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Commentary

Stigma at the time of the COVID-19 pandemic

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Respiratory infectious disease outbreaks marked by significant morbidity and mortality tend to elicit serious distress in the general population. Physical distancing is necessary to reduce the chances of transmission of the pathogen. But this practice may engender stigma and discrimination, which can have the counterproductive effect of hindering disease control. People start to hide their symptoms, avoid seeking medical attention and testing until they are seriously ill, and do not collaborate in efforts to investigate contacts.

Epidemic outbreaks have historically been accompanied by stigma, discrimination, and xenophobia. Tuberculosis, HIV, and leprosy are well-known stigmatized infectious diseases. More recently, survivors of the 2013–16 West Africa Ebola outbreak have faced exclusion and unemployment once they returned to their communities [1].

Beginning in late January 2020, when the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) disease (COVID-19) epidemic was still largely limited to China, verbal and physical attacks against Chinese people or people of Asian descent were documented in many countries [2]. In Italy, for example, numerous racial and violent actions took place, including physical violence. In the Vicenza province a young Asian man was beaten and verbally assaulted, and a young Asian woman was insulted and accused of spreading COVID-19 [3]; in Rome some private stores began to exclude clients of Asian origin, barring 'all people coming from China' from entering [2]. Similar incidents have been reported in countries like France, where there were cases of people refusing to be served by Asian persons in shops and restaurants, and the United States of America, where a single week in March saw around 650 racist acts against Asian Americans [4].

Use of language by some media, newspapers and political leaders sometimes contributes to fuelling stigma. For instance, in January 2020 numerous Italian newspapers used the terms 'Chinese virus' and 'Chinese syndrome', as if a nationality could be attributed to a virus or a disease [5]. Likewise, in France, provocative and imprudent headlines such as the 'Alert Jaune' ('Yellow Alert') appeared in *Le Courrier Picard*.

The President of the United States of America has frequently described COVID-19 as the 'Chinese virus'. In Italy, some politicians accused Chinese people of poor hygiene and unhealthy cultural practices, including that of 'eating live mice' [6]. In Rome, a school principal asked all Chinese students to exhibit a formal medical certificate declaring that they were disease-free before they were to be allowed to attend classes [2]. Some regional governors proposed excluding children of Chinese descent from class. Counteracting this language with gestures such as the condemnation of race-based discriminatory behaviour by the Italian Prime Minister or the visit of the Italian President to a primary school in Rome where half the children are of Chinese origin might be insufficient to mitigate the stigma and fear already created. In France, initiatives such as the hashtag *#JeNeSuisPasUnVirus* (I am not a virus) spread on Twitter after provocative headlines in French newspapers.

Once the pandemic reached Italian territory, the stigma was rapidly redirected towards ethnic Italians [7]. The blame went immediately towards people from the north of Italy, the area initially affected by the COVID-19 epidemic, with (fortunately isolated) threats from people from southern Italy not to rent houses to

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those from the north. Stigmatizing a population can also serve political needs. Some Italian political parties, for example, managed to shift the blame to Germany, stating that the Italian outbreak originated in that country [8].

When COVID-19 became a pandemic, affecting more than 100 countries, stigma and discrimination changed their patterns once again. It is well documented how healthcare workers and ambulance crews in the most affected areas in some Latin-American, African, and European countries became the targets of stigma and discrimination [9]. The general public started to see them as the 'anointers'—those individuals perceived to voluntarily favour the spread of plague in the community during the Middle Ages—and, as a result, deplorable actions have been documented. For instance, in the city of Pisa, Italy, a medical doctor going back home found a notice in which the neighbours asked her to be careful not to touch anything in the common area of the building where she lives. COVID-19 survivors also have had to cope with stigma, especially from neighbours. Given the shortage of testing kits and the overwhelming of laboratories, people who survive could not always be retested as proof of final cure. This led to avoidance and social isolation due to the fear of becoming infected [10]. Even uninfected COVID-19 people may face discrimination when applying for jobs in some countries that may implement COVID-19 passport strategies, despite recommendations of the World Health Organization against such a practice [11].

Most countries are struggling to implement an appropriate risk communication strategy to prevent and mitigate COVID-19-related stigma. The role played by stigma and discrimination in favouring the spread of infection has been repeatedly highlighted [12,13]. Stigma, for instance, can lead ill people to hide their symptoms in an attempt to avoid marginalization. This reactive behaviour facilitates the spreading of infectious pathogens, especially among those with mild symptoms who avoid seeking medical attention and act as usual in order to not raise suspicion of their condition. Besides easing transmission, this behaviour can be conducive to deterioration of clinical conditions and may have psychological consequences. On the other hand, patients with a diagnosis of COVID-19 frequently suffer from anxiety and depression, mainly as a consequence of hospitalization or home quarantine, or because of a sense of guilt towards family members or acquaintances.

The world cannot bear a parallel pandemic of stigma, which serves only to boost the spread of infectious diseases and worsen people's health conditions and social behaviours. It is noteworthy that individuals with COVID-19 may develop poor health-seeking behaviours (e.g. avoiding testing) because, by anticipating and fearing stigma, they may perceive that there is a risk of losing their jobs and being marginalized in society. This stress, together with the stress caused by hiding symptoms, may further exacerbate conditions linked to biological stress response (i.e. elevated cortisol) leading to immune depression and delay in timely and adequate treatment [12].

Governments, backed by civil societies, have the responsibility to act urgently and make a definite commitment to fight any form of stigmatization, discrimination and xenophobia fuelled by infectious outbreaks [13]. We need to identify and isolate those who exploit the human tragedies of infectious epidemics for their own political aims. Interventions to mitigate social stigma should embrace risk communication strategies to fill the knowledge gap in the general population, with additional attention to specific, vulnerable segments such as migrants and ethnic minorities, and to prevent 'fake news' from spreading. For instance, medical and scientific societies should encourage healthcare and public health professionals to develop *ad hoc* materials to educate patients and the general public. In doing so, public health authorities should seek advice from communication and social media experts, especially when developing key messages (e.g. on mask use) and technical guidelines, as these can be potentially misunderstood by the media and the general public. Technical information should also be paired with comprehensible and clear messages for non-technical recipients.

Public health and healthcare professionals need also to address psychosocial distresses faced by COVID-19 patients and survivors and healthcare workers. In general, these groups may face anxiety and depression also because of stigma and discrimination. To cope with these feelings, psychological assessment and support should be guaranteed to them, taking into account their different needs (e.g. ensuring a culturally sensitive approach). Furthermore, social support is essential to alleviate the negative effects of stigma that may lead to further spread of the disease and social unrest. Multidisciplinary teams—formed by medical, social and behavioural scientists and communication and media experts—should be established to handle this crucial task and to ameliorate the risk of unclear messages and misinformation [14].

If we want to move towards a world where precise public and global health interventions prevail, then precise communication to prevent stigma is imperative.

Author contributions

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Transparency declaration

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