Lifting lockdown policies: a critical moment for COVID-19 stigma

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Abstract

COVID-19 “lockdown” policies may have unintended consequences for individuals, households and country economies. Hence lockdown may be unsustainable despite the risk of a resurgence of new COVID-19 infections. The repeal and alteration of lockdown policies marks a symbolic transfer of responsibility for epidemic control from state to individual. This has the potential to catalyse fear, blame and judgement within and between populations. We draw on experience from the HIV pandemic to show that this will worsen during later phases of the pandemic if COVID-19 stigma increases, as we fear it could. We suggest policy recommendations for “lockdown lifting” to limit COVID-19 stigma. We suggest three policy priorities to minimise potential increases in COVID-19 stigma: limit fear by strengthening risk communication, engage communities to reduce the emergence of blaming, and emphasise social justice to reduce judgement. “Lockdown” policies cannot continue uninterrupted. However, lifting lockdown without unintended consequences may prove harder than establishing it. This period has the potential to see the emergence of fear, blame and judgement, intersecting with existing inequalities, as governments seek to share responsibility for preventing further Sars-Cov-2 transmission. As we have learned from HIV, it is critical that a wave of COVID-19 stigma is prevented from flourishing.

Keywords: COVID-19; stigma; community; human rights; public health

Introduction

Countries around the world are at different stages in their experience with Sars-CoV-2. Some have experienced a first peak of infection and are seeking to prevent a second wave; others still have rising case numbers. Many countries have introduced "lockdown" including restrictions on mass gatherings, school closures, public transportation closures, travel restrictions, workplace closures and/or other public health quarantine measures. However, lockdown measures have unintended consequences for individuals, households and country economies. As such, governments are grappling with the question, "what next?" (Sumner et al., 2020)

In this Commentary, we argue that the repeal and alteration of lockdown policies marks a critical moment for COVID-19 stigma. "Lockdown lifting" marks a symbolic transfer of responsibility for epidemic control from state to individual. This has the potential to catalyse fear, blame and judgement within and between populations. We draw on experience from the HIV pandemic to show that this will worsen during later phases of the pandemic if COVID-19 stigma increases, as we fear it could. We suggest policy recommendations for "lockdown lifting" that will limit COVID-19 stigma.

Stigma arises when people are "marked" as carrying a trait or identity and "othered" within society. Society identifies an "us" and a "them" in relation to the trait and marked individuals can be feared, blamed and judged. Discrimination occurs when these underlying processes bubble to the surface in the form of gossip, verbal or physical abuse, or reduced healthcare, housing, employment and educational opportunities (Parker & Aggleton, 2003; Stangl et al., 2019). Disease stigma intersects with existing inequalities and may exacerbate existing prejudice, such as racism. Infectious diseases such as HIV, TB and leprosy, and non-

communicable conditions such as mental health and cancer, have long carried a stigma with them.

From early in this new pandemic, the potential for stigma to attach itself to COVID-19 has been recognised (Logie, 2020; Logie & Turan, 2020). A *Nature* paper called for a stop to racism and discrimination of people from South East Asia that had emerged in the early days of the epidemic ("Stop the Coronavirus Stigma Now," 2020). The term "China virus" propagated through social media, catalysing further racism (Budhwani & Sun, 2020). Further, COVID-19 has revealed ageism linked to the more severe effects among older individuals (Fraser et al., 2020). These early signs of stigma attached to COVID-19, intersecting with existing prejudices and social and economic inequalities, should sound an alarm.

Fear of infection is a driver of stigma (Stangl et al., 2019). Misinformation, stigma and conspiracy theories are prevalent with respect to COVID-19, and these factors can reduce healthcare engagement and adherence to public health practices, as seen with Ebola (Earnshaw et al., 2019) and HIV (Pantelic et al., 2020). Where risk of infection is perceived as related to the behaviour of others, this can result in blame. For instance, not all persons are equally able to wear face masks due to pre-existing health conditions such as autism, asthma, and deafness (Spencer, 2020). Will transferring responsibility to individuals to prevent COVID-19 lead to blaming of perceived 'non-compliance'? Where inequality and existing prejudice are prevalent, and trust is low, judgement can emerge. COVID-19 crackdowns that target populations affected by social marginalization can aggravate stigma, as has been seen among lesbian, gay, bisexual and transgender persons in Uganda and South Korea, and Roma settlements in Slovakia (Holt, 2020; The Lancet HIV, 2020)).

Stigma can have powerful, negative public health impacts. For instance, stigma has been a root cause of many thousands of HIV infections and AIDS deaths by acting as a barrier to prevention, testing and treatment. To illustrate, young people avoid picking up condoms and getting tested because the act of asking may single them out as linked with HIV (Thapa et al., 2018). People living with HIV may not wish to pick up medicines for fear of being seen and abused at, or on the way to, the clinic (Katz et al., 2013). Female sex workers, men who have sex with men, transgender women, people who inject drugs—and those at the intersection of these identities—experience both elevated HIV risk and pervasive, intersecting stigma including from family, healthcare, and communities (Kerrigan, Vazzano, Bertoni, Malta, & Bastos, 2017; Monteiro, Villela, Soares, 2013; Ritterbusch, Salazar, & Correa, 2018; Turan et al., 2019). If analogous effects occur with COVID-19 stigma, this will undermine global efforts to bring the COVID-19 pandemic under control.

Discussion

The conditions for COVID-19 stigma to worsen appear present in many settings. But this is not inevitable. Policy shifts away from lockdown can either exacerbate or ameliorate these forces. We suggest three policy priorities to minimise potential increases in COVID-19 stigma: limit fear by strengthening risk communication, engage communities to reduce the emergence of blaming, and emphasise social justice to reduce judgement of others (see Table 1).

Table 1: Policy recommendations to avoid stigma when lifting COVID-19 lockdown

Policy area	Aim	Principles for policy implementation
Strengthen COVID-19 risk	Address knowledge attitudes, values and beliefs in order to motivate uptake of COVID-19 preventive practices	Avoid focusing on fear and threats; tailor public health information; consider contexts, efficacy, and personal/collective norms

communication to reduce fear	Improve interactions between public and stakeholders (e.g. policy makers, health providers)	Foster dialogue, debate and problem solving in relation to policy choices & COVID-19 risks
	Tackle social norms, values, stressors and linkages between conspiracy theories and existing biases	Address misinformation, conspiracy theories, raise critical consciousness
Enhance community engagement to limit blaming	Support cooperation between different political groups, communities and countries	Build coalitions; avoid divisive language and blaming; acknowledge and address barriers and facilitators to adhering to preventive practices
	Support institutions in preparation for lockdown lifting, including schools, hospitals, long-term care facilities, factories, shops.	Economic protection policies for persons required to self-isolate; mass distribution of free/affordable PPE, including for healthcare workers and essential service providers
	Nurture climates of collective self-efficacy, kindness and respect	Provide resources to mutual aid/cooperative initiatives; support in-group and out-group interpersonal stigma interventions
Equitable social policy to reduce judgement	Balance a focus on individual agency and responsibility with structural perspectives on inequities	Provide resources to address inequities, e.g. support access to water and sanitation, resources for persons experiencing homelessness to isolate
	Signal value, worth and dignity of stigmatized persons and expand access to services	Mass media and advertising can integrate accurate risk information with opportunities to reflect on values, biases and the harms of stigma; multi-sectoral training and information on reducing stigma
	Increase trust and social justice outcomes	Limit criminalization of breaching COVID-19 public health policies; engage community leaders and agencies to support persons with difficulty adhering to COVID-19 public health practices

First, to limit fear as lockdown policies are repealed, COVID-19 risk communication must be scaled up with clear and accurate information. Funding is required to support mass media advertising and public campaigns that convey contextually specific, accurate COVID-19 information (Garrett, 2020). As lockdowns lift, risk communication must address the questions that people have, and reflect the evolving dynamics of COVID-19. The public should be engaged on the policy choices and risks associated with them. The aim must be to support debate, and to increase the capacity of people to make changes in their lives. Policy makers must recognise the role that accurate, available information from trusted authority sources plays, but also the local discussion needed to influence behaviour.

Risk communication must be tailored for different populations and contexts. e.g. by age, gender and for those with pre-existing morbidities. Accessible approaches are required for persons with disabilities, these can include sign language interpreters and transparent masks for health workers (Armitage & Nellums, 2020). Strategies can also include culturally-tailored public information for migrants and refugees (Orcutt et al., 2020). Public health messages must demonstrate congruence between engaging in safe practices and personal/social norms if they are to be effective and limit stigma. Increasing awareness of COVID-19 stigma alongside prevention messaging can itself reduce the expression and experience of stigma. Messaging can pro-actively tackle racism and prejudice linked with COVID-19, particularly toward groups who may experience xenophobia (Orcutt et al., 2020).

Efforts should also be made to build the skills to identify misinformation, conspiracy theories, and assess credibility of COVID-19 news. Motivational drivers beyond fear, such as social group approval, must be leveraged to reduce perceived threat of the 'other' and foster empathy. Focusing on threat and fear messaging for COVID-19 prevention will exacerbate stigma, and can increase helplessness. Hand hygiene behavior, a key COVID-19 prevention strategy, is influenced by social, physical and personal contexts. Fear of disease was not an effective hand hygiene motivator in a study spanning 11 countries, instead nurture (care for to others), feelings of comfort, and affiliation (conforming to social norms) were key motivators (Curtis et al., n.d.). Similarly, a focus on behavioural drivers such as pleasure may motivate uptake of HIV preventive practices such as condom use (Castellanos-Usigli & Braeken-van Schaik, 2019).

Second, lockdown policy shifts must include community engagement efforts to build an enabling environment and limit blaming. Information alone is not enough to reduce stigma and dismantle stereotypes. Policy shifts must break down the distinctions between in/out groups—

us vs. them—that buttress stigma. Cooperation between different political groups, communities, and countries in the COVID-19 response can strengthen cooperation and reduce blaming. Policy must address the barriers and facilitators to individuals adhering to COVID-19 preventive practices. Approaches to COVID-19 prevention, testing, and care that reduce social divisions and mistrust should be emphasized.

Institutions that have the potential to see transmission as lockdown is lifted, such as schools and workplaces, will need support. Efforts are needed to identify those occupations and life situations where tensions exist between a return to pre-lockdown conditions and risk of transmission. Ensuring enabling environments whereby persons have the opportunity to practice COVID-19 mitigation strategies requires tackling the social determinants of health. For example, economic protection policies for those asked to self-isolate during trace and isolate interventions should be considered. Mass distribution of necessary tools such as masks, sufficient PPE for healthcare providers and other essential workers should be prioritised. Limitations and fees that constrain access to healthcare and economic support services for migrants and refugees should be lifted (Orcutt et al., 2020).

Policy shifts must promote collective self-efficacy and foster kindness, respect and trust if they are to support public cooperation with COVID-19 prevention strategies (Van Bavel et al., n.d.). Mutual aid and cooperation can be leveraged to reflect community strengths and shared identities that result in caring and concern. Providing resources to develop shared collective purpose can reduce stigma while increasing COVID-19 prevention (Spencer, 2020). Interpersonal stigma in-group interventions can provide a place for sharing lived experiences of marginalization, for instance, of intersecting COVID-19 stigma and racism, and building coping and advocacy skills. Social contact approaches, where persons who are impacted by the

infection share their experiences with others to generate empathy are also needed. There is a rich evidence base of HIV stigma reduction interventions to leverage (Nyblade et al., 2019).

Third, as lockdown policies are lifted, a commitment to fairness and social justice will be central to reducing judgement associated with COVID-19. If governments put a large weight on the capacity of individuals to negotiate the crisis, this can lead to the intersection of disease stigma with existing prejudice. For instance, COVID-19, like HIV, is disproportionately impacting Black and ethnic minority populations in the UK and Black Americans in the US (Dorn et al., 2020). Structural factors shape this risk for those who disproportionately work in front-line positions and may experience barriers to accessing health care (Dorn et al., 2020). Governments must address structural factors to reduce COVID-19 vulnerabilities for groups including persons who are homeless, incarcerated, elderly and front-line workers. Aligned with the global call to action for including migrants and refugees in COVID-19 responses, leaders can relocate persons living in crowded reception, transit and detention centres to places that are safer and allow for physical distancing and recommended hygiene practices (Orcutt et al., 2020).

Reducing the conditions that fuel stigma will require policy choices that engender trust rather than judgement, and signal the value, worth, and dignity of affected persons. Multiple tactics are required including protecting rights and expanding access to services, promoting education to change public opinion through mass media and advertising, resource distribution, skills building and inter-personal intervention (Rao et al., 2019). Risk information needs to be provided alongside opportunities for critical reflection on one's values, biases and practices to enhance understanding of the ways that stigma produces harm (Nyblade et al., 2009). Efforts are required to train health providers in stigma reduction to enhance access to COVID-19

testing and care. Healthcare providers may experience stigma and limitations on accessing services such as banking due to their occupation. Training can leverage these experiences to reduce judgment based on COVID-19 risks and other identities, including race, sexual orientation, age, homelessness, drug use, among others.

The law should be used cautiously. There is no evidence that criminalisation of "deviant" behaviours is an effective way of improving public health outcomes and can create the conditions in which stigma, blame and judgement flourish. UNAIDS among others (Abdool Karim, 2020; KELIN, 2020; Straube, 2020) warn that criminalization of COVID-19, as with HIV, will not be equally applied and already marginalized communities, such as persons experiencing homelessness, people who use drugs, those with precarious immigration status, and ethno-racial minorities, will be disproportionately impacted by punitive polices (UNAIDS, 2020). Rather than judging individuals for not adhering to public health orders, leaders should explore barriers and facilitators to adhering and provide resources to support community systems.

Conclusions

"Lockdown" policies cannot continue uninterrupted in the majority of settings. However, lifting lockdown without unintended consequences may prove harder than establishing it. This period has the potential to see the emergence of interpersonal fear, blame and judgement, layered over existing inequalities, as governments seek to share responsibility for preventing further Sars-Cov-2 transmission. As we have learned from HIV, it is critical that a wave of COVID-19 stigma is not allowed to flourish.

Strengthening risk communication, building enabling environments and implementing social justice oriented policies should be priorities across diverse global settings as lockdown is eased. Evidence-based sigma reduction interventions can be integrated into public health practices. While these strategies will necessarily be tailored for context and populations, at the core should be a commitment to reducing social inequities that fuel COVID-19 and other health inequalities, including HIV. The response offers an opportunity to advance not only COVID-19 prevention, but HIV prevention and care engagement more generally.

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