

Combating Stigma and Health Inequality of Monkeypox: Experience from HIV

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Abstract: With Western Pacific Region reporting more imported cases, the World Health Organization (WHO) declared monkeypox a public health emergency of international concern in July. Currently, we are now at the beginning of forming stigmatization toward monkeypox. Based on the experience of combating HIV stigmatization for over 30 years, in this comment, we proposed measures based on the three stages of the stigma formation process. We believe the paper may be of particular interest to the readers of your journal as it offered implications for both healthcare professionals and researchers in Western Pacific Region.

Keywords: infectious disease, stigmatization, global public health, measures

With Western Pacific Region reporting more imported cases, the World Health Organization (WHO) declared monkeypox a public health emergency of international concern in July this year.^{1,2} The population at increased risk for contracting monkeypox is primarily those who have close physical contact with symptomatic monkeypox-infected individuals.^{2,3} Among all diagnosed cases, men who have sex with men (MSM) account for a large proportion.⁴ Media have started to frame the correlation among MSM, monkeypox, and HIV to obtain public attention via clickbait. This could lead to the further stigmatization of monkeypox carriers. The WHO and Centers for Disease Control and Prevention have appealed to reduce the stigma toward monkeypox through proper public communication and community engagement.^{5,6}

Stigma is conceptualized as the dynamic process of a subject (the stigmatizer) devaluing the object (the stigmatized). Stigma ultimately causes health inequality through unbalanced societal-level conditions toward a socially marginalized population. There are three major stages of stigma formation: emergence, development, and proliferation (Figure 1). Once formed, stigma can have a profound negative impact on the stigmatized individual.

Stigma can trigger monkeypox-infected individuals, especially marginalized individuals, to abandon formal health care services, limiting the use of monkeypox counseling and testing services. Meanwhile, health care professionals are less likely to seek out monkeypox cases if public environmental stigma is formed. Stigmatization is detrimental to the prevention of monkeypox and may lead to further spread of the disease. At worst, the stigma can even rationalize exclusionary or offensive verbal violence against the stigmatized object. This will lead to monkeypox-infected individuals being socially isolated and lacking social support. Therefore, more effective measures to destigmatize monkeypox should be developed and implemented.

Since the de-stigmatization of HIV has been ongoing for over 30 years, we can learn lessons from combating HIV stigma and health inequality.⁷ We propose the following measures based on the three stages of the stigma formation process.

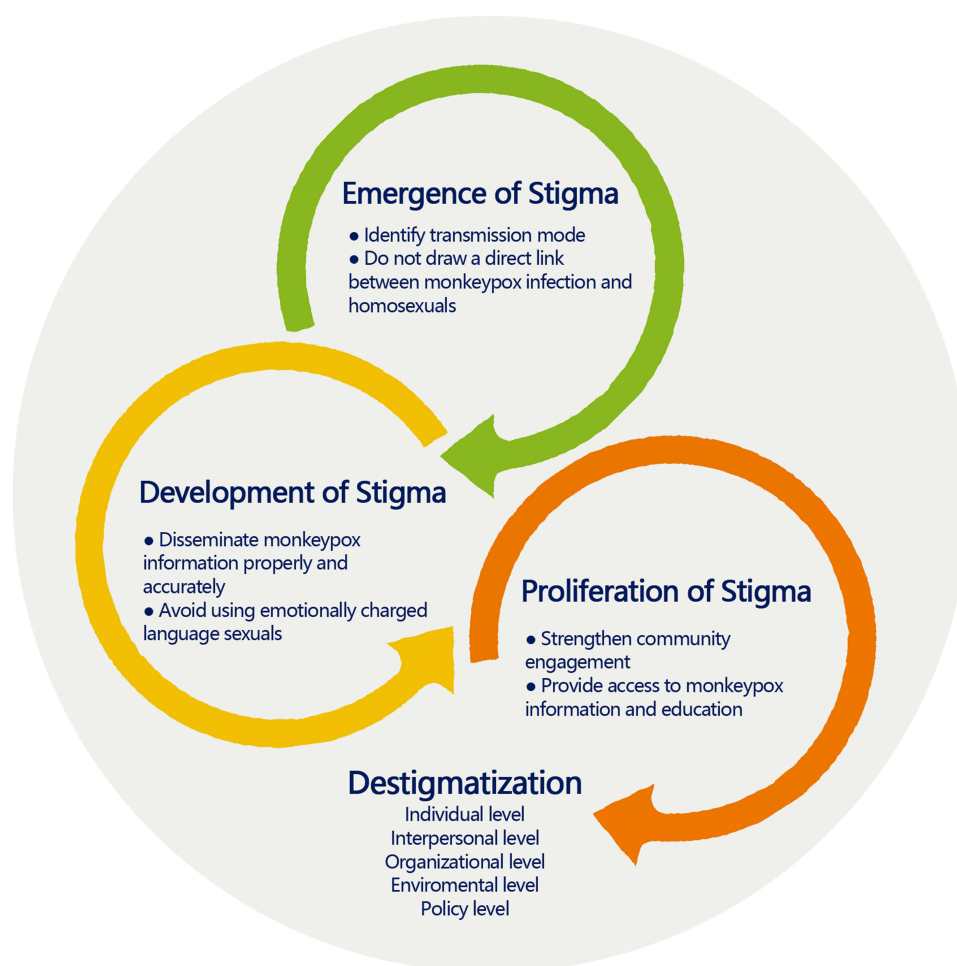


Figure 1 Three stages of stigma formation toward monkeypox infection.

First, identifying the transmission mode is helpful in reducing stigma and health inequality. Vague, ambiguous, and uncertain information could be used as an excuse to attack vulnerable populations and cause public structural stigma. Previous evidence has found that the primary transmission of monkeypox virus could be through broken skin, respiratory tracts, eyes, noses, or mouths (animal or human),^{8,9} and in secondary transmission, aerosols play an important role.¹⁰ Monkeypox could also be contracted through contact with objects contaminated with the virus, such as bed linens and clothing.¹¹ Therefore, it is not appropriate to draw a direct link between monkeypox infection and homosexuality. This take-home message should be disseminated to the public.

Second, monkeypox information should be disseminated properly and accurately. The terminologies and descriptions used to describe monkeypox are crucial in the establishment of its stigma. In the 1980s, media described HIV as “gay-related immunodeficiency” and “gay cancer”, which enhanced HIV stigma globally for the next 40 years.¹² Many of our ideas about HIV come from appalling images that first appeared in the early 1980s. Lack of information and outdated beliefs ultimately leads to fear of HIV infection,¹³ which is the same for monkeypox. However, the only difference is that we are currently facing an information overload, including fake news and biased media. Identifying and disseminating monkeypox information properly and accurately can remove social perceptions about monkeypox being caused solely by sexual misbehavior.

In addition, it is recommended to avoid using emotionally charged language to describe monkeypox. Using sensational headlines and incorrect content should not be methods used by media to gain social media traffic. Media may incite public fear to achieve their political or workplace goals toward a certain population (eg, MSM). People are encouraged to stand up against monkeypox stigmatization becoming a moral debate and argue against monkeypox serving as a judgment of God.

Finally, community engagement should be strengthened to decrease the proliferation of stigma. It is critical for the community to provide public access to monkeypox information and education so that individuals can achieve a more complete understanding of the disease. Once the public is well informed, they will progressively eradicate the fear and discrimination associated with monkeypox. When advocating for culture change and stigma reduction in the community, we should use neutral or inclusive language rather than phrases that may evoke negative impressions, such as “unsafe” and “high risk”. This will help people infected with monkeypox build a sense of social support when coping with self-stigma.

Currently, we are now at the beginning of forming stigmatization toward monkeypox. Based on the experience of combating HIV stigmatization for over 30 years, we recommend that proper public communication and community engagement should be involved to prevent the emergence, development, and proliferation of monkeypox stigmatization.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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