**Title Page**

**Title:** “The things society does hurts us more than the virus” – a narrative inquiry of stigma among patients with COVID 19 in Chennai, India.

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**“The things society does hurts us more than the virus” – a narrative inquiry of stigma among patients with COVID 19 in Chennai, India.**

**Abstract**

**Introduction:** The COVID 19 pandemic has left a serious impact on the lives of people globally. One of the social consequences of the infection has been the stigma associated with it. **Objectives**: This study was conducted to explore the lived experiences of stigma among persons recovered from COVID 19 in Chennai, India. **Methods**: Using narrative inquiry approach, in depth telephonic interviews were conducted among 12 persons who had recovered from COVID 19 in Chennai. The participants were encouraged to narrate their experiences of stigma. The telephonic interviews were transcribed and coded by both the researchers. The codes were then grouped into meaningful themes and the lived experiences of stigma described with the help of rich narrative quotes. **Results**: The common manifestations of stigma were exclusion from public spaces, and essential services, loss of livelihood, loss of social support and in an extreme case physical violence. The stigma also manifested in health facilities in the form of neglect, and rude and insensitive treatment of patients. The factors that aggravated the stigma included fear of infection, lack of information, legitimization of segregation by forced public health interventions, involvement of police in contact tracing and isolation. Stigma was associated with psychosocial consequences such as loneliness, uncertainty, anxiety, anger, and humiliation. Demonstration of empathy, advances in communication technology, solidarity in communities and protecting confidentiality could potentially mitigate stigma. The intersectionality of age, gender, poverty, and disability worsened the experience of stigma. **Conclusions**: People who recovered from COVID 19 experienced various degrees of social stigma. The future course of the pandemic will depend strongly on the ability of health systems to address stigma.

**Key words**: COVID 19, stigma, social isolation, segregation, intersectionality

**Article Summary:**

Strengths and Limitations of this study

* To the best of our knowledge this is one of the first empirical studies to explore the lived experiences of stigma among persons recovered from COVID 19
* The narrative inquiry approach allowed a detailed understanding of the lived experiences, meanings, and perceptions of stigma among persons with COVID 19
* The stigma was found to be aggravated by coercive public health interventions, involvement of police in infection control, lack of awareness, fear of infection and was associated with substantial psychosocial impact on the stigmatized person.
* The findings of the study provide an opportunity to address the stigma and reduce it to enhance further disease control efforts.
* The findings are relevant to the local socio-cultural context and similar contexts in other low- and middle-income countries. Further broader explorations of the phenomenon of stigma in different contexts is required.

**“The things society does hurts us more than the virus” – a narrative inquiry of stigma among patients with COVID 19 in Chennai, India.**

**Introduction:**

The COVID 19 pandemic spread widely and rapidly throughout the world starting from late 2019.(1) The SARS CoV2 virus, by virtue of being highly infectious and leading to a large proportion of subclinical and mild infections, became a suitable candidate for creating an outbreak of pandemic proportions.(2) Though the mortality rate due to the virus was not very high, the pandemic itself caused serious disruptions in normal life. Restrictive lockdowns seriously hampered global economy.(3) The fragile health systems of low- and middle-income countries faced a major shock, which worsened the outcomes for even moderately severe infections. One of the important social impacts of this pandemic was the stigma associated with the disease.(4)

Stigma is defined as the phenomenon in which the stigmatized person possesses an attribute that reduces their value in the society and degrades them in that context.(5) Many diseases are associated with stigma including tuberculosis, leprosy, HIV/AIDS and mental illnesses. Several scholars have attempted to understand and describe the lived experience of stigma associated with these illnesses.(6) One of the major consequences of stigma is refusing to seek care for the illness out of fear of being stigmatized.(7) This has seriously impaired the efforts to eliminate diseases like tuberculosis and leprosy, as people hesitate to seek care and undergo treatment for these conditions.(8) Stigma has also been associated with poor outcomes of disease.(9)

COVID 19 has been associated with different patterns of stigma.(10) The infection originated in China and so early during the pandemic, people of Asian descent were stigmatized all over the world.(11) In India there were reports of people from North Eastern states being discriminated as they have Asian physical racial characteristics.(12) There was a large religious gathering in New Delhi, following which many clusters of COVID 19 were identified throughout the country.(13) This led to a severe form of stigmatization of people belonging to that religion. Doctors, nurses and health care providers were stigmatized based on their high-risk occupation and were evicted from their rented houses and excluded from public spaces.(14) Health care providers who died due to COVID 19 have been denied space for burial or cremation of their mortal remains due to fear of contagion.(15) There were also reports of stigmatization of people who recovered from COVID 19 on returning home.(16)

There is very scant exploration and understanding of the lived experiences of stigma among persons diagnosed with COVID 19. We conducted this study as a narrative inquiry of the lived experiences of stigma among persons diagnosed with COVID 19 at various stages of their disease from the point of onset of illness, diagnosis, care seeking, hospitalization, isolation, recovery, discharge to returning home after recovery.

**Methods:**

Using a narrative enquiry approach, we conducted in depth interviews among purposively selected persons who were diagnosed to have COVID 19 and who had recovered from the illness. Narrative enquiry is the best approach to understand lived experiences. It moves back and forth between data collection and analysis till a detailed understanding of the narration is obtained.(17) Both of us, VG (male) and SS (female) conducted the in-depth interviews over telephone in order to maintain physical distance and reduce the risk of transmission of the virus. Both of us are trained in qualitative research methods and interview techniques. We were actively involved in COVID 19 control activities in our respective institutions. While SS was coordinating the public health activities, VG was delivering clinical services in COVID 19 outpatient settings.

We identified the participants from the isolation ward and outpatient departments of our respective hospitals. There was a rapport established between us, the researchers, and the participants before the interviews. To enable the narrative inquiry process, we selected only such patients whom we perceived as capable of providing rich descriptive narratives.

Initially we sampled eight individuals including both men and women from the two health facilities. We performed a preliminary coding at the end of 8 interviews and identified a few emerging themes. We then conducted four more interviews of specific participant groups to better study intersectionality of various social factors influencing stigma. From the preliminary analysis we found that the narratives of women, the elderly and persons with disabilities were different from the narratives of men, the young and persons without disabilities. In order to achieve saturation of themes and comprehensiveness of the experiences of stigma, we purposively sampled an elderly woman from a non-poor background, a young man from a non-poor background without disability and a young woman from a poor background with disability. We conducted one more additional interview to confirm data saturation, which had started appearing from the 10th interview.

We took prior permission from the selected participants to make phone calls and conduct the interviews. We called them and administered a verbal informed consent. Each interview last between 20-40 minutes. Since we conducted the interviews telephonically, we could achieve privacy. We used a checklist of items to guide the interview which is provided in Supplementary File 1, but mostly the interview was open ended and was guided by the narration of the participants. We transcribed the interviews within 24 hours, enriching them using notes taken during the interviews.

VG did the preliminary analysis by performing open coding of the narratives obtained from the initial 8 interviews on Microsoft Excel Spreadsheet. After this SS reviewed the codes and we both discussed the coding of the data. After this, we identified the main emerging themes and decided on further sampling to gather information to fill the gaps in the emerging understanding of experiences of stigma. We completed four more interviews, achieved data saturation, coded all interviews, grouped themes, and identified main emerging concepts related to stigma. The coding tree is provided in Supplementary File 2. We then identified representative quotes from the transcripts to support our themes. We also performed an intersectional analysis by representing the key manifestations of stigma and psychosocial consequences in the columns of a matrix and observed the density of the manifestations and consequences among different groups of people with intersecting social determinants namely age, gender, poverty and disability in the rows. We used this to infer the intersectionality in social determinants of stigma.

The study was reviewed and approved by the Institutional Ethics Committee of the ESIC Medical College and PGIMSR with IEC No. IEC/2020/1/13 on 08 May 2020. The interviews were conducted between May and July 2020.

**Results:**

Stigma was perceived as a social evil which violates the rights of people. Stigmatization of persons with COVID 19 led to loss of trust in humanity. COVID 19 as a disease leads to lot of suffering and loss of life, but the stigma associated with it was perceived to be worse than the disease itself. The stigma was characterized as ‘inhuman’, ‘unacceptable’, ‘violation of rights’.

***Manifestations of Stigma against persons with COVID 19***

Stigma manifested itself in the community as exclusion from public spaces, exclusion from the neighbourhood, and loss of support from friends and neighbours. Neighbours who were previously helpful, stopped providing any form of support once the diagnosis of COVID 19 was made. A participant admitted in the isolation ward said,

*“Previously when my wife was hospitalized, our neighbours were immensely helpful. They came and visited us in the hospital and took care of our food. This time they avoided us completely after knowing that I am COVID 19 positive.”*

This experience of exclusion was prominent among people who lived in over-crowded resource-poor neighbourhoods. People who lived in the more well-off parts of the city, and people who lived in apartment complexes did not express this kind of exclusion from neighbourhood and public spaces.

In one case, the family of the patient who recovered from COVID 19 stigmatized and excluded their own family member. A participant said,

*“Do you know that the society will not accept people with coronavirus? My own wife will not allow me to come inside my home now. She is telling me that I will infect her and our sons. She is asking me to stay away from my own home. All this is because of you (health system doing testing and treating activities).”*

Patients who recovered from COVID 19 experienced exclusion from essential services due to stigma. They described inability to eat in public dining spaces such as hostel canteen, to bathe in public bathrooms in hostels, to go to a shop to buy grocery, and inability to collect water from the public tap. Such exclusion from necessities caused severe hardships for these persons. A resident intern said,

*“The other major problem is when I go to the mess (common dining room) to have my food. When I enter and sit in the dining table, all the girls sitting nearby get up and move away. They are not even subtle. They are obvious.”*

Simple logistics which were quite easy to perform earlier seemed cumbersome after the diagnosis for people with COVID 19. This difficulty in carrying out even simple activities was a serious manifestation of stigma. One of the participants said,

*“I have diabetes and high blood pressure. Now how will I eat proper diabetic and low salt food if I am sent out of my own house? How will I manage my life?”*

Some of the persons interviewed mentioned that they were excluded from their workspace and lost their livelihood. Loss of job and livelihood is a serious consequence of stigma associated with COVID 19 and could have implications far worse than the disease itself. A participant said,

*“I was at work when the call came. My phone is very loud and so all the people working by my side could hear everything that the official said in the phone. So when they heard that I have coronavirus, they all got shocked and just like that dropped all the clothes they were holding and moved out of the room. when I finished the call and looked up, there was nobody else in the room.”*

She lost her job and her source of livelihood after the diagnosis due to the stigma. There was also a report of physical violence due to stigma. One participant said,

*“One of the rogues in my colony took a stone and threw it at me. It hit my forehead and I fainted. When I fainted, they lifted me and took me away to the hospital.”*

Stigmatization was not only present in the community, even health facilities stigmatized the patients. Patients reported that they were neglected and ignored by many health care providers in the hospitals. They expressed this kind of stigmatization starting from the person at the reception desk up to the doctor providing care for them in the isolation ward. A participant said,

*“After the nurses started suspecting that I have COVID 19, they stopped coming near me. They stopped checking my temperature and BP. They even stopped giving me tablets and medicines. They kept the medicines and tablets on the table and my daughter had to go and pick it up. Till that time, I was happy with the treatment in the hospital, but after they started avoiding me, I got very angry and upset.”*

One of the participants narrated,

*“For the first two days we were admitted, nobody came to check us or examine us. We were contacted by phone and they asked us to check our own pulse, BP, oxygen saturation and text it to the doctors. Along with us there were two housekeeping staff and a staff nurse and her husband. We were asked to examine them and monitor them also. Only after two days a doctor came to check on us and draw blood samples. We felt like even our own doctors do not care for us.”*

Health care providers were perceived as being insensitive to the condition of the patients. A participant who recounted the experiences of being stigmatized and discriminated in the health facility said,

*“Seeing the doctor literally run away from me, my son got angry. He asked the doctor why he was reacting like that. The doctor shouted at my son and said that he should also stay away from me if he wanted to be alive. My son got even more angry.”*

A participant suffered the serious social consequences of ostracization from his apartment community because of stigma. He remarked that health care providers at health facilities act in a socially insensitive manner. He said,

*“This corona test is just another test for you. You think you have to ask a few questions, keep the stethoscope here and there and check us and then order the test. With that your job is over. But do you know how much we have to suffer because of the results of the test?”*

***Factors aggravating the stigma***

The interviews revealed several individual and health system level factors that aggravated the stigma. The single largest contributor to stigma was fear of transmission of the virus. The fear of transmission to themselves as well as their families led people to exclude and discriminate against those with the infection. There were reports of people dying in large numbers due to COVID 19. This also led to fear. Lack of awareness about the disease and irrational beliefs aggravated the fear and this in turn worsened the stigma. These irrational beliefs did not even spare health care providers. A participant experienced stigmatization among her colleagues. She said,

*“The day I returned to duty after my 14 days of isolation was the worst (day). The staff nurses asked me to go away. They said that they all have young children at home and I am a hazard to them.”*

Implementation of public health legislation and forced isolation of patients diagnosed with COVID 19, though done with the intention of containing the disease, was reported to be the major aggravating factor behind stigma. It compromised the autonomy of the individual. A participant ready to be discharged from the isolation ward broke down into tears and said,

*“Then the health officers came to my house in an ambulance and they forced me to get into the ambulance. I kept saying, “I am ok, I am ok” and kept crying. Everyone was watching me…”*

Police was involved in identification, contact tracing and isolation of patients with COVID 19 in Chennai, India. The involvement of police worsened the stigma as police involvement made people associate COVID 19 with crime. A participant recollected that the worst part of the stigma was involvement of the police in admitting her to the hospital. She said,

*“The sub inspector of police from the nearby police station came to my home. As soon as he came, all my neighbours gathered around my house. The police forced me to go to the hospital. That was the worst part of the whole experience.”*

Public health professionals who were interacting with the patients on the field were rude to many of the patients and this was perceived as another reason for worsening of the stigma. A participant recollected the rude behaviour of the frontline health worker,

*“I felt extremely scared. I started crying when I got the phone call from the corporation officer. He was very rude. He kept asking me about my contacts. He kept calling again and again to check if I have gone to the hospital. Every time my phone rang, I was worried, and I was crying continuously. I was so scared of what will happen to me.”*

Hiding information, lack of transparency created fear and the fear aggravated the stigma. One of the patients, who was just discharged from the isolation ward said,

*“…they did not even tell me about the diagnosis. I understood it myself that I must have tested positive for Covid 19. My son and daughter in law were not asked to come to the hospital. They must have tested negative.”*

He felt that this inadequate provision of information created room for rumours and fear among his neighbours thus worsening the stigma. Unregulated and poor-quality media coverage of the disease was perceived as a major reason for worsening of the stigma. A participant who recovered from COVID 19 said,

*“I think the main reason is because of news and media. Everybody is talking about the disease and how it is spreading and killing a lot of people. Everyone is afraid that it will spread to them and they will also die.”*

***Factors mitigating stigma***

There were measures adopted by individuals and communities to mitigate the stigma that patients with COVID 19 faced. Some patients understood the disease characteristics, accepted the risk, and isolated themselves. They used this individual level coping style to mitigate the stigma. A participant, completely isolated herself, thus avoiding high levels of stigma. She said,

*“Then I thought, being there (in the hostel) I may spread the infection, and people will also feel awkward so better I may go there (to the isolation ward).”*

In one unique case, a patient explained how solidarity and a sense of community helped mitigate stigma. A participant said,

*“Most of the members of our community work in various capacities in the industrial estate. Our occupation is our linking factor. We are a closely knit community and we all know each other well. We participate in family functions and festivals together. This community link was useful in bringing us together.”*

Some of the measures adopted by the public health system such as distribution of foods and groceries inside containment zones, deployment of volunteers to cater to the needs and to provide physical support to those isolated in their homes were reported as being helpful in overcoming the stigma in the community. A participant who recovered from COVID 19 said,

*“Our entire area was completely sealed out. outsiders could not enter our area and we could not go out. The corporation officials arranged for vegetables and other provisions to be delivered to us in our street. That way we were together in this difficult time. We supported each other and helped each other.”*

People also felt that when the number of persons affected by COVID 19 is more in an area the level of stigma tends to be less. A participant explained how their area did not have much stigma due to COVID 19 because many people were infected and they all became familiar with the illness early. He said,

*“One of the senior members of our community, also a security guard, was the first person to be diagnosed to have COVID 19. After that, his entire family got the infection, then my immediate neighbours got it. We got it after them. So, we all knew about the disease. We stuck by each other.”*

Advances in mobile based information and communication technology was perceived as a substantial mitigating factor by providing opportunities to retain lines of communication despite isolation. A participant who was admitted in the isolation ward said that having the ability to communicate through mobile helped her overcome the mental trauma associated with the loneliness and stigma. She said,

*“…I also became comfortable because I could talk to my family over the phone.”*

One interviewee mentioned that if only the public health system trusted people to follow advisories and protected their confidentiality rather than publicly disclosing their COVID 19 positive status, it would greatly reduce the stigma. A participant, who suffered serious stigmatization in her community recommended,

*“Yes, in future when patients come to your hospital, please do not inform the corporation whether we have coronavirus or not. Please keep the information between us. We will obey all government orders and restrict ourselves in our homes. We will not move outside and infect others. We will also get admitted and follow all orders. We will be responsible. But if you reveal it to the corporation and they come in the ambulance and pick us up and take us away. This is bad because everyone in the neighbourhood knows about our disease. This is the main reason for stigma. If you maintain our information as a secret, all of us can benefit. Please do not inform the corporation.”*

The efficiency of the public health system in some instances reassured the people and helped them adhere to instructions provided by the system. This helped them avoid and overcome stigma. A participant who was highly satisfied with the services offered by the hospital and the public health system said,

*“…. I went to the hospital where I gave the test (RT-PCR test for COVID 19). The doctor examined me and told me that even though I am COVID 19 positive, as I do not have any symptoms, I can isolate myself at my home. It sounded like a good plan and so I accepted. The doctor gave me a form to sign. I signed it …. everything happened efficiently”*

***Psychosocial consequences of stigma***

People who experienced the stigma due to COVID 19 reported several psycho-social consequences. The most prominent were the feelings of loneliness, anxiety, anger, humiliation, and helplessness. A participant who was getting ready for discharge from the isolation ward said,

*“I am feeling very lonely here in the hospital. I want to go home. I am feeling slightly better that I will be going home today.”*

Though the wards were full of patients, people perceived a loneliness because of the absence of their loved ones and people who could attend to and take care of them. A patient commented,

*“Though the wards were full of patients with fever, cough and cold. I was initially very scared and felt lonely in the ward….”*

There was a general uncertainty and anxiety about possible stigma when people would go back to their community. One participant was getting discharged from the isolation ward, but he was worried about the possibility of facing stigma once he goes back home. He said,

*“Today is the fifth day and the doctors have told me that I can be discharged. But I am very much disturbed and worried about going home. I am afraid people will isolate me in my community”*

Anger was a prominent consequence of stigma. Stigma is an issue of injustice, as there is perceived unfairness and discrimination due to illness. This injustice caused anger among those who were stigmatized. A participant explained,

*“My son was so angry, but he could not say anything to them (neighbours who excluded them). He came back and felt very bad.”*

In one extreme case of stigma, a participant, reported her experience of being humiliated in her community by her landlord. She said,

*“I got a phone call from the houseowner that she has packed everything that belonged to me and kept it near the garbage bin in the corner of the street. She asked me not to even enter the street. I have to pick up my things from that place and go to a new place to live.”*

The other prominent psychological expression of the stigma was a feeling of helplessness. A participant reported that,

*“The day I got admitted, my wife and children were very scared. My wife was crying inconsolably. She was afraid. The news is full of disease and death. So, she was really afraid. I was unable to help her or comfort her. At that time, I really regretted having myself tested. I was afraid to leave them in the apartment alone where people would really discriminate against them”*

***Intersectional Analysis of determinants of stigma***

The intersectionality of age, gender, poverty, and disability in the experience of stigma due to COVID 19 was analysed through a matrix. The matrix is shown in Table 1. It is seen that the intersection of age, poverty and disability created a higher density of codes highlighting the manifestations and psychosocial consequences of stigma. While exclusion from public spaces and essential services were common across all groups, it is noted that loss of livelihood and physical violence were present only in a poor woman caring for a child with disability. It is also noted that uncertainty and loneliness were common psychosocial experiences across all groups, but humiliation and helplessness were more among the poor with disabilities. The people disadvantaged by older age, female gender, disability, and poverty were more likely to experience higher level of stigma than their younger, male, non-poor counterparts without disabilities.

**Discussion:**

This study has documented the lived experiences of social stigma among patients with COVID 19 in the south Indian city of Chennai. Some of the unique characteristics of the stigma experienced by people with COVID 19 are exclusion from public spaces and essential services and in some cases exclusion from their own homes and families. The people who were stigmatized found it difficult to even obtain essential services like food in a common dining hall, washing in a common bathroom and shopping in the neighbourhood grocery stores. In case of other stigmatizing illnesses like tuberculosis, leprosy, HIV/AIDS and mental illnesses, exclusion has a different dimension. It manifests usually as exclusions from celebrations and functions, exclusion from marital prospects, and in some cases neglect by the family and friends.(18,19) But social exclusion from basic essential services is a worse form of discrimination and it was noted prominently with COVID 19.

Previous studies of stigma in patients with HIV/AIDS and tuberculosis have demonstrated loss of livelihood due to stigma.(20,21) A similar loss of livelihood was found in this study due to stigma related to COVID 19. The co-existence of stigma and violence among transgendered persons living with HIV in Maharashtra showed that multiple layers of marginalization and disadvantage such as transgender, poverty and HIV positivity worsened the stigma and was associated with violence.(22) Since violence is a manifestation of power and stigma is yet another such manifestation, the co-existence of violence and stigma in case of COVID 19 was anticipated and observed.

Loss of social support, neighbourly support and in extreme cases even support of the own family was identified as manifestations of stigma in this study. COVID 19, by virtue of being easily and widely transmitted through droplets and surfaces created a deeper fear of transmission compared to other stigmatizing diseases such as Tuberculosis, Leprosy and HIV/AIDS, which had less vigorous transmission. Therefore, the extent of stigmatization was more intense compared to these other illnesses.

One other unique characteristic of the stigmatization associated with COVID 19 was that health care providers and hospital staff also discriminated against people diagnosed with COVID 19. This is likely because of the high rates of infection and mortality among health care providers during the pandemic.(23) There have been reports of doctors refusing admission and treatment of patients with COVID 19 due to risk of infection.(24–26) Similar stigmatization of patients with HIV by health care providers has been reported.(27) The stigmatization manifested as ‘differential treatment’, and ‘refusal to treat’. Patients were not only denied treatment for COVID 19, but also for other common illnesses due to fear of COVID 19. In addition, the patients also perceived health care providers as being rude and insensitive. Disrespectful behaviours by health care providers not only blocks channels of communication between them and the patients, it also impacts on the clinical outcomes.(28)

Social stigma has been reported to be associated with mental health consequences. The stigmatized persons experience anger, depression, and adoption of adverse health behaviours such as smoking and alcohol.(29) Such psycho-social stress related to stigma was also reported in this study. However, it was reported as loneliness, anxiety, uncertainty, and helplessness.

One of the major aggravating factors for stigma associated with COVID 19 was the mandatory public health interventions such as display of stickers and application of tin sheets as barricades outside houses of people with COVID 19 and forced admission to isolation facilities. Such mandatory interventions compromised the autonomy and liberty of individuals. Though they may be justified during public health emergencies for the sake of common good, they were seen to worsen the perception of stigma. The segregation of infected people and families legitimized the stigma.(4,10) The words “isolation”, “quarantine” became household terms and the frequent use of these words in public health communication gave legitimacy to social segregation of people, thus increasing the burden of stigma on the infected.

The use of police in enforcing the lockdown to achieve physical distancing of people to control the pandemic and the utilization of police force for contact tracing and identification of the infected also resulted in aggravation of the stigma associated with COVID 19.(30) Involvement of the police is associated with compulsion and force. People also associate involvement of police with some wrong act and this comes with its own baggage of stigma. The appearance of police officers at their doorsteps created fear, panic and aggravated the stigma that they experienced.(31)

This study also unravelled the social determinants of stigma and the intersectionality between age, gender, poverty, and disability in worsening the stigma faced by persons with COVID 19. Stigma has four components to it. Identification and labelling of differences happens first, during which people with the particular adverse attribute are identified, in this case COVID 19 illness. Then ‘stereotyping’ takes place, which includes associating some adverse social or cultural attribute with the identified condition. For example, when many individuals who attended a social gathering of a particular religious group in India developed COVID 19, the members with the religious affiliation was stereotyped as ‘super spreaders’ of COVID 19.(32) The process of ‘othering’ or differentiation of people with the attribute as ‘them’, very different from ‘us’ happens and this strengthen the justification for exclusion of the stigmatized. Finally, discrimination and status loss takes place which disempowers people.(5) This theory of stigma proposes that a power imbalance is essential for stigma to act. This was demonstrated clearly in this study. The poor woman, single parent of a child with developmental disability had a denser experience of stigma compared to the non-poor man without disability. The power differential that exacerbated the stigma was caused by the presence of intersectionality between age, gender, poverty, and disability. The intersectionality between the disease and race, gender, sexuality, disability has been studied as a factor perpetuating stigma in various illnesses such as HIV/AIDS, mental illness and physical disability.(33)

This study is a systematic attempt at documenting the lived experiences of stigma among persons who were diagnosed with COVID 19. The strength of the study is the diversity of the sampling and attempt at achieving theoretical saturation to capture the dimension of intersectionality in aggravating stigma. The deep immersion of the researchers in providing COVID 19 care in isolation facilities is both a strength and a limitation. It is a strength because the researchers had an insider perspective to the experience of stigma in the health facility. It is a limitation because it is possible that some of the patients were inhibited by the fact that the interviewers were health care providers themselves, though they were not directly involved in their care in the isolation facilities.

The findings of this study help in understanding one of the social consequences of the pandemic, namely stigma. Though the World Health Organization and governments are taking actions to increase awareness and reduce the stigma associated with COVID 19, stigma continues to be a major obstacle in achieving effective disease control. All stakeholders must take measures to limit stigma associated with the illness, lest the stigma turns out to be worse than the illness itself.

**Conclusions**

People treated and discharged from isolation facilities for COVID 19 experienced various degrees of social stigma. This was aggravated by social factors including lack of awareness, forced public health interventions and involvement of police force in public health activities. People experienced various degrees of mental distress because of the social stigma. There is an intersectionality between age, gender, poverty, and disability in worsening the stigma experienced by persons with COVID 19. There is a need to immediately address this stressful problem of social stigma associated with COVID 19 to effectively control the pandemic.

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**Contributorship Statement:**

VG and SS conceptualized and designed the study. VG conducted 11 interviews and SS 1 interview. VG did coding and preliminary analysis of the data. SS validated the data analysis. VG drafted the manuscript and SS edited it substantially. Both VG and SS approve the final submitted manuscript.

**References:**

1. Huang C, Wang Y, Li X, Ren L, Zhao J, Hu Y, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. Lancet. 2020;6736(20):1–10.

2. Wu JT, Leung K, Leung GM. Nowcasting and forecasting the potential domestic and international spread of the 2019-nCoV outbreak originating in Wuhan, China: a modelling study. Lancet [Internet]. 2020;6736(20). Available from: http://dx.doi.org/10.1016/S0140-6736(20)30260-9

3. Human Rights Watch. India: COVID-19 Lockdown Puts Poor at Risk Ensure All Have Access to Food, Health Care [Internet]. New York; 2020. Available from: https://www.hrw.org/news/2020/03/27/india-covid-19-lockdown-puts-poor-risk

4. Krishnatray P. COVID-19 Is Leading to a New Wave of Social Stigma. The Wire2 [Internet]. 2020 May 20; Available from: https://thewire.in/society/covid-19-social-stigma

5. Link B, Phelan J. Conceptualizing Stigma. Annu Rev Sociol. 2001;27:363–85.

6. Baral SC, Karki DK, Newell JN, Smith I, Rieder H, Rouillon A, et al. Causes of stigma and discrimination associated with tuberculosis in Nepal: a qualitative study. BMC Public Health [Internet]. 2007;7(1):211. Available from: http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-7-211

7. Sirey JA, Bruce ML, Alexopoulos GS, Perlick DA, Friedman SJ, Meyers BS. Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. Psychiatr Serv. 2001;52(12):1615–20.

8. Patil S, Mohanty KK, Joshi B, Bisht D, Rajkamal, Kumar A, et al. Towards Elimination of Stigma & Untouchability: A Case for Leprosy. Indian J Med Res [Internet]. 2019 Jan;149(Suppl):S81–7. Available from: https://pubmed.ncbi.nlm.nih.gov/31070183

9. Kane JC, Elafros MA, Murray SM, Mitchell EMH, Augustinavicius JL, Causevic S, et al. A scoping review of health-related stigma outcomes for high-burden diseases in low- and middle-income countries. BMC Med [Internet]. 2019;17(1):17. Available from: https://doi.org/10.1186/s12916-019-1250-8

10. Bhattacharya P, Banerjee D, Rao TSS. The “Untold” Side of COVID-19: Social Stigma and Its Consequences in India. Indian J Psychol Med [Internet]. 2020 Jul 14;0253717620935578. Available from: https://doi.org/10.1177/0253717620935578

11. Misra S, Le PD, Goldmann E, Yang LH. Psychological impact of anti-Asian stigma due to the COVID-19 pandemic: A call for research, practice, and policy responses. Psychol Trauma Theory, Res Pract Policy. 2020;

12. Wangchuk RN. Stop Calling People From the Northeast ‘Coronavirus’. It’s Unacceptable. The Better Home [Internet]. 2020 Mar 18; Available from: https://www.thebetterindia.com/220430/india-coronavirus-covid19-delhi-northeast-racism-unacceptable-opinion-nor41/

13. Trivedi S. Coronavirus: The story of India’s largest COVID-19 cluster. The Hindu [Internet]. 2020 Apr 11; Available from: https://www.thehindu.com/news/national/coronavirus-nizamuddin-tablighi-jamaat-markaz-the-story-of-indias-largest-covid-19-cluster/article31313698.ece

14. Zaman R. Nurses face stigma in Covid-19 fight. The Telegraph Online [Internet]. 2020 May 12; Available from: https://www.telegraphindia.com/north-east/coronavirus-outbreak-nurses-face-stigma-in-covid-19-fight-in-assam/cid/1772460

15. Jane S, Omjaswin M. Chennai neurologist denied dignified burial as mob vandalises ambulance, injures staff. The New Indian Express [Internet]. 2020 Apr 20; Available from: https://www.newindianexpress.com/cities/chennai/2020/apr/20/covid-19-chennai-neurologist-denied-dignified-burial-as-mob-vandalises-ambulance-injures-staff-2132770.html

16. TNN. Recovered coronavirus patients face social stigma in Bihar. The Times of India [Internet]. 2020 Apr 10; Available from: https://timesofindia.indiatimes.com/city/patna/recovered-corona-patients-face-social-stigma-in-state/articleshow/75071886.cms

17. Bruner J. The narrative construction of reality. Narrat Intell. 2003;1:41–62.

18. Mukerji R, Turan JM. Exploring Manifestations of TB-Related Stigma Experienced by Women in Kolkata, India. Ann Glob Heal [Internet]. 2018 Nov 5;84(4):727–35. Available from: https://pubmed.ncbi.nlm.nih.gov/30779523

19. Loganathan S, Murthy SR. Experiences of stigma and discrimination endured by people suffering from schizophrenia. Indian J Psychiatry [Internet]. 2008 Jan;50(1):39–46. Available from: https://pubmed.ncbi.nlm.nih.gov/19771306

20. Chidrawi HC, Greeff M, Temane QM, Doak CM. HIV stigma experiences and stigmatisation before and after an intervention. Heal SA Gesondheid [Internet]. 2016;21:196–205. Available from: http://www.sciencedirect.com/science/article/pii/S1025984815000356

21. Courtwright A, Turner AN. Tuberculosis and stigmatization: pathways and interventions. Public Health Rep [Internet]. 2010;125 Suppl(Suppl 4):34–42. Available from: https://pubmed.ncbi.nlm.nih.gov/20626191

22. Ganju D, Saggurti N. Stigma, violence and HIV vulnerability among transgender persons in sex work in Maharashtra, India. Cult Health Sex [Internet]. 2017/01/30. 2017 Aug;19(8):903–17. Available from: https://pubmed.ncbi.nlm.nih.gov/28132601

23. Lai X, Wang M, Qin C, Tan L, Ran L, Chen D, et al. Coronavirus Disease 2019 (COVID-2019) Infection Among Health Care Workers and Implications for Prevention Measures in a Tertiary Hospital in Wuhan, China. JAMA Netw Open [Internet]. 2020 May 21;3(5):e209666–e209666. Available from: https://doi.org/10.1001/jamanetworkopen.2020.9666

24. Ahmad M. COVID-19 Patient Delivers Baby in Hospital Corridor After Doctors “Refuse” to Treat Her. The Wire [Internet]. 2020 Jun 8; Available from: https://thewire.in/health/kashmir-covid-19-pregnant-woman-refused-treatment

25. DNHS. Jalappa hospital refuses to treat COVID-19 patients. Deccan Herald [Internet]. 2020 May 16; Available from: https://www.deccanherald.com/state/kolar-chikkaballapur-tumakuru/jalappa-hospital-refuses-to-treat-covid-19-patients-838446.html

26. Yamunan S. Fear of Covid-19 spread makes private hospitals turn away patients – or charge them higher bills. Scroll.in2 [Internet]. 2020 Apr 23; Available from: https://scroll.in/article/959727/fear-of-covid-19-spread-makes-private-hospitals-turn-away-patients-or-charge-them-higher-bills

27. Dong X, Yang J, Peng L, Pang M, Zhang J, Zhang Z, et al. HIV-related stigma and discrimination amongst healthcare providers in Guangzhou, China. BMC Public Health [Internet]. 2018 Jun 15;18(1):738. Available from: https://pubmed.ncbi.nlm.nih.gov/29902990

28. Grissinger M. Disrespectful Behavior in Health Care: Its Impact, Why It Arises and Persists, And How to Address It-Part 2. P T [Internet]. 2017 Feb;42(2):74–7. Available from: https://pubmed.ncbi.nlm.nih.gov/28163550

29. Frost DM. Social stigma and its consequences for the socially stigmatized. Soc Personal Psychol Compass. 2011;5(11):824–39.

30. Mangla A, Kapoor V. How policing works in India in Covid-19 times. The Hindu Business Line [Internet]. 2020 Jun 2; Available from: https://www.thehindubusinessline.com/opinion/columns/how-policing-works-in-india-in-covid-19-times/article31729922.ece#

31. Satish D. Social Stigma, Fear of Police, Onus on God: Why Cops are Facing a Tough Time Tracing Suspected Covid-19 Patients. News 18 [Internet]. 2020 Apr 2; Available from: https://www.news18.com/news/india/social-stigma-fear-of-police-onus-on-god-why-cops-are-finding-it-difficult-to-trace-suspected-covid-19-patients-2561469.html

32. Associated Press. As Muslims Face Stigma and Blame for Surge in Infections, India’s Coronavirus Fight Weakens. News 182 [Internet]. 2020 Apr 25; Available from: https://www.news18.com/news/india/as-muslims-face-stigma-and-blame-for-surge-in-infections-indias-coronavirus-fight-weakens-2592251.html

33. Jackson-Best F, Edwards N. Stigma and intersectionality: a systematic review of systematic reviews across HIV/AIDS, mental illness, and physical disability. BMC Public Health [Internet]. 2018;18(1):919. Available from: https://doi.org/10.1186/s12889-018-5861-3

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| **Table 1: Analysis of intersectionality between age, gender, poverty and disability in manifestations and psychosocial consequences of stigma** | | | | | | | | | | | | |
| **Characteristics of Respondent** | **Manifestations of stigma in Community** | | | | | | **Psychosocial consequences of stigma** | | | | | |
| **Exclusion from community** | **Exclusion from essential services** | **Exclusion from own home** | **Loss of livelihood** | **Physical violence** | **Hurtful comments** | **Uncertainty** | **Anger** | **Loneliness** | **Humiliation** | **Anxiety** | **Helplessness** |
| Older Male without disability and poor | Yes | No | No | No | No | No | No | No | No | No | No | No |
| Older Male with disability and poor | Yes | Yes | No | No | No | Yes | Yes | No | Yes | No | Yes | Yes |
| Younger Male without disability and poor | Yes | No | No | No | No | No | Yes | No | Yes | No | No | No |
| Younger Male without disability and non poor | No | No | No | No | No | No | Yes | No | Yes | No | No | No |
| Younger Male without disability and non-poor | No | Yes | Yes | No | No | No | Yes | No | Yes | No | Yes | No |
| Younger Female without Disability and non-poor | Yes | Yes | No | No | No | Yes | Yes | No | Yes | No | Yes | No |
| Younger Female without Disability and poor | Yes | Yes | No | Yes | No | Yes | Yes | No | Yes | No | Yes | No |
| Younger Female without Disability and non-poor | No | Yes | No | No | No | No | Yes | No | No | No | Yes | No |
| Younger Female without Disability and poor | Yes | Yes | No | No | No | No | Yes | No | No | No | Yes | No |
| Younger Female with disability and poor | Yes | Yes | No | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
| Older Female belonging to religious minority and non-poor | No | No | No | No | No | No | Yes | No | Yes | No | Yes | Yes |
| Younger male without disability and non-poor | No | No | No | No | No | No | Yes | No | Yes | No | No | No |