



Emerging Considerations for Addressing MPV in Higher Education Settings: Promoting Health Equity and Reducing Stigma

September 1, 2022

Since the eradication of smallpox in 1980 and the subsequent end of routine smallpox vaccination, monkeypox virus (MPV) has emerged as the most concerning orthopoxvirus for public health. MPV was first identified in humans in 1970 in the Democratic Republic of Congo. The first U.S. case was reported in 2003 and resulted in more than 70 cases. The virus re-emerged in the U.S. in July 2021, and since then, there have been [thousands of confirmed MPV cases](#) across the country. In response to this increase in cases, the U.S. Department of Health and Human Services declared MPV a public health emergency on August 4, 2022.

MPV is generally a self-limited infection that resolves without specific treatment, but the following factors contribute to concern about the virus:

- Spread of the virus through close, skin-to-skin contact, including during intimate sexual contact
- Spread of the virus through fomites, defined as objects or materials which can carry infection (e.g., towels, sheets, and clothing)
- Stigma associated with visibility of skin lesions
- Oppressive systems that create stigma as well as barriers to prevention and care – specifically racism, heterosexism, and cissexism
- Pain associated with lesions
- Relative scarcity of vaccine and treatment
- Duration of prodrome and illness duration (approximately 2-4 weeks)
- Broad differential diagnosis (e.g., herpesviruses, chickenpox)
- Reduced inventory of quarantine and isolation housing on many campuses

This ACHA series, "[Emerging Considerations for Addressing MPV in Higher Education Settings](#)," aims to supplement available CDC guidance to support college health clinical and health promotion professionals.

*A note on nomenclature: ACHA is referring to the virus as MPV to align with the nomenclature for other commonly transmitted infections in the college setting – e.g., Epstein-Barr virus (EBV), human papillomavirus (HPV) – that include virus in the acronym. This also aligns with the naming convention currently used by the American Academy of Family Physicians (AAFP).

Sources:

<https://www.who.int/news-room/fact-sheets/detail/monkeypox>

<https://www.cdc.gov/smallpox/vaccine-basics/index.html>

<https://jamanetwork.com/journals/jama/fullarticle/2793516>

Purpose of this Brief

The purpose of this brief is to offer **considerations and resources** for promoting health equity and reducing stigma to assist college health professionals with decision-making as the science of MPV and the current outbreak evolve.

Definitions

- **Health equity:** the state in which everyone has a fair and just opportunity to attain their highest level of health ([CDC](#))
- **Stigma:** a mark of disgrace associated with a particular circumstance, quality, or person ([Oxford English Dictionary](#))

A Note about Language

This brief will use “queer” as an umbrella term to describe students whose sexual orientation is not heterosexual/straight, and “trans” as an umbrella term to describe students who are not cisgender.

Introduction and Call to Action

“Given how little we know about the epidemiologic characteristics of the current outbreak, it is prudent to heed an observation made during the first year of the HIV/AIDS pandemic: ‘... any assumption that it will remain restricted to a particular segment of our society is truly an assumption without a scientific basis (Fauci, 1982).’” (Lane and Fauci, 2022)

As with any other infectious disease, MPV does not affect all populations in the same way due to intersectional systems of oppression. Since the current outbreak began in May 2022, [available data](#) have consistently shown that **queer cisgender men, trans people, and their sexual networks** have – so far – been the most affected groups. As such, addressing the current MPV outbreak **requires** that the sexual health of queer and trans people is discussed openly and accurately while ensuring unfettered access to vaccination, testing, and treatment.

There are also [racial and ethnic disparities](#), as well as disparities [among people living with HIV](#), highlighting the need for an intersectional approach to prevention and response that examines and eliminates access barriers and addresses the [social determinants of health](#).

While stopping the spread of an infectious disease in any community is inherently beneficial to those communities and the broader public, we must also remember that larger populations will be affected if the current outbreak is not controlled among those who are most affected first.

Stigma against a group that is currently most affected perpetuates myths that only certain groups can get MPV, causing underestimation of risk and making those who are not most affected less likely to engage in harm reduction practices and seek care.

Without careful attention to health equity and reducing stigma, the negative consequences for individuals and communities most affected by MPV are great – resulting in discrimination, hate and bias, violence, poor mental health, avoidance of help-seeking, and potentially death.

Existing Health Equity and Stigma Reduction Resources

While certainly not a comprehensive list, the following resources are recommended for review as college health practitioners work to support students who are most impacted by the current MPV outbreak. Not all resources listed are directly about MPV, but many principles can be taken from them and applied to MPV as appropriate.

Due to MPV’s current location at the intersections of sexual orientation, gender identity, race and sexual health, HIV organizations could serve as great resources as well – and many of them have been on the front lines of the current MPV outbreak since it began.

Resources from LGBTQIA+ Organizations/Creators

- [Fact Sheet for Reporters on Monkeypox \(MPV\) and the LGBTQ Community](#) (GLAAD)
- [Special Advisory: Covering Monkeypox](#) (Association of LGBTQ Journalists)

Resources from the Centers for Disease Control and Prevention

- [Reducing Stigma in MPV Communication and Engagement](#)
- [Health Equity Guiding Principles for Inclusive Communication](#)

Resources from ACHA

- [Supporting Vulnerable Populations During the COVID-19 Pandemic](#)
- [Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings](#)
- [Standards of Practice for Health Promotion in Higher Education](#)

Systems of Oppression

To eliminate health disparities, we must be aware of and address any [systems of oppression](#) that cause and exacerbate them.

Given the demographics that are most affected by the current MPV outbreak, this brief will focus on racism, heterosexism, and cissexism.

The following definitions were taken from the [online glossary](#) of the LGBTQIA+ Resource Center at University of California, Davis.

Racism: The systematic subordination of people from marginalized racial groups based on their physical appearance, ethnic or ancestral history, or cultural affiliation. Racism is considered a deeply pervasive, systemic issue perpetuated by members of the privileged racial group holding dominant social power over others. Discrimination, prejudice, or xenophobia may be more accurate terms for describing individual acts of oppression. While these individual acts likely stem from systemic racism, at the individual level the power dynamics that enable racism are not at play in the same way.

Heterosexism: The assumption that all people are or should be heterosexual. Heterosexism excludes the needs, concerns, and life experiences of lesbian, gay, bisexual, and queer people while it gives advantages to heterosexual people. It is often a subtle form of oppression, which reinforces realities of silence and erasure.

Cissexism: The pervasive system of discrimination and exclusion founded on the belief that there are, and should be, only two genders and that one's gender or most aspects of it, are inevitably tied to assigned sex. This system oppresses people whose gender and/or gender expression falls outside of cis-normative constructs. Within cissexism, cisgender people are the dominant group and trans and gender non-conforming people are the oppressed group.

Context Matters

The response to the current MPV outbreak has been slow, and there have been many barriers – not only to accessing vaccines, testing, and treatment, but also to accurate diagnosis of infection.

Over the summer of 2022, many individuals have:

- Waited hours in long lines for even a *chance* at receiving a dose of the JYNNEOS vaccine (further constrained by having very few vaccination sites and limited operating hours).
- Suffered in agonizing pain while sometimes waiting weeks to receive test results.

- Been misdiagnosed or had their concerns brushed aside by providers — including receiving inadequate pain management.
- Not had access to available treatment.
- Developed permanent, visible scarring after recovering from MPV.

In addition to these experiences, some media outlets and those seeking to harm the communities most affected have used the current MPV outbreak as a tool to stigmatize and incite violence against them. It should come as no surprise, then, that the communities most affected are frustrated and concerned.

We must recognize that many of our students are bringing these experiences and feelings with them to our campuses, and it is our responsibility to try and build (or re-build) trust with them. This is a major opportunity for us to demonstrate to students that we support and care about them.

Creating Equitable Access Matters

When developing MPV resources for students, it is incumbent upon us to center our approach to reaching those who experience the most barriers to accessing information and services, and then tailor our resources to meet their needs. Historical trauma is real, and this is about cultivating relationships and earning trust. Students will not utilize resources just because they are available — particularly when they may not feel safe doing so.

In addition to talking with students to learn about their lives and concerns, we must ask ourselves where any systems of oppression are showing up. For example, how can our work dismantle racism, heterosexism, or cissexism so that students are seen and supported?

Some questions for consideration when designing MPV interventions around the needs of those most affected include:

- How is our health center perceived by students?
- Have we made any public missteps that have caused harm? If so, have we tried to repair those relationships?
- Do students trust us?
- How are we providing mental health support and reducing stigma at every point of student contact?
- Is this particular service offered at a time that is convenient for students? This may be a vaccine clinic or educational event.
- If we advertise that we are safe and inclusive, how can we demonstrate to students that those statements are true?
- Are staff trained in the needs of queer and trans students of color, and do they know how to address those needs?
- Does our health center have the capacity to diagnose and treat MPV (or any other sexual health needs)? If not, do we know where to refer patients for inclusive and affirming care?
- Do we have protocols in place to affirm and support a student who:
 - has health concerns and needs help obtaining a JYNNEOS vaccination?
 - is asymptomatic, but has had close contact with someone who has MPV?
 - has symptoms and seeks testing for MPV?
- If providing the JYNNEOS vaccine intradermally, are we explicitly [screening for history of keloid scarring](#) before administering?
 - If the patient has a history of keloid scarring, are we offering subcutaneous dosing instead?
 - Are we educating students about what keloid scarring is?

In addressing these questions, it is important to engage in ongoing assessment and evaluation processes to best tailor resources and services.

One tool for ensuring queer and trans inclusion at your health center is the [Human Rights Campaign's Healthcare Equality Index \(HEI\)](#). According to the Human Rights Campaign's website, HEI is a "national LGBTQ+ benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ+ patients, visitors and employees."

People Diagnosed with MPV Matter

We must not let our prevention efforts hinder our ability to support students who are diagnosed with MPV. Anti-stigma messaging and campaigns can be very powerful tools, and it is important that we also provide students, staff, and faculty with tangible ways they can support their fellow campus community members.

Here are some general sentiments that are important to communicate throughout campus for reducing stigma and enhancing support:

- Being diagnosed with MPV does not mean someone is "dirty," immoral, irresponsible, or unworthy of being treated with dignity and respect.
- Being diagnosed with MPV does not indicate a person's sexual orientation.
- Being diagnosed with MPV does not indicate that it was acquired from sexual contact.

As of this writing, the [CDC's Isolation and Prevention Practices for People with Monkeypox](#) states that the isolation period can be 2-4+ weeks. That is a much longer time than was required with COVID, and campuses have undoubtedly learned many lessons about how to support students in quarantine or isolation that can be applied to the current MPV outbreak.

Given the differences between what we know about COVID and MPV, the following are some questions to consider around providing support to students diagnosed with MPV – particularly while they are isolating:

- While certainly not every student diagnosed with MPV will be queer or trans, how will your campus policies and procedures prevent "outing" them (to their peers, parents/guardians, professors, academic advisors, etc.)?
- If a student is "outed," how do you plan to reduce harm?
- How will you ensure students diagnosed with MPV will experience the least disruption to their academics as possible?
- How will you help students manage the intense physical pain that MPV often brings?
- How will you provide mental health support?
- How will you enhance and reiterate any existing campus protections against hate, bias, and discrimination?
- How will you train resident advisors to raise awareness and facilitate conversations about MPV stigma and provide support to peers diagnosed with MPV?
- How will you help ensure that the campus community will not be afraid to be in the same room with queer and trans people?

Protecting Privacy and Confidentiality

Many students delay or avoid seeking medical and mental health care due to privacy concerns. This is particularly true if they are a dependent and under someone else's insurance plan or do not have access to comprehensive insurance outside of their institution.

With COVID-19, the need for testing and symptom monitoring caused the health information of both employees and students to be much more intertwined with their professional and academic lives. The fact that sexual contact is the most common route of MPV transmission in the current outbreak creates a layer of stigma and concern that has not been present in campuses' efforts to respond to COVID-19. As such, it is imperative that explicit attention be given to addressing such layers.

In addition to reviewing the "Addressing Confidentiality" section of [ACHA's Best Practices in Sexual Health Promotion and Clinical Care in College Health Settings](#), it is recommended that campuses consult with their campus legal counsel about the intersections of FERPA and HIPAA to protect our students' health information and prevent stigma.

Language and Framing Matter

The purpose of this section is to provide recommendations and considerations for reducing stigma in MPV communication by discussing some common phrases that have been frequently used during the current outbreak.

Two general guidelines to think about before sending messages about MPV and the communities most affected are:

1. Consider the audience.
2. Develop messaging *about* a particular group *with* that particular group.

Using Systems-Centered Language (SCL)

[Developed by Dr. Meagan O'Reilly](#) to be more specific about the intersections of systemic racism and COVID-19, SCL aims to clarify that systems of oppression are responsible for health disparities, not the people experiencing them. With the current MPV outbreak, those systems are primarily racism, heterosexism, and cissexism.

As often as possible, it is recommended to call attention to these systems in public health messaging — not just for COVID-19 and MPV, but any illness or negative health outcome. As Dr. O'Reilly's article states, "SCL is a linguistic call to action that seeks to end the dehumanization of people that occurs while discussing how they are experiencing oppression."

Comparing MPV to HIV

Be judicious when making comparisons between the current MPV outbreak and HIV. While there are *some* similarities between the two viruses in terms of which populations are currently most affected and the most common route of transmission (i.e., sexual activity), there are major differences in social, political, and historical contexts.

Instead, consider taking the extraordinary [lessons learned from the HIV epidemic](#) and applying them to campus' MPV response.

Here are a couple of helpful HIV-specific resources that could be applied to the current MPV outbreak:

- [NASTAD's Re-envisioning Community Engagement: A Practical Toolkit to Empower HIV Prevention Efforts with Marginalized Communities](#)
- [Supporting Someone Living with HIV](#) (HIV.gov)

"Monkeypox"

As the New York City Department of Health and Mental Hygiene outlined in their [advocacy letter to the World Health Organization](#), exclusive use of the term "monkeypox" is [scientifically inaccurate](#) (monkeys are not known to be the original MPV host) while promoting racist misconceptions about the virus' history and how it is transmitted. To help reduce stigma and harm, it is recommended to use terms such as "MPV," "MPX," "MPOX," or "MPXV" instead. When speaking, an option is "M-pox."

“New Virus”

It is important to remember that while the *current outbreak* is new, MPV has been circulating in west and central African countries for decades. Until the current outbreak, the virus had gone largely unnoticed by the rest of the world. In fact, [20 million doses of the vaccine expired in 2017](#). Consider how this language around MPV being “new” highlights structural racism as a global health issue. It is important to specify “current outbreak” when discussing MPV.

“Men Who Have Sex with Men” (MSM)

An epidemiological term that was created to describe specific populations according to behaviors instead of identities, “men who have sex with men” (MSM) is often used in public health literature when discussing STIs/HIV.

While this term is useful in promoting that sexual *orientation* does not always correlate with sexual *behaviors*, critics argue that this term — especially when used broadly — reduces queer people down to sexual behaviors while ignoring the social, cultural, and political aspects of their lived experiences. Depending on how sexual orientation and gender identity are being reported (if at all), MSM can also exclude trans people — or harmfully include them (e.g., trans women or nonbinary people).

The queer and trans population is incredibly diverse. While still imperfect, an alternative is to name communities according to their identities when possible. For MPV awareness, examples could include “queer cisgender men, trans people, and their sexual networks” or “gay and bisexual cisgender men and trans people.” It is also recommended to ask students how they would like to be named when they are discussed.

“The General Population”

While this term is often used to quell fear among those who are *not* most affected by the current outbreak (e.g., “the risk to the general population is low”), this phrasing can sometimes exacerbate stigma when communicating about who is at risk by creating an “us vs. them” dichotomy against communities that already experience marginalization. It can also create a false sense of safety as the outbreak evolves.

Before using this phrase, consider the audience and if it may be more appropriate to name specific behavioral risks instead. Applying lessons learned from COVID-19 and HIV, an example of an evidence-based message for a general audience that promotes risk reduction without creating panic could be:

MPV is not nearly as widespread or infectious as the virus that causes COVID-19, and they are very different viruses. As we continue to learn more about the current MPV outbreak, it is recommended to continue some basic practices that we already know help to keep us healthy: wash your hands often, stay home and seek care if you feel sick or notice a new rash, wear a mask around others when you feel sick, talk to any sexual partners about symptoms beforehand, and [practice safer sex](#).

“High Risk Group”

It is important to communicate risk for infectious diseases in simple terms that the public will best understand. At the same time, we must consider how stigma can be reinforced when we talk about populations most affected being “high risk.”

Instead of calling a group of people “high risk” — especially if they already experience marginalization — consider using “most impacted” or “most affected.”

“Anyone Can Get MPV”

Yes, anyone can get MPV. However — as with any other virus — not everyone *is* getting MPV during the current outbreak or being affected by it in the same way.

In addition to clarifying that viruses do not infect people based on who they are, consider highlighting that stigma and systemic oppression (e.g., racism, heterosexism, cissexism) exacerbate spread and that people diagnosed with MPV deserve to be treated with dignity and respect.

Focus on the need to improve access to information, vaccines, testing, and treatment for communities most affected, while making a demonstrable commitment to stand against stigma.

Sex Positivity Matters

MPV is not currently classified as a sexually transmitted infection, but it can be acquired through skin-to-skin sexual contact. Despite that, there is no way around the fact that the current outbreak involves sexual contact among networks of queer cisgender men and trans people. As such, we must address queer and trans sexual health.

Further, in order to access the limited vaccine supply in many locations throughout the country, people are having to disclose various sexual behaviors — for example, that they have multiple sexual partners, had a recent STI, are on HIV pre-exposure prophylaxis (PrEP), attended a sex venue, or engaged in sexual activity with someone they did not know. These disclosures require an existing level of trust.

For strategies and resources to promote sexual health on campus, it is recommended to review ACHA's existing guidance: [ACHA's Best Practices in Sexual Health Promotion and Clinical Care in College Health Settings](#).

If college health professionals are uncomfortable having frank, judgment-free, comprehensive discussions with students about sexual health, then it is recommended that training from an inclusive, science-based source be provided. It is also recommended that students are made aware of local LGBTQ-specific health centers, clinics, and resources.

Some Training Resources:

- [LGBTQIA Health Education Center](#) (Fenway Institute)
- [National Network of STD Clinical Prevention Training Centers](#)

The Messenger Matters

One of the first rules of health communication is to include voices and perspectives from the communities most impacted when developing messages and initiatives — to always let the community lead. MPV is no exception, and how a message is received depends on how it is framed as well as the source credibility of the sender to the audience of that message.

Both inside and outside the LGBTQ+ community — from public health professionals to those who are not — there has been considerable debate about how to discuss risk factors and those communities most impacted by the current outbreak. While *intentions* on all sides of the debate are good and there are nuances to consider for each message, what ultimately always matters is the message's *impact*.

To Name or Not to Name?

It is important for communities most impacted to not only be supported, but to also feel and recognize the sincerity of that support. It is also important that those communities are aware of any risks to their health so that they can take action to reduce harm and stay as healthy as possible.

In addition to reviewing the resources at the beginning of this document for guidance, consider balancing this tension by eliminating stigma as much as possible in any message — no matter who the audience is. At the very least, always provide context when a specific group is named. In any MPV-related messages for general audiences, for example, try explaining that:

- Infectious diseases spread more quickly in tightly knit social networks.
- Viruses do not infect people because of who they are.
- Systems of oppression such as racism, heterosexism, and cissexism prevent access to resources and information.
- Stigma causes harm and makes people less likely to seek care.
- There are campus resources available to report hate and bias.
- Membership in an impacted group is not in any way an indication of infection or contagion.

As with other public health decisions, there are harms and benefits; not everyone will agree. However, when naming is done in a thoughtful and intentional way that is grounded in science and community feedback, the benefits will often outweigh the harms.

Prevention and Harm Reduction

Simply put, messages about MPV developed by and for queer cisgender men and trans people will always be best received when they are sent by queer cisgender men and trans people.

Consider what such directives as “limit your sexual partners” or “stop engaging in sexual activity” might imply when they come from people who are not most affected. People do not want to feel “othered” or that their behaviors are being policed by an outside group – especially when their sexuality is already policed and marginalized. This creates stigma and mistrust.

Given these challenges, work with your campus’ LGBTQ+ center or your local LGBTQ+ community center – along with health educators and health promotion specialists – to collaborate on any targeted public health messaging to ensure it is affirming and rooted in harm reduction. These centers could also offer consultation before campus-wide messages are released or educational materials are published.

Consider the acronym **PIED** to guide health behavior messaging. Always ensure that messages are:

- P**ositive
- I**nclusive
- E**mpowering
- D**oable

Some Community-Led Resources:

- [6 Ways We Can Have Safer Sex in the Time of Monkeypox](#) (by Nicholas Diamond, MPH, Joseph Osmundson, PhD, and Grant Roth, MPH)
 - [Infographic](#) by Fenway Health
- [MPOX/MPV](#) (Building Healthy Online Communities)
- [Monkeypox: What You Need to Know](#) (Human Rights Campaign)
- [MPV: What the LGBTQ+ Community Needs to Know](#) (APLA Health)
- [Monkeypox and Gay and Bisexual Men: Fact Sheet](#) (Fenway Institute)
- Podcast: [Monkeypox: Just the Facts](#) (Fenway Health)
- [Monkeypox Info and Updates](#) (San Francisco AIDS Foundation)

A Work in Progress

As the MPV outbreak evolves, so will this guidance document. Please consult with fellow college health professionals and share your campus’ MPV efforts and resources on the [ACHA Connect discussion board](#), and get involved in one of the many ACHA [sections](#) and [coalitions](#).

These briefs were developed by the MPV Working Group with representatives from ACHA’s Sexual Health Coalition, LGBTQ+ Health Coalition, Vaccine-Preventable Diseases Advisory Committee, and Emerging Public Health Threats and Emergency Response Coalition: Theyv S. Chai, MD; Blake Flaughner, MPH, CHES; and Lindsey Mortenson, MD.



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