Countering Stigmatization in the Context of COVID-19

**Paper prepared by Results Group 1 Centrality of Protection sub-group
for the IASC Operations and Advocacy Group**

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Background

This paper was prepared by the Results Group 1 Centrality of Protection sub-group to inform the 18 June dedicated session of the OPAG on the protection implications COVID-19. It is focused specifically on the issue of stigmatization as a common underlying dynamic, heightened as a result of COVID, which is creating and exacerbating risks of violence, coercion, and deliberate deprivation of vulnerable people. The aim of this paper is (1) to provide an overview of trends, key resources and actions to identify and counter stigma, and anticipate it's potential consequences, as a humanitarian system-wide effort, and (2) to inform OPAG discussion and consideration of possible actions needed to enhance IASC efforts to anticipate, prevent, mitigate, and respond to COVID-19-related stigmatization and its consequences, including opportunities to strengthen and build on existing efforts. It is not intended to be a comprehensive analysis on this topic.

Other protection implications of COVID-19 may also warrant future OPAG discussion and consideration, for example, (a) armed conflict and other situations of violence with respect to the protection of civilian populations and critical infrastructure (b) the deprivation of liberty, and (c) protection concerns associated with the restriction of population movements. The Centrality of Protection sub-group welcomes feedback from the OPAG on protection concerns it wishes to address.

Stigmatization in the Context of COVID-19

Stigma in Humanitarian Crises

Stigma is defined as "*the co-occurrence of its components: labeling, stereotyping, separation, status loss, and discrimination' in a context in which power is exercised"* and *"leads the stigmatised person to be 'reduced... from a whole and usual person to a tainted or discounted one".*[1]

As humanitarian actors, these dynamics are known phenomenon. We observe them regularly in humanitarian crises. Stereotyping, marginalization, and discrimination on racial,[2] ethnic, religious, cultural, and political grounds, along with other human rights abuses, are often at the root of humanitarian crises and people's vulnerability during crises. Refugees, internally displaced people, and migrants often face compounded labeling, status loss, and exclusion as a result of their displacement and as a matter of State policy and practice towards displaced people. The rise of xenophobia in societies and State policy in recent years adds to the stigma experienced by migrants, displaced people, and disadvantaged minorities, with stigma often reinforced through harmful rumours, hate speech, and false narratives propagated rapidly and widely via social media. Children may also be at higher risk of experiencing cyberbullying, especially those perceived to be different or

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[1] *[Experiences of mental illness stigma, prejudice and discrimination: a review of measures,](#)* Elaine Brohan, Mike Slade, Sarah Clement, and Graham Thornicroft, March 2010

[2] Racism means *'any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.* See [Article 1 of the International Convention on the Elimination of all Forms of Racial Discrimination](#).

at greater risk of catching or spreading COVID-19.[3] Migrant and displaced children will be disproportionately affected as a result of stigma and suffer long after the public health crisis ends.[4]

The widespread availability and speed of social media has also been exploited to deliberately and systematically stigmatize some groups of people and orchestrate violence against them. Again, as a humanitarian community, we know these dynamics well and can anticipate how they may rapidly escalate, causing human suffering on a massive scale, for example as seen in Rakhine and Sri Lanka.

As noted in a recent report:

> *Social media platforms amplify and disseminate hate speech in fragile contexts, creating opportunities for individuals and organized groups to prey on existing fears and grievances. They can embolden violent actors and spark violence — intentionally or sometimes unwittingly. The rapid proliferation of mobile phones and Internet connectivity magnifies the risks of hate speech and accelerates its impacts. Myanmar serves as a tragic example, where incendiary digital hate speech targeting the majority Muslim Rohingya people has been linked to riots and communal violence.[5]*

Stigma in Pandemics

Specific manifestations of stigma have been well-documented in epidemics and pandemics, for example, harassment, exclusion, and abandonment of or violence against individuals or population groups believed to be "carriers" as well as social rejection of individuals believed to be infected or recovering from contagion. As already evident in the COVID 19 context, women as caregivers, indigenous people, LGBTI people, persons with disabilities, older persons, migrants, refugees, IDPs and health workers are particularly stigmatized in pandemics.[6] "Us versus them" fear-mongering in epidemics is common and, as a result, historical grievance, societal division, and pre-existing ethnic, religious, and political stigma may be act as fault lines for stigmatization as societies focus their fear on someone to blame. This leads to social, psychological isolation, stress and may result in reluctance to access health services by the stigmatized individuals. Even when access to health care for migrants, refugees and IDPs is guaranteed by States, discriminatory restrictions of movement, stigmatization, and xenophobic attitudes and practices can make access to health and other essential services impossible or people may fear reaching out to them.[7] The spread of misinformation and the use of stigmatizing narratives can keep people from coming forward with symptoms or for contact tracing.[8]

This hampers the provision of adequate care, undermines community solidarity, and fundamentally compromises public health efforts to mitigate the spread of disease. The manner in which measures to mitigate the public health crises – such as quarantines and restrictions on movement -- are communicated and undertaken may add to stigma if not undertaken in a manner which respects international human rights and protection standards. Stigmatization in pandemics has been described as co-morbidity whereby the burden of stigma can exceed the burden of disease.

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[3] *COVID-19 and its implications for protecting children online*, Global Partnership to End Violence Against Children, April 2020

[4] *Migrant and displaced children in the age of COVID-19: How the pandemic is impacting them and what can we do to help*, Danzhen You, Naomi Lindt, Rose Allen, Claus Hansen, Jan Beise and Saskia Blume, June 2020

[5] *The Weaponization of Social Media,* Mercy Corps, November 2019

[6] *COVID-19 and Human Rights: We're all in this together*, UN (April 2020)

[7] For example, in Lebanon, where dozens of municipalities enacted discriminatory restrictions of movement for Syrian refugees threatening them at times with arrest, evictions and expulsions. In the same country, a toxic narrative of "refugees spreading the virus" has been fueled even by high level politicians creating tensions and not favoring public health policies. *Lebanon: Refugees at Risk in COVID-19 Response, Discrimination Risks Harming Syrians, Lebanese Alike* (HRW, 2 April 2020)

[8] *IOM statement on Covid-19 and mobility*, IOM, 20 March 2020

Pandemics, and the phenomena of stigmatization in pandemics, are further exacerbated by loss of trust in formal authorities and institutions. In an era of rapid propagation of disinformation and misinformation,[9] this loss of trust not only impedes effective public health interventions but provides additional fuel for the spread of stigma and exacerbates the risk of violence.

Stigma in the Contest of COVID-19

Our current challenge is that COVID-19 is not only a public health pandemic but is also testing our principles, values, and shared humanity.[10] The COVID-19 pandemic is generating a wave of stigma, discrimination, racism and xenophobia against certain individuals and groups.[11] Ceding space to stigmatization including through disinformation, misinformation, and hate speech will not only compromise efforts to mitigate the spread and impact of COVID-19 but have severe implications for human rights, sustainable development, and international peace and security.[12]

Already we have seen vigilante violence – for example in Brazil and India -- against people believed to be carriers as well as abusive enforcement of restrictions by State security forces (Kenya, Nigeria, the Philippines, South Africa), explicit denial of health services to ethnic minorities (India), refugees denied asylum or return to country of origin as perceived carriers (for example, Afghans returning from Iran), but also of the denial of entry and forced returns of migrants[13] and evictions of people believed to be infected or perceived carriers or using a public health pretext (Brazil). People who have been tested or quarantined have had their hands stamped (India) or stickers placed on their homes (Pakistan) thereby reinforcing stigmatisation.

Foreigners, including health and other humanitarian personnel, have commonly been seen as carriers of the virus, for example in Bangladesh, Central African Republic, Nigeria, and South Sudan. There are reports of people of countries believed to be carriers put into quarantine or evicted regardless of travel history or health status, for example, in China. COVID-19-driven evictions are reported as a concerning trend in Bangladesh, Iraq, Italy, Kenya, Lebanon, and Niger.

In addition, the possible stigmatization of certain groups, and tensions between communities, might increase the risk of family separations should people be forced to move. For example, children are at risk of separation from their caregivers and women in Iraq have expressed fear of being separated from family, and subjected to exploitation, if found positive for COVID-19. Pictures of people seeking health care have been posted on social

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9 Misinformation is understood as spreading incorrect information without the intent to deceive; Disinformation is understood as spreading incorrect information with the intention to deceive or manipulate others, including false new stories, manufactured protests, doctored context, and tampering private communications. See *The Weaponisation of Social Media*, Mercy Corps, 2019 and *Symposium Report: Digital Risks in Armed Conflict*, ICRC, 2018, for more.

[10] As noted by UN High Commissioners Grandi and Bachelet, *The coronavirus outbreak is a test of our systems, values and humanity: Joint statement by Michele Bachelet and Filippo Grandi,* 12 March 2020

[11] "Since the pandemic emerged, individuals perceived as ethnically Chinese or Asian, or belonging to certain ethnic and religious minorities, migrants, and foreigners have been blamed and vilified for spreading the virus. In some instances, this is grounded in misinformation and rumours, however, more insidious instances of hate speech related to COVID-19 being used to target already marginalized populations have also been reported. Conspiracy theories attributing the spread of the virus to Jews, Muslims, Christians, Bahai's or minority groups has fueled discriminatory speech against such individuals, in some instances resulting in hate crimes or discrimination against them in the response to COVID-19." *UN Guidance note on countering Covid-19 related Hate Speech* (UN, 11 May 2020) Recent assessments by Save the children in Somalia found that of more than 3,000 people surveyed, 27% felt COVID-19 generated a stigma against specific minority groups in their community. Of these, 32% also felt it stigmatised all foreigners. In Tanzania, an assessment of 121 people revealed that 86% thought that COVID-19 generates stigma against particular groups. (Save the Children rapid assessments, April 2020)

[12] See: *The coronavirus outbreak is a test of our systems, values and humanity: Joint statement by Michele Bachelet and Filippo Grandi,* 12 March 2020, and *UN Guidance note on countering Covid-19 related Hate Speech*, UN, 11 May 2020

[13] *Forced Returns of Migrants must be suspended in times of COVID-19* (UN Migration Network, 13 May 2020); and *Joint Statement Bay of Bengal & Andaman Sea*, IOM-UNHCR-UNODC, May 2020

media leading to their social exclusion. Rumours that certain military forces are deliberately spreading COVID-19 illustrates how COVID-19-related disinformation takes on context-specific political dynamics.

The diversity and complexity of these dynamics, and the scope and scale at which they are occurring, is extremely worrisome not only for prevention of the spread of COVID-19, and ensuring timely and dignified care for those who need it, but for the risk that societal divisions and stigma could lead to violence.[14] We have seen similar pre-cursors to escalations in communal conflict and disproportionate use of force by security forces in recent crises, such as Sri Lanka and Rakhine. Social unrest or communal violence, for example, may subsequently be met with disproportionate use of force by State security forces. This could further exacerbate marginalization of stigmatized communities, compound grievances, and undermine confidence in authorities and in COVID-19 mitigation measures, deepening existing humanitarian crises and creating new ones.

While the phenomena of stigma has been widely recognized in the humanitarian ecosystem, resulting in several strong guidance notes on taking stigma into account in the COVID-19 response, a more comprehensive effort is needed to address different manifestations and consequences of this phenomena at multiple levels, to effectively prevent and counter stigma, and in order to anticipate and prepare for the potential of highly polarized situations escalating into mass violence.

Fortunately, our humanitarian community includes individuals and organizations who have studied these phenomena in detail, continuously track the dimensions and implications of stigma in the COVID-19 context, and over the years have deepened good practice to prevent and counter stigma. The challenge of stigma is recognized in the Global Humanitarian Response Plan and there is much knowledge and expertise that can be drawn on to strengthen the evidence base to address stigma and undertake a comprehensive strategy to counter stigmatization and its effects.

Recommendations

The [IASC Principals Statement on the Centrality of Protection in Humanitarian Action](#) (2013) emphasizes the criticality of enhancing people's protection from harm as central to humanitarian action. The pervasiveness of stigma in the COVID-19 pandemic, and the potential severity of its consequences, warrants elevating this issue for a whole-of-system effort to anticipate and reduce these risks. The [IASC Protection Policy](#) (2016) underscores the importance of coordinated, coherent, and strategic multi-disciplinary strategies, grounded in in-depth and integrated analysis and reinforcing the roles and obligations of relevant authorities to achieve the outcome of reduced risk experienced by people in humanitarian crises. It is this mindset and approach that will be essential to counter stigmatization in the COVID-19 pandemic.

Key elements of a comprehensive strategy will include multiple levels of action and draw on a diversity of expertise, including:

- Strategic and evidence-based communications to advance specific objectives to counter stigma and the potential for violence, including through use technology, engaging new and traditional media, and by investing in effective and continuous two-way communication with vulnerable and marginalized individuals, in local languages;

- Intensified dialogue with relevant State and non-State authorities not only for the COVID-19 response, but to encourage measures to avoid and counter stigmatization and to reduce the risk of violence, coercion, and deliberate deprivation of vulnerable people as a result of stigma; as well as, upon request, support States with technical support to develop policies and build capacity to address stigmatization;

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[14] *[UN Guidance note on countering Covid-19 related Hate Speech](#)*, UN, 11 May 2020

- Diversifying and leverage partnerships – including regional organisations, journalists, parliamentarians, opinion leaders, media and social media platforms, national and local civil society organisations, and youth and faith actors to address and counter COVID-19 related stigma;

- Monitoring, collecting data, and analysing trends on COVID-19 related stigma at global and national levels, to support decision-making, early warning, and targeted responses;

- Supporting victims of stigmatization through holistic, multi-sectoral and multi-disciplinary programming, involving the most affected individuals and communities, to promote social solidarity and measures to ensure that the rights of victims are upheld and their needs addressed, including through advocacy for remedies and access to justice. This should include adapting existing systems to monitor protection risks as well as beginning longer term investments in conjunction with development and peacebuilding actors that address the root causes of stigmatization and discrimination alongside the emergency response;

- Comprehensively accounting for the resource implications of a comprehensive strategy, particularly to ensure the necessary capacities for actionable analysis and to ensure the unique capacities and expertise of smaller organizations make an effective contribution to a joint effort.

Specific recommended actions for OPAG consideration:

1. Condemn COVID-19-related stigma, including hate speech, and promote messages of humanity, inclusion, solidarity, and human rights, particularly freedom of opinion and expression and the right to equal treatment and non-discrimination; Express solidarity with victims and support those who challenge and counter such expressions, such as political leaders and other influential figures.[15] [IASC Principals, Humanitarian Coordinators, and Humanitarian Country Teams]

2. Encourage governments to counter and address stigma publicly and ensure that stigmatizing and discriminating behaviours and practices are identified and stopped as an explicit part of COVID-19 national prevention and response plans.[16] This should include reinforcing existing obligations of security forces and law enforcement entities under domestic and international law, including with respect to harmful online speech. The requisite expertise[17] should be mobilized as needed to support practical recommendations for governments. [Humanitarian Coordinators, Humanitarian Country Teams]

3. Take steps to counter hostility and hate speech directed at vulnerable and excluded groups, including but not limited to migrants, IDPs, returnees, refugees, and ensure pandemic responses do not make these populations more vulnerable to violence and discrimination or prevent them from accessing care. Ensure that online and offline victims of stigmatization, especially vulnerable or marginalized groups, know where to access and have access to relevant services, including psychosocial support through national helplines and legal remedy if available. [All clusters, intersectoral response planning, all operational actors]

4. Work with civil society and community-based platforms and networks (including Community Based Protection networks, social media, radio, and television) to support digital literacy and to undertake two-way communication with communities – in local languages – on their role in preventing stigmatization, mitigate the spread of disinformation and misinformation, build community trust and ensure frequent sharing of information. This should incorporate messages aimed at mitigating the risk of violence against health workers. [Interagency community engagement and risk communication platforms]

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[15] For example see recent statements of the High Commissioner for Human Rights Michele Bachelet *Coronavirus: human rights needs to be front and centre in the response, says Bachelet* and *Disproportionate impact of COVID-19 on racial and ethnic minorities needs to be urgently addressed* as well as joint statements, such as, *The coronavirus outbreak is a test of our systems, values and humanity: Joint statement by Michele Bachelet and Filippo Grandi* and *The rights and health of refugees, migrants and stateless must be protected in COVID-19 response: A joint statement by UNHCR, IOM, OHCHR and WHO*.
[16] For example, the Prime Minister of Ethiopia addressed the nation following advocacy by the HC
[17] For example, calling on OHCHR to advise on human rights and effective policing

5. Mobilize comprehensive and timely community engagement and risk communication as soon as harmful patterns are identified.[18] [Humanitarian Country Teams]

6. Collect, monitor, and analyse incidents, manifestations of stigma, and trends of discrimination and exclusion to support early warning, timely action, and effective responses to widespread harm, including the risk of violence, at country and global levels. Collection, disaggregation, and analysis of data should enable humanitarian actors identify and address inequalities, and structural discrimination that contributes to poor health outcomes, including for COVID-19, and risks of targeted violence. [GHRP, and other global level analysis platform/s; Clusters/Intercluster; RG 1 Preparedness, Early Action and Readiness Subgroup]

7. Monitor and detect online propagation of stigma, disinformation and misinformation, rumors, and misperceptions[19] and carry out accurate, clear and evidence-based information and awareness raising campaigns against stigma, discrimination, and xenophopbia, including by building relationships with national and local level journalists, media outlets, and national and local opinion leaders.[20] [Humanitarian Coordinators/Humanitarian Country Teams, GHRP platform, for example by engaging the capacities specialized organizations]

8. Collect and share good practices, resources, knowledge to address COVID-19 stigma and discrimination [GHRP platform]

Useful resources
- COVID-19 Guidance, Section on Stigmatisation, xenophobia and racism, OHCHR
- COVID-19 and Human Rights: We're all in this together, UN (April 2020)
- COVID-19 and its implications for protecting children online, Global Partnership to End Violence against children (April 2020)
- Disinfodemic: Dissecting responses to COVID-19 disinformation, UNESCO
- Guidance Note on Addressing and Countering COVID-19 related Hate Speech, UN (11 May 2020)
- Internews COVID-19 Resources
- Language Diversity in the COVID-19 Pandemic, Translators without Borders
- A Guide to Preventing and Addressing Social Stigma Associated with COVID-19, UNICEF, IFRC, WHO (February 2020)
- Rights in the time of COVID-19: lessons learned from HIV for an effective, community-led response, UNAIDS (2020)
- Risk Communication and community engagement readiness and response to coronavirus disease (COVID-19), WHO, OCHA, IFRC (March 2020)
- Technical Guidance WHO, Risk Communication and Community Engagement Readiness and Response to Coronavirus disease (COVID-19)
- "Verified" website to counter COVID 19 related misinformation, UN
- The Weaponization of Social Media, Mercy Corps (November 2019)

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[18] See for example COVID 19 RCCE Tracking

[19] See for example South Sudan Rumour Tracking Initiative, and the recently launched UN initiative ""Verified"

[20] For example, Nigeria successfully contained the 2014 Ebola outbreak that affected three other countries in West Africa partly through employing targeted social media campaigns to disseminate accurate information and correct hoax messages circulating on Twitter and Facebook. The intervention was particularly effective because international non-governmental organisations (NGOs), social media influencers, celebrities and bloggers used their broad platforms to forward and share information and opinions on the health communication shared. Fayoyin, A. 2016. Engaging social media for health communication in Africa: Approaches, results and lessons. Journal of Mass Communication and Journalism, 6(315).