

Public health advice on understanding, preventing and addressing stigma and discrimination related to mpox



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This public health advice from WHO provides information on the potential impact of stigma and discrimination in the context of mpox outbreaks. It includes recommended language and actions to counter stigmatizing attitudes discriminatory behaviour and policies related to mpox outbreaks.

Overview

Mpox is a viral infection that can cause a painful rash, enlarged lymph nodes, fever, headache, muscle ache, backache and low energy. Most people fully recover, but some can get very sick. Children, pregnant people and people with weak immune systems, including people living with uncontrolled HIV, can develop serious illness from mpox and can become seriously ill or die.

A global outbreak of mpox began in 2022 and predominantly affected communities of gay men, bisexual men, other men who have sex with men and transgender and gender-diverse people and their sexual partners.

In 2024, ongoing and emerging outbreaks in African countries are affecting people across all genders, sexual orientations and age groups, including children, highlighting broader risk factors and new social challenges.

Although more research is needed, the 2024 outbreak of a new clade appears to be more transmissible and can be especially severe for children, immunocompromised individuals and pregnant people.

Stigma and discrimination connected to any disease, including mpox, are never acceptable. They can seriously affect health outcomes and undermine the outbreak response by making people reluctant to come forward or seek care. This increases the risk of transmission – both within the most affected communities and beyond.

People often stigmatize other people without being aware that they are doing it and without any malicious intent. People automatically make judgements about

other people without realizing how it might affect them. We all find ourselves perpetuating harmful stereotypes or falling back on unconscious biases at times. Being aware of one's own unconscious bias is important, but even more important is to not allow these implicit biases that can cause discrimination to be enabled or ignored.

Proactively reflecting and acting on our own language, behaviour and intentions as individuals and as agencies is essential to reduce the harm caused by stigma and discrimination. Having good intentions is not enough – this guidance is for everyone working on or concerned by mpox.

Fear of perpetuating stigma and discrimination should not stop individuals and organizations from speaking up on important issues; the most important thing we can do is to be reflective, seek feedback, call out stigma and discrimination where we see it and be open to learning and changing our behaviour.

Who this document is for

This public health advice is for governments, United Nations agencies, nongovernmental organizations, health-care workers, community leaders, schools and other educators and mass media involved in the mpox response.



Addressing stigma and discrimination



Health-related stigma and discrimination stem from negative attitudes and beliefs about individuals with a disease or specific health condition. These attitudes can be exacerbated by the individuals belonging to or associated with certain groups and are often fuelled by lack of knowledge, fear and/or unconscious biases. This results in discriminatory behaviour: treating someone differently or negative action such as stereotyping, harassment or exclusion from health-care services.

To prevent harm caused by stigma and discrimination, individuals and organizations must actively reflect on their own biases, use inclusive language in risk

communication and community engagement activities and foster environments in which those living with or affected by mpox feel welcome, safe and supported to adopt protective behaviour, seek testing, treatment and vaccines if available and protect others.

People understandably feel confusion, anxiety and fear about a disease, especially if they are learning about it for the first time, but not letting fear fuel harmful stereotypes is important.

What do stigma and discrimination look like in practice?

Stigma can take many forms, including:

- stereotyping
- negative attitudes
- hostility
- judgement
- perceptions that the individual(s) “cause” or “deserve” bad things
- negative portrayals in popular culture, the mass media or public discourse.

Examples of discrimination include:

- policies, services and opportunities that exclude or miss certain people who need them
- isolating some groups of people from others
- hostile behaviour
- hate speech
- using harmful, mocking or derogatory language
- harassment
- violence
- bullying.

Stigma and discrimination associated with mpox may be associated with the following factors:

- Mpox is being found in new places and is transmitted in different ways. There are still many unknowns. Fear of the unknown often increases feelings of anxiety and may fuel a desire to assign blame or responsibility to other people.
- Although mpox symptoms vary, with some people having no visible rash, those who do have visible marks or scars during or after infection may experience speculation and unwelcome questions or comments related to mpox. Similarly, some people may assume that people with skin conditions unrelated to mpox may be experiencing mpox infection.
- Many people have existing unconscious biases around people different from them, including in relation to religion, race and sexual behaviour, which can unintentionally fuel stigma and discrimination.
- Some people with important contributions to addressing mpox, including health-care workers, may avoid engaging for fear of association with the disease and those most severely affected.
- Mpox may be used as an opportunity by those already focused on hate, racism, and bigotry. Some communities may already be subject to racism, societal perceptions and judgemental attitudes about their lives.

Approaches for understanding, preventing and addressing stigma and discrimination



1. Collecting and using evidence from social and behavioural data

Collect social and behavioural data, which is key to identifying how stigma affects how people perceive mpox, the information they can access, their health care seeking behaviour and activities in which they engage, and other social norms regarding mpox. What is experienced as stigmatizing and discriminatory can vary between people and between or within communities; up to date social and behavioural data is necessary to ensure that interventions are not based on assumptions. and discriminatory can vary between people and between and/or within communities, and so up to date social and behavioural data is necessary to ensure that interventions are not based on assumptions.

2. Sharing accurate information

Stigma and discrimination are often linked to misinformation. Provide evidence-informed, clear, transparent, context-based, and accurate information on how mpox is transmitted, treated and prevented. Share country- and community-specific data about epidemiological trends and vaccination, where available, treatment options and when, how and where to access health care. Access to clear information that also addresses people's needs and concerns helps to reduce fear and misconceptions and limit the spread of misinformation and rumours.

3. Using empathy

Empathy is critical in reducing stigma and discrimination. It helps people with potentially stigmatizing attitudes and discriminatory behaviours to understand the experiences of others, and helps people affected to feel understood and less isolated in experiencing rejection and discrimination. Actively create and maintain dialogue using empathetic language that upholds dignity and acknowledges the difficulties people are experiencing. This fosters a supportive environment and helps to

ensure respectful interactions throughout. This helps to build a supportive environment for discussing and addressing the disease without fuelling fear or judgement.

4. Developing the capacity of frontline workers

Train all frontline workers, including health workers, surveillance officers and case management teams, on psychosocial support skills and interpersonal communication skills. Equip them to identify and address stigma and discrimination and to understand how it affects the response, while also ensuring privacy and confidentiality when collecting information and/or dialoguing with patients, minimising distress and promoting dignity. Equip frontline workers with referrals to services as needed. If possible, adopt a total-facility approach so that all members of the workforce, regardless of role, are supported to treat service users appropriately. This can build trust between community members and health-care infrastructure and improve care-seeking behaviour. It is important to remember that frontline workers may come to their role with their own personal biases, as well as those of the system in which they work.

5. Engaging trusted community influencers

Leverage trusted community figures to share facts about mpox and to advocate against stigma and discrimination. Ensure that influencers, including religious leaders, traditional practitioners and healers, are culturally and geographically aligned with the audiences they target and assess them carefully to avoid inadvertently promoting stigmatizing attitudes. Networks of religious leaders living with HIV exist in many countries. They have experience in working to support communities in overcoming stigma and discrimination related to communicable diseases. Authentic and informed voices that are already well known and trusted by communities can play a powerful role in counteracting misinformation

and harmful stereotypes, especially through social media. They can also be keen to support people who have experienced mpox to safely reintegrate into community life. Community-based entry points, including schools, community and faith-based centres, can also be useful points from which to engage communities.

6. Sharing stories of lived experiences

Personal stories from individuals who have experienced mpox or stigma can humanise people with the disease and reduce fear. Sharing these stories helps others to relate to the situation and understand that, guided by medical intervention, most people recover from mpox, and that steps can be taken to reduce the risk of onwards transmission. Highlight both the health recovery process and the harmful impact of stigma and share successful efforts and approaches to combat discrimination.

7. Listening to affected communities

The experience of stigma and discrimination is context-specific and varies widely across individuals and communities. To effectively address these issues, engage in meaningful consultation with groups affected or at risk of mpox and experiencing stigma and discrimination. Data collection, feedback systems, community dialogues and monitoring public discourse (online and offline) can provide valuable data to guide action. This ensures that interventions are tailored to the real needs and concerns of the affected people and brought to where they are found and feel safe. There is no one-size-fits-all solution.

8. Diverse representation in interventions

Ensure that all communications and overall mpox interventions about mpox reflect the diversity of those affected, as informed by the epidemiological situation. Use inclusive images, language and symbols (co-created and pretested with communities experiencing stigma) that portray people of different ethnic backgrounds, genders and ages. Avoid implying that any group is more responsible for or more severely affected by mpox. If feasible, involve affected communities in co-creating materials and messages that are factual, relevant and acceptable, and test messages to check that they are having the desired impact.

9. Promoting ethical journalism

Mass-media reporting influences public perception. Give journalists accurate information about mpox and encourage them to use non-judgmental language in their reporting. Mass-media outlets should avoid focusing on individual behaviour or assigning blame to specific groups, since this may increase stigma and

discrimination. Promote timely engagement and capacity building for journalists through subject experts and media mentors on what and how to report or share information. Remember that journalists may have their own personal biases, and may work within institutions that have biases, too.

10. Self-assessment and awareness of bias

Good intentions do not exempt anyone from unintentionally perpetuating harmful stereotypes or discrimination. Organizations and individuals must regularly evaluate their own attitudes, behaviour and policies to identify any unconscious bias or potential for stigma and discrimination.

Continually engage in consultations with affected communities to identify key issues and areas for improvement. This process should create a non-judgemental environment in which people can reflect on their biases and commit to change without fear of judgement. Feedback systems should be in place for people to share perceptions of how language and approaches are stigmatizing so that they can be monitored and acted on.



Language guide: using non-stigmatizing language in all areas of the outbreak response



The language we use matters in all parts of the outbreak response and not just in communication and community engagement activities. When people talk about mpox, certain words and language may have a negative meaning or connotation and may fuel attitudes based on context. This is important whether you are talking to many people through the mass media or in one-on-one settings between health-care workers and patients or among community members.

Below are some dos and don'ts on language when talking about mpox.

- Do talk about mpox when referring to people who are ill with the disease.
 - Do not use the term monkeypox. Although it is still used to describe the virus, it is no longer used to describe the disease. WHO changed the term in 2022 following concerns that the term was being used in the context of racist and stigmatizing abuse.
 - Do acknowledge that terms may vary across languages and regions. In languages where mpox is not yet widely adopted, provide context about the ongoing transition from monkeypox to mpox.
 - Don't assume universal adoption of mpox. Be prepared to explain the rationale behind the name change when using it in contexts in which it is not yet standard.
 - Do talk about mpox and the communities most severely affected. Take care to communicate that anyone in contact with the virus can get it.
 - Don't attach labels of specific demographics, geographical location or occupation to the disease. For example, mpox is not a "gay" or "sex worker" disease and is not a "rural" or "X region" disease.
 - Do talk about "people who have [and/or have had] mpox".
 - Don't talk about mpox cases in communicating to communities or the public, since this can be dehumanising. The term mpox cases is more acceptable in epidemiological presentations and articles but should not be used in general communication.
- Do talk about the behaviours that can lead to acquiring or contracting mpox if the virus has entered social networks.
 - Don't talk about people spreading mpox or infecting others, since this implies that someone is doing this intentionally.
 - Do speak accurately about risk based on the latest science and health advice.
 - Don't repeat or share rumours or misinformation.
 - Do talk positively, emphasizing that most people recover on their own and that prevention and treatment measures are effective.
 - Don't overemphasize or dwell on the negative or the threat or use hyperbolic language or language that generates fear.
 - Do be careful and conscientious when choosing photos or developing graphics to show mpox symptoms, ensuring that you protect privacy and right to anonymity and understand sociocultural sensitivities. Obtain consent before use.
 - Don't use images that can identify individuals or use images without personal consent.
 - Do use photos of mpox symptoms on a diverse array of skin colours and seek out photos from the current outbreak and from people represented in your community.
 - Don't rely on photos from previous outbreaks that may reinforce misleading stereotypes about who can or cannot get mpox.

- Do emphasize that everyone who has close contact with someone who is infectious risks contracting mpox.
- Don't imply that only people who are sexually active, have a specific sexual orientation or have multiple sex partners can get mpox. Similarly, don't imply that people who hunt, deal in wild game or bush meat or live in caves are the only ones affected.
- Do use the term sexual orientation when talking about the sex or gender of the people to which specific people are attracted to. This should be informed by local context.
- Don't use the term sexual preference. Sexual orientation refers to a person's physical, romantic and/or emotional attraction towards other people. It comprises three elements: sexual attraction, sexual behaviour and sexual identity.

- Do use gay, bisexual and other men who have sex with men when talking directly to these people and men who have sex with men when talking more generally.
- Don't use acronyms such as MSM since this can be perceived as lazy and dehumanising – use men who have sex with men.
- Don't use prostitute or prostitution, since this can have judgemental overtones.
- Do use sex work and sex worker or the preferred local term of these communities.
- Do provide the global context when discussing mpox, acknowledging its history and current global distribution.
- Don't frame mpox as a disease of any country, community or region.

