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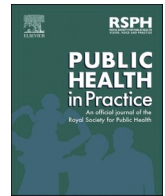
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Editorial

The global monkeypox outbreak: Germ panic, stigma and emerging challenges



Monkeypox has been in the headlines following the detection of multiple cases in more than two dozen countries worldwide [1]. As of June 2, 2022, there have been 780 laboratory confirmed cases reported in countries where the disease is not normally endemic. The rapid rise in the number of detected cases was unexpected. Yet we should not have been surprised. Monkeypox is not a new disease with human cases recognized since the 1970s. There have been thousands of cases in West and Central Africa where the disease is endemic [2]. Consequently, the risk of importation to non-endemic settings has always been lurking in the background.

Neither is it surprising that the global outbreak has attracted much media interest and generated public alarm. New exotic sounding emerging infectious diseases that the public are unfamiliar with can induce public anxiety that is disproportionate to the actual risks [3]. Indeed, it can lead to “germ panic” and fear of contagion that are further exacerbated by the perception of the disease insidiously and rapidly spreading in the population. The media clamour and broadcasting of the disturbing visible pox disfigurements will undoubtedly heighten concerns further. Social media misinformation is likely to fuel public anxiety, as we have seen with the recent COVID19 pandemic as well as past epidemics such as Ebola in 2014 [4].

The public health problem with germ panic is the likely effect it will have on stigmatizing the condition. Affected individuals may be perceived to be in some way “unclean” vectors of disease. It is therefore unfortunate that the current global outbreak of monkeypox appears to predominantly involve gay, bisexual and men who have sex with men (GBMSM). Unfortunately, a strong undercurrent of homophobia still persists in many societies worldwide. Consequently, there is a real danger that monkeypox will lead to further stigma being directed to those who are GBMSM.

We know all too well of the huge impact that the HIV/AIDS epidemic, and the associated stigma generated, has had on the GBMSM population. Indeed, they were blamed as the source and cause of spread of the HIV/AIDS epidemic despite the fact that the majority of spread was via heterosexual intercourse [5]. Their sexuality was also linked with notions of immorality and negative stereotypes of promiscuity against a backdrop of deeply held religious beliefs and cultural norms, especially in more conservative societies. The stigmatisation was greater for those from ethnic minority backgrounds where racial prejudices compounded the stigma [6]. The perceived “otherness” of the infected individual further widens the gulf between them and “wider” society. Unfortunately, much prejudice and discrimination remains despite considerable efforts to address this through public education programmes and equal rights legislation [7].

Experience from the HIV/AIDs has shown that the stigma can have

wide ranging and serious consequences [8]. From a public mental health perspective, there are adverse impacts on the mental and emotional wellbeing of the individuals affected, as well as on their social and sexual relationships, that could lead to rejection and social isolation.

At the moment, the disease is containable provided there is effective contact tracing, early detection and isolation of infected cases to break the chains of transmission. However, stigma can result in delays in health-seeking, the extent to which infected individuals may be prepared to disclose their contacts, as well as reduced compliance with isolation and other public health measures. These in turn hamper both outbreak investigations and disease control efforts. If we want to contain this disease, we will need the GBMSM on-side rather than marginalised.

Addressing public fears and deep rooted stigma will not be easy. It will require clear, timely and transparent public education about the disease to allay concerns and address misinformation. Targeted health messaging to high risk groups, such as those who are GBMSM, needs to be handled sensitively to avoid alienating these individuals. Information needs to come from a trusted source – in this regard, collaborative work with the LGBTQ + charities on public communications will be vital. In addition, as transmission appears to be mainly in the GBMSM population and social networks currently, these charities may hold the key for effective outreach.

It is also essential that monkeypox is not erroneously labelled as a “gay disease”. Individuals are not infected by their sexual orientation. We know that close physical contact is likely to be the main route of transmission of monkeypox which is one reason why the risk of spread is higher in affected households as reported for previous outbreaks in countries in Africa where it is endemic [9]. So, whilst cases have been seen in GBMSM individuals, health professionals will need to be alert to the occurrence of cases in non-GBMSM individuals, especially women and children. If we aren’t looking, we’ll miss the spill over of infections. Furthermore, the danger of mis-portrayal of the monkeypox outbreak as a GBMSM-only phenomenon is that others at risk may not realize their risk and fail to take precautions to protect themselves.

In the short term, undoubtedly many countries will be desperately trying to contain, suppress and hopefully eliminate the monkeypox outbreaks. There is a real risk of spill over into an immune naïve population, and for the infections to take hold and become a low endemicity disease, especially if there is insufficiently robust and timely public health response in affected countries. One possible measure needed is targeted pre-exposure vaccination of high-risk groups. Further research is also needed, for example, to better understand the transmissibility of this disease, including the possibility of asymptomatic transmission, and zoonotic risks particularly for domestic pets. One Health surveillance for this disease is another key requirement.

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However, it is also worth reiterating that this is not a new disease. Whilst it has been endemic in parts of Africa for decades, there has been little in the way of investment in therapeutics and vaccine development, or adequate resourcing of disease control programmes in those countries where it is endemic. High income countries have seen this as someone else's problem. Unfortunately, the lesson we should have learned from COVID-19, and indeed from MERS-CoV, Ebola, SARS and other infectious diseases before, we cannot ignore such outbreaks in a globalised world. If we seriously want to eliminate this threat, we will have to also address it at source. Our health securities are all intertwined, and the next epidemic is only a flight away.

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A.C.K. Lee*

University of Sheffield, Sheffield, UK

J.R. Morling

University of Nottingham, Nottingham, UK

* Corresponding author.

E-mail address: andrew.lee@sheffield.ac.uk (A.C.K. Lee).