Case Discussion
Shaming and Stigmatizing Healthcare Workers in Japan During the COVID-19 Pandemic

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Stigmatization and sharming of healthcare workers in Japan during the coronavirus 2019 (COVID-19) pandemic reveal uniquely Japanese features. *Seken*, usually translated as 'social appearance or appearance in the eyes of others,' is a deep undercurrent woven into the fabric of Japanese life. It has led to providers who become ill with the SARS-CoV-2 virus feeling ashamed, while concealing their conditions from coworkers and public health officials. It also has led to healthcare providers being perceived as polluted and their children being told they were not welcome in schools. Although such experiences are not isolated to Japan and have appeared in other parts of the world, the cultural forces driving them in Japan are unique. Overcoming stigmatization and shaming of Japanese healthcare providers will require concerted efforts to understand cultural barriers and to view such practices as raising human rights issues affecting the safety and well-being of all.

> *My colleague, Dr. M, started to show symptoms April 4, 2020. Despite the urging of other physicians at our clinic, he refused to get tested for the SARS-CoV-2 virus. He elected instead to self-isolate. Four days later, when his symptoms worsened, he was admitted to the hospital with pneumonia. The clinic manager posted to our website that our clinic head, a reproductive endocrinologist, had suffered an angina attack. Clinic physicians and staff were told that computed tomography (CT) scans did not show evidence of* coronavirus 2019 (COVID-19)*-related pneumonia. The following week, Dr. M's secretary tested positive for the SARS-CoV-2 virus; five days later, on April 15, I was notified that Dr. M had the novel coronavirus too and was on a ventilator at the hospital.*
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> *Hearing the news of a second positive case at our clinic, I urged the clinic manager to notify patients who had contact with Dr. M or his secretary, but she resisted. The manager said she feared how seken-tei would cause people to see our hospital and ruin its reputation. Even the public health officials, who arrived to investigate, said that it was not required to report the incident due to seken-tei. We are not alone. In the Shibuya district alone, eighteen institutions have confirmed cases of COVID-19, yet only one has made their situation public.*

This is a personal experience; yet it is not an isolated event. *The Japan Times* reports that patients across Japan who test positive for the SARS-CoV-2 virus face stigma and shaming, as do their patients, families, co-workers and neighbors. When a single case of a teacher testing positive was reported in the Fukushima Prefecture, students and staff were ridiculed and a student wearing the school uniform was called disparaging names (Staff, 2020a). One of us (T.S.), a physician, was told not to bring her daughter to the Tokyo nursery school where she was enrolled to avoid spreading contagion. Reports of similar experiences among healthcare providers and their families both on and off the frontlines in Japan have emerged. One of the earliest reports told of a recovered patient who was sickened with the novel coronavirus aboard the Diamond Princess cruise ship. After recovering, the patient was later scorned by neighbors in the Osaka Prefecture where they lived, who said that by walking in the neighborhood they were spreading disease. In addition to prejudice fueled by fears of the disease, shortages of supplies to prevent disease have

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generated alarm. One Tokyo area physician described their hospital as, 'collapsing and screaming to get attention' due to lack of testing and personal protective equipment (Staff, 2020b; Anonymous Physician, 2020). When access to personal protective equipment is limited, healthcare workers and their children are often viewed as a public health menace.

Japan is hardly alone. In many parts of the world, healthcare workers are being ostracized. During the COVID-19 pandemic, reports surfaced of healthcare providers in Mexico, India, and Pakistan being viewed as vectors of contagion, leading to assaults and abuse (Semple, 2020). In the U.S. and Australia, safety concerns arose for some groups of physicians and nurses, while in China, laws banning threats against medical workers were enacted (Staff, 2020c). In the Philippines, a nurse caring for patients with the SARS-CoV-2 virus was doused with bleach and blinded (Semple, 2020).

Targeting healthcare workers is not new. It occurs against a broader background in which violence toward healthcare workers is widespread. According to the World Health Organization (WHO), between 8% and 38% of healthcare workers globally have reported physical violence at some point in their careers (WHO, 2002). Part of what makes targeting healthcare providers so troubling during an infectious disease outbreak is that they expose themselves to risk to help us. It is in the course of making sacrifices that they are scorned and stigmatized. Stigmatization has far reaching effects, extending beyond simply ridiculing a feature of an individual; it involves putting down a person in their entirety. The word, *stigma*, originally designated the physical marking of a person, usually by burning the skin with a hot iron, to create 'a sign of severe censure or condemnation,' a branding (Oxford University Press, 2020). In its modern guises, stigmatization pertains to social identities, rather than bodily signs; it indicates a person being disgraced, 'reduced in our minds from a whole and usual person to a tainted, discounted one' (Goffman, 1963, 2).

In healthcare, stigmatization has a long, checkered history, often applying to patients with certain conditions society maligns. In the U.S., people with cancer were shunned during the 1950s and 1960s due in part to cancer's association with death. While there is greater acceptance today, some people with cancer continue to report being stigmatized (Major, Dovidio, Link, Calabrese, 2017; Else-Quest and Jackson, 2014; Oken, 1961; Knapp, Marziliano, Moyer 2014) During the 1980s and 1990s, prejudice against men who had sex with men and people who injected drugs led to stigmatizing individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Today, about a quarter of people with this condition report stigmatizing behaviors shown towards them by medical personnel (Schuster *et al.*, 2005). Societies around the globe also struggle with acceptance of people with gender dysphoria; opiate addiction; mental health conditions, such as depression; and obesity. Accumulating evidence indicates health-harming effects of stigma, which contributes to health disparities between persons who are stigmatized and persons who are not (Link *et al.*, 2017). Part of what makes stigmatization within the domain of healthcare so intractable is that disease and impairment can be a jarring and unwelcome reminder of our own human frailty. We may be uncomfortable and unsure how to behave when someone falls ill, in part because we feel unease about our own susceptibility.

While there are many stigmatizing circumstances, both inside and outside healthcare, they share certain cross-cutting features. Instances of stigmatization typically involve a process of

1. labeling human differences;
2. stereotyping what is labeled as bad;
3. separating labeled individuals from oneself (or one's group) by regarding their differences as indicative of their whole identity;
4. reducing the status of those who are different; and thereby,
5. eroding their political, social and economic powers (Link and Phelan, 2001).

The features that comprise stigmatization lead people to regard its victims as 'spoiled' and less valuable than 'normal' people (Goffman, 1963, 1). Stigma's power springs precisely from how it infiltrates and damages people's identities in their entirety. As Lindemann puts it, 'a person's identity is damaged when she endorses, as part of her self concept, a dominant group's dismissive or exploitive understanding....' (Lindemann, 2001, xii).

Japanese society has its own unique brand of stigmatization. In Japan, stigma occurs in tandem with a deep-seated fear of being cast out of one's group and a strong yearning to blend-in. The name sometimes used to refer to this is *seken* (in Japanese, *seken-tei*) which is derived from the Sanskrit 'loca,' the word 'seken-tei' has no direct correlate in English but is usually translated as 'social appearance or appearance in the eyes of others' (Murayama *et al.*, 2011, 167). Osawa describes seken's contemporary meaning as indicating 'human relationships with people one knows, such as people in one's workplace, school or hometown, as well as people who

meet through hobbies' (Osawa *et al*., 2012, no page). A more precise rendering is offered by Abe, a seken researcher, who defines 'seken' as 'the link which connects people' (Abe, 1995, no page), indicating bonds that gather force through a people's sense of who they are and where they belong (Abe, 2003, no page). Abe holds that every Japanese belongs to some seken and that Japanese people equate their identity with their seken, i.e., their bonds with others.

According to Motoyama, the Japanese word, *seken-tei*, existed long before Japanese words for 'society' and 'individual' were introduced to Japan:

> the words for 'society' and 'individual' were brought to Japan and translated into Japanese in the early Meji Era when modernization and westernization were being spread...The Western sense of an 'individual' refers to one who has autonomy and makes their own decisions, while 'society' is the overall network among 'individuals. Before the introduction of these words, there was no word referring to 'individuals' because Japanese thought they were part of a village or country rather than an individual self (Motoyama, 2009, 38–39).

Unlike their western counterparts, Japanese conceptions of 'society' and 'individual' are overlaid by the desire to preserve seken, adding complexities to interactions between people. One way preserving seken impacts relationships is by inclining people to prioritize others' feelings (*hairyo*); not transgress group norms; and avoid acting in ways that would sully their reputation in others' eyes. Preserving seken also colors relationships because people not only seek belonging, but 'gain the meaning of their existence through their relationships with people who are in the same seken' (Motoyama, 2009, 43). The entanglement of identity and meaning with seken begins early, reflected in Japanese child-rearing practices which aim to raise children 'who are mindful of *seken-tei* (public appearances)' and feel 'fierce indignation toward perceived troublemakers' (Naoki, 2020). The Japanese saying, 'the nail that sticks out gets hammered down,' teaches the lesson that deviance will be met with resistance. Finally, preserving seken is entwined with traditional Shinto notions, such as *kegare*, which can spoil it. *Kegare* indicates '[a] polluted and evil condition; a concept opposite of purity. A condition of taboo....' (Kazuhiko, 1994). *Kegare* is thought to arise through contact with certain kinds of natural phenomena, including disease and death. Its presence can pollute a community and keeping it out can purify seken. Shunning healthcare workers who might have been exposed to the SARS-CoV-2 virus might be perceived as a way to protect seken by purifying the community against *kegare*.

Seken may contribute to Japan's relative 'tightness' compared with other countries, a feature that has been associated with lower death rates from COVID-19 (Lawlor, 2020). Gefland et al. define a 'tight' culture as one that allows a relatively narrow range of behaviors, exhibits more pervasive social norms, and shows less tolerance of deviance and a 'loose' culture, as one where the opposite is true, i.e., it allows a wider range of behaviors, exhibits fewer social norms, and shows more tolerance for deviance (Gefland, 2018). In a comparative analysis of 33 nations, Japan scored higher than average on tightness, whereas countries, such as the U.S., scored relatively low (Gefland *et al*., 2011).

On the upside, concern about others' perceptions means that during a health emergency like the COVID-19 pandemic, even absent laws requiring stores and businesses to close, Japan can rely on seken to ensure public safety, since people will voluntarily shelter at home to reduce disease spread. Leveraging the power of seken, the government can urge restraint (*jishuku*) and count on people to obey (Naoki, 2020). Related features of Japanese society, such as universal access to high quality healthcare, mask wearing, avoidance of public displays of affection and handshakes, few religious assemblies, removing shoes indoors, cleanliness of public toilets, not eating with hands, and other considerations, may contribute to low numbers of COVID-19 cases (Kopp, 2020; De Vries, 2020; World Population Review, 2020; Iwasaki and Grubaugh, 2020). Despite the fact that its population is the oldest on earth, which makes Japan more vulnerable to the SARS-CoV-2 virus (CDC, 2020; Verity et al., 2020), its death rates have remained low compared to its neighbors. Naoki compares Japanese receptiveness to public mask wearing to shoe removal, claiming both are motived by an underlying desire to protect oneself from the perceived contamination of an outside world:

> 'wearing a mask is an expression of the desire to separate the clean outside from the pure inside...This is also the reason that, whenever Japanese people move from outside to inside (such as when they return home), they remove their shoes, wash their hands, and gargle....the traditional understanding of *kegare*, which serves as a basis for seken rules, has contributed to keeping Japan's death toll from COVID-19 much lower than the West's' (Naoki, 2020, no page).

Yet, in other respects, seken has a negative underbelly. It accomplishes compliance through shaming and generates concealment as a way to avoid humiliation.

During the COVID-19 pandemic, seken might be partly responsible for the flight of physicians and nurses from jobs at a time when hospitals needed them. It was too difficult for many to keep working when their children were told they were not welcome at school and the whole family was considered tainted. At one Tokyo hospital, more than twenty staff took leave or quit, taxing already short supplies of vital workers (Staff, 2020b). Seken may also play a role in the emergence of self-restraint police (*jishuku keisatsu*) during the COVID-19 crisis, vigilante groups that bullied and threatened shops and businesses that failed to strictly adhere to official requests (Naoki, 2020). Similar fears were on display in 2011, following the Fukushima No. 1 nuclear disaster, when evacuees were ostracized, bullied, and considered polluted. With COVID-19, Japan is reporting higher rates of harassment, bullying, discrimination and suicide (Staff, 2020d; Rich and Hida, 2020). Finally, seken shows its influence in a negative way when it impedes public health measures to conduct testing and contact tracing. Like Dr. M, many people in Japan refuse to take the risk of being tested, or refuse to disclose positive test results necessary for contact tracing.

What is the best way forward? For Japan, a first step should be measures to weaken seken's harmful effects. Its vice grip on Japanese people can be weakened through giving individuals greater control over their health information (Momose and Asahara, 1996, 1). For example, Japan would benefit from enhanced privacy protections for testing for the SARS-CoV-2 virus and efforts to make testing at home more accessible. Home-based polymerase chain reaction (PCR) tests are available in Japan, but they are currently cost prohibitive for many Japanese (about $300 USD). Seken's negative influence is also potentially lessened when individuals lead by example. For instance, high-profile people and professional groups can contribute to modeling better values by visiting hospitals and standing in solidarity with frontline workers while showing compassion for victims. Japanese society saw moral leadership in action during the aftermath of the Diamond Princess cruise ship outbreak. When citizens vilified former passengers as 'germs' and told them not to take their children to nursery schools, the Japanese Association for Disaster Medicine spoke up, condemning such behaviors and identifying them as 'human rights issues' (Japanese Society for Disaster Medicine, 2020, no page). By contrast, seken's harmful effects were intensified when a kabuki star infected with the SARS-CoV-2 virus apologized publicly for being sick (Kimura, 2020). Apologizing makes sense only if a person acts wrongly, not simply because they are sick. The kabuki star's apology was reminiscent of others that emanate from the same kind of shame, such as Koda's apology to the Japanese people for being taken hostage by the al-Qaeda terrorist group in Iraq (Staff, 2004). Like being taken hostage, being infected with the SARS-CoV-2 virus makes a person stand out; yet standing out is not itself a crime. A braver and more helpful course for public figures stricken with the novel coronavirus would be revealing their diagnosis unapologetically and calling for kindheartedness. This approach fosters an ethic of solidarity that encourages communities to stand with patients and support healthcare workers. It can weaken the hold of tactics, like exclusion, that divide people.

This caliber of moral leadership was reported in the Phillipines, when activists led the fight against COVID-19-related discrimination. Local governments supported activists' efforts by passing emergency legislation to forbid discriminatory behavior against healthcare workers and others who tested positive for the SARS-CoV-2 virus. In Manila, the 'Anti-COVID-19 Discrimination Ordinance of 2020' was signed into law, which penalized perpetrators of discrimination, in effect shaming them for their discriminatory conduct and making Manila a COVID-19 anti-discrimination zone (Hallare, 2020; Parrocha, 2020). Similar ordinances were passed elsewhere in the Phillipines, forbidding 'stigma, disgrace, shame, humiliation, harassment, or discrimination' against COVID-19 positive people, including patients, people being monitored and investigated, healthcare workers and front liners (dela Pena, 2020). While it is difficult to gauge the impact of such changes, they clearly contribute to a climate of solidarity and can facilitate efforts, such as testing and contract tracing, which reduce disease spread. In addition, they facilitate the kind of social cooperation that supports positive collective action, such as physical distancing and masking, which are vital to the public interest during an infectious disease outbreak.

In the case of Japan, Dr. M undoubtedly felt it was his moral duty to hide his medical condition to protect his family and community from shame. Speaking openly was at odds with a powerful imperative to maintain social harmony. Yet, however well-intentioned and altruistic such efforts might have seemed, they are at odds with public health ethics and thwarted efforts to save lives by means of robust testing and contact tracing. Only when stigmatizing and shaming healthcare workers is frown upon will Japan's efforts to promote public health make good. We imagine a future Japan in which the family's seken comes under threat not by having a member who is ill, but by discriminating against people who fall ill or their family members.

Among the broader lessons Japan's experience teaches are that efforts to advance public health must pay heed to contextually driven features of the societies in which they are applied. During the COVID-19 pandemic, public health campaigns that challenged stigmatization and shaming of healthcare workers were needed in Japan and other nations to shape the public conversation in ways that support public health. Rather than attempting to rid Japanese society of seken, public health efforts should be attuned to and draw on its powerful positive aspects. Public health campaigns should encourage aspects of seken that promote public health and reinterpret those than hinder it and put lives at risk.

In different societies, different public health emphases are needed. For example, when Americans touted liberty and rejected mask mandates, public health campaigns were needed to champion the rights of people to be free from the health threat posed by unmasked people. Likewise, when former U.S. President Donald Trump refused to don a mask, fostering a 'toxic masculinity' which views protective behaviors as going against masculine toughness, (Palmer and Peterson, 2020; Gupta 2020; Moran and Del Valle, 2016), public health campaigns should have interceded with messaging to suggest that 'real men wear masks' (Pelosi, 2020).

Yet, in response to these suggestions, it might be thought that value neutrality should govern public health planning, or that public health ethics should embrace ethical relativism (the view that the values of each society are equally valid), not attempt to impose its own values by putting the public's interest first. In reply, we reject the guise of value neutrality. As Baylis et al. rightly argue, public health ethics by definition commits to particular values, such as promoting the common good (Baylis *et al*., 2008). Contemporary bioethical values that emphasize individual autonomy are hardly neutral; instead, they commit to particular values too, values originally designed to safeguard individual interests in clinical and research encounters. While individual autonomy remains the appropriate emphasis in such contexts, it is ill-suited to take center stage when population-level problems arise, such as a global pandemic. Adopting different values for individual versus population problems should not be mistaken with ethical relativism, because such values can be 'objectively' suited for individuals everywhere or for the populations of any society.

Beyond the COVID-19 pandemic, more emphasis within bioethics on population-level issues is called for to supplement the already strong focus on individuals and respect for autonomy. An ethics focused just on individuals gets the aperture wrong—drawing a circle that is too narrow and leaving the public health agenda unguided. By contrast, an ethics focused on populations can capture the myriad ways that social and political contexts impact people's health and point to ways to address this. The COVID-19 pandemic has made vivid the ethical urgency of promoting not just the good for individuals but for the whole society. In the long run, a dynamic balance will be needed. Future research must modulate the balance, placing greater emphasis on the public good during public health emergencies or when setting policies to mitigate racial or other health disparities and placing more focus on individuals when designing institutional policies for clinical and research settings.

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References

Abe, K. (1995). *Seken' toha nanika (What is seken?).* Tokyo: Koudansha Gendaishinsho.

Abe, K. (2003). *Nihon shakai de ikiru toiukoto' (the Meaning for Living in Japan).* Tokyo: Asahi Shinbunsha.

Anonymous Physician. (2020). Quoted in staff, 'Virus Stigma Driving Tokyo's Front-Line Hospitals to Edge of Collapse'. *Japan Times*, 25 April, available from: https://www.japantimes.co.jp/news/2020/04/25/national/tokyo-front-line-hospital/#.XqPh1C-z3UI [accessed 2 January 2021].

Baylis, F., Kenny, N. P., and Sherwin, S. (2008). A Relational account of Public Health Ethics. *Public Health Ethics*, **1**, 196–209.

Boonyasiri, A., Cori, A., Cucunuba, Z., Fitzjohn, R., Gaythorpe, K., Green, W., Hamlet, A., Hinsley, W., Laydon, D., Nedjati-Gilani, G., Riley, S., van Elsland, S., Volz, E., Wang, H., Wang, Y., Xi, X., Donnelly, C. A., Ghani, A. C., and Ferguson, N. M. (2020). Estimates of the Severity of Coronavirus Disease 2019: A Model-Based Analysis. *Lancet Infectious Disease*, **20**, 669–677.

Centers for Disease Control and Prevention (CDC). (2020) available fromhttps://www.cdc.gov/corona

virus/2019-ncov/need-extra-precautions/older-adults.html [accessed 2 January 2021].

De Vries, P. (2020). Why Japan Gets No Covid-19 Respect. *Asia Times*, 17 April, available from: https://asiatimes.com/2020/04/why-japan-gets-no-covid-19-respect/ [accessed 2 January 2021].

Else-Quest, N. M., and Jackson, T. L. (2014). Cancer Stigma. In P., Corrigan (ed.), *The Stigma of Disease and Disability*. American Psychological Association, pp. 165–182.

Gefland, M. J. (2018). *Rule Makers, Rule Breakers: How Tight and Loose Culture Wire Our World*. New York: Scribner.

Gefland, M. J., Raver, J. L., Nishii, L., Leslie, L. M., Lun, J., Lim, B. C., Duan, L., Almaliach, A., Ang, S., Arnadottir, J., Aycan, Z., Boehnke, K., Boski, P., Cabecinhas, R., Chan, D., Chhokar, J., D'Amato, A., Ferrer, M., Fischlmayr, I. C., Fischer, R., Fulop, M., Georgas, J., Kashima, E. S., Kashima, Y., Kim, K., Lempereur, A., Marquez, P., Othman, R., Overlaet, B., Panagiotopoulou, P., Peltzer, K., Perez-Florizno, L. R., Ponomarenko, L., Realo, A., Schei, V., Schmitt, M., Smith, P. B., Soomro, N., Szabo, E., Taveesin, N., Toyama, M., Van de Vliert, E., Vohra, N., Ward, C., and Yamaguchi, S. (2011). Differences between Tight and Loose Cultures: A 33 Nation Study. *Science*, **332**, 1100–1104.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.

Gupta, A. H. (2020). How an Aversion to Masks Stems from Toxic Masculinity. *New York Times*, 22 October.

Hallare, K. (2020). Manila Passes Anti COVID-19 Discrimination Ordinance. *Inquirer.net*, 2 April, available from: https://newsinfo.inquirer.net/1253198/manila-passes-anti-covid-19-discrimination-ordinance#ixzz6ITVvGdSq [accessed 2 January 2021].

Iwasaki, A., and Grubaugh, N. S. (2020). Why Does Japan Have so Few Cases of COVID-19? *EMBO Molecular Medicine*, **12**, 212481–21248N/A.

Japanese Society for Disaster Medicine. (2020), quoted in staff, Japan Sees Rise in Harassment, Bullying and Discrimination. *Japan Times*, 2 March, available from: https://www.japantimes.co.jp/news/2020/03/02/national/japan-sees-rise-harassment-bullying-cases-linked-coronavirus-outbreak/#.XqSYry-z3UI [accessed 2 January 2021].

Kazuhiko, N. (1994). *Kegare, in Encyclopedia of Shinto, English Transl. of the Shinto Jiten*, by Kokugakuin University, Institute for Japanese Culture and Classics. Tokyo: Kobundo.

Kimura, T. (2020). Absurdity and Hazard of Japanese Society Mocking Miyafuji Kankuro for being Infected with COVID-19. *President Online*, 25 April, available from: https://president.jp/articles/-/34828?page=2 (Japanese) [accessed 2 January 2021].

Knapp, S., Marziliano, A., and Moyer, A. (2014). Identity Threat and Stigma in Cancer Patients. *Health Psychology Open*, **1**, 205510291455228–205510291455210.

Kopp, R. (2020). Does Japan's Culture Explain Its Low COVID-19 Numbers? *Japan Times*, 1 April, available from: https://www.japantimes.co.jp/community/2020/04/01/general/japan-culture-low-covid-19-numbers/#.XqSJlS-z3UI [accessed 2 January 2021].

Lawlor, T. (2020). How A Country's History and Culture Can Predict Its Success in Combatting COVID-19. *WGBH News, Boston Public Radio*, 10 July, available from: https://www.wgbh.org/news/lifestyle/2020/07/10/how-a-countrys-history-and-culture-can-predict-its-success-in-combating-covid-19 [accessed 2 January 2021].

Lindemann, H. N. (2001). *Damaged Identities, Narrative Repair*. Ithaca: Cornell University Press.

Link, B. G., and Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, **27**, 363–385.

Link, B. G., Phelan, J. C., and Hatzenbuehler, M. L. (2017). Stigma as a Fundamental Cause of Health Inequality. In B., Major, J.F., Dovidio, B.G., Link (eds), *The Oxford Handbook of Stigma, Discrimination, and Health*. Oxford: Oxford University Press.

Major, B., Dovidio, J. F., Link, B. G., and Calabrese, S. K. (2017). Stigma and Its Implication for Health. in B. Major, J.F. Dovidio, B.G Link, eds., *The Oxford Handbook of Stigma, Discrimination, and Health*. Oxford: Oxford University Press.

Momose, Y., and Asahara, K. (1996). Relationship of 'Seken-Tei' to Utilization of Health, Social and Nursing Services by the Elderly. *Nihon Koshu Eisei Zasshi*, **43**, 209–219. Japanese with English abstract).

Moran, K. B., and Del Valle, S. Y. (2016). A Meta-Analysis of the Association between Gender and Protective Behaviors in Response to Respiratory Epidemics and Pandemics. *Plos One*, **11**, E0164541–N/A.

Motoyama, K. (2009). Coming Out Experiences Of Non-Heterosexual and their Families in Japan: Asserting Normality and Preserving Harmony. Osaka University Knowledge Archive. DOI: 10.18910/56037, available from: https://ir.library.osaka-u.ac.jp/repo/ouka/all/56037/28129_論文.pdf [accessed 2 January 2021].

Murayama, H., Taguchi, A., Ryu, S., Nagata, S., and Murashima, S. (2011). Is Seken-Tei Associated with Attitudes toward Use of Care Services? *Geriatrics Gerontology International*, **11**, 1676–1173.

Naoki, S. (2020). Obeying the Rules Around Us: The COVID-19 Pandemic's Impact on Japanese Society. *Nippon News*, 14 August, available from: https://www.nippon.com/en/in-depth/d00589/ [accessed 2 January 2021].

Oken, D. (1961). What to Tell Cancer Patients. *Journal of the American Medical Association*, **175**, 1120–1128.

Osawa, M., Yoshimi, S., Washida, K., and Mita, M. (2012). *Gendai Shakaigaku Jiten (Encyclopedia of Contemporary Sociology)*. Tokyo: Koubundou.

Oxford University Press. (2020). "Stigma, n." In *OED Online*. Oxford: Oxford University Press.

Palmer, C. L., and Peterson, R. D. (2020). Toxic Mask-Ulinity: The Link between Masculine Toughness and Affective Reactions to Mask Wearing in the COVID-19 Era. *Politics and Gender*, **09** July: 1–14. DOI: 0.1017/S1743923X20000422.

Parrocha, L. (2020). Metro Manila Now COVID-19 Anti-Discrimination Zone. *Philippine News Agency*, 20 April, available from: https://www.pna.gov.ph/articles/1100391 [accessed 2 January 2021].

dela Pena, J.A.L. (2020). Aklan passes anti-COVID-19 discrimination ordinance. 30 September, available from: https://aklan.gov.ph/sp-general-ordinance-no-2020-007/[accessed 2 January 2021].

Pelosi, N. (2020). Quoted in T. Reny, Masculine Norms and Infectious Disease. *Politics and Gender*, **07** July. DOI: 10.1017/S1743923X20000380.

Rich, M., Hida, H. (2020). The Pressure to Be Perfect Turns Deadly for Celebrities in Japan. *New York Times*, updated 06 October.

Schuster, M. A., Collins, R., Cunningham, W. E., Morton, S. C., Zierler, S., Wong, M., Tu, W., and Kanouse, D. E. (2005). Perceived Discrimination in Clinical Care in a Nationally Representative Sample of HIV-Infected Adults Receiving Health Care. *Journal of General Internal Medicine*, **20**, 807–813.

Staff (2004). Japanese Traveler Held Hostage in Iraq. *Japan Times*, 28 October.

Semple, K. (2020). Afraid to Be a Nurse: Health Workers Under Attack. *New York Times*, 27 April.

Staff. (2020a). Coronavirus Fears Give Rise to Stigma in Japan's Local Communities. *Japan Times*, 09 April, available from: https://www.japantimes.co.jp/news/2020/04/09/national/social-issues/coronavirus-stigma-japan/#.XqN1TC-z3UJ [accessed 2 January 2021].

Staff. (2020b). Virus Stigma Driving Tokyo's Front-Line Hospitals to Edge of Collapse. *Japan Times*, 25 April 2020. At: https://www.japantimes.co.jp/news/2020/04/25/national/tokyo-front-line-hospital/#.XqPh1C-z3UI [accessed 2 January 2021].

Staff. (2020c). Health Workers Become Unexpected Targets during COVID-19. *The Economist*, 11 May.

Staff. (2020d). Japan Sees Rise in Harassment, Bullying and Discrimination. *Japan Times*, 2 March, available from: https://www.japantimes.co.jp/news/2020/03/02/national/japan-sees-rise-harassment-bullying-cases-linked-coronavirus-outbreak/#.XqSYry-z3UI [accessed 2 January 2021].

Verity, R., Okell, L. C., Dorigatti, I., Winskill, P., Whittaker, C., Imai, N., Cuomo-Dannenburg, G., Thompson, H., Walker, P. G. T., Fu, H., Dighe, A., Griffin, J. T., Baguelin, M., Bhatia, S., Boonyasiri, A., Cori, A., Cucunubá, Z., FitzJohn, R., Gaythorpe, K., Green, W., Hamlet, A., Hinsley, W., Laydon, D., Nedjati-Gilani, G., Riley, S., van Elsland, S., Volz, E., Wang, H., Wang, Y., Xi, X., Donnelly, C. A., Ghani, A. C., and Ferguson, N. M. (2020). Estimates of the Severity of Coronavirus Disease 2019: A Model-Based Analysis. *Lancet Infectious Disease*, **20**, 669–677.

World Health Organization. (2002). *Framework Guidelines for Addressing Workplace Violence in the Health Sector*. Geneva: International Labour Organization (ILO) and Geneva: World Health Organization (WHO).

World Population Review (2020). Best Healthcare in the World 2020, available from: https://worldpopulationreview.com/countries/best-healthcare-in-the-world/ [accessed 2 January 2021].