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In the spring and summer of 2022, monkeypox spread throughout the world, and had a prominent impact on the United States.[1] The outbreak became so prevalent that the US Department of Health and Human Services declared monkeypox to be a national emergency in August.[2] While transmission seems to have slowed during the last few months (likely due to the distribution of vaccines) there are serious issues for the US moving forward in terms of how the government reacts to outbreaks, particularly ones that predominantly impact marginalized communities.[3]

Monkeypox is a rare disease which causes the development of painful sores across skin, which tend to last approximately two to four weeks.[4] LGBTQ men, particularly men who have sex with men ("MSM"), are the demographic most impacted.[5] In the US, 99% of the people infected with monkeypox were men, and 97% of those men reported having sexual contact with other men.[6]

While monkeypox has not officially been classified as a sexually transmitted disease, a growing group of researchers believe it spreads more through sexual intercourse than through skin contact.[7] As such, the medical community has taken to referring to it as sexually associated as opposed to sexually transmitted.[8] Some health professionals have expressed concern that labeling the disease as sexually transmitted will put off groups of people from receiving the vaccine, as individuals who are sexually inactive will think they will not need protection.[9] Labeling monkeypox as sexually transmitted could also have harrowing consequences for infected people who live in countries where homosexuality is a crime punishable by prison or even death.[10]

As monkeypox has spread among queer men, stigma has followed.[11] Since most victims of the disease have been among queer men, society and health officials have generally attached the risk of monkeypox to this group.[12] A growing concern among activists and public health officials is the outbreak's similarities to the HIV/AIDS outbreak in the 1980s.[13] John Farley, nurse scientist and the Leadership and Innovation Endowed Chair at Johns Hopkins University School of Medicine told CNN, "it took almost a decade to get the heterosexual community to pay attention and realize that HIV was not a gay disease. We cannot allow the same form of inaccurate information to guide our public health practice today."[14] The stigma has already played out in politics, as Congresswoman Marjorie Taylor Greene attributed monkeypox cases in children to child abuse at the hands of LGBTQ individuals.[15]

Additionally, treatment and vaccination options have been limited, largely due to supply shortages.[16] Ofole Mgbako, an HIV primary care doctor at NYC's Bellevue Hospital and assistant professor at NYU School of Medicine, wrote an opinion piece for Stat News about patients he's seen who have been turned away from other treatment centers.[17] Mgbako argues that had the disease been an outbreak primarily among children, there

would have been a swift response to protect them.[18] Because it is a disenfranchised group being impacted, the response was more reactive than proactive, and was largely ineffective in the first few months without adequate resources to vaccinate, test and treat patients.[19] The resistance from public health officials to swiftly take action is a reminder of the discrimination that exists in the medical field toward LGBTQ Americans, such as the ban on MSM from donating blood[20] and the continuing efforts to limit access to gender-affirming surgery.[21] Discrimination like this has been linked to discouraging LGBTQ folks from getting the medical care they need.[22]

While vaccinations have seemed to have been successful at slowing the outbreak, there are other issues regarding the vaccine rollout.[23] While the federal government distributed the first doses of the vaccine to states, the limited amounts were quickly depleted by those trying to get appointments.[24] Sexual health clinics, who were at the front of vaccine distribution, were stretched thin by the demand.[25] Even after the federal government released more doses of the vaccine, funding was not provided to administer them efficiently, and many clinics were forced to find costly ways to adjust to the demand.[26]

Additionally, the limited supply of vaccines on hand forced the government to spread out the doses. Standard doses were split into five doses, stretching the supply but reducing the amount of vaccine in each dose given.[27] Instead of administering the vaccine subcutaneously (under the skin), these smaller doses were given intradermally (between layers of skin).[28] While the limited available research suggests the smaller dose will not compromise immunity for patients, the new administration of the doses came with other problems.[29] The intradermal technique leads to a bubble of liquid under the skin, which causes firmness, itchiness, and redness.[30] These bumps last for days or weeks,[31] and some have reported bumps lasting for upwards of four weeks.[32] If the government had procured enough vaccines for the at-risk community, they would not need to be cutting the doses to extend supply, which has made the vaccination process more painful and difficult than it needed to be.[33]

Finally, there is a huge racial disparity in terms of who is being affected by the disease.[34] According to data from the end of September of this year, 51% of monkeypox vaccines have been administered to white people, although white people only represent 30% of reported cases.[35] Black people have been administered 13% of the vaccines, despite making up 35% of reported cases.[36] Hispanic people have been administered 22% of doses, compared to their 30% of reported cases.[37] The data illustrates concerning trends around the need for minority communities to receive access to the vaccine.

Despite the numbers of infection receding,[38] the federal government should continue to order more doses of the vaccine and increase funding for sexual health clinics to account for the increased demand in response to the monkeypox outbreak. After procuring more doses, health officials should return to administering the dose subcutaneously to minimize discomfort for those choosing to get it. States should also be required to prioritize urban and predominantly minority neighborhoods for the vaccine to ensure minority communities receive a fair

share of vaccines. Finally, it is important for society and the government to recognize the ways in which the response to the monkeypox outbreak can be a lesson regarding how we respond to diseases impacting marginalized communities in the future.

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