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Monkeypox: between precision public health and stigma risk

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The World Health Organization (WHO) is on alert due to an unprecedented Monkeypox outbreak in non-endemic countries, such as Europe, which have been affected recently. Despite the low pandemic potential, the recent SARS-CoV-2 pandemic has contributed to heightened levels of public concern in the face of the threat of new global health emergencies[1].

As of May 13, 2022, Monkeypox has been reported in 23 Member States across the four WHO regions, for a total as of June 1, 2022, of 257 laboratory-confirmed and 120 suspected cases[2].

Monkeypox is a viral zoonosis endemic in several countries in Central and West Africa. With an average incubation period of between six and 13 days, it is characterized by a period ranging from zero to five days of fever, headache, lymphadenopathy, asthenia and myalgia, followed by skin rashes approximately one to three days after the onset of fever. Skin eruptions tend to be more localized on the faces and extremities, and may also occur on the oral, genital, conjunctival and corneal mucosa. Usually self-limiting, tends to resolve in two to four weeks[1].

Monkeypox is not a sexually transmitted infection (STI), although it can be spread through intimate contact during sexual intercourse, when there is an active rash. However, the disproportionate number of cases among the gay population and other men who have sex with men (MSM) has led the WHO to issue recommendations aimed exclusively at this population[3], which particularizes and places the sexuality dimension - affective-sexual position - of this population in prominence and in the target of greater surveillance, mobilizing a set of disadvantageous repercussions for the life and health of these people.

Some 40 years after the first cases of HIV/AIDS, which resulted in a profound stigmatization, with impacts that are still felt today, the question that arises is much more about the balance between precision public health interventions aimed at who needs them and ostracization that may result from this particular direction, than from the expanded concern of Monkeypox's involvement for the community in its countries and on a planetary scale. This reveals a re-updating of previous mechanisms controlling bodies and violating human experiences, especially those that contradict cisgenderism and heterosexuality, which insists on remaining in a compulsory, dual, arbitrary, oppressive and sexist way.

The epidemic sociohistory, particularly in the context of HIV/AIDS infection, but also of other diseases (such as the recent case of the hepatitis A outbreak in Portugal), initially associated with specific groups (e.g., MSM, migrants, homeless people and prisoners)[4], showed us that it is important to separate public health interventions, whether in terms of promoting healthy lifestyles or disease prevention, from the particular and/or behavioral characteristics of these groups, in order to avoid the formulation of prejudice and the constitution of stigma. Anchored in the chronological historical facts of the epidemics, we question, therefore, whether the current targeting of information on the Monkeypox outbreak to the MSM population may not contribute to a greater expression of cases in this population or, for instance, to delay diagnosis and the search for health

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care, due to fear of public hostility and/or institutional violence.

That said, there are still some aspects for reflection: the fact of relating sexual orientation to the Monkeypox virus does not make any sense, as there are communication options that can prove to be equally effective, such as focusing on sexual intercourse between infected individuals, without categorizing specific sexualities or practices, taking a globalized position of sanitary actions and epidemiological control. In this way, stigmatizing rhetoric can quickly and profoundly disable the evidence-based response, fueling cycles of fear that drive away key groups that may be in vulnerable social contexts, such as health services, which impedes efforts to identify cases and encourages the adoption of ineffective punitive measures[5] that may be crossed by stereotyped and conspiratorial formulations, which strengthen health misinformation.

It is based on an analysis of this scenario that we point out an infodemic related to the new Monkeypox outbreak to stigma about the disease and its characteristics, since it prints a socially undesirable image, producing social distancing/isolation, repulsion, depreciation, discredit and less value for society.

Again, it is necessary to align and refine the speeches. The United Nations AIDS agency (UNAIDS), for instance, has expressed concern that some public reporting and comments about Monkeypox reinforce homophobic and racist stereotypes. As a disadvantageous consequence for global public health, the damages of this association can intensify social advances made for mitigation of lgbtphobia among countries, such as Brazil, one of the countries that kills the most Lesbians, Gays, Transvestites, Trasexuals/Trans people, Queers, Intersex, Asexuals, Pansexuals and with experiences of gender variability (LGBTQIAP+), as well as restriction of rights to comprehensive health care. More than that, they can encourage distancing from health services, actions and programs, increasing morbidity and mortality and the impacts caused by the physical, socioeconomic and psychological sequel of stigmatized MSM.

In this particular case, what is observed is the perennial social inequity in health and the State's public debt, from actions of its rulers towards LGBTQIAP+ population's demands and health needs and identity experiences, which, through so many social scourges, such as the COVID-19 pandemic[6], has been experiencing an overlap of vulnerabilities that impact social protection, access to education, good levels of health literacy, prevention of diseases and injuries, possibilities of exercising health promotion and maintenance of good life and psychosocial well-being.

Considering the surveillance position, we draw attention that the Monkeypox outbreak illustrates that communities will continue to face virus threats and that international coordination and collaboration are essential for public health, which implies the call of nurses to manage scenarios. To this end, it will be necessary to develop global, equitable, inclusive and coherent strategies that respect the specificities of countries, territories and communities. A successful example is the partnership with the team of Grindr[7], the most popular dating app among MSM, and the UK Health Safety Agency, which sent its users (there are about 40 million worldwide) smallpox warnings to raise awareness of the risk of contagion among its users, revealing possibilities of how to conduct health education and communication actions, which can be explored and led by nursing teams in their scenarios.

The epidemiological scenario is one more scenario conducive to nursing leadership. Considering the Monkeypox outbreak, it is up to nursing professionals to advocate for the LGBTQIAP+ population, having an attitude of vigilance, reception, social and scientific responsibility in the search for the elimination of discrimination in health, in a broad understanding of health and disease processes and in the promotion of dissident sexual and gender identities. In the particular case of episodic epidemic diseases, nursing teams must act in order to guarantee safety and collective protection. They must also produce culturally adapted, uniquely gendered care, using its metaparadigmatic structure to guide professional work, in order to make it scientific and be socially referenced, whether through the application of its constructs, models and theories, or through the identity positioning of defense of life, the recognition of responses human beings and the life processes of each person in their environment.

Finally, it is recommended that nursing teams engage in gender equity work, build non-segregating or stigmatizing therapeutic approaches, develop health education instruments for the community, design action and care plans focused on controlling transmission, screening, monitoring and surveillance of cases, support differential diagnosis, demystifying the association with STIs, especially through the appearance of lesions in the genital and perianal region, as well as empowerment of the population for risk self-management and health vulnerability reduction. In the particular case of MSM affected by Monkeypox, it is recommended that nursing teams be trained to act in the face of a disease with a high burden of stigma, especially as it affects self-image, self-perception and coping mechanisms. This raises greater attention to interventions aimed at ineffective coping that maintain ethics in the relationships established between users and action teams and that build a new epistemology of self-care aimed at the MSM population.

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