CONSENSUS STATEMENT ON
RESPONSE TO THE MONKEYPOX OUTBREAK

We are united in calling for urgent action to prevent Monkeypox (MPX) becoming endemic in the UK.

Since May 2022, the UK MPX outbreak has become a crisis; with case numbers rising steeply, clinics are overwhelmed. MPX can be highly infectious through close contact, requiring people to isolate. Although the outbreak was unexpected, public health strategies have failed.

We need urgent action, now, to eliminate MPX in the UK. Allowing MPX to become endemic risks harming the health of our population and exacerbating the health inequalities experienced by gay and bisexual men and other men who have sex with men.

We need urgent action:

- System-wide coordination with clear lines of accountability.
- Funding to achieve outbreak control, optimise MPX care, protect existing sexual health services and support people required to isolate.
- An appropriately resourced vaccine programme with a clear delivery plan.

Rationale

Serious risk to health

- Pressures from MPX are growing daily. 1,552[1] cases have been diagnosed in the UK just two months.
- Delays in MPX diagnosis risks further transmission and harm to individuals.
- MPX has destabilised services for sexually transmitted infections (STIs), HIV pre-exposure prophylaxis (PrEP) and long-acting reversible contraception (LARC) with many services reporting significant reductions in non-MPX activity and some describing 90% reduction in PrEP and LARC access.[2]
- Delayed access to STI treatments increases transmission and the risk of antibiotic resistance.
- Reduced access to PrEP and HIV testing risks the UK not meeting HIV Action Plan targets.
- MPX risks moving from level 2 (transmission within a defined sub-population with high number of close contacts) to level 3 (transmission within multiple sub-populations or larger sub-populations). Whilst, so far, all of those affected in the current outbreak have recovered, the risk of severe illness or death is higher in young children and pregnant women – wider population transmission will yield avoidable harm.

Lack of resources

- Demand on sexual health services was already high. Managing MPX adds significant burden with additional time required for assessing patients and applying infection control.
- MPX management is being delivered by local sexual health systems without additional funding or staffing.
- Individuals diagnosed with MPX are required to self-isolate, sometimes for long periods, with no financial or practical support. This can result in stigma, mental ill-health, loss of work, and other hardship. For people in vulnerable circumstances (shared housing, sex work), or with unsupportive employers, this can be devastating.

Inadequate vaccine access

- The current vaccination roll-out is too slow; vaccine access is hampered by lack of co-ordination between the agencies responsible for different parts of the system.
- There are insufficient numbers of vaccines, too few men have been vaccinated, and communication about vaccine to affected communities has been poor.
- We have seen no plans for how, or when, suboptimal access to vaccines will be resolved.

[1] UKHSA, Monkeypox outbreak: epidemiological overview, 8 July 2022
[2] Data collected by BASHH

Lack of coordination and accountability

- No-one is currently responsible for whether MPX is controlled. No-one is accountable for setting and meeting targets to reduce infections.
- At present there are multiple parallel and overlapping meetings. Some of these have no clear terms of reference. They have unclear powers and no clear accountability.
- Not all key stakeholders are involved in developing response strategy and planning.
- There is lack of detailed information about case severity and risk factors. This limits our ability to provide clear and accurate information to people at risk.
- Pathways are unclear which can lead to poor experiences for patients.

MPX disproportionately impacting already marginalised communities

- GBMSM continue to be disproportionately impacted by MPX.
- The current MPX response risks exacerbating health existing inequalities.
- There have been multiple examples of stigmatising language.

Bold action is needed

Vaccine programme

The Department of Health and Social Care (DHSC), in collaboration with expert and community stakeholders, must produce and publish a Vaccine Procurement and Delivery Plan, including:

- Detail on vaccine quantities, and a procurement timeline, ensuring all eligible people receive the recommended two doses, 28 days apart. We estimate that 250,000 doses of vaccine must be procured for 125,000 people.[3]
- A plan and funding to deliver the programme through community and sexual health services, based on BASHH estimates: £62.63 to deliver two vaccine doses, including health promotion.
- Clear eligibility criteria[4] developed with sexual health experts, which prioritise those at highest risk of MPX exposure.
- A resolution of licensing issues to reduce prescribing and administering bureaucracy.

[3] Estimate comprised: approx. 60,000 people taking PrEP; approx. 30,000 GBMSM living with HIV and highly sexually active; approx. 4,000 healthcare staff; excess vaccine to meet the needs among sex workers and those GBMSM with a bacterial STI in the previous 12 months.
[4] See BASHH clinical criteria for reference.

- A clear communications strategy for those at risk of and affected by MPX including a process for contacting eligible individuals, and centralised management of questions from the public.

Funding

DHSC must fund:

- Sexual Health Services to provide MPX assessment, treatment, care and vaccination. We estimate this requires an urgent investment of £51m5 to contain and eliminate MPX. Wider MPX transmission may necessitate a more costly national vaccination programme and the costs of hospitalising even just 10% of people with MPX will be far higher than this.
- A clear package of support, using COVID-19 as a benchmark, for people advised to self-isolate.

Coordination and accountability

- Clear accountability, with a named Minister responsible for the MPX response, supported by a National MPX Response Lead with the ability to direct national agencies.
- A national multi-agency group, led by the National MPX response lead, including relevant stakeholders such as commissioners, community organisations and Directors of Public Health. This group should oversee:
    - All MPX responses, including vaccination.
    - A national plan for testing, assessment, treatment and prevention.
    - A joint communications strategy for clear, non-stigmatising messaging.
    - The formation of regional co-ordinating groups to implement MPX responses.
- Coordinated national, regional, and local responses with the needs and welfare of affected people at their core.
- Open access to appropriately anonymised, regularly updated data, to inform public health messaging and service planning.

Commitment to work together

We are a coalition of organisations working in sexual health, from commissioning or providing services, to policy and advocacy.

These recommendations will enable our health systems to respond to this latest public health emergency. Early action is vital.

[5] These figures are based on the BASHH funding assessment for delivery of Monkeypox services in Sexual health and GUM clinics and include: £286.87 to assess a suspected case; £441.16 if positive test result; £43m total projected costs for above; £7,828,750 to deliver two doses of vaccine to 125,000 people.

We need to prevent MPX becoming endemic. We have the tools to stop this crisis and to prevent future outbreaks.

We are fully committed to working together with each other, and with national agencies, to achieve the best possible response. This must start now.

Organisational Signatories

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