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(IJHMP) **Combating Stigmatization and Social Discrimination
Phenomena Arising From Covid-19 Pandemic Health Responses in
Nigeria**



**Combating Stigmatization and Social Discrimination Phenomena
Arising From Covid-19 Pandemic Health Responses in Nigeria**



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Abstract

Purpose: This paper attempted to x-ray the incidence of COVID-19 global pandemic and the resulting unfortunate stigmatization and social discrimination experiences which people with the pandemic are going through. The paper as a theoretical paper examined the effects of the instances of stigmatization arising from fear, misinformation, lack of adequate information and the corresponding social tension. Some of the discriminatory behaviours that accompany such fear, as they damage not only the socio-cultural fabric in the long-run, but also compromise present efforts to contain the disease were discussed.

Methodology:

Findings: from the paper revealed that everyone is capable of helping to stop stigma related to COVID-19 through assisting oneself and others to cope with the stress associated with the pandemic in order to make the community stronger. Attempt was therefore made to highlight some strategies that could be considered and explored by different stakeholders such as the government, media, community, the individuals and research institutes towards mitigating the effects of stigmatization and social discrimination created by the global pandemic called COVID-19. It concluded that we all have a responsibility to help correct the misconceptions through policy shift and interventions that can promote less chances of stigmatization in case of any pandemic.

Unique contribution to theory, policy and practice: While continuous public health education should be mandatory and accessible to everyone by the relevant agencies and stakeholders.

Keywords: *Stigmatization, Social Discrimination, COVID-19 Pandemic, Combating Strategies and Nigeria*

Introduction

The Corona Virus disease of 2019 (COVID-19) was first recognized and reported in Wuhan, Hubei Province, China on the 31st December 2019, before it rapidly spread across the world. The European Centre for Disease Prevention and Control (2020), reported that the virus was first identified in the 60s and named Corona due to the specific appearance of crown-like sugar proteins that surround the particle. It is commonly found in animals and it is possible to transmit some of the viruses to humans and bats are a natural host of the virus (ECDPC, 2020).

The first case of coronavirus disease (COVID-19) in Nigeria was confirmed on the 27th of February 2020. The case is an Italian citizen who came from Milan, Italy to Lagos, Nigeria on the 25th of February 2020. He was confirmed by the Virology Laboratory of the Lagos University Teaching Hospital, part of the Laboratory Network of the Nigeria Centre for

Disease Control (Channels TV, 26th February 2020). Within March 2020-July 2020, the virus had spread to more than 10, 614, 903 cases and caused up to 514, 628 in over 187 countries of the world. Although, Nigeria can still be classified as a low incidence country, it is on record that within March 2020 and June 2020, the nation recorded 25, 694 cases, 590 deaths even when 9, 746 number of people who tested positive had been discharged. This is about 38 % of the total number of those admitted into the isolation centres (Nigeria Centre for Disease Control, 2020).

Since the outbreak of this global pandemic, several governments and agencies (national and international) have instituted a variety of measures to contain and curb the spread of the virus. Chowdhury and Heng (2020) observe that “to date, non-pharmacological interventions have been the mainstay for controlling COVID-19”. The World Health Organization (WHO) has introduced some key interventions aimed at addressing this pandemic. Specifically, it has established a planning and coordinating structure aimed at coordinating and promoting statutory community and voluntary services that support the outbreak responses (WHO, 2019).

The organization has also been involved in communicating information on the disease and public health measures for combating COVID-19. It has been equally been involved in promoting compliance to reduce transmission. Many countries have responded to all through these banning of social gatherings to promote physical distancing, setting up of quarantine and isolation centres, procurement of test kits and testing of people for COVID-19, closure of state and national and international borders/airports, national lockdowns and series of awareness campaigns and jingles. However, the resultant effects of these interventions, particularly on peoples’ perception of COVID-19 patients, when tested and found positive and even discharged have been quite unfortunate and highly discouraging. Those who have not been tested are even scared of making themselves available for such tests for fear of stigmatization and social discrimination.

This paper therefore attempts to briefly carry out some conceptual clarifications, do a review of instances of stigmatization and social discrimination, highlight some of the possible effects of such instances on the social system, with stakeholders’ role in the control of the of stigmatization and social discrimination resulting from COVID-19 testing and treatment discussed.

Conceptual Clarification

The major concepts of concern here are stigmatization and social discrimination. Stigmatization as it applies to this discussion concerns social stigma towards people, places or things resulting from fear and anxiety about a disease. Goffman (1963) as quoted in Essays, UK. (November, 2018) described stigma as a Greek word meaning mark, cut or burn into the skin, to identify criminal slaves as polluted and shunned in public. Centres for Disease Control and Prevention (CDC, 2020), describes stigma as a phenomenon that occurs when people associate a risk with a specific people, place, or thing – like a minority population group – and there is no evidence that the risk is greater in that group than in the general population. Stigmatization is especially common in disease outbreaks. Erving Goffman (1963) who happens to be the original initiator of the concept as early as the 1960s, defined stigma as ‘the process by which the reaction of others, spoils normal identity. He observed that “persons who become associated with a stigmatized condition thus pass from a “normal” to a “discredited” or “discreditable” social status”.

Stigma is a mark of disgrace that sets a person apart from others. When some persons are labelled by their illness they are no longer seen as individuals but as part of a stereotyped

group. Ramaci, Barattuci, Ledda & Rapisarda (2020) describe social stigma in the context of health as “the negative association related to people or a group who have a specific disease in common”. They went further to say that in an epidemic, this may mean that people are labelled, stereotyped and discriminated against because of a perceived link to the epidemic, particularly a highly contagious disease. USAID (2020) through its Health Policy Project describes stigma is a powerful social process of devaluing people or groups based on a real or perceived difference—such as gender, age, sexual orientation, behaviour, ethnicity or diseases such as leprosy or viral attack. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on that socially identified status. Stigmatization involves identifying and marking an undesirable characteristic in a way that narrows a person’s social identity to that characteristic.

Persons found to be COVID-19 positive are in the contemporary societies of today vulnerable to stigmatization, probably because the society is already building up a perception to live in fear and to regard such virus as a fatal sin. Unsurprisingly, in this modern day, people live in the fear that being around someone who is COVID-19 positive enhances the chances of them being contaminated by them. Some have the belief that the virus is contagious by being around such persons. The tendency has been for such individuals’ families and friends to more often shun them and want to keep away from them. Negative attitudes and beliefs toward this group create prejudice which leads to negative actions and discrimination.

Discrimination on the other hand implies treating a person or particular group of people differently, especially in a worse way from the way in which you treat other people, because of their skin colour, sex, health conditions etc (Ngubane, Matambo & Nkosi, 2020). It imposes a disadvantage on certain persons relative to others. It is the treating of somebody unfairly, denying someone a benefit or even excluding him or her because of a characteristic like race, disability sex, age, or any unfortunate health conditions (Antelo & Khan, 2012). It can target a person or group of people and in this case, people who test positive (symptomatic or asymptomatic) for COVID-19. Sometimes it can be hardly noticeable, even though it could be direct, indirect, systemic, or in form of harassment through comments or conduct that are unwelcome to the affected individual.

Discrimination towards patients is the behavioural response of prejudice and can be understood in terms of social processes of power and domination with some groups, which serve to devalue the stigmatized (Wagner, et.al. 2014; Nyblade & Mac Quarrie, 2006). Stigma and discrimination tend to persist in the long term, even after quarantine has ended and the epidemic has been contained. This presentation, however, looks at social discrimination from the angle of indirect discrimination and harassment due to the declaration of an individual as being COVID-19 positive. The range of such discriminatory acts vary from verbal abuse to violent attacks. The implication of this on any affected individual or persons is social exclusion and its attendant effects. Discrimination and social exclusion are, therefore, capable of leading to damaging social outcomes, especially in the face of infectious diseases.

Instances of Stigmatization and Social Discrimination arising from COVID-19

The beginning of an uncontrollable set of instances of stigmatization due to COVID-19 pandemic can be attributed to the time when some political leaders insisted on and persisted in naming COVID-19 as “a Chinese virus”. They attached the virus to Chinese (people), Chinese Americans and Asian Americans, who then were suspected as carriers of this virus.

Ngubane, Matambo & Nkosi (2020) observed that we have had instances of prejudice, racial discrimination, and rise of anti-foreigner sentiments due to the blaming of certain groups for the spread of COVID-19 becoming highly noticed in some countries of the world. For instance, he cited many examples like, in Kenya a Member of Parliament (MP) was reported as having said that his constituency had the right to verbally abuse and physically threaten Chinese visitors who were not quarantined. Also, in South Africa a tourist bus in Johannesburg was repeatedly heckled with “corona, corona” shouts by locals.

Incidents of stigmatization have not only been limited to direct physical and verbal attacks, but have also been found on social media platforms – the global ‘misinfo-demic’. In this un-monitored online space numerous posts on Facebook and Twitter, for instance, abound with claims that the virus was imported from China. This can probably be attributed to President Trump’s comment which portrays the virus as “Chinese Virus”.

There is also the case of protestors in Abidjan, Côte d’Ivoire who, in April, 2020 destroyed a COVID-19 test site, for fear that its location would expose them to the virus. Although the Ivorian government confirmed that the destroyed site was for ‘testing purposes’ rather than a ‘treatment centre’, the response by the citizens is indicative of the social tension and violence arising from an already pre-existing fears and prejudice about COVID-19. Ngubane, Matambo & Nkosi (2020) further remarked that Abidjan is not unique in this case, as he cited another case in the Province of Limpopo, South Africa, where concerns were expressed about the decision to locate quarantined citizens who had been evacuated from Wuhan, China.

The European Union for Fundamental Human Rights in its Bulletin No.1 of February 20, 2020 reported the case of a Chinese student in Germany who was prevented from renting a flat on the grounds that the owner “did not want to have Coronavirus”. Likewise, the Bulletin revealed that media in Denmark, Finland and Estonia had reported “incidents of persons of Asian origin experiencing prejudice and/or discrimination connected with COVID-19, such as name-calling, inappropriate staring and being avoided”.

In the Nigerian society, it is a known fact that when anybody is known to have tested positive to any infectious disease, there is that tendency for such person(s) to be denied regular access to other people. There is that consciousness for people to want to maintain a gap and this has created serious problem of social exclusion for the affected person(s). News reports and social media platforms have documented incidents of bullying, labelling, slandering and use of derogatory language on the affected persons. Such bias motivated incidents are known to impact not only on their direct victims but also the wider community.

Usman, a health worker in Jigawa State, Ministry of Health, after a 36-year old medical doctor died of COVID-19, was confronted by a Professor when he came to say his early morning prayer and was advised to stay away from the mosque for the next 2 months, for fear of spreading COVID-19. This is a very bad instance of stigmatization. Illustration of the effect of the following scenarios on persons with COVID-19 case:

Demola is a 20-yr old NCE student who is trying to secure an accommodation in Oto-Awori. The caretaker asks him to fill a form. There is a section in the form that requires giving information on whether the potential tenant has ever tested positive to COVID-19, to which Demola responded "Yes but found asymptomatic". When he got back to the caretaker he was told "sorry it is the landlord's policy not to give out his apartment to anybody with health challenge like COVID-19".

Uh, you have Corona!"

"At school, someone made a "joke": "Uh, you have Corona!" Even though it was meant to be "fun" and just a "joke", I found it to be racism. An elderly woman looked at me intensely in the Munich subway. Shortly thereafter, she pulled her scarf to protect her mouth and nose and quickly passed me. When I'm in public, I feel watched and uncomfortable. On the train, I have the feeling that nobody wants to sit with me because of my Asian descent. A constant feeling of malaise, exclusion and anger accompanies me (UNICEF, 2020) "

Figure 1: Effect of the following scenarios on persons with COVID-19

Impact of the Instances

The IFRC and WHO (2020) report that stigma is capable of undermining social cohesion and prompting possible social isolation of groups, which might contribute to a situation where the virus is more, not less, likely to spread. This, it is believed can lead to disastrous consequences for everyone and for our fight against this global pandemic. Chen (2016) listed the consequences of stigmatization to include marginalization and in some cases, dehumanization and these have severe social implications on the people and the society. The social effects of the pandemic extend to the inside of our homes, where many people find themselves in sudden forced proximity with their immediate family.

Brooks et al. (2020) observed that people who are subjected to quarantine or self-isolation are at risk of confusion and anger, as well as emotional tendencies that can be explosive when multiple household members simultaneously endure them for weeks or months on end. Indeed, some studies (Ellemers & Jetten, 2013; Greenaway, Jetten, Ellemers, & van Bunderen, 2015; & Owen, 2020), suggest that forced proximity is a risk factor for aggression and domestic violence.

Again, the effect of stigmatization on health workers themselves can best be imagined. Health professionals and volunteers working in the field may become stigmatized, leading to higher rates of withdrawal for service provision and burnout. Ramaci et. al. (2020) conducted a research to investigate the relationship between stigma and work outcomes, and on the role of job demands and self-efficacy of healthcare workers (HCWs). The results undoubtedly showed that stigma positively impacts fatigue and burnout, and negatively impacts satisfaction. The role of job demands, although having an effect on negative outcomes, appears to be reduced compared to the interaction with stigma perceptions. Self-efficacy also appears to relate more to the processes of discrimination and satisfaction than to those of emotional reaction (fear) and negative outcomes.

Stigmatization and social discrimination also alter the trajectories of our intimate relationships. It is now a known fact that love and romance are getting sour with COVID-19 as relationship sharing and physical expression of it has become a thing that is now cautiously practised, e.g. elbow to elbow way of greeting, or cases of husband and wife getting more conscious of limited hugging opportunities for fear of contracting the disease and later getting stigmatized. Closely related to this is the gradual erosion of some cultural values and norms. It is no more a practice to find people organising social events for felicitation. Likewise, mode of greetings is changing as people are now becoming more

conscious of considering the safest ways of greeting each other. So, people now want to avoid hugging, kissing on the cheek, and even handshake.

There is also the fear of stigma which causes those affected to ignore sickness test aimed at determining whether they are affected and require treatments, consequently deciding to remain silent about the virus, leading to their being denied the essential treatment and social care. Stigma worsens a person's illness and can lead to a reluctance to seek and/or accept necessary help. The implication of this that many people could fake not having the virus just because of being scared of being labelled as the "one with the Coronavirus".

The idea of portraying a disease as belonging to one group, discourages members of that group from coming forward and receiving the care they need or testing for the virus itself. This puts everyone at greater risk of infection (Marlink, 2020). It further affects families as they become reluctant to want to disclose cases of COVID-19 within the family and thereby feel like not seeking medical support and assistance. Discrimination and social exclusion can undermine efforts to identify, isolate and contain the transmission of the virus. Furthermore, social stigma reduces the likelihood of them coming forward for help, preventing medical practitioners from effectively containing and treating the disease at early stages. In extreme cases, patients have even been reported to have attempted to escape from isolation centres, as it previously occurred during the outbreak of other infectious diseases like Ebola. Furthermore, the Department of Health, of the Government of Western Australia (2020) reported that stigmatization results in stereotyping, prejudice and discrimination, all of which bring experiences and feelings of:

- shame
- blame
- hopelessness
- distress
- secrecy
- derogatory labeling
- misrepresentation in the media
- being treated differently than the rest of the society
- loneliness, isolation and social exclusion/avoidance

Stigma, therefore, affects the emotional or mental health of stigmatized individuals and even sometimes the communities they live in. This is because persons experiencing stigma can be disproportionately impacted by depression. Although the highlighted effects of stigmatization created by COVID-19 might not be exhaustive, it is important to note that the stigmatizing attitude against China generated during the initial outbreaks of the pandemic at the beginning of the year is unlikely to disappear soonest and is currently exacerbated by a recently reported discrimination against Nigerians in China, and the corresponding reactions from citizens across Africa.

Summary

This paper has attempted to x-ray the incidence of COVID-19 global pandemic and the resulting unfortunate stigmatization and social discrimination experiences which people with the pandemic are going through. This fear of an unknown disease is perceived as a part of

human nature, especially when they are deadly and highly infectious. Stigmatization of COVID-19 led by some politicians such as Donald Trump might have reinforced such discrimination and social exclusion. Nevertheless, this paper was able to highlight some of the discriminatory behaviours that accompany such fear, as they damage not only the socio-cultural fabric in the long-run, but they also compromise present efforts to contain the disease.

Attempt was made to highlight some strategies that could be considered and explored by different stakeholders such as the government, media, community, the individuals and research institutes towards mitigating the effects of stigmatization and social discrimination created by the global pandemic called COVID-19. The paper tried to take a position that people need to realize that the coronavirus infects all human beings, but it seems to have spread a more venomous infection into certain minds dealing with stereotyping. Hence, the need to enlighten people that the Coronavirus, and any other views that instigate a form of discrimination, should never be encouraged in our society.

Conclusion

From the discussion so far, it can conclude that stigmatization and social discrimination are phenomena which arise in most societies when people are confronted with a global pandemic like COVID-19. It can also be concluded that the respective stakeholders have a responsibility to help correct misconceptions about COVID-19. Finally, respecting the right to confidentiality, sharing positive stories and giving COVID-19 a human face will go a long way in reducing incidences of stigmatization and discrimination arising from the pandemic. This could be completed with mandatory continuous public health education that is accessible to everyone.

Recommendations

Everyone can help stop stigma related to COVID-19 by helping ourselves and others cope with the stress associated with the pandemic in order to make our community stronger. Our roles as stakeholders; students, teachers, government, the media, the community and even research institutes in the fight against the pandemic is therefore very germane. As stakeholders we are therefore expected to play some key roles. These are prescribed in the next few paragraphs.

Individuals and the community: This category of stakeholders would usually include, persons living in and around our community, students, lecturers and other persons. Specifically, encouraging people to alter or adjust customary cultural practices that bring people too close to one another would help slow down or alter the transmission of the disease. For example, the practice of standing shoulder to shoulder and feet to feet while praying in the mosque or the sharing of chalice or cups during Holy Communion in the church can both reduce the spread of COVID-19 and its resultant effect of stigmatization where there are known cases.

Members of any community experiencing COVID-19 cases must be ready to maintain privacy and confidentiality of people with such cases so that they will not be unnecessarily exposed to instances of stigmatization and discrimination. Traditional rulers will be expected to play key role in demystifying COVID-19 by initiating and participating in sensitization programmes with the support of relevant health agencies. Community wide social marketing campaigns must be embarked upon to promote the shift of public attitudes regarding testing positive to COVID-19 and the danger of stigmatizing such people. This could be through

speaking up when friends, family members or colleagues, use any language and/or misinformation that perpetuates false beliefs and negative stereotypes about COVID-19 cases.

Government and health workers: In a situation where the government through its relevant agencies initiate efforts for general education and provides public health information about COVID-19 disease and the rationale for quarantine and isolation, it is possible to reduce the incidence of stigmatization and discrimination. Also, government involvement in aggressive screening, early identification, patient isolation, contact tracing, quarantine and infection control methods can help address the risk of stigmatization among populations and reduce the possible attendant negative effects.

Timely public health interventions capable of addressing cultural impact and the risk of stigmatization along with proper screening, treatment and follow up will reduce any anticipated spike in the spread and resultantly bring down the chances of stigmatization and discrimination. Government would also need to take actions that would ensure that, response measures to COVID-19 do not target or discriminate against any individuals/group, and equal access to emergency services to people is provided.

Again, government must ensure that such response measures respect the rights of all people and that persons with COVID-19 cases' confidentiality is protected even as authorities take steps to identify them. Government would need to work to combat stigma and discrimination by training health workers on COVID-19 using mass media (posters, charts, flyers etc.) and school networks to expand public awareness of human rights and recognizing the fact that the virus knows no boundaries and recognizes no distinction of race, religion, nationality or ethnicity.

Health workers would need to be more conscious of the names of diseases and using of words and phrases such as "epidemic", "the epicenter of the disease". This is because these can create stigma against some geographic regions and fear in some specific populations, thereby resulting in biases and panic. WHO (2015) reported that there have been cases where certain diseases' names provoked backlash against members of a particular religious or ethnic group, leading to the creation of unjustified barriers to travel, commerce and trade, with serious consequences for people's lives and livelihoods?

There is need by government to consider the replacement of the term "social distancing" with "physical distancing". This is because it is a more preferable term as it allows for people to understanding social connection is possible even when people are physically separated. This is unlike social distancing which may imply that one needs to cut off meaningful social interactions.

The Media: The information sharing role of the media is very important to reduce the incidence of stigmatization resulting from COVID-19. Brooks et.al. (2020) observe that that media reporting is a powerful tool to influence public opinion and can help reduce stigmatization where it is well managed. So, the media must be ready to initiate and provide general education, information and awareness as well as rationale for actions being taken by the government in response to the pandemic. This will reduce the chances of developing negative attitude towards people with COVID-19 cases.

The media personnel equally need to be cautious about the images that are shared by making sure that they do not reinforce stereotypes. They must be very careful in their choices of awareness materials. They will be expected to initiate positive and corrective campaigns to

challenge stereotypes and decrease prejudice. The social media can be very useful in this case provided it is not used derogatively. Rather, they should be used to correct any misinformation about the disease because misinformation is a driver of fear and stigma.

It is crucial to have effective engagement strategies with communities so as to dispel misinformation, provide facts about the decisions being made, thereby mitigating possible social tension and conflict.

Research institutes: Scholars would need to be encouraged to get involved in action researches that can promote the development of vaccines and drugs that can help reduce the menace of COVID-19 which is currently characterized by deaths and numerous instances of stigmatization and discrimination. Also, they should be funded to come up with technologies that are informationally rich, dyadic and temporally synchronous for generating empathy and connection for people to get familiar with and take advantage of. Researches that promote online interactions should also be encouraged as they can foster a sense of connection and bolster psychological well-being. However, need to be cautious of enhanced passive use of social media, as research suggests that it may not contribute to one's sense of social connection (Helliwell & Huang, 2013).

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