To Stem the Spread of Monkeypox, Health Departments Tap Into Networks of Those Most at Risk

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On July 23, the World Health Organization declared monkeypox a public health emergency of international concern. It was a contentious decision, with the WHO's director-general, Dr. Tedros Adhanom Ghebreyesus, making the final call and overruling the WHO's emergency committee. The advisory committee's disagreements mirrored debates that have been unfolding among public officials, on social media, and in opinion pages over the past several weeks. Is monkeypox a public health emergency when it's spreading "just" among gay and bisexual men and trans women? To what degree do other populations need to worry?

Behind those questions are concerns about stigma and how best to allocate scarce resources. But they also reflect an individualistic understanding of public health. Rather than asking what the monkeypox outbreak means for them now, the public could be asking how the monkeypox outbreak could affect them in the future and why and how it could be contained now.

The longer monkeypox transmission goes unchecked, the more likely it is to spill over into other populations. There have already been a handful of cases among women and a couple of cases in children because of household transmission. In otherwise healthy people, monkeypox can be extremely painful and disfiguring. But in pregnant women, newborns, young children, and immunocompromised people, monkeypox can be deadly. Those groups would all be in danger if monkeypox became entrenched in this country.

Stopping transmission among men who have sex with men will protect them in the here and now and more vulnerable populations in the future. But with a limited supply of monkeypox vaccine available, how can public health officials best target vaccines equitably for impact?

It won't be enough to vaccinate close contacts of people with monkeypox to stop the spread. Public health officials have been unable to follow all chains of transmission, which means many cases are going undiagnosed. Meanwhile, the risk of monkeypox (and other sexually transmissible diseases) isn't evenly distributed among gay and bisexual men and trans women, and targeting all

of them would outstrip supply. Such a strategy also risks stigmatizing these groups.

The Centers for Disease Control and Prevention recently expanded eligibility for monkeypox vaccination to include people who know that a sexual partner in the past 14 days was diagnosed with monkeypox or who had multiple sexual partners in the past 14 days in a jurisdiction with known monkeypox cases. But this approach depends on people having access to testing. Clinicians are testing much more in some jurisdictions than in others.

Alternatively, public health officials could target monkeypox vaccinations to gay and bisexual men and trans women who have HIV or are considered at high risk for HIV and are eligible for preexposure prophylaxis, or PrEP (medication to prevent HIV infection). After all, there's a lot of overlap between these populations and those at risk for monkeypox. But only 25% of people eligible for PrEP in the U.S. are prescribed it, and that proportion drops to 16% and 9% among Hispanic and Black people, respectively. This approach risks missing many people who are at risk and exacerbating racial and ethnic disparities.

This is why some LGBTQ+ activists are advocating for more aggressive outreach. "We talk about two kinds of surveillance," said Gregg Gonsalves, an epidemiologist at the Yale School of Public Health and a longtime AIDS activist. "Passive surveillance, where I show up to my doctor's office. Active surveillance is where we go out and we seek cases actively by going where people are at. There are parties, social venues, sex clubs where we could be doing monkeypox testing."

This will be especially critical outside gay-friendly cities, where both patients and providers may be less informed and gay sex more stigmatized.

In New York City, the epicenter of monkeypox in the U.S., disparities in access to monkeypox vaccines have already emerged. The city's health department offered appointments for first doses of the vaccine through an online portal and promoted them on Twitter. Those initial doses were administered at a sexual health clinic in the well-to-do Chelsea neighborhood.

"It was in the middle of the day," Gonsalves said. "It was in a predominantly gay white neighborhood. … It really was targeted at a demographic that will be first in line for everything. This is the problem with relying on passive surveillance and people coming to you."

Michael LeVasseur, an epidemiologist at Drexel University, said, "The demographics of that population may not actually reflect the highest-risk group. I'm not even sure that we know the highest-risk group in New York City at the moment."

Granted, three-quarters of the city's cases had been reported in Chelsea, a neighborhood known for its large LGBTQ+ community, but that's also a reflection of awareness and access to testing. Although more labs are offering monkeypox testing, many clinicians are still unaware of monkeypox or unwilling to test patients for it. You have to be a strong advocate for yourself to get tested, which disadvantages already marginalized populations.

The health department opened a second vaccination site, in Harlem, to better reach communities of color, but most of those accessing monkeypox vaccines there have been white men. And then New York City launched three mass vaccination sites in the Bronx, Queens, and Brooklyn, which were open for one day only. To get the vaccine, you had to be in the know, have the day off, and be willing and able to stand in line in public.

How can public health officials do the active surveillance that Gonsalves is talking about to target monkeypox vaccination equitably and to those at highest risk? Part of the answer may lie in efforts to map sexual networks and the spread of monkeypox, like the Rapid Epidemiologic Study of Prevalence, Networks, and Demographics of Monkeypox Infection, or RESPND-MI. Your risk of exposure to monkeypox depends on the probability of someone in your sexual network having monkeypox. The study may, for example, help clarify the relative importance of group sex at parties and large events versus dating apps in the spread of monkeypox across sexual networks.

“A network map can tell us, given that vaccine is so scarce, the most important demographics of folk who need to get vaccine first, not just to protect themselves, but actually to slow the spread,” said Joe Osmundson, a molecular microbiologist at New York University and co-principal investigator of the RESPND-MI study.

During the initial phase of covid-19 vaccine rollout, when vaccines were given at pharmacies and mass vaccination centers, a racial gap emerged in vaccination rates. Public health officials closed that gap by meeting people where they were, in approachable, community-based settings and through mobile vans, for example. They worked hard with trusted messengers to reach people of color who may be wary of the health care system.

Similarly, sexual health clinics may not be a one-size-fits-all solution for monkeypox testing and vaccination. Although sexual health clinics may feel welcoming to some, others may fear being seen there. Others may not be able to go to sexual health clinics because of their limited hours of operation, on weekdays only.

It isn’t new for public health officials to meet members of the LGBTQ+ community where they are. During a 2013 outbreak of meningitis among gay and bisexual men and trans women, health departments across the country forged relationships with community-based LGBTQ+ organizations to distribute meningitis vaccines. Unlike New York, Chicago is now leveraging those relationships to vaccinate people at highest risk for monkeypox.

Massimo Pacilli, Chicago’s deputy commissioner for disease control, said, “The vaccine isn’t indicated for the general public nor, at this point, for any [man who has sex with men].” Chicago is distributing monkeypox vaccines through venues like gay bathhouses and bars to target those at highest risk. “We’re not having to screen out when people present because we’re doing so upstream by doing the outreach in a different way,” Pacilli said.

Monkeypox vaccination “is intentionally decentralized,” he said. “And because of that, the modes by which any individual comes to vaccine is also very diverse.”

Another reason to partner with LGBTQ+ community organizations is to expand capacity. The New York City Department of Health and Mental Hygiene is one of the biggest and best-funded health departments in the country, and even it is struggling to respond quickly and robustly to the monkeypox outbreak.

“Covid has overwhelmed many public health departments, and they could use the help, frankly, of LGBTQ and HIV/AIDS organizations” in controlling monkeypox, Gonsalves said.

But even as public health officials try to control the transmission of monkeypox among gay and bisexual men and trans women in this country, it’s important not to forget that monkeypox has been spreading in West and Central Africa for years. Not all of that transmission has been occurring among men who have sex with men. Strategies for controlling monkeypox will need to be informed by the local epidemiology. Social and sexual mapping will be even more critical but challenging in countries, like Nigeria, where gay sex is illegal. Sadly, wealthier nations are already hoarding monkeypox vaccine supply as they did covid vaccines. If access to monkeypox vaccine remains inequitable, it will leave all countries vulnerable to resurgences in the future.

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