

Stigma: the social virus spreading faster than COVID-19

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Novel epidemics and pandemics are inherently plagued by scientific uncertainties and a rapidly evolving nature. This can lead to widespread fear and confusion—directly proportional to the level of disease impact and subsequent media coverage, which perpetuates panic.¹ Evolutionary psychologists argue that as response to fear humans tend to distance from those considered a source of danger (infections), guided by self-preservation, desire to find control or unfounded beliefs that those infected bear responsibility. Yet, this leads to misplaced reactions and stigmatisation.²

Originally from ancient Greek, the term 'stigma' was used to 'permanently mark people as criminals, traitors or slaves'. Nowadays, it describes negative associations and discrimination against people with certain attributes (social, physical, behavioural).³ Examples of stigmatisation can be found throughout infectious disease history, affecting communities, caregivers, family and those infected. Among the most stigmatised have been those affected by or associated with HIV/AIDS.⁴ Many other examples exist, towards Jewish immigrants during the 1892 typhus fever and cholera outbreaks in New York City,¹ towards 'African-ness' during Ebola outbreak(s), towards 'Asian-ness' during SARS⁴ and towards those of Mexican/Latin American descent during 2009 H1N1 influenza pandemic (inadequately called 'Mexican flu'). These stigmas significantly limited the ability to control diseases and affected mental wellbeing.

This is not different for COVID-19. The pandemic provoked worldwide discriminatory behaviours—including violence—and social stigma towards those (perceived) to have or been in contact with the virus or those of specific ethnic backgrounds (especially those of Asian descent and immigrants). This includes deplorable examples such as the use of 'Chinese virus' by government representatives or use of pejorative expressions towards healthcare workers.⁵

Such stigmatisation can increase transmission, have critical hidden human costs on those stigmatised and exacerbate already difficult circumstances of the most vulnerable populations (especially in low- and middle-income countries).⁴⁻⁸ First, people with or at risk of disease may be more reluctant to seek healthcare when needed or may try to hide the disease or misreport symptoms, reducing early detection and treatment.⁴ Second, certain health behaviours are required to prevent disease, while stigma may hinder adherence due to avoidant coping strategies or mistrust in public health agencies by those stigmatised.⁶ Third, experiencing and anticipating stigma can lead to stress, elevated depressive symptoms and suicidal ideation.⁹ Similarly, internalised stigma may result in individuals seeing themselves as inferior or not worthy.⁶ Fourth, social stigma can often lead to neglect, catastrophic costs and poverty, increasing susceptibility to disease.⁷ Fifth, stigma may lead towards distorted perceptions of risk and disproportionate allocation of health resources.⁷ Worryingly, social stigmatisation often persists even after outbreaks, epidemics or pandemics have ended (eg, continuous social rejection of Ebola survivors).⁸ Finally, stigma from multiple sources (eg, infectious disease, mental health, disability) can co-occur and interact with each other and other dimensions (eg, ethnicity, employment), increasing impact and inequalities.¹⁰

Furthermore, like previously described by Logie and Turan, tensions exist between COVID-19 mitigation, containment and the prevention of stigma. For example, while physical distancing is essential to prevent COVID-19 spread, othering can result in mistreatment and social avoidance of stigmatised individuals. Similarly, travel restrictions may prevent COVID-19 spread, while potentiating xenophobia or stigma by generating ideas of 'foreign invasion'. Consequently, it can be difficult for governments to balance between appropriate mitigation and preventing fear and stigmatisation.¹¹

Social stigma is not inevitable. Various strategies reducing disease-related stigma during pandemics exist—with vital roles for government, media, private sector and citizens (Figure 1)⁵. These strategies should be used to tackle sources of stigma and to assist those stigmatised. First, timely, honest risk communication, addressing misinformation and improving awareness, is deemed essential for all involved. Stigma reducing messaging can foster empathy while appropriately reflecting evolving COVID-19 patterns and normalising physical distancing.⁶⁻¹¹ Communication should be framed both for the general population as for the affected population in appropriate channels and language.¹ Second, strategies improving employment sick leave and access to testing have potential to address underlying social inequalities aiding stigmatisation.¹¹ Third, involving community leaders, their communities⁶ and those most affected by COVID-19¹¹ provides crucial information on contextually specific approaches. Furthermore, messages designed to foster a sense of altruism in behaviours¹² should feature diverse audiences, showing their contribution. Fourth, when public outreach and information campaigns are not enough, implementation of skill training and educational programmes may be beneficial.⁶ Nonetheless, further research is needed to clarify COVID-19-specific drivers of stigma at individual/structural levels and its impact on health.

Efforts should be focused on providing an adequate science-based COVID-19 response that includes the prevention of social stigma derived from COVID-19.

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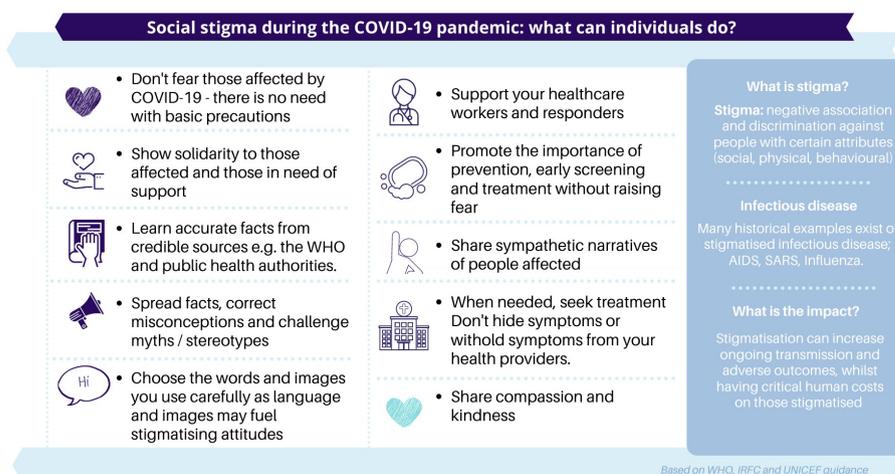
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Figure 1 Social stigma during the COVID-19 pandemic: what can individuals do? (Based on World Health Organization (WHO), International Federation of Red Cross and Red Crescent Societies (IFRC) and United Nations Children's Fund (UNICEF) guidance.)⁵



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