On July 23, 2022, the World Health Organization (WHO) Director-General declared the monkeypox outbreak a public health emergency of international concern. While the virus had previously been endemic only in West and Central Africa, new cases emerged in 2021 in both the United Kingdom and the United States. Data show that the current global outbreak of monkeypox has disproportionately affected self-identified gay, bisexual, and other men who have sex with men (GBMSM). According to one study tracking monkeypox infections across 16 countries from April to June of 2022, 98% of persons infected were gay or bisexual men. By September 18, 2022, the WHO reported that the global rate of infection among GBMSM was still high —90.9% out of the available sample of cases.
There is limited data on the rate of infection among transgender people. Some countries with available data also report high rates of cases among people living with HIV.

While some experts, including the WHO, have been reluctant to strictly associate monkeypox with GBMSM or LGBTQ people to avoid stigmatizing a particular population, the current spread of monkeypox through sexual contact suggests that social and sexual networks among GBMSM may be important drivers of the outbreak and therefore critical targets of resources for prevention and treatment. Indeed, recent surveillance reports by the WHO show concentrations of monkeypox among GBMSM. According to the WHO's External Situation Report from October 5, 2022, of the 17,337 cases where sexual orientation was reported, 89.9% of the people infected identified as GBMSM. Of the 12,070 cases where transmission was reported, 87.1% were through mucosal contact during sexual activities. And, of the 19,242 cases where known HIV status was reported, 49.2% were people living with HIV.

LIMITED GLOBAL DATA ON INCIDENCE OF MONKEYPOX AMONG LGBTQ PEOPLE

Despite these global reports, which include discussion of variables related to sexuality, few national agencies are disaggregating data to confirm the prevalence of monkeypox at the country level among LGBTQ people, GBMSM, or people living with HIV. National reports in the U.S., the UK, France, Peru, and Australia generally point...
to GBMSM as the population most affected by monkeypox. Spain has also recognized the high prevalence of monkeypox among MSM. However, among these countries, only the U.S. and the UK are publishing accessible data on subpopulations, including statistics on gay, bisexual, or other men who have sex with men. The Brazilian Ministry of Health published limited data on MSM but has not included such data in its epidemiological updates.

Likewise, few national jurisdictions are collecting disaggregated data to evaluate the impact of the outbreak on gender minorities. Only the U.S. Centers for Disease Control and Prevention (U.S. CDC) includes disaggregated data on gender, including transgender women, transgender men, and other gender minorities. Current U.S. CDC data show that transgender people represent a small percentage of the affected population that reported gender, but there are no data on transmission of monkeypox cases between transgender men and other GBMSM. Out of the available data from all accumulated cases in the U.S. that reported their gender (19,682 / 25,341 reported cases as of September 27), transgender men represent 0.24% of the total accumulated cases by gender. There are no public data on common means of transmission among transgender people, infection rates among transgender people living with HIV, or other important interactions to show differences in trends to better target prevention campaigns and treatment protocols.

Some countries report disaggregated cases based on binary genders (men and women), including Mexico and Germany, but such data are insufficient to understand the effects of the pandemic on transgender populations. French health authorities only report transgender people as a possible risk group if they have multiple partners, and no data on cases among transgender men are provided. The lack of data on the effects on transgender

21 Calculated from the data available at the CDCs page, as of September 27th, 2022, on cases which reported age, gender, race/ethnicity, and symptoms. CDC, “Monkeypox Cases by Age and Gender, Race/Ethnicity, and Symptoms,” September 8, 2022, https://www.cdc.gov/poxvirus/monkeypox/response/2022/demographics.html.
populations also limits data on the potential interactions between the monkeypox vaccination and hormone replacement therapy or other forms of gender-affirming medical care.

**DATA GAPS MAY HINDER PREVENTION AND TREATMENT OF MONKEYPOX**

The failure of governments to measure the impact of monkeypox on LGBTQ populations affects public health responses and hinders the ability to effectively target vaccines and other resources to communities most in need. Knowledge of affected populations and modes of transmission are essential to designing and implementing interventions to prevent spread.25

Limited data on LGBTQ communities and inadequate responses by national governments have prompted civil society organizations in many countries to demand further support and resources for at-risk populations. In Latin America, for example, where Peru, Colombia, and Mexico are among the countries worldwide with the highest number of reported cases of monkeypox, activists have mobilized to pressure governments for action in declaring a health emergency grounded in scientific evidence from other countries. On August 29 to 31, civil society representatives from 21 countries gathered in Mexico City to call on governments to recognize sexual contact as a primary transmission vehicle for the virus and to recognize GBMSM as a priority population for accessing the vaccine. Likewise, they called on governments to implement a plan of action to counter stigma, discrimination, and violence targeting gay and bisexual men.26 Indeed, stigma and discrimination can hinder public health responses to disease outbreaks by causing at-risk populations to avoid seeking medical care.27

In response, the Secretary of Health of Mexico City released a statement affirming the WHO’s emergency declaration and verifying that the majority of confirmed cases of monkeypox in the city were MSM, including one transgender person.28 Among other things, the statement underscored the importance of data for communicating risks and providing care to affected populations, including GBMSM. It also echoed activists’ calls for rejecting discrimination and stigma against GBMSM.

In Africa, failure to collect data has similarly constrained the response for at-risk LGBTQ communities. When asked about the prevalence of monkeypox cases among MSM in Africa, Director of the African Centres for Disease Control and Prevention (Africa CDC), Ahmed Ogwell, stated that such data were not collected and maintained that data are not a relevant indicator on the continent.29 He argued that data collection on the continent since 1970 has not shown MSM is a population significantly affected by monkeypox and that this outbreak has been driven by “traditional” drivers (i.e., close contact in confined spaces and living in communities in contact with infected animals).30 This declaration appears to contradict the Africa CDC’s own recommendations for communications

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targeting “specific populations currently impacted and at risk [of monkeypox]” including sex workers, suggesting recognition of sexual activity as a driver of transmission. Moreover, some researchers argue that the absence of new registered cases of monkeypox among MSM is not due to its absence within the population but rather a lack of testing capacity on the continent and stigma that MSM face in the healthcare system.

Even in countries with more access to treatment and prevention, stigma continues to pose barriers to receiving care. In the U.S., despite an ostensibly coordinated national response to the virus, individuals still report difficulty accessing treatment and testing, in some cases finding physicians who are not knowledgeable about monkeypox health care protocols. Some gay men, harboring memories of stigma and discrimination during the HIV/AIDS crisis, may be reluctant to come forward and seek care. And Black people, in particular, face compounded barriers due to racial and sexual orientation-based stigma. Currently, Black people represent only 10% of vaccine recipients despite making up nearly 40% of monkeypox cases.

**BARRIERS TO ACCESSING MONKEYPOX VACCINES**

Structural disparities between countries in the Global North and Global South, as well as lack of data collection, may impact access to the monkeypox vaccine for LGBTQ people. Danish pharmaceutical company Bavarian Nordic manufactures the only government-approved vaccine to prevent monkeypox. Since cases of monkeypox appeared outside countries where it had been endemic, the U.S. and European countries began purchasing batches of the vaccine, and Grand River Aseptic Manufacturing, a U.S. company, confidentially negotiated the rights to share the technology and manufacture the vaccine for domestic use. Other low- and middle-income countries have not had the same access. As of August 31, the U.S. held nearly 80% of the global vaccine supply, constraining even other European countries from accessing future shipments. Priced between USD 90 and USD 110 per dose, countries in the Global South are unable to afford the billions of dollars necessary to purchase what vaccine supplies may become available, and they have neither the technology nor the infrastructure to produce it.

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37 In the US, the authorized vaccine is Jynneos, in Canada it is marketed as Imvamune, and as Imvanex in the EU. See https://www.ema.europa.eu/en/documents/public-statement/possible-use-vaccine-jynneos-against-infection-monkeypox-virus_en.pdf.


This inequality also results from a broader market failure where some diseases are neglected unless there are incentives that spur research and development. Pharmaceutical companies have less incentive to invest in vaccines for diseases that predominantly affect countries with health insurance systems that have low ability-to-pay or with potential consumers that cannot afford the medication, which is often set at very high prices to recoup investments. At the same time, when mechanisms are in place to address market failure, such as the Priority Review voucher program in the U.S., it can create monopolies over specific drugs that nevertheless produce “public health failure” in which drugs remain unavailable to certain countries. Bavarian Nordic, for example, received 1.9 billion USD in funding between 2003 and 2021 from the U.S. government, making it the only laboratory with funding to research, develop, and market the monkeypox vaccine.

While vaccine rollout in the U.S. and European countries has led to a global decline in monkeypox cases, supply shortages and lack of commercial agreements between Bavarian Nordic and countries in the Global South may be linked to a rise in cases in Latin America and a deadlier rate in Africa. Brazil currently reports the second highest number of cases worldwide but just recently negotiated access to the vaccine through the Pan American Health Organization (PAHO), months after Bavarian Nordic signed deals with the U.S., Europe, Canada, Australia,  

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and Israel. While Brazil, Peru, and Chile confirmed the arrivals of the first batches of vaccines through the PAHO Revolving Fund in late September and early October 2022, no other information about vaccine access or distribution by other countries in the region has been made available. To date, according to the WHO and the Africa CDC, African countries are still struggling to access the vaccine, which might not be available until 2023.

Vaccine inequity within affected countries is further exacerbated by a lack of data regarding sexual orientation, gender identity, and sexual behavior. Public, disaggregated data can allow public health authorities to understand which populations are at higher risk of contracting the virus. If LGBTQ people are not captured by existing data collection systems, governments may feel no urgency to acquire vaccines or provide resources to support treatment and prevention among at-risk communities. In Mexico, for example, the government has refrained from acting to mitigate the particular risks facing GBMSM, despite the warnings by researchers. Insofar as the Subsecretary of Health declared vaccination is not an option in the short-term in Mexico, Mexican activists have compared such inaction to the “State-based homophobia” that allowed many GBMSM to get sick during the HIV epidemic.

RECOMMENDATIONS TO POLICYMAKERS AND PUBLIC HEALTH OFFICIALS

1. Collect data on sexual orientation, sexual behavior, and gender identity along with other sociodemographic variables to be published as part of national-level epidemiological updates.

2. Report the epidemiological data on monkeypox cases to inform incidence among GBMSM, recognizing the globally available data on the high percentage of patients who identify as such.

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3. Develop communication campaigns that address the multiple ways monkeypox can be transmitted while recognizing intimate sexual contact is currently the most efficient mode of transmission.

4. Strengthen coordination with civil society organizations and research institutions to initiate data collection and policies that target information, prevention, vaccination, and attention campaigns for most-at-risk populations of monkeypox, explicitly assessing GBMSM.

5. The U.S. government, as the world’s largest holder of the stockpile of monkeypox vaccine, should work with other regional and local partners to transfer technology and donate vaccines to the Global South.\textsuperscript{57}

\textsuperscript{57} South Africa’s Aspen Pharmacare is one of the firms offering to support the fill and finish of monkeypox vaccines.
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