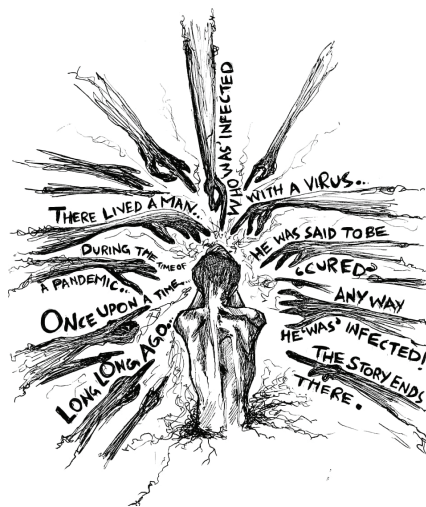


# Global Perspective and Ways to Combat Stigma Associated with COVID-19

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“Stigma” is a Greek term originally referring to bodily signs such as a burn or a cut to denote a negative/depreciative condition referred to a person (e.g., being a slave, a criminal, a sinner, or a social outcast) and, therefore, to indicate which people should be “avoided.”<sup>1</sup> Currently, stigma is not usually related to a purely physical sign but frequently includes the negative discriminatory thoughts, feelings, and behaviors towards people with certain physical, behavioral, or racial features perceived as displeasing or a threat by other members of the society.<sup>1</sup>

Since its appearance in December 2019, COVID-19 has fueled fear, anxiety, and



panic worldwide, due to its novelty, high infectivity, and absence of effective evidence-based treatment.<sup>2,3</sup> Faced with this blurry and uncertain situation, fear and its associated behaviors are not uncommon human reactions. The wide media coverage of the pandemic has contributed to the spread of the fear of contagion and subsequent stigmatizing behaviors.<sup>4</sup> Following the declaration of COVID-19 as a pandemic, people around the world easily adopted stigmatizing beliefs and behaviors towards those diagnosed with COVID-19 and their close contacts and also places, people (e.g., healthcare workers [HCW]), and ethnic groups (e.g., Chi-

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nese people) believed to be the cause of the pandemic.<sup>5,6</sup>

## Stigma and Infectious Disease Outbreaks

The manifestation of stigma during infectious disease outbreaks takes several forms, including isolation and verbal and physical aggression. These occur at various levels, including individual (self-stigmatization), interpersonal, and institutional. Currently, across the globe, people receiving treatment for COVID-19 and their families are experiencing different forms of stigmatizing and discriminatory behaviors. Following the trend of other infectious disease outbreaks, we do not expect these to end anytime soon unless drastic measures are taken to decrease the coming stigma epidemic.<sup>7-11</sup>

Before the COVID-19 pandemic, those affected with many other infectious diseases, such as Hansen's disease (commonly known as leprosy), tuberculosis (TB), human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and the severe acute respiratory syndrome (SARS) had faced the damaging impact of stigma.<sup>12-15</sup> Despite the differences in the above infectious diseases in terms of at-risk populations and mode of transmission, their association with stigmatizing beliefs and behaviors highlights the importance of addressing stigma associated with the COVID-19 pandemic. Moreover, individuals who suffer from any condition associated with stigma may develop self-discrimination that significantly influences their behavior, such as a decrease in the use of health services, with consequent poorer health outcomes.<sup>16</sup> Self-stigma is a component of the wider social phenomenon of stigma<sup>17</sup> when negative stereotypes and prejudices about a certain condition are widespread in the common thinking of the population.<sup>16</sup> This is widely known for noncommunicable diseases, such as severe mental illness (SMI),<sup>16</sup> substance use disorders (SUD),<sup>18</sup> and epilepsy<sup>19</sup> and communicable diseases such as HIV,<sup>20</sup> and as such, could also occur in people with COVID-19. Research on how stigma had hindered the control of the above-mentioned infectious disease outbreaks might also shed some light on the potential impact of stigma in the battle

against the COVID-19 pandemic. The literature reports that stigma associated with a diagnosis can drive individuals to undertake behaviors that increase the risk of transmission to others, such as delaying testing,<sup>21,22</sup> concealing symptoms,<sup>23,24</sup> and avoiding healthcare.<sup>12,25</sup> During the Ebola virus disease (EVD) outbreak, stigmatization of patients and relatives through social isolation and verbal and physical abuse led to an alienation of people from the government. This brought about a decrease in case reporting and contact tracing and, ultimately, an exponential increase in the number of EVD cases.<sup>26</sup> While implementing preventive and protective measures during the rapid spread of an infectious disease, particular care should be taken to not turn them into stigmatizing measures.<sup>13</sup>

It is also important to acknowledge and address the significant impact of stigma on the mental health of the affected population and HCWs.<sup>27-29</sup> During a pandemic, stigma may worsen the fear and anxiety in the general population and may result in the development of certain mental health conditions. Social stigma towards certain diseases has been associated with a negative impact on public health efforts.<sup>14,21,30</sup> Stigmatizing attitudes may result in emotional disturbances such as worries, anxiety, and a sense of helplessness.<sup>31</sup> The mental health impact of an infectious disease may occur not only during the pandemic but also in the postpandemic period. Fear and stigma can lead to social isolation, which may reduce the social support that HCWs and people who are infected need, preventing them from receiving the much-needed mental health support.

COVID-19 represents a new challenge due to the speed of the outbreak, the singularities of its not fully understood infective patterns, and its emergence in a globalized world with limitless real-time exchanges of communication. In particular, lockdowns and other measures of physical distancing have limited the possibilities of face-to-face interactions. Nevertheless, strategies to understand and address the stigma related to it can find inspiration in what has proven effective in other general medical diseases (i.e., HIV and TB)<sup>32-35</sup> and SMI.<sup>34</sup> Com-

mon strategies to reduce stigma, which have heterogeneous levels of evidence, frequently use a multilevel approach and have been largely based on education, social contact (through the use of telecommunication means), counseling, problem-solving, advocacy, and social marketing.<sup>34,36,37</sup>

## COVID-19-Related Stigma

Description of COVID-19-related stigma in the represented countries was provided by the co-authors, using a semistructured guide that addressed negative and depreciative terminology referring to the coronavirus and people with COVID-19, common rumors and myths present globally about COVID-19, stigma-related behaviors and attitudes towards certain ethnic groups and communities during all phases of the pandemic, and the presence of antistigma initiatives or interventions towards COVID-19-related stigma.

Negative terminologies identified in the represented countries, contributing to COVID-19-related stigma included terms such as "Chinese virus," "rich man's disease," "corona case," "Wuhan virus," and "Chinese plague." These negative terminologies were rampant in all sampled countries and were found to form the basis of the stigmatizing beliefs and behaviors. Regarding myths and rumors contributing to stigma, the belief that the pandemic was a religious curse or a biological weapon by the Chinese was identified across the countries. In some countries, there were rumors about governmental involvement in the spread of the virus. This led to distrust in the government by the people and, consequently, discouraged them from abiding by the strategies aimed at controlling the pandemic. In religious countries, the pandemic was attributed to a religious curse and those diagnosed were stigmatized for being "spiritually unclean." During the early phase of the pandemic, when the majority of those diagnosed with COVID-19 were travelers, there was much stigma towards people traveling into the represented countries as well as migrants of Asian descent. There was anger towards various governments for allowing people to travel into the countries. This led to people hiding their travel history

for fear of stigmatization. In some countries, there were public demands for a list of people diagnosed with COVID-19 to be made public. These stigmatizing attitudes and beliefs led to various governments adopting some form of antistigma strategies, such as CDC guideline against stigma in the United States.

Amid unpredicted and ambiguous outbreaks, it is not uncommon for people to create and spread myths (i.e., beliefs that contradict logic or evidence) and misinformation through rumors (i.e., unsubstantiated ideas that may or may not be true, presented as definitive truths grounded on sound evidence), possibly to relieve their uncertainty and fears about the situation. Myths vary from one culture to another and are usually driven by the sociohistorical, traditional, and religious background of the community. During the COVID-19 pandemic, religious-themed misconceptions and myths have been widely spread in various countries, with some religious leaders and traditional healers having laid claim to possessing cures. Such beliefs might increase the stigma towards the illness, as those who become infected could be then labeled as “nonbelievers” or “sinners.” Other forms of myths and misconceptions about COVID-19, not religious, can also lead to stigmatizing behavior towards those with the illness.<sup>38,39</sup> Unsubstantiated beliefs, such as that the infection is a bioweapon developed by a government or terrorist organization,<sup>40</sup> that people of African origin do not get the infection, or that the virus is transmitted via mail packages and products from China,<sup>41</sup> might increase the stigma related to the illness, particularly when the infection becomes tagged to a particular ethnic or racial group.

Country reports from our semistructured guide highlight the need to adopt and perform pertinent measures and interventions to fight the already experienced COVID-19-associated stigma worldwide. We developed a psychoeducational guide tailored to the general population, intended to address COVID-19-related stigma. Emphasis was laid on correcting negative terminologies, using neutral terminologies, and correcting myths and misinformation. This psychoeducational guide can be used by the general public and in the training of media personnel to ensure ethical reporting of COVID-19-re-

lated news, to decrease stigma (Box 1). Furthermore, a mental health preparedness action framework, described below, was developed to integrate antistigma strategies and interventions at every stage of the COVID-19 pandemic, using the previously published conceptual framework for mental health intervention as a guide.<sup>2</sup> A set of general interventions, strategies, and conceptual guidelines too was developed to address key points relat-

ed to stigma and to suggest measures and tools that can be used in the fight against COVID-19-related stigma (See Table 1).

## Recommendations to Combat COVID-19-Related Stigma

Stigmatizing beliefs and behaviors affect not only the control of the outbreak, thus contributing to a greater number of

### BOX 1.

#### COVID-19-Related Antistigma Psychoeducation Guide

Education to the general public should focus on the negative misconceptions, terminologies, myths, and rumors that have been shown to be instrumental in propagating discriminatory and stigmatizing beliefs and behaviors. Concerning the COVID-19 pandemic, below is a suggested guide for psychoeducation.

- Raise awareness about COVID-19 without disseminating fear, social panic, paranoia, or anger
- Avoid social rejection and violent behavior towards stigmatized categories (i.e., healthcare workers, Asian people, etc.)
- Avoid geographical/ethnic/racial-connoted names for the SARS-CoV-2 and COVID-19.
  - o Avoid negative terminologies (i.e., “Chinese virus,” “rich man’s disease,” “wealthy people’s disease,” “Wuhan virus,” “viral apocalypse,” “COVID-19 plague,” “Wuhan pneumonia”)
  - o Avoid negative or depreciative terminologies referring to people with COVID-19 (i.e., “COVID-19 case,” “COVID-19 suspect,” “suspected case,” “positive,” “positive case,” “infected,” “corona case”)
  - o Avoid negatively connoting terminologies to refer to healthcare workers (e.g., “potentially infecting healthcare worker”)
- Encourage neutral terminology (i.e., “people with,” “people who have,” “people who are being treated,” “people who have recovered,” “people who died after contracting”)
- Respect confidentiality, anonymity, and privacy
- Discourage stigmatizing behaviors towards
  - o Chinese and Asian people (i.e., migrants, citizens/residents)
  - o people who relocated from higher risk areas
  - o people who have recently traveled
  - o healthcare professionals and emergency responders
- Discourage dissemination of rumors and myths (“false facts”). Correct misconceptions by using accurate and scientifically based information to clarify myths based on local cultures, such as
  - o Conspiracy theories about the origin of the virus as a bioterrorist attack/war/biological warfare
    - China vs America, America vs China
  - o Conspiracy theories about the origin of the virus as laboratory designed by pharmaceutical companies to sell the vaccine
  - o Conspiracy theories about the reasons/motivations for dissemination of the virus, such as:
    - It is specifically designed to kill older adults due to overpopulation, the raising of the average age, poor financial resources to provide them, etc.
    - It is a divine tool (part of a superior divine plan)
    - It is aimed to rebalance the natural equilibrium (recently dysregulated due to air pollution, human beings, technology, overheating, etc.)
  - o Conspiracy theories about the modality to disseminate the virus
    - 5G technology
    - eating in Chinese, Asiatic, Asian fusion, or Japanese restaurants
    - receiving letter/packages from China
    - buying and wearing Chinese dresses
    - by other vaccines (“no-vax theory”)
  - o The false and firm belief that
    - the virus is not so severe, but the government wants to disseminate this false information
    - spring and summer will eradicate the virus (due to the high temperatures)
    - the virus cannot spread in tropical countries
  - o some ethnic groups (e.g., Indonesian people, African descents) are protected from the virus
    - “Miracle”/bizarre remedies to kill the virus
      - using essential oils, saltwater, sodium bicarbonate, some herbs, plants, vacuum steam; chewing garlic; drinking hot water; drinking alcoholic beverages; smoking cigarettes; gargling with bleach, acetic acid, etc.
    - Religious and mystic practices, including remaining confined in holy places

TABLE 1.

## Specific Antistigma Interventions and Strategies

### Health Institution Level

1. Determine factors associated with stigma
2. Determine prevalent forms of stigma associated with COVID-19
3. Develop action plan to help address factors associated with stigma and forms of stigma
  - a. Educate on stigma using the psychoeducation manual
  - b. Provision of Personal Protective Equipment (PPE) by hospital management
  - c. Training in the management of COVID-19 for all cadre of health staff
  - d. Avoid labeling of case file or bed post or wards with "COVID-19"
  - e. Set up disciplinary panel for HCW who stigmatize despite training
  - f. Provide yearly trainings in management of infectious disease with potential for global spread
  - g. Set up regular antistigma campaign for all forms of infectious diseases

### Community Level

1. Determine factors associated with stigma
2. Determine prevalent forms of stigma associated with COVID-19
3. Develop action plan to help address factors associated with stigma and forms of stigma
  - a. Train the media to ensure ethical journalism
  - b. Identify and correct myths and misinformation
  - c. Celebrate memorial days and COVID-19 heroes
  - d. Use social influencers
  - e. Provide accurate and up to date information concerning COVID-19
  - f. Infomercials on COVID-19 should not focus on any particular ethnic or racial group and should be produced in partnership with public figures and celebrities
  - g. Provide regular broadcasted messages on infectious disease with potential for global spread
  - h. Highlight strengths and positive aspects of the country when providing updates on COVID-19
  - i. Put policies in place to help citizens recover from the socioeconomic consequences of the pandemic

### Individual Level

1. Identify and respond to the needs of the stigmatized population
  - a. Determine factors associated with stigma
  - b. Determine prevalent forms of stigma associated with COVID-19
    - Ensure confidentiality when requested
    - Provide policies on accessing healthcare postpandemic (health insurance and government facilities)
    - Provide psychosocial support through methods such as group support system, virtual support system, hotlines, video conferencing
    - Support victims of stigma in developing an attitude of dialogue, empathy, and forgiveness towards close sources of stigma
    - Make individualized mental healthcare widely available and readily accessible

HCW, healthcare worker.

people being infected, higher mortality, and greater socioeconomic consequences on the affected communities, but also may have had short- and long-term negative consequences on the mental health of those affected, HCWs, and the affected communities.<sup>42-45</sup> Antistigma activities and strategies should be developed ahead of time and carefully planned for, tailored, and progressively adapted throughout the COVID-19 pandemic to suit the specific phase of COVID-19 outbreak in each country.<sup>2</sup> This framework emphasizes the need for continuous surveillance of interventions and appropriate communication to all stakeholders

to decrease the mental health consequences attributable to COVID-19-related stigma.

## Public Authorities

1. At the national and local levels, create a public office responsible for:
  - a. receiving stigmatic information and threats
  - b. prevention and promotion of positive beliefs and attitudes
  - c. coordination of research about the sources and means of propagation of stigma
  - d. mediation with mass and social media and influencer groups

2. Provision of a dedicated helpline to address the concerns of both victims of stigma and people who might be fearful and unsure about how to behave when being next to infected or exposed individuals.
3. At the local level, provision of social mediators (i.e., a person trained in social work with good communication skills) who can help in promoting dialogue and solve discrepancies among neighbors when there is a concern about how the proximity of a high-risk individual or neighbor diagnosed with COVID-19 impacts the others.

## Health Authorities

1. Involve in public education and sharing of resources and in training HCWs to help assess and heal those affected by stigma.
2. Develop a support network for HCWs who are at increased risk of COVID-19-related stigma.
3. Create means at the institutional level to report COVID-19-related stigma.

## Law Authorities

1. Create effective and dedicated channels to allow victims and witnesses to report stigmatizing behaviors and get a rapid response.
2. Provide information about the legal consequences of stigmatizing behaviors.

## Social and Mass Media

1. Social media platforms should monitor and rapidly flag or remove (when appropriate) contents that contravene their terms of use and promote violence or discrimination against individuals or groups.
2. Editors and producers of mass media platforms are responsible for ensuring the truthfulness of their contents and the promotion of positive attitudes.
3. Information should be provided timely, with proper context and realism, avoiding pointing out at certain groups or individuals and overwhelming with an excess of news and negative contents, while highlighting hopeful messages and appreciation for HCWs and other people providing essential services.



- The public would benefit from attaching “human faces” to those suffering from COVID-19 and its consequences, by hearing positive stories of recovery and solidarity.

## Influencer Groups and Individuals

- Be aware of the power of their messages and behaviors among the public.
- Self-testimonies and supportive attitudes from celebrities and community leaders are perceived as helpful, and their interventions during the current pandemic may spread hope and inspiration.
- Structured social groups, such as religious organizations, should watch the potential confusion of facts about COVID-19 and cultural and religious beliefs while powerfully harnessing their influence and structure to provide information and support to their members.

## General Public

- Be aware that stigma is often originated and propagated inadvertently by individuals without ill intentions.
- The general public and individuals are the first line of preventive, identification, and intervention strategies as they are the primary supporters of the affected individuals.
- Good educational and informative efforts would lead them to feel responsible for keeping up to date about the facts regarding the virus and the effective physical distancing measures, to spread truthful information, and to identify their feelings and fears about the pandemic and the affected or exposed individuals in their proximity.
- A sense of empathy and constructive dialogue with those infected or exposed to coronavirus should be encouraged to prevent stigmatizing attitudes and behaviors as much as possible.
- Every individual should feel responsible for speaking up and intervening proportionately against the stigmatizing attitudes they witness and for asking for forgiveness and palliating the effects of their potential attitudes if it is the case.
- Empathetic dialogues with victims and potential sources should be encouraged.

- All should be aware that the measures of physical distancing between each other, and especially with regards to those infected or exposed, do not preclude individuals from showing civility and kindness and providing support to all, particularly to those most affected.
- Social contact strategies to reduce stigma could be implemented by fostering close telecommunication between the public and the affected individuals.

The above strategies to combat COVID-19-related stigma can be tailored at the institutional, community, and individual levels, as seen in **Figure 1**, and tailored to fit any phase of the COVID-19 pandemic.

## Conclusions

Preventing the dissemination of stigma-related attitudes and behaviors may help decrease the spread of the COVID-19 pandemic, as stigma may lead to underreporting of symptoms and decrease the use of health facilities. Public authorities, by their greater visibility, should be exemplary in their language and behavior and should promote a sense of collective endeavor. Education is the key to address this challenge. COVID-19-related stigma can be mitigated by educating the general population and media, by adapting our language and terminology, by celebrating those at the forefront of the pandemic, by fighting myths and misinformation, and by putting down policies to protect most people, including HCWs, who were infected and have survived COVID-19. Furthermore, mental health professionals should also plan to implement antistigma interventions in the postpandemic period to limit self-stigma amongst survivors and HCWs.

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