RESEARCH BRIEF

Monkeypox vaccination for sex workers: Evidence to inform equity-based responses

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BACKGROUND

On July 23, 2022, the World Health Organization declared the global monkeypox virus (MPXV) outbreak a public health emergency of international concern at a time when over 16,000 cases were reported in 75 countries and territories[1]. As of August 31, 2022, the number of monkeypox cases reported in Canada were 1251, with 137 in the province of British Columbia[2]. Following authorization of Imvamune® vaccine, the Government of Canada had deployed over 70,000 doses of the vaccine by July 23, 2022[3], with the Province of British Columbia (BC) receiving 14,480 doses[4].

In consideration of limited vaccine supply, those most at risk are prioritized under the guiding principles: maximize benefit, equity, and transparency. Prioritized demographic has been those identifying as gay, bisexual men, and men who have sex with men (MSM)[5]. This approach is consistent with evidence of overrepresentation of MSM among those affected (up to 98 percent of cases)[6].

As vaccination rates increase among the initial target demographics, there is a need to expand the vaccination program to include other groups likely to be affected. As most cases are passed on during sexual intimacy[7], sex workers are among those at risk[8]. Other at-risk groups include those who might not access health care services such as those experiencing homelessness and those who are immunosuppressed such as those with untreated HIV/AIDS[9]. At higher risk could be those at the intersection of sex work, homelessness, and immunosuppressed. While men sex workers who are gay, bisexual, or MSM are included as a priority population in the current MPXV vaccination drive, women sex workers are not. The latter is an underserved demographic facing social and health inequities, such as limited access to health care, insecure income, and unsafe working and living conditions[10].

The 2018 Canadian guidelines on HIV pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP), for instance, does not include specific recommendation for sex workers[11]. There is need to shift this approach and prioritize health access to sex workers. Due to the nature of their work, sex workers might be unable to adhere to prevention recommendations around condom use, having fewer sexual partners, and avoiding anonymous partners[12].

The COVID-19 pandemic further marginalized sex workers, socially and economically. Despite significant financial impact, little support was afforded through government economic relief programs[13]. The monkeypox virus outbreak comes at a time when sex workers are already financially vulnerable. Prior studies have linked poverty to increased risk of infectious diseases. One study, for instance, found significant association between food insecurity and increased HIV risk among youth sex workers in Metro Vancouver, as immediate needs override longer-term risk considerations[14].

While financial support is beyond the scope of MPXV vaccination, this highlights the importance of ensuring this demographic is vaccinated early on.

EVIDENCE FROM PREVIOUS VACCINATION INITIATIVES WITH SEX WORKERS

Studies indicate that vaccine intention among sex workers is typically high. However, they face multiple barriers to vaccination including fear, concerns over vaccine safety, need to involve their partner, need for more information, lack of confidence, lack of time, concerns of health experimentation, and personal illness[15]. Other potential barriers to health service in general include poor treatment by health workers, limited hours of operation, and language barriers[16].

Vaccination strategies should therefore aim at reducing such barriers and making information accessible to this demographic. A study on Human Papillomavirus (HPV) vaccination among sex workers highlighted the need to mitigate associated costs of vaccination — relatively high vaccination intention was significantly reduced by anticipated out-of-pocket expenses[17].

Sex workers and non-profit organizations supporting this group of workers have been, and continue to be, at the frontlines of reducing such barriers and mitigating transmission of infectious diseases to this demographic.

BEST PRACTICE CONSIDERATIONS

1. Engage community organization already supporting sex workers to increase vaccine uptake, including through supporting translation of public health advisory.
2. Ensure workers in the frontlines of vaccination are trained on trauma-informed and non-judgemental service provision. First contact can discourage vaccination, information that is likely to be passed on within sex workers communities.
3. Use messaging that does not contribute to misperception that monkeypox is exclusively spread within the LGBTQ+ community or/and by sex workers, while also meeting the health needs of those most affected. Negative messaging might result in stigma to those already stigmatized and marginalized in society.
4. Public health messaging to this demographic should be designed with organizations serving sex workers (and where possible, with direct involvement of sex workers) to ensure reduced stigma and use of common language for this demographic.
5. Vaccination outreach should aim at meeting sex workers where they are at in terms of both locations and times of operations. Engagement organizations serving this demographic would be insightful on such public health intelligence.

At the beginning of the HIV/AIDS epidemic in Canada, for instance, those most affected mobilized to gather and share information, including through community-based research, and develop resources on HIV prevention and management. These initiatives were the premise of approaches such peer education, community outreach, and harm reduction; methods which continue to inform health access strategies[18].

Such community initiatives were also observed during the COVID-19 pandemic. At the height of the pandemic, for instance, SWAN Vancouver (Supporting Women's Alternatives Network), supported migrant and immigrant workers in massage parlours by making information accessible including through translating public health measures. They also provided direct services such as PPE, emergency funds, and mental health support. The intention was to ensure women have sufficient information to make informed decisions in a context where pandemic measures directly impacted their ability to earn a living[19]. Over the course of one year (2020–2021), SWAN had served over 400 women sex workers; this could be attributed to its outreach activities which represent over 60% of services provided[20].

Research on hepatitis B vaccination among sex workers in Metro Vancouver area revealed gaps in vaccination among immigrant and migrant women, while women using drugs and those accessing HIV and STI services were more likely to vaccinated. This study highlighted a need to focus on reaching immigrant sex workers through community and culturally safe spaces, and a consideration to integrate vaccination with harm reduction and HIV/STI services[21].

Working with organizations which have already established a positive relationship with sex workers would increase the reach of vaccination drives as this would potentially reduced fear, build confidence, and offer flexibility of schedule. The PACE society's response to COVID-19 vaccination exemplified the potential of increasing vaccination uptake through community partnerships. With the approval of Vancouver Coastal Health, PACE opened a pop-up clinic at their officers where they administered COVID-19 vaccine to their members and other sex workers: 99 vaccines were administered in one day.

Barriers to access were reduced by not requiring IDs[22], as lack of documentation can present a barrier to migrant sex workers[23]. Utilizing a personal approach through such outreach initiatives, has been evidenced to increase vaccination uptake[24].

Endnotes

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