# GBV AoR HELPDESK

## Gender-Based Violence in Emergencies

# Briefing Note: Understanding Mpox and Its Links to Gender-Based Violence

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## Introduction

This briefing note aims to provide gender-based violence (GBV) practitioners and policymakers with essential information about Mpox, a viral disease. During public health emergencies like Mpox outbreaks, women and children may face increased risk of exposure to disease, greater obstacles to receiving accurate health information and services, and greater likelihood of experiencing GBV. Addressing these risks through inclusive communication strategies, ensuring access to critical services, and understanding specific GBV vulnerabilities is vital for the delivery of safer GBV programming and more effective control and prevention of Mpox.

The brief has been prepared through a desk review of available literature.[1] It highlights current knowledge about Mpox, including how Mpox differentially affects women and girls, and explores linkages between Mpox and GBV. It also outlines key considerations to strengthen GBV preparedness, risk reduction, response and prevention programming for women and girls. A list of supplemental resources is also provided.

## What is Mpox?

Mpox (formerly known as Monkeypox) is a DNA virus from the Poxviridae family, genus Orthopoxvirus. It was first identified in 1958 in laboratory monkeys and was recognized as a human pathogen in 1970 following the infection of an infant in the Democratic Republic of Congo (DRC). (See Box 1 for a timeline of key events in the history of the virus).[2] Mpox has two main types: Clade I, the more severe strain associated with higher fatality rates and found in Central/East Africa, and Clade II, historically found in West Africa. The DRC has been one of the countries most affected by the Clade I strain, with a fatality rate of approximately 10%.[3] Each type also has two sub-types.

After smallpox vaccinations stopped in 1984, Mpox transmission gradually increased in specific African regions, mainly

[1] Search terms included: Mpox / monkeypox +gender-based violence, violence against women and girls; outbreak + Mpox / monkeypox +gender-based violence, violence against women and girls. The document search was limited to English language documents and does not claim to be comprehensive as scientific and social research related information regarding this topic is constantly evolving. Several references are grey literature, not publicly available, but shared directly with the author.

[2] Schwartz, D. A. (2024). High Rates of Miscarriage and Stillbirth among Pregnant Women with Clade I Mpox (Monkeypox) Are Confirmed during 2023–2024 DR Congo Outbreak in South Kivu Province. *Viruses*, *16*(7), 1123. https://doi.org/10.3390/v16071123 P. 1. And Jezek Z, Fenner F. Human Monkeypox. New York, NY: Karger; 1988.

[3] Ibid.

remote rainforest areas where sporadic outbreaks occurred due to human contact with infected animals or humans or other contaminated materials.[4] In 2022, a multi-country outbreak affecting 116 countries resulted in increased attention to the virus.

Key features of the 2022 outbreak include,

- ✓ The virus spreading to populations with no travel history to endemic areas, leading to cases in new regions;
- ✓ This previously sporadic and limited pathogen now started infecting large numbers of animals and people.

Scientists currently report that the virus's epidemiology changed during the 2022-23 multi-country outbreak compared to previous outbreaks during 1970-2021, with shifts in age at presentation, case numbers, and geographical distribution.[5]

### *Mpox transmission*

Mpox can be transmitted from person to person through the following means:

- Direct physical contact with Mpox blisters, scabs or lesions (including with sexual contact, kissing, cuddling or other skin-to-skin interaction);
- Touching items or surfaces used by someone with Mpox, such as clothing, bedding or towels;
- Exposure to respiratory droplets through coughs or sneezes of a person with Mpox;
- Contact with an infected animal, including being bitten, touching animal fur, skin, blood, body fluids, lesions, or eating animal meat.

### *Mpox symptoms*

While most Mpox infections are asymptomatic, the disease can express in a variety of ways. (See Box 2 for some key symptoms reported by Mpox patients). The incubation period is approximately 12 days and can last as long as a month. The virus usually resolves without

### Box 1: Mpox timeline

1958 – Mpox is discovered in laboratory monkeys.

1970-1980 – Fifty-nine cases reported in western and central African rainforests.

1981-1986 – WHO surveillance data shows 400 additional cases in humans (mostly children who play outdoors).

1996-1998 – Large outbreak in the DRC (exacerbated by conflict driving populations deeper into rainforests).

2003 – The United States Centers for Disease Control and Prevention (CDC) announces evidence of the first community-acquired case of Mpox. A link with sick imported prairie dogs is identified.

2022 – Multi-country outbreak, impacting 116 countries.

July 2022 – The World Health Organization (WHO) declares Mpox a public health emergency of international concern (PHEIC-- a designated status under the 2005 International Health Regulations (IHR)) as it spreads rapidly via sexual contact across a range of new countries.

2023 - The emergence and rapid spread of a new strain, Clade 1b, heavily impacting DRC and spreading to neighboring countries, mainly through sexual networks.

May 2023 – The 2022-3 PHEIC is declared over after sustained decline in global cases.

2024 – The WHO Director-General again declares Mpox as a PHEIC due to its spread in DRC and other countries in Africa and calls for *"a coordinated international response [which] is needed to stop these outbreaks and save lives."*

September 2025 - The WHO Director-General determines that the Mpox event no longer constitutes a PHEIC.

[4] Schwartz, D. A. (2024). High Rates of Miscarriage and Stillbirth among Pregnant Women with Clade I Mpox (Monkeypox) Are Confirmed during 2023–2024 DR Congo Outbreak in South Kivu Province. *Viruses*, *16*(7), 1123. https://doi.org/10.3390/v16071123 p.1

[5] Ibid. p. 5.

treatment.

**Box 2. Mpox symptoms may include:**

- Fever
- Headaches
- Pains
- Fatigue
- A rash which often starts on the trunk and then spreads and can includes a rash on palms of hands and soles of feet as well as the face.
- Lesions (which may resemble pimples, blisters or pustules). This can include anal, genital and oral lesions.
- Swollen lymph nodes
- Pregnant women may miscarry or have stillbirths

*Diagnosis*

How Mpox is diagnosed may vary from setting to setting according to availability of diagnostic equipment and trained clinicians. Options include:

1. **A clinical evaluation**: This involves a trained health worker observing and assessing a patient for Mpox symptoms (such as those describe in Box 2) and according to self-reports from the patient.
2. **Differential diagnosis:** This involves a trained clinician ruling out other diseases commonly mistaken for or having similar symptoms to Mpox, such as chickenpox, herpes simplex virus, allergic skin reactions, syphilis, other pustular skin diseases.
3. **Laboratory testing**: This involves a Polymerase Chain Reaction (PCR) test taken from the fluids or crust of a lesion using a swab. This type of testing is recommended (where accessible) when someone has a new, unexplained rash consistent with Mpox, especially if they have directly interacted with a confirmed case or had exposure through sexual or intimate contact.
4. **Other types of clinical testing:** This might include a viral culture or an antibody test. These tend to be used less because they have significant clinical requirements, or limitations, such as interaction with the smallpox vaccine.

*Treatment*

Treatment for Mpox largely focuses on managing symptoms, preventing complications, and using antivirals in moderate to higher-risk cases (e.g. pregnant women, children, immunocompromised people). Symptom management may involve pain relief medication, intravenous (IV) fluids to support hydration, and skin-care support to manage itchiness and prevent secondary infection. Where antiviral treatment is advised it may be administered orally or through IV fluid. Children may require closer monitoring as they may be more vulnerable to serious symptoms.

*Prevention*

According to the World Health Organization (WHO)[6]and CDC[7] there are several vaccines available to help prevent and reduce the symptoms of Mpox:

- **MVA-BN** (also known as Imvamune®, Imvanex® or Jynneos®): This vaccine is given as an injection delivered under the skin (subcutaneously). It can also be given between layers of the skin (intradermally), this technique allows for a smaller dose to be administered.
- **LC16m8** (also known as LC16-KMB®): This vaccine is given by lightly pricking the skin multiple times with a special needle to deliver the vaccine just under the skin.

Both MVA-BN and LC16m8 contain a weakened form of a related virus called vaccinia virus (sometimes referred to as the smallpox vaccination) to stimulate an immune response in the body. Smallpox vaccination can provide significant

[6] See WHO (27 January 2025) for details https://www.who.int/news-room/questions-and-answers/item/Mpox-vaccines
[7] See CDC (15 September 2025) for details https://www.cdc.gov/monkeypox/vaccines/index.html

protection against infection with Mpox (85 percent or higher, according to some expert analysis).[8] In addition, a vaccine known as ACAM2000 is currently licensed in the United States for prevention of Mpox. However, due to side effects in some people, use of this vaccine is restricted.

In 2024, the Director-General of WHO triggered the process for Emergency Use Listing for Mpox vaccines, with the objective of accelerating vaccine access for lower-income countries which have not yet issued their own national regulatory approvals. The Emergency Use Listing also enables partners including Gavi and UNICEF to procure vaccines for distribution.[9] Equitable access to vaccines, therapeutics, diagnostics and other tools remains crucial to counter the spread of the virus and reduce health inequalities.

### *Scale and reach of the virus*

According to the CDC there have been more than 46,000 cases of Clade I Mpox in several countries in Central and Eastern Africa. The ongoing Clade IIb strain of Mpox has caused more than 100,000 cases in 122 total countries, including 115 countries where Mpox was not previously reported.[10] In DRC specifically, as of May 26, 2024, there were a total of 7851 Mpox cases resulting in 384 deaths reported from health zones across 26 provinces, with most infections acquired through heterosexual contact between sex workers and their clients. The average age of people contracting the infection is 21 years, with more than 50 percent of cases occurring in women. This represents a markedly different epidemiology than the 2022–2024 multi-country Mpox epidemic, in which 98 percent or more of affected persons were gay or bisexual men.[11] This aligns with a systematic review published in 2024 which found that in endemic countries, the proportion of women infected with the virus is almost 10 times that in non-endemic countries (most of which are high-income countries).[12]

### *Risk factors for Mpox infection*

Anyone can acquire Mpox, regardless of gender identity, sexual orientation, or age. However, systematic reviews have identified several key risk factors associated with Mpox infection, including having HIV or other sexually transmitted infections (STIs).[13] Since, HIV infection may increase the risk of Mpox, while Mpox lesions could also facilitate the transmission of HIV and other STIs[14]. Women living with HIV who contract Mpox are more likely to exhibit more severe symptoms and to require hospitalization compared to those without HIV. This highlights the importance of providing

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[8] Lewin, S., (2010). Chapter 45 - Gender Differences in Emerging Infectious Diseases, Editor(s): Marianne J. Legato, Principles of Gender-Specific Medicine (Second Edition), Academic Press, p.503. https://doi.org/10.1016/B978-0-12-374271-1.00045-9.

[9] See WHO (14 August 2024) WHO Director-General declares Mpox outbreak a public health emergency of international concern. https://www.who.int/news/item/14-08-2024-who-director-general-declares-Mpox-outbreak-a-public-health-emergency-of-international-concern

[10] See CDC (14 Nov 2025). *Monkeypox in the United States and Around the World: Current Situation.* https://www.cdc.gov/monkeypox/situation-summary/index.html

[11] Schwartz, D. A. (2024). High Rates of Miscarriage and Stillbirth among Pregnant Women with Clade I Mpox (Monkeypox) Are Confirmed during 2023–2024 DR Congo Outbreak in South Kivu Province. *Viruses*, *16*(7), 1123. https://doi.org/10.3390/v16071123

[12] See Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., .& Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.6.

[13] Ugwu C.L.J., Bragazzi, N.L., Wu, J., Kong, J.D., Orbinski, A.A.J., Woldegerima, W.A. - *Risk factors associated with human Mpox infection: a systematic review and meta-analysis:* BMJ Global Health 2025;10:e016937. https://doi.org/10.1136/bmjgh-2024-016937 p.1

[14] Whether this association is due to similar risk factors or whether HIV predisposes to mpox is yet to be explored. See Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., ... & Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.6 and Ghaffar, R. A., Shahnoor, S. & Farooq, M. (2022). Increased prevalence of HIV among Monkeypox patients - An alarming update. New Microbes New Infect. 49, 101039 for further details. https://www.sciencedirect.com/science/article/pii/S2052297522000919?via%3Dihub

additional support for women living with HIV and developing evidence-based preventive strategies to protect women's sexual and reproductive health. [15]

Other notable risk factors include engaging in unprotected sex and having physical or sexual contact with someone who is infected.[16] Individuals who identify as men who have sex with men are also at increased risk of contracting Mpox. Trans women who are sexually active with multiple partners also face a higher risk of infection.[17] These at-risk groups may encounter discrimination and stigmatization related to their sexual orientation and/or gender identity, including when accessing treatment for Mpox. [18] Social stigma during disease outbreaks can lead to other adverse effects, such as infected people hiding the disease, in turn accelerating spread of the virus and making it more challenging to trace. This phenomenon has been observed in other high fatality infectious disease outbreaks, such as HIV/AIDS and COVID-19, where misinformation and fear have contributed to increased stigmatization and isolation of affected individuals. Current data underscores the need to expand preventive strategies specifically for at-risk women, including trans women and sex workers, as well as men who have sex with men.[19]

Studies focusing on women during Mpox outbreaks in DRC from 2007 to 2024) have shown that pregnant women infected with the Clade I strain of the disease experienced high rates of miscarriage and stillbirth--ranging from 50-75 percent—because the virus can infect both the placenta and the fetus.[20] These findings emphasize the need for targeted preventive strategies, enhanced disease surveillance, and specialized care for pregnant women and girls.

In addition to these specific risk factors, more generalized conditions have been identified that increase vulnerability to Mpox infection. These include living in overcrowded settlements, lacking access to safe drinking water, and poor sanitation. The risks are further exacerbated in conflict zones, where breakdowns in infection control, inadequate disease surveillance, impeded access to affected populations, and the movement of refugees and aid workers can all contribute to the spread of Mpox and other infectious diseases.[21]

## GBV- and gender-related impacts on women and girls in Mpox outbreaks

### *GBV risks associated with public health emergencies*

Available information regarding gender- and GBV-related impacts of Mpox is limited. Nevertheless, previous public health emergencies (PHEs) such as Ebola, Zika and Covid-19 have shown that various forms of GBV increase, including

[15] See Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., & Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.6

[16] See Ibid. p.4 and Lapa, D. et al. Monkeypox virus isolation from a semen sample collected in the early phase of infection in a patient with prolonged seminal viral shedding. Lancet Infect. Dis. 22, 1267–1269 (2022).

[17] See Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., .& Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.4.

[18] Studies which explain this in more detail include Sah R, Mohanty A, Reda A, Padhi BK, Rodriguez-Morales AJ. (2022). *Stigma during monkeypox outbreak.* https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2022.1023519/full and Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., & Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.2

[19] Satapathy, P., Shamim, M. A., Padhi, B. K., Gandhi, A. P., Sandeep, M., Suvvari, T. K., & Sah, R. (2024). Mpox virus infection in women and outbreak sex disparities: A Systematic Review and Meta-analysis. Communications Medicine, 4(1), 188. DOI: 10.1038/s43856-024-00595-8 https://pubmed.ncbi.nlm.nih.gov/39349678/ p.6.

[20] Schwartz, D. A. (2024). *High Rates of Miscarriage and Stillbirth among Pregnant Women with Clade I Mpox (Monkeypox) Are Confirmed during 2023–2024 DR Congo Outbreak in South Kivu Province. Viruses*, *16*(7), 1123. https://doi.org/10.3390/v16071123 p.1

[21] Lewin, S. 2010: 497.

intimated partner violence (IPV) and sexual exploitation**.**

- Isolation to reduce the spread of infection can lead to increased IPV, particularly in camps/displacement settings. When containment strategies are applied (such as curfews), women and girls can remain trapped in dwellings with perpetrators. Unprotected sex and rape may occur with greater regularity.
- Primary care-giver roles in and outside the household adds an extra care burden which places female and child headed households at increased risk. Performing this role may force women and girls to walk long distances, walk at night, break imposed restrictions, walk through dangerous routes or terrain, and/or adapt negative coping strategies to meet their families' basic needs, thereby increasing their vulnerability and exposure not only to the outbreak/disease but also to the threat of sexual violence and other forms of GBV.[22]
- In conflict-affected areas there are likely to be measurable increases of sexual violence, HIV and other sexually transmitted diseases as well as high rates of social stigma. Stigma and discrimination and the fear of transmission can result in discriminatory practices and further marginalize affected individuals, increasing the risk of further violence and abuse. [23]

### *Gender-related barriers to care and vaccination*

Disease outbreaks can strain health systems but also strain, disrupt or suspend critical services for survivors. Crisis situations, poverty, malnutrition, educational and other social inequities fuel the spread of disease.[24] Existing gender inequalities create barriers to health information and services as well as access to vaccines and protection services, worsening women and girls' physical and mental health. WHO has found that less is spent on healthcare for women and girls worldwide compared to men and boys, and 70 percent of the 1.2 billion people living in extreme poverty are women. Unemployment is higher among women in most countries, and when employed, women's salaries are lower. Access to doctors, clinics, and hospitals is hampered by the fact that women remain in rural areas, while men travel to work in urban areas with more accessible medical care. High illiteracy rates among women in developing nations also create obstacles to care.[25]

> *"Monitoring pregnant women during outbreaks must become an integral part of public health investigations. If general guidelines exist for an emerging infectious disease outbreak, pre-event recommendations for prophylaxis and treatment of pregnant women must also be specifically provided, rather than cobbling together guidelines for these vulnerable women and their fetuses during an emergency."*
>
> Lewin, S. (2010): 498)

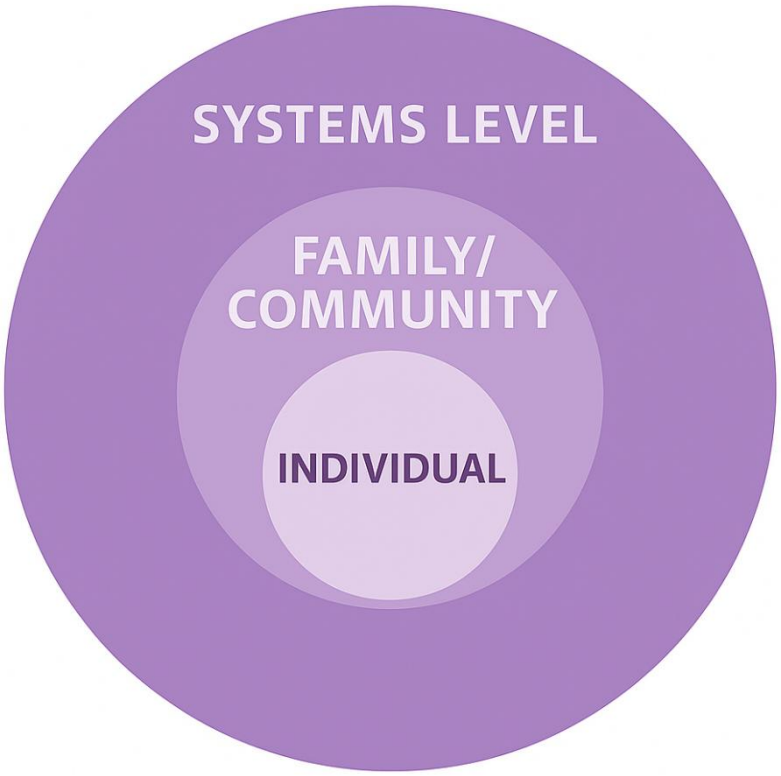
There are well documented gender related barriers and risks to vaccination. Many of these are laid out in a GBV AoR Helpdesk paper *COVID-19 Vaccine Rollout and Gender-Based Violence Risks*. In the case of Mpox, some specific issues have been put forward in studies focused on pregnant women, who may have poorer health outcomes because they are denied medications and vaccines due to their unknown effect on the fetus. Physicians can overestimate the risk to the fetus of medication, resulting in healthcare workers declining to offer interventions that are likely to protect or benefit women and their fetuses.[26] Healthcare workers and public health officials must be knowledgeable about benefits and risks of drugs and immunizations in pregnancy, so they can assist their patients in making informed decisions.[27]

[22] UNICEF (2024). Implementing GBV risk mitigation and response actions in Mpox.
[23] Save the Children (N.D.). Mpox SGBV tip sheet. Unpublished.
[24] Lewin, S. 2010: 498
[25] Ibid.
[26] Sanz, E., Gómez-López, T., & Martínez-Quintas, M. J. (2001). Perception of teratogenic risk of common medicines. *European journal of obstetrics, gynecology, and reproductive biology*, *95*(1), 127–131. https://doi.org/10.1016/s0301-2115(00)00375-4
[27] Cono, J., Cragan, J. D., Jamieson, D. J., & Rasmussen, S. A. (2006). Prophylaxis and treatment of pregnant women for emerging infections and bioterrorism emergencies. *Emerging infectious diseases*, *12*(11), 1631–1637. https://doi.org/10.3201/eid1211.060618

*Putting it all together: a socio-ecological framework for understanding key impacts of Mpox on women and girls*

For GBV practitioners, managing the challenges of the Mpox virus requires understanding its impacts on a variety of levels. A socio-ecological framework is useful to capture some of the key issues across these levels.

*Figure 1: The socio-ecological model (adapted from Heise, L. 1998*)




**Systems level impact examples:**

- Strained health and social care systems, including lack of trained health and social care providers;
- Increased numbers of sick health and social care workers, resulting in treatment gaps;
- Health and social workers with discriminatory attitudes that harm patients and feed into misinformation (e.g. myths and stereotypes about specific marginalized groups);
- Lack of data on gendered impacts of outbreaks resulting in less effective treatment and prevention protocols.

**Family / community level impact examples:**

- Adverse economic impacts resulting in increased poverty levels or increased reliance on harmful coping strategies (which include child marriage and sexual exploitation).

**Individual level impact examples:**

- Increased isolation and psychosocial harm if in confinement;
- Increased risk of miscarriage and stillbirth for pregnant women with Mpox;
- Discrimination against and exclusion of pregnant women with Mpox from antenatal services;
- School absence and a lack healthy routines for children;
- Extra caregiving duties and increased risk of contracting the virus for women and girls in close contact with family or community members with the virus;
- Increased stigmatization and exclusion experienced by sex workers and LGBTQI+ individuals due to discriminatory attitudes and behaviors.

## Implications for GBV specialists and GBV programming

*Key considerations*

It is important for GBV specialists to understand some of the core actions key to implementing programs during public health emergencies (see Box 3). These actions support GBV actors to understand and address risk factors for specific

populations as well as geographical variations, in order to build evidence-based strategies for the delivery of safer GBV programming and more effective control and prevention of Mpox.

**Box 3 - Key considerations for GBV programming during public health emergencies (PHEs)**

- **Safety analysis:** Monitor and audit PHE preparedness and response efforts to ensure that facilities and services meet the safety and privacy needs of women and girls (including those with disabilities and diverse SOGIESC).
- **Women and girls' participation and engagement**: Hold regular consultations with women and girls to assess their safety and wellbeing, design appropriate interventions with and for them, and engage them actively in implementing and monitoring PHE interventions.
- **Capacity Building:** Train and support frontline workers across all sectors of PHE response to make them aware of and equip them with knowledge and skills to protect women and girls from GBV and be ready to safely handle disclosures of GBV incidents reported to them, and to link survivors with available specialists.
- **Safe Referrals**: Ensure women and girls at risk of or experiencing GBV as well as boys and men who may also experience violence during outbreaks can access available services from specialists in a safe and timely manner.
- **Data collection**: Disaggregate and analyze data by sex and age (and, if possible, by disability) to understand the gender dynamics of PHEs and better guide the response. At minimum collect sex- and age-disaggregated data in all pillars of the PHEs (e.g., surveillance). Do not seek out survivors of GBV and or attempt to collect any data regarding GBV survivors/ GBV incidents during PHEs.

**Source:** UNICEF (2024). Implementing GBV Risk Mitigation and Response Actions in Mpox 2024.

### *A checklist of actions*

Drawing from these key areas above, the checklists below provide additional activities across the areas of outbreak preparedness; GBV response; and GBV risk mitigation. The list is not exhaustive but is meant as a starting point. Taking these actions--to understand and prepare for the health impacts of the virus on women and girls and other at-risk groups, understand and support their help-seeking behaviours, and build out quality health and GBV services and risk mitigation strategies--will help to ensure more effective action during Mpox outbreaks.

**Outbreak preparedness actions for public health and GBV staff**

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|---|
| ✓ All frontline workers must be<br>• trained on the GBV Pocket Guide[28]<br>• trained on PSEA and safe and ethical referral.<br>• aware of health care services available in their communities.<br>• aware of any existing GBV referral pathways and how to use/access them.<br>• prepared and ready to link GBV survivors with available specialists. |
| ✓ Ensure relevant GBV staff and volunteers receive comprehensive PHE emergency preparedness and response training and are ready to respond within 72 hours of an outbreak. Ensure training is accessible to female staff and staff with disabilities. |
| ✓ Ensure GBV programs have contingency plans which include actions relating to public health emergencies |
| ✓ Ensure hazard monitoring/surveillance activities are conducted 24 hours a day, 7 days a week, throughout the year.[29] |

[28] Refer to the *https://gbvguidelines.org/en/pocketguide* / or download the GBV Pocket Guide App.

[29] As recommended in the World Bank. *Ready 2 Respond Diagnostic Guidelines: Emergency Preparedness and Response Systems. Updated 2025*. Washington, D.C.: World Bank Group. See Appendix 2: workbook (Excel file - information sheet – criteria 2.2 Early Warning Systems; indicator 2.2.1 Hazard Monitoring. https://www.gfdrr.org/en/publication/ready-2-respond-diagnostic-

| | |
|---|---|
| ✓ | Develop simple, accurate warning messages and deliver in real time to provide those at risk with constructive and reasonable response actions. Ensure warning messages are consistent with international best practice in communicating with vulnerable populations, use technological advances, and are adapted for literacy levels, cultural context, etc. |
| ✓ | Pre-position emergency stocks (e.g. dignity and hygiene kits) and equipment ready for use. |
| ✓ | Review shelter and evacuation locations and conduct safety audits of these locations and apply GBV risk mitigation measures so that GBV risks are reduced. |

**GBV response actions for GBV staff**

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| ✓ | Develop and display IEC materials in GBV service delivery sites (e.g. WGSS/ One Stop Centers). |
| ✓ | Ensure case workers and community outreach teams can recognize the signs of GBV in women and girls. |
| ✓ | Provide psychological first aid and non-judgmental support, listening to and validating GBV survivors' experiences. |
| ✓ | Coordinate with health care providers who can offer both GBV and Mpox support. |
| ✓ | Manage GBV/Mpox disclosures in accordance with GBV guiding principles and safely refer cases. |
| ✓ | Ensure women and girls (including women and girls affected by Mpox) are engaged and consulted throughout the outbreak to understand their safety concerns and how they are impacted by Mpox and increased risks of GBV. |
| ✓ | Ensure case workers receive regular supportive and constructive supervision to guide them in the application of GBV guiding principles and apply GBV case management guidelines to their practice. Hold regular debriefing sessions to discuss challenges, near misses or critical incidents. |
| ✓ | Help women and girls maintain healthy routines and activities that promote their safety, health and well-being and provide holistic support, e.g. nutrition, hygiene kits etc. |
| ✓ | Reduce contact activities and ensure that GBV service delivery sites (e.g. WGSS/ One Stop Centers) are routinely sanitized and there is access to personal protective equipment (PPE) materials including face-masks and hand sanitizer. |
| ✓ | Expand access to confidential and accessible hotlines / helplines and telehealth to increase options and availability of support to GBV survivors who contract the virus. |
| ✓ | Fight against the stigmatization of women, girls and other at-risk groups by educating women and children accessing GBV service delivery sites and providing them with accurate information about the virus, its transmission, treatment and prevention. |
| ✓ | Address stigma in GBV and healthcare sectors by training GBV staff and volunteers about stigma and undertake educational campaigns to reduce the risk of stigma and discrimination. Urge infected/suspected staff/volunteer to report the infection and isolate themselves until treatment is provided. |
| ✓ | Engage in existing coordination mechanisms to avoid duplication and promote efforts to address GBV. |
| ✓ | Advocate for GBV services to remain open, available and adequately resourced to provide quality care to GBV survivors and remain operational throughout the health and social care crisis. |
| ✓ | Encourage self- and collective care practices for and among GBV response staff to enable a healthier work/life balance. |

**GBV risk mitigation for non-GBV sectors (especially health and WASH)**

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|---|---|
| ✓ | Train and equip frontline staff (including health/WASH) with knowledge on how to mitigate GBV risks in program delivery using the GBV Guidelines. |

guidelines-emergency-preparedness-and-response-systems

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|---|---|
| ✓ | Ensure PHE staff conduct safety analysis and/or safety audit of Mpox response facilities through observation, FGDs and key informant interviews to assess and address GBV risks in Mpox response. This should be done with inputs from women and girls, including those with disabilities. |
| ✓ | Ensure Health & WASH establish and support safe and accessible sex-segregated facilities including treatment centers, isolation centers, toilets, etc. |
| ✓ | Distribute GBV risk reduction supplies (where applicable and possible). Include dignity kits and other risk reduction items and supplies (including core messages about available GBV services) in Mpox distribution efforts to improve GBV risk mitigation outcomes. |
| ✓ | Develop and disseminate core messages on available GBV services for survivors and how to access them. |
| ✓ | Ensure PHE staff fight against the stigmatization of women, girls and other at-risk population groups by educating women and children accessing service delivery sites and providing them with accurate information about the virus, its transmission, treatment and prevention. |
| ✓ | Develop culturally acceptable health messages that provide accurate and timely information on Mpox symptoms and prevention strategies. |
| ✓ | Use various channels to communicate information about the virus, such as health websites, dating apps, or media programs (radio and tv). |
| ✓ | Ensure PHE staff consult with women and girls to identify existing communication channels in their communities and their preferences for disseminating and receiving messages. |
| ✓ | Ensure PHE staff consult with women and girls to develop and disseminate age, gender, and context appropriate messages with their inputs. |
| ✓ | Work with risk communication and community engagement actors to integrate appropriate messages on available GBV services in outreach efforts (including in PHEs distribution efforts with other sectors). |

## An endnote on sexual exploitation and abuse linked to public health crisis response

While not the focus of this paper, it is nevertheless critical to promote protection from sexual exploitation and abuse (PSEA) by aid workers during public health emergencies. Given the widespread impunity for SEA, the risk of demanding sex in exchange for employment will likely be present to some extent within the Mpox response in areas and at times of vaccine administration where health sector recruitment is scaled up rapidly. Risks may be attributed to the following factors which are often a feature in humanitarian settings:

- Low availability and high demand for services
- Male-dominated health/vaccine response teams and dominance in supervisory positions.
- Lack of accessible and effective reporting and accountability mechanisms
- A lack of trust in reporting and accountability mechanisms

Measures to prevent and mitigate risks include SEA training and codes of conduct for vaccinators, community-based complaints mechanisms, investigative capacity for holding perpetrators to account, and access to safe, confidential, and quality GBV services for survivors of SEA. These must be in place to avoid harm during disease outbreaks and the public health response to them.

## Further Resources and Guidelines

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## *The GBV AoR Help Desk*

*The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.*

### The GBV AoR Helpdesk

*You can contact the GBV AoR Helpdesk by emailing us at:*
*enquiries@gbviehelpdesk.org.uk*

*The Helpdesk is available 09.00 to 17.30 GMT Monday to Friday.*

*Our services are free and confidential.*