduce discrimination and prejudice to a large audience.

Influencers who are asked to communicate information about monkeypox (or any other disease) must be personally engaged and geographically and culturally aligned with the population they intend to influence. Before hiring influencers, you have to make sure that they will not contribute to the stigmatization of any group of people.

• Bring the voices, stories, and images of people who have experienced monkeypox, stigma, or discrimination to a large audience.

First-person stories and images help others relate to unfamiliar situations and circumstances. This can help humanize people suffering from the disease and reassure them, given that most of those who contract monkeypox have spontaneous, full recoveries. It can also help share stories about the negative impact of stigma and discrimination, and how people have dealt with them.

• Making the facts known

Stigma can be increased by lack of knowledge about how monkeypox is transmitted and treated, and about how to prevent infection. Share clear, simple, transparent, accurate, and country- and community-specific information about the outbreak, about options for treatment and vaccination, and about where to access health care and get further information.

• Representing diverse people

Anyone can get monkeypox. Be sure to make clear the diversity of people who may be affected by the disease. All materials should feature a diversity of affected people (race, gender expression and identity, age, etc.) working together to prevent the spread of monkeypox. Ensure that typeface, symbols, and formats are neutral and do not suggest any particular group.

• Supporting ethical journalism

The words used in the media are especially important, as they are likely to shape popular language and communication about monkeypox. Negative information can influence the perception and treatment of people with monkeypox or who are suspected of having it, as well as their families and affected communities.

- **Make sure that the media receive accurate information and guidance on monkeypox, and encourage them to use non-critical language in their reporting.**
- **Be aware that journalistic reports that focus excessively on individual behavior or that attribute blame increase stigma toward people who may have the disease or who are part of a community perceived to be responsible for its spread.**

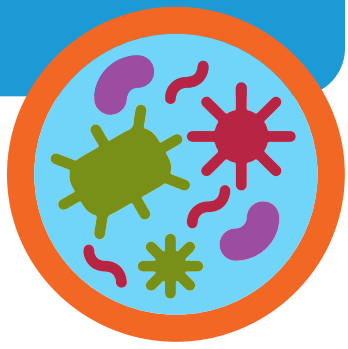
• Health care facilities and workers

It is urgent to identify the resources and the health personnel to which people with symptoms have the best access. The facilities that identify the most cases may be STI care facilities, health centers, pre-exposure prophylaxis programs, facilities open to sexually diverse individuals, infectology and dermatology clinics, and consultation and treatment facilities for HIV, proctology, and emergency care.

There is also a need to sensitize and inform personnel at all levels of each country's ministry of health, subnational administrative divisions, academic and professional organizations, and civil society. Awareness-raising must not be limited to the clinical aspects of monkeypox or the protection of individual health workers; rather, it must also foster inclusive, person-centered care that respects patients' rights and minimizes institutional stigma and discrimination. This approach will have significant impact not only during the current outbreak, but on health access and care for all populations.

Key messages

- Monkeypox is caused by the monkeypox virus (genus Orthopoxvirus, family Poxviridae).
- Monkeypox is a viral zoonotic disease that occurs primarily in tropical rainforest areas of Central and West Africa, and that sporadically jumps to other regions.
- Monkeypox typically presents clinically with fever, rash, and swollen lymph nodes, and may lead to a variety of medical complications.
- Monkeypox is usually a self-limiting disease with symptoms lasting from two to four weeks. Severe cases can occur. In recent times, the case fatality ratio has been between 3% and 6%.
- The monkeypox virus is transmitted to humans by close contact with an infected person or animal, or by material contaminated with the virus.
- The monkeypox virus is transmitted from one person to another by close contact with lesions, body fluids, respiratory droplets, and contaminated objects such as bedding.
- The clinical presentation of monkeypox resembles that of smallpox, a related infection that was declared eradicated worldwide in 1980. Monkeypox is less contagious and less severe than smallpox.
- Vaccines used during the smallpox eradication program also provided protection against monkeypox. New vaccines have been developed, one of which has been approved for the prevention of monkeypox.
- A previously developed antiviral for the treatment of smallpox has been authorized to treat monkeypox.



4. TALKING ABOUT MONKEYPOX MEANS TALKING ABOUT SEXUALITY.

The current monkeypox outbreak mostly affects gay and bisexual men, and other men who have sex with men and who have multiple sexual partners.

Information from the United States Centers for Disease Control and Prevention (CDC) indicates that 76% of people diagnosed with monkeypox had sex with more than one sexual partner in the three weeks prior to diagnosis[2]. The same data source reports that cases of monkeypox have increased among users of HIV pre-exposure prophylaxis (PrEP).

A concentrated epidemic

A study published in the New England Journal of Medicine analyzed the demographic and clinical characteristics of 528 monkeypox cases in 16 countries *(6)*, and found that: 98% of those infected were gay or bisexual men whose average age was 38 years; 41% of cases were people living with HIV, the great majority of them with well-controlled HIV infection; 96% of those with HIV infections were taking antiretroviral therapy; and the HIV viral load was undetectable in 95% of cases.

In view of these data, which show that the majority of cases are concentrated in MSM, many of whom have HIV infections, communication must be directed to the appropriate recipients at each juncture of the emergency—targeting the priority audiences without creating excessive attention that could be counterproductive for those groups, while effectively informing the rest of the population of the risks.

The strategy calls for creating information adapted for each segment of the population (general population and affected populations) using correspondingly specific language and distribution channels.

Excessive focus on sex and sexual intercourse

Monkeypox has not yet been classified as a sexually transmitted disease, but close contact during sexual intercourse has been identified as the main situation in which the virus is transmitted. WHO estimates that 95% of transmissions occur during sexual intercourse.

When reporting on monkeypox and communicating with the general public, there should be less emphasis on sexual intercourse, even if this jeopardizes the communication of key information for prevention. The disease is transmitted among men who have sex with other men.

[2] As of July 22nd, CDC analyses of the history of sexual exposure in the three weeks prior to diagnosis indicate that 27% of these patients had one partner, 40% had two to four partners, 14% had five to nine partners, and 19% had ten or more partners.

In addition, public health officials and some organizations are discussing whether to specifically advise gay and bisexual men to abstain from sex during the current outbreak or to reduce their casual sexual contacts. However, HIV/AIDS has demonstrated the failure of exclusively promoting abstinence, as was the case when the "ABCs" of prevention were recommended (Abstain, Be faithful, use Condoms).

It is key to be very clear about the target audiences and to create messages that will be acceptable to the most affected populations, who must be listened to and actively involved in the creation of the messages. It is also necessary to focus information and communication activities on the places and events where the risk of exposure is greatest.

Fear-based campaigns—which reinforce the idea that the danger is the people among whom the outbreak is concentrated, rather than in the virus itself—can have a negative effect and increase stigma.

Sexual practices cannot be controlled

One of the serious mistakes in the response to HIV and STIs was thinking that we can tell people how to behave in their sexual practices. Specialized health workers can talk openly with patients, as couples counselors can with clients, but it has been shown that risk reduction advice given in association with HIV tests does not change practices involving risk of exposure to HIV or STIs, a lesson that can be extended to monkeypox.

In this case, it is essential to know the most common practices of gay and bisexual men in order to understand the mechanics of exposure and focus the dialogue on prevention on concrete practices that reduce exposure within the usual forms of sexual encounter. It is very important not to underestimate the importance of listening, given that changes in some practices have already been observed. Health personnel should understand that the person in front of them is the last person who wants to contract monkeypox.

Providing clear, evidence-based information can encourage people to assess risk and make decisions to reduce or limit it. Some people will continue the sexual practices that are the most pleasurable for them. We must not forget that there are people who seek a sense of danger, and increase their casual sexual encounters accordingly. With these people, the approach should not be punitive, but should promote risk reduction through reliable and honest information, while encouraging autonomous adoption of protective behaviors.

Symptomatic infection by monkeypox can be extremely painful, and dehumanized treatment can make it even more painful. Nor does it help to treat people with monkeypox as if they were irresponsible children. Accordingly, health workers should be especially careful with the language they use. For this to happen and to increase adherence to physical distancing, health personnel must provide appropriate, detailed information and explain the social protection measures to follow during the monitoring period, and must do so with empathy throughout.

Why gay and bisexual men are more exposed to monkeypox

The answer seems quite simple: the sexual practices that are currently popular among gay, bisexual, and other men who have sex with men involve exposure

to skin and mucous membranes, in some cases for an extended time and with multiple people at the same time.

The following sexual practices are common among gay, bisexual, and MSM men, and in the places they frequent, which are connected with exposure to monkeypox.

Sexual practices and symptoms

Oral sex and anal penetration have been associated with clinical forms of monkeypox: proctitis with receptive anal sex, and pharyngitis with receptive oral sex.

Places where there may be more transmission of monkeypox

A significant percentage of sexual practices occur in private homes and hotels, but there are other settings. It is important to note that anywhere anonymous and group sex practices occur is a setting that provides an opportunity for context-specific prevention activities with those who oversee such spaces, and their users:

- **Dark rooms.** There are establishments with labyrinths, booths, and spaces—many of them dark or unlit—where sexual encounters with one or more people take place.
- **Parks and public baths.** Many gay and bisexual men move about parks and public baths, especially at night, in search of sexual partners.
- **Saunas.** Saunas in general, and saunas for gay and bisexual men in particular, are places for couples and groups to meet and have sex.
- **Game rooms.** In the culture of sadomasochism (S/M) and in within the dynamics and games of bondage, domination/submission, sadism, masochism (BDSM), there are establishments that rent rooms equipped for these practices.
- **Hotels and private apartments.** The increasing practice of long sessions of group sex involving 'chemsex' has moved these practices to private spaces.
- **Bars, discotheques, parties.** Some members of the gay community engage in group dancing, with the physical contact, hugs and kisses, and skin contact with bare torsos, which increases the risk of exposure to monkeypox if someone is infected. Advising participants to keep shirts on, or making the use of shirts mandatory in these places during an outbreak of monkeypox, can help to reduce the spread of the virus.

Current trends that increase the number of sexual relations

- **Social media and dating apps.** EPractically every city in the world has businesses that provide apps to quickly find people for sexual encounters. They are also used by couples and groups. These apps can be an excellent tool for conveying messages that create awareness of the issue and increase its visibility.
- **Chemsex.** As the word suggests, chemsex involves combining chemicals, i.e., recreational drugs, with sexual activity *(1)*. This sexualized use of substances is an emerging trend in the sexual practices of gay and bisexual men *(13*), and has spread especially in group situations. Not all sexual practices that occur while under the influence of drugs are considered chemsex. An inhibition-reducing, stimulating, analgesic, muscle-relaxing, and sexual performance-enhancing effect is what makes chemsex a practice that fosters the circulation of monkeypox, STIs, and viral hepatitis *(14)*.

The most commonly used substances in the practice of chemsex are GHB/GBL (liquid ecstasy), mephedrone ('meph'), cocaine, amyl nitrite ('poppers'), methamphetamines, ketamine, and MDMA ('molly'). Some of these psychoactive substances create heavy dependence *(15)*. Chemsex has been associated with overdoses, suicide, addiction, mental health problems, and sexual assault. It can also have a heavy impact on sexual health and well-being.

- ***Slamming***. This term is used to describe the injection of drugs in a recreational sexual setting (not in other contexts), usually involving gay and bisexual men *(16)*. The most commonly used substances are methamphetamine and mephedrone. The goal is the same as in chemsex: to reduce inhibition and extend the duration of the sexual encounter. Many people share syringes during a slamming session, and this is the most efficient way of transmitting HIV and viral hepatitis. This form of drug use in the context of sexual relations has not become as widespread as chemsex. Many of the risks of injectable drugs are due to the sharing of needles during these sexual activities.

Demographics of these practices

Initially, chemsex and slamming were concentrated in a sub-population of middle- and upper-middle class gay men with the resources needed to acquire the substances and organize the group sex events *(17)*. However, there is a trend to promote the participation of gay, bisexual, and other MSM, and young people in particular, as guests at these events *(18)*. For this reason we should not pigeonhole the populations most involved in this practice. Both practices are still subject to a degree of taboo within the gay and bisexual community. This, added to the illegal status of the drugs used in this context, makes it difficult for people to talk openly with health workers, or even with friends.

5. MONKEYPOX AND HIV

As would be expected, the first gay and bisexual people whose diagnoses were communicated to the corresponding epidemiological surveillance system are those who most frequently consult health professionals: gay and bisexual men living with HIV and in treatment with antiretrovirals. Their recurrent health care visits could explain how readily they are diagnosed. For the same reason, gay and bisexual people in PrEP programs are also over-represented in some analyses of the outbreak emergency.

There is no evidence that HIV infection predisposes a person to contracting monkeypox, but there are many things we do not yet know and that are being researched. Any differentiated approach to treating acute monkeypox (including such approaches as prophylaxis through vaccination) is in the private sphere and is connected with professional health practices and the guidelines implemented by the relevant authorities and professional associations. In any case, gay and bisexual men who regularly attend combined prevention services such as PrEP are candidates for more expeditious diagnosis and have better access to testing for monkeypox.

That said, this publication does not set out to provide an exhaustive analysis of comprehensive care for gay mean and MSM as one of the five key populations. Accordingly, it is advisable to read Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations *(1)*.

The fact that a significant percentage of diagnosed monkeypox cases are in people with HIV may be related to the fact that these people have greater access to the health system and better knowledge of it, and need to periodically visit health care facilities. Another factor is the fact that HIV infection leads to more open relationships between health personnel and patients, which creates a safe space to talk about issues related to patients' sexual practices and the possible appearance of STIs or viral hepatitis. Hence, what we see today in the figures on diagnosed cases of monkeypox may reflect an epidemiological bias due to the fact that people with HIV generally have better and more timely access to health services than other populations.

For example, the vast majority of gay and bisexual men who do not live with HIV rarely consult a medical specialist, and indeed, the health system may not even provide them such access. In the Region of the Americas, this is evident in the fact that the implementation of large-scale HIV PrEP programs has been significantly delayed. In addition to the lack of incentive for gay and bisexual men to regularly visit a health center, there is a limited supply of sexual health services for this population. By their very nature, most health services are the main barrier to the identification and timely treatment of monkeypox, HIV, and STIs.

6. MONKEYPOX VACCINES

Some studies have reported that vaccines used during the smallpox eradication program also provide protection against monkeypox in approximately 85% of those vaccinated.

Following the eradication of smallpox, vaccines against the disease continued to be developed to make them available if needed. These vaccines were used in some countries for pre-exposure prophylaxis in laboratory personnel handling poxvirus, as well as in personnel assigned to specific activities in countries where the virus was endemic.

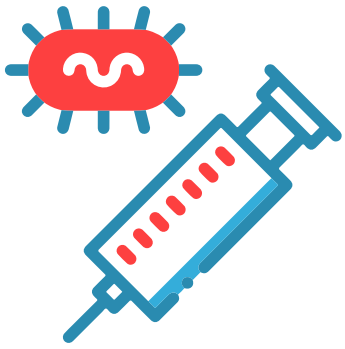
A still newer vaccine, based on Modified Vaccinia Ankara (MVA), was approved for the prevention of monkeypox in 2019. The vaccine is administered in two doses with an interval of four weeks in between. Some countries have used it for outbreaks triggered by imported cases of monkeypox.

It is important to note that this vaccine is a cell-based vaccine, which takes longer to be made available than new vaccines such as those for COVID-19. The availability of this vaccine is also limited because it was initially produced simply to maintain strategic stocks in some countries as part of preparedness for potential bioterrorism.

Independent of the issue of monkeypox vaccine supply, mass vaccination is neither necessary nor recommended at this time. Not enough information is available today to determine the effectiveness of vaccines against the current outbreak.

Some countries have already begun providing vaccines to specific populations or to contacts of monkeypox cases. It is important that countries implement a system to generate data on the effectiveness of these interventions.

In the meantime, it is recommended that vaccinated individuals continue taking steps to protect themselves from infection by avoiding close skin-to-skin contact, including intimate contact, with anyone who has monkeypox.



7. MYTHS TO ERADICATE THROUGH MESSAGES ABOUT MONKEYPOX

MYTH: Monkeypox is a sexually transmitted infection.

Monkeypox has not been classified as an STI. The presence of the virus in skin lesions and mucous membranes, in microdroplets that occur when speaking and sneezing, and in body fluids, means that the virus is transmitted by routes additional to the exchange of fluids during sex.

MYTH: Monkeypox is a disease of gay and bisexual men.

Currently, it is estimated that 98% of people with monkeypox infection are gay or bisexual men who have a significant number of casual sexual partners. A single sexual relationship or contact is sufficient to expose you to the virus, but an increased number of sexual partners increases the likelihood of exposure. However, monkeypox can also be transmitted to children, adolescents, young people, heterosexual men, women, and trans people.

A significant number of cases are expected within the gay, bisexual, and MSM population because the outbreak began there, but it will likely spread to other population groups, including heterosexual men, pregnant women, and children. It is essential at this stage that activities for information, awareness, vaccination, and diagnosis target the group most affected. However, in making these interventions, care must be taken not to exacerbate stigma and discrimination against gay and bisexual men.

It is important to communicate that, biologically speaking, every person, regardless of sexual orientation and practices, can develop the disease if exposed to the virus.

MYTH: Abstinence is the only way to protect yourself from monkeypox.

From the clinical and virological perspective, people who refrain for an extended period from any form of sexual intercourse or, broadly speaking, close contact, are unlikely to contract the infection. However, experience with HIV has given us ample evidence that abstinence is very difficult to achieve and sustain in people with an active sex life. Currently, many gay and bisexual men say they are practicing abstinence for fear of exposure to monkeypox until biomedical measures that provide effective protection become available. This is a possible strategy for effective protection, but requires a personal decision that each person must make independently after receiving clear and reliable information.

Taking all of this into account, actions and messages designed to reduce risk can be implemented. Such efforts to inform and create awareness must be based on truthful and clear information that provides the evidence on which individuals must make their own conscious decisions. The exponential growth of monkeypox cases in a community that has become more knowledgeable about the outbreak demonstrates that access to information does not always translate into behavioral change, and that the complexity of human sexuality is an impediment to behavioral change interventions as a form of prevention.

We must reiterate that anyone can be exposed to monkeypox by contact with fluids of a person who has the virus, and that the specific fluids with the highest viral load are those coming from skin lesions.

8. WORKING WITH STAKEHOLDERS TO IMPROVE RESPONSE

The personal and community impact of the monkeypox outbreak can be mitigated by a comprehensive response from each of the actors or stakeholders in each country. The following is a non-exhaustive list of actors, along with some recommendations.

Governments, health authorities, and specific programs

Faced with a health emergency, national governments (through their health agencies and specific programs) must invest technical and economic resources to address and contain the outbreak.

Countries are urged to develop national guidance, with specific management guidelines based on available scientific evidence and knowledge. Frequent updates should also be released as knowledge accumulates in this very dynamic outbreak situation.

The teams created by the national health authority must have community representatives to ensure communication that is well designed for the target audience. It is important to: review international recommendations and recommendations of scientific organizations; consider the most recent discoveries; listen to the experiences of health workers providing care for cases; and above all, listen to representatives of civil society and communities as a source of advice for fine-tuning actions, interventions, and recommendations.

Community-based LGTBIQ+ and HIV organizations

Community organizations for the LGTBIQ+ community and people with HIV are a critical link for effective response to the monkeypox outbreak. These organizations enjoy the most direct access to the vulnerable populations most affected by the disease and can function as intermediaries that provide the community with information and user-friendly services.

It is important for community organizations to be on the front line of communication, prevention, early diagnosis of cases, and outbreak containment. They should be composed of and led by the vulnerable populations themselves, providing first-hand knowledge and advice on how to reach communities with evidence-based recommendations in language that is inclusive and transparent. Early in the AIDS epidemic, some of the LGTBIQ+ (sexual diversity) movement was reluctant to work on HIV for fear of reinforcing the gay/HIV association and the associated stigma and discrimination. However, the current monkeypox outbreak affects almost exclusively gay and bisexual men; without the involvement of their organizations, the response will be only partial.

The participation of LGTBIQ+ and HIV organizations is a key tool for monitoring the language used, and thus avoiding the harmful impact of discriminatory language.

The media and influencers

Two current issues can exacerbate misinformation and lead to superficial treatment of information about the outbreak in today's media. First, it is increasingly uncommon for companies to have journalists specializing in scientific and health issues; and second, traditional media such as television and newspapers often pick up and repeat news from social networks, increasing the risk of inaccurate or false information. Thus, the media often function as a sounding board for disinformation, exacerbating the infodemic.

Through their policy advocacy and reporting of human rights violations, LGTBIQ+ organizations working on HIV, sexual health, reproductive rights, and the rights of people living with HIV have been able to generate a network of journalists, communicators, and influencers in the Region of the Americas who have empathy in this context and are equipped to deal appropriately with information and news about this outbreak. It is recommended that communities take ownership of the monkeypox story and journalistic narratives, and approach communicators in order to sensitize them and provide clear and accurate information. WHO, PAHO, and UNAIDS can provide fact sheets.

In addition, it will be key to involve people with a social media presence (influencers) who are willing to devote some time talking about monkeypox. It is not advisable to wait until a newspaper publishes a front-page headline with stigmatizing language before approaching journalists with accurate information and appropriate language.

9. USE OF INCLUSIVE LANGUAGE

Table 2 presents examples of questionable or discriminatory phrases, expressions, and attitudes, along with the appropriate alternatives.

Table 2. Alternative language and communication options related to monkeypox

ERRONEOUS OR DISCRIMINATORY LANGUAGE AND IMAGERY	SUITABLE ALTERNATIVES
Monkeypox is a gay disease.	Monkeypox, the virus, and the most affected communities.
Sick people and people infected with monkeypox	People who have or have had monkeypox
Don't ask a person how they think they've been exposed or got infected.	Express interest in how the person who has or had monkeypox feels
People who spread a disease (note the word "spread").	Behaviors that can expose people to monkeypox
Never use the words infected, infectious, or infection.	Use the phrase "people who have monkeypox"
Do not focus exclusively on transmission through sex.	There are many forms of contact with monkeypox in addition to sexual activity. Speak of "close physical contact" or "intimate contact."
Do not use information without a scientific basis, or repeat rumors or assumptions.	Use information provided by reliable scientific sources, such as WHO and PAHO.
Avoid the use of alarmist language and excessive and unnecessary comparison with other epidemics and pandemics.	Emphasize that, given proper diagnosis, people with monkeypox can take steps to reduce transmission of the virus and protect others. Emphasize that their health will improve within a few days.
Do not use lurid images or images that could lead to a 'witch hunt' of people with lesions. Do not show pictures with faces. Avoid images of people with lesions whose skin color could suggest that they come from previously affected countries.	Use the appropriate necessary images to help health workers and potentially affected people recognize lesions and other symptoms early.
Sexual preference	Sexual orientation
Do not use the term "men who have sex with other men" or the "MSM" acronym in isolation.	If necessary, use "gay, bisexual, and other men who have sexual relations with men."

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