RCCE STRATEGIES FOR MONKEYPOX RESPONSE

SSHAP
Social Science in Humanitarian Action Platform

Given the health, social, and economic upheavals of the COVID-19 pandemic, there is understandable anxiety about another virus, monkeypox, quickly emerging in many countries around the world. In West and Central Africa, where the disease has been endemic for several decades, monkeypox transmission in humans usually occurs in short, controllable chains of infection after contact with infected animal reservoirs. Recent monkeypox infections have been identified in non-endemic regions, with most occurring through longer chains of human-to-human spread in people without a history of contact with animals or travel to endemic regions. These seemingly different patterns of disease have prompted public health investigation. However, ending chains of monkeypox transmission requires a better understanding of the social, ecological and scientific interconnections between endemic and non-endemic areas.

This brief is intended to be read in conjunction with the companion brief entitled 'Social Considerations for Monkeypox Response'.[1] In this set of briefs, we lay out social considerations from previous examples of disease emergence to reflect on 1) the range of response strategies available to control monkeypox, and 2) specific considerations for monkeypox risk communication and community engagement (RCCE).

These briefs are intended to be used by public health practitioners and advisors involved in developing responses to the ongoing monkeypox outbreak, particularly in non-endemic countries.

This brief on RCCE strategies for monkeypox response was written by Megan Schmidt-Sane (IDS), Syed Abbas (IDS), Soha Karam (Anthrologica), and Jennifer Palmer (LSHTM), with contributions from Hayley MacGregor (IDS), Olivia Tulloch (Anthrologica), and Annie Wilkinson (IDS). It was reviewed by Will Nutland (The Love Tank CIC/PrEPster) and was edited by Victoria Haldane (Anthrologica). This brief is the responsibility of SSHAP.

CURRENT KNOWNS, UNKNOWNS, AND PERCEPTIONS ABOUT MONKEYPOX

There are many unknowns and much uncertainty in connection with the recent monkeypox outbreak affecting non-endemic countries. It is critical that risk communication and community engagement (RCCE) strategies used in the monkeypox response acknowledge what is not yet known, including whether there has been undetected transmission for some time and why cases are not presenting with the classical clinical picture for monkeypox.[2] Strategies must also be informed by what we do know, including what has been learned from past epidemics like HIV/AIDS.

The recent monkeypox outbreaks in non-endemic countries have been shaped in the public eye by stigma around the group(s) in which the virus has been identified as well as by the perceived origins of the virus. Many frame the virus as 'coming out of Africa' – a harmful, stigmatising, and misguided conception of the disease, much as was the case initially with COVID-19 and China. In addition, to date many cases of monkeypox have been detected among dense sexual networks of men who have sex with men (MSM), leading to perceptions that monkeypox is a disease of concern only to gay men. However, identification of cases in these groups may not represent the full spread of the virus.

Considering these assumptions, it is important to develop RCCE strategies that address current perceptions (e.g., only MSM are 'at risk'), as these may have the following implications:

- **Other populations may not be seen as vulnerable.** Communication that frames monkeypox as a risk only for MSM may mask other groups' vulnerability to monkeypox. Such messaging minimises the risks to other high-risk groups, including sex workers and those with untreated

HIV/AIDS. Targeted messaging can focus on MSM, but we also need wider engagement with at-risk community groups.

- **Some symptomatic individuals may not seek care.** Those who do not self-report as MSM may not seek health care, even if they have symptoms of monkeypox. Others (not MSM) with symptoms of monkeypox may be wary of seeking health care because of fears of discrimination, or they may assume they do not have monkeypox if messaging has labelled it as a 'gay' disease. There is an urgent need to expand awareness and nuanced messaging about monkeypox.
- **Other routes of transmission may be ignored.** Individuals who have contracted monkeypox, but not through sexual contact, might not seek care or may worry about being accused of infidelity and/or stigmatised behaviour. RCCE efforts should include messaging around other transmission routes.
- **Social and legal implications in countries with anti-homosexuality laws.** MSM in countries with anti-homosexuality laws are already less likely to access services, particularly sexual health care.[3] These laws shape who with monkeypox symptoms can access health care, and data on monkeypox among MSM in restrictive countries may be sparse or non-existent. Messaging should be sensitive to and reflective of local context, and public health engagement should include groups that know how to reach MSM in restrictive contexts.

Box 1. Stigma and discrimination

Stigma occurs when institutions and individuals label, stereotype, and ostracise groups of people, preventing their access to social, economic, and political power.[4,5] It is highly dependent on social context, which usually also involves **discrimination** against stigmatised individuals or groups. Stigma and discrimination increase the chance of experiencing violence, homelessness, and other forms of social exclusion and can negatively affect health-seeking behaviour.[6,7] In the monkeypox outbreak, labelling MSM as primary drivers of transmission could contribute to stigma and discrimination against gay, bisexual, and transgender people.

High levels of uncertainty about an emerging infectious disease can manifest as social anxieties or panic, particularly in areas where there is already stigma against a specific group such as MSM. Equally, rhetoric and messaging that frames monkeypox as a problem of MSM, people with multiple sexual partners, or those who attend mass gatherings (like raves) can contribute to social anxieties, stigma, and discrimination. Therefore, it is important to co-produce messages with organisations that work closely with affected communities – for example, LGBTQ+ organisations, HIV service providers, and other community groups. To better create and promote messaging about monkeypox, we can learn from past infectious disease prevention and response activities. For example, PrEPster, which aims to educate and advocate for pre-exposure prophylaxis (PrEP) access in England and beyond, draws on rich strategies for HIV prevention outreach and advocacy in community settings. Their work has raised awareness about PrEP and has mobilised an entire community around HIV prevention.

MSM is a complex category

MSM is a category commonly used in public health to represent a range of behaviours and identities that involve male-male sexual intercourse.[4] Coming from the HIV literature of the 1990s, MSM is a term that emphasises how behaviours, rather than identities, place individuals at risk of HIV infection. While useful, this category masks the wide range of terms (gay, bisexual, or other culturally-specific designations) and variations in sexual behaviour.[5] The use of the term MSM in the monkeypox outbreak may similarly mask these differences. For example, although transgender people may be at risk of monkeypox, those who do not identify as male would not fit the MSM category – and therefore would not be characterised as an at-risk group. It is important to ensure that RCCE does not equate MSM only to cisgender men. Communication and messaging about monkeypox should emphasise risk behaviours. When categories (i.e. MSM) are used, messaging must reflect social complexities.

Other populations potentially vulnerable to monkeypox virus

Monkeypox transmission occurs through contact with virus in blisters and scabs, which form on the skin, as well as other bodily fluids of an infected individual or animal. Material that has been in contact with infected body fluids can also spread the virus, including bedding.[6] As such, populations other than MSM are also at risk of contracting monkeypox. There is a risk of monkeypox transmission in hospitals and health facilities; health care workers, cleaners, and other staff should be provided with information on monkeypox prevention strategies. Facilities should provide workers with appropriate personal protective equipment and training on its use.

To stop ongoing transmission requires a consideration of the unique needs, resources, and preferences within communities, as well as the specific needs of at-risk or vulnerable groups. Given that some infections reported in the current outbreak have been linked to recent sexual encounters, sex workers should be engaged in monkeypox prevention and RCCE efforts. Other at-risk groups may include those who are less likely to seek health care services, including people experiencing homelessness and injection drug users. Those vulnerable to severe disease include small children, pregnant women, and immunocompromised individuals (e.g., those with untreated HIV/AIDS). RCCE efforts should equip other organisations and providers, such as drug clinics or shelters, with information on prevention, signs and symptoms of monkeypox, and links to care.

SOCIAL CONSIDERATIONS FOR RISK COMMUNICATION

Looking beyond MSM and intimacy-related transmission.

Messaging about monkeypox should not focus solely on MSM. Nor should messaging focus only on those who have had intimate contact with a person infected with monkeypox. Instead, risk communication should consider a wider range of potential contacts, including household members of people with monkeypox. Messaging about prevention should include all known routes of transmission.

Crafting appropriately targeted messaging.

Communications about risk should not be overly broad, or it can be interpreted that everyone is equally at risk. This may cause public anxiety or panic. A two-tiered approach may be appropriate. Health officials may focus on specific risks or routes of transmission in communities more broadly. Meanwhile, local community-based organisations and HIV service providers may offer more targeted, contextually appropriate, and co-designed messaging about risk, prevention, and care seeking for groups with higher risk of infection.

RCCE efforts should engage community groups such as local LGBTQ+ organisations, sex worker outreach projects (i.e. local SWOP chapters), homeless outreach groups, HIV service providers, gay social media apps and online platforms, and gay clubs, bars, and other relevant social spaces.

Campaigning against stigma and discrimination.

Localised efforts should be paired with effective campaigns to counter stigma and discrimination. National and international public health organisations should work with representatives of at-risk populations to design messaging and campaigns that aim to reduce stigma against gay, bisexual, and transgender people.

Addressing stigma and the risk of violence.

In many places where MSM face stigma and discrimination, rates of violence against the community are also high. This is also true for transgender people and street-based sex workers. We must recognise the real, lived implications of stigma. Risk communication messaging must avoid language that blames individual groups or behaviours. Already-vulnerable groups could face additional violence if labelled a source of monkeypox due to ‘risky’ behaviour.

Using diverse pictures, images, and language.

Using only photos from endemic African countries may perpetuate stereotypes about the virus. Messaging should use diverse pictures to provide information on what monkeypox signs and symptoms look like in the current outbreak.

Furnishing clear guidance to health care providers.

Primary care providers, emergency care centres, sexual health clinics, and other health facilities must share information about the monkeypox virus. Building on lessons learned from COVID-19, clear guidance will be needed to avoid stigmatising or panic-inducing messages.[7] This includes crafting communications that:

- Talk about monkeypox virus, but do not associate the disease with a particular group, as this is **not** a 'gay disease' or a risk only for MSM.
- Use person-centred language and describe 'people with monkeypox', rather than 'victims' or cases.
- Explain how people 'acquire' or 'contract' monkeypox, but do not talk about people 'transmitting monkeypox,' 'infecting others,' or 'spreading the virus.' It is essential to avoid judgmental statements or labels about people who have casual, anonymous, or multiple sexual partners.
- Speak accurately about the risk posed by monkeypox, based on scientific data and the latest official health guidance. Do not repeat or share unconfirmed rumours and avoid exaggerated language like 'plague.'
- Emphasise patient privacy and avoid judgment of people's behaviours or choices.
- Talk positively, and highlight that the potential severity of monkeypox depends on a person's medical history. Do not emphasise messages that are threatening or cause further panic.

Communicating the risk of severe monkeypox

Pregnant women and individuals who are immunocompromised, including those with untreated HIV, are at a higher risk of severe monkeypox outcomes. MSM are more vulnerable to HIV and in some contexts may be unable to adhere to antiretroviral therapy (ART). Therefore, it is crucial that LGBTQ+ organisations and HIV service providers provide targeted messaging about untreated (versus treated) HIV and monkeypox severity. In Portugal, for example, out of 27 recently-confirmed monkeypox cases, 14 were HIV positive.[8]

Bringing public health messaging to places where at-risk groups gather

Media and public narratives have focused on raves, festivals, and other places where MSM gather for sexual encounters. As a result, some locations and events have closed or been cancelled due to the monkeypox outbreak.[9] However, shutting down these spaces risks cutting off key avenues for public health messaging to reach MSM and other at-risk groups. Clubs, bars, and festivals are important places to reach an otherwise 'dispersed' population, and public health workers should engage with these venues to identify opportunities to reach at-risk groups.

Taking a harm reduction approach

Risk communication messaging that focuses on reducing the number of sexual partners or abstaining from sex is fundamentally flawed in that it increases stigma and discrimination. Instead, risk communication should take a 'harm reduction' approach. Harm reduction is a strategy directed toward individuals or groups that aims to reduce the harms associated with certain high-risk behaviours. Such an approach recognises that sexual encounters will continue, but it equips people with the knowledge they need to prevent monkeypox, identify symptoms, and access care. This might include sharing information that emphasises how to safely and without judgment:

- Check for symptoms of monkeypox.

- Encourage people to refrain from sexual encounters until they have sought care, and if infected to refrain until they are well.
- Ask partners about recent symptoms.
- Ask to be contacted by partners if they become unwell or are diagnosed.
- Ask for partner contacts (when/if it is safe to do so), to ensure contact is possible in case of monkeypox diagnosis.

SOCIAL CONSIDERATIONS FOR COMMUNITY ENGAGEMENT

Apply lessons learned from COVID-19

Many countries have recently experienced stringent COVID-19 measures like lockdowns, and populations are experiencing fatigue in adhering to public health and social measures (PHSM). This may lead to a lower uptake of PHSM in response to monkeypox. Monkeypox, like COVID-19, may give rise to concerns about a lack of support for those quarantining or isolating -- such as a loss of income or an inability to access medications or other essential items. People may be unwilling to provide details of recent contacts or may be unwilling to report symptoms if there is a fear of lost income.

Build and maintain community trust

Public health staff should work to build and maintain trust with MSM and other at-risk communities. This includes maintaining positive working relationships with embedded organisations and activists and leveraging existing networks and relationships, such as those developed over decades of response to HIV/AIDS. Trust can be further built by producing solutions, community engagement strategies, and risk communication messaging in collaboration with diverse representatives of at-risk communities and working to reduce stigma and discrimination.

Link monkeypox engagement to other public health needs

Maintaining trust will require meeting other community needs by listening to, and when possible, acting on, their self-identified public health priorities. To understand community needs, public health workers can engage in listening sessions with at-risk communities. Spaces for engagement include venues where LGBTQ+ and other at-risk communities meet regularly. These sessions can be informal or formal in tone. Importantly, they help to build trust by providing a safe space for community members to voice their concerns and needs, while also receiving public health information about monkeypox.

Work with LGBTQ+, sex worker, and other community organisations

Community organisations often have well-established networks, outreach strategies and locations, and ways of working. Monkeypox response efforts can work within these existing structures, but public health departments should not overburden already under-resourced organisations. In-kind or financial support for partner community organisations provides compensation for community engagement efforts in monkeypox response. At a national level, the UK Health Security Agency has been working with professional agencies, including the British Association of Sexual Health and HIV, and third sector organisations, including the Terrence Higgins Trust and Stonewall, to develop communication and community engagement strategies and address stigma.[10] This is one model for other public health efforts.

Engage communities for case finding and contact tracing

Identifying people infected with monkeypox (case finding) and contact tracing will be much easier if people know and trust the person asking questions. For monkeypox contact tracing, engage with prevention outreach workers or other outreach workers from community organisations, and build on

HIV/AIDS and sexual health care efforts. Contact tracing will require a relationship of trust. In case of transmission related to sexual contact, contact tracing will not always be possible, as many sexual partners may be anonymous. Therefore, a community-wide intervention should also be prepared for in case of a cluster of cases, for example, through targeted venues.[11]

Use venue-based strategies for monkeypox response

Building on the successes of HIV engagement, targeted venue-based strategies may be appropriate to reach MSM, transgender people, sex workers, and others at risk. This may include engagement with local LGBTQ+ community bars or clubs, or mass gatherings, such as festivals. Public health workers can provide accurate, practical, and targeted information to organisers and participants. Response work at mass gatherings should also build on information and services that should or would otherwise be given.

CONCLUSION

While there is great uncertainty about the current monkeypox outbreaks, particularly in non-endemic countries, there are several lessons for RCCE strategies based on experiences from past infectious disease outbreaks. This is an important moment to bring in that learning and ensure that risk communication is evidence based and does not reinforce stigma or discrimination. We must also expand our consideration of who is at risk, while focusing on targeted community engagement. Community engagement should focus on venue-based strategies and work with community-based organisations with histories of outreach and engagement.

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ACKNOWLEDGEMENTS

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The Social Science in Humanitarian Action is a partnership between the Institute of Development Studies, Anthrologica and the London School of Hygiene and Tropical Medicine. This work was supported by the UK Foreign, Commonwealth and Development Office and Wellcome Grant Number 219169/Z/19/Z. The views expressed are those of the authors and do not necessarily reflect those of the funders, or the views or policies of IDS, Anthrologica or LSHTM.

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Suggested citation: Schmidt-Sane, M., Abbas, S., Karam, S., & Palmer, J. (2022). RCCE strategies for Monkeypox response. Social Science in Humanitarian Action Plaform (SSHAP). DOI: 10.19088/SSHAP.2022.020
Published June 2022