# “*The Fear Within…*”: Dimensions of Social Stigma, Othering and Orientalism during COVID-19 in India

Prama Bhattacharya(Indian Institute of Technology Kanpur, India)
Debanjan Banerjee(National Institute of Mental Health and Neurosciences, India)

The Coronavirus disease (COVID-19) pandemic has emerged as an unprecedented public health threat with significant psychosocial and economic offshoots. The fear of infection, uncertainty about the spread and cure, widespread misinformation, lack of awareness and conspiracy theories have amplified the already prevalent discriminative attitudes in the community, giving rise to social stigma, prejudice and othering. Certain populations are especially vulnerable to these xenophobic attitudes consequent to the pandemic such as the frontline workers, age and gender minorities, socio-economically impoverished groups, the COVID-affected people and their families. Infectious disease outbreaks and such social stigma have historical relationship that can lead to adverse public health outcomes and increase the psychological burden. Given that India is one of the worst-hit countries during the ongoing outbreak and its socio-culturally diverse and huge population, this article highlights the various dimensions of social stigma and orientalism that have evolved in the nation during COVID-19 and discusses the strategies to mitigate it.

## 1. Infectious Disease Outbreak and Social Stigma: The Intersections

Erving Goffman, the Canadian sociologist, theorized that social stigma is an attribute or behaviour that socially discredits an individual from a “privileged identity” being classified

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as the “undesirable other” (Goffman, 1963). Social stigma has a long historical association with illness. It segregates health from those who are ill through “othering” that, in turn, creates stereotypes and prejudices. The concept of “othering”, proposed initially by philosopher Edmund Husserl, describes the reductive action of labelling and defining a person as a subordinate in terms of the category. This generates a “we versus they” dichotomy that establishes the socio-economic hierarchy where the “ill” is the “undesirable other” and therefore stigmatized against in a socially approved manner.

Stigma and prejudice have had a historical relationship with the pandemics and epidemics of infectious disease outbreaks. In the 18$^{th}$ century England, Mary Malon, became in famous as “Typhoid Mary,” guilty of spreading the infection amongst affluent families, though she was unaffected. Though the concept of “asymptomatic carriers” came quite later, the history and medical textbooks still bear her name associated with an illness(Leavitt, 1996). The spread of infections has always been associated with “poverty, filth, and class,” to maintain a false sense of assurance and safety for the higher sections of society. The “pestilences” of bubonic plague, Asiatic fluand cholera, Middle East Respiratory Syndrome(MERS), and Ebola outbreak in Africa, all have been associated with polarization, racism, blame against certain ethnicities, and resultant psychological distress(Bhattacharyaetal. 2020). “Epidemic Orientalism”, the practice of naming illnesses by the country or place of origin is an other prevalent example of social labelling and stigma(Anderson,1996). For decades, Human Immuno deficiency Syndrome(HIV) / Acquired Immuno deficiency Syndrome(AIDS) had been pejoratively termed as the “Gay Plague,” a “divine punishment” for homosexuality(Wyngaard,2006). The tradition is still reflected in the legislation of many countries that prevents homosexual men from donating organs and blood.

Evolutionarily, the fear and uncertainty of ‘the unknown’ affect human behaviour significantly. Victim blaming, panic, illogical beliefs, aggression, and “othering” are some of such unhealthy expressions of that fear. The Coronavirus Disease 2019 (COVID-19) is one of the most uncertain and unprecedented events modern society has faced in a long time. Cumulatively as of November 22 2020, 57.8 million confirmed cases and 1.3 million deaths have been reported (WHO Weekly epidemiological update - November 24 2020)- the numbers rising as we speak. The outbreak has created social stigma and discriminatory behaviour towards individuals who are perceived or apprehended to have any contact with the disease.

Pandemics like these are much beyond just medical phenomena. The psychosocial impact of the pandemic bears the risk of outlasting the infection by far and long. Besides the direct psychological impact of stress, fear, anxiety, and mass hysteria, COVID-19 has led to the emergence of significant stigma, "othering," prejudice, and blame. Ever since its origin at Wuhan, China, the infection has been termed as "Chinese virus" or "Kung Flu," which fostered conspiracy theories about biological warfare. Ironically, the social stigma around the disease has spread faster than the virus itself. This commentary briefly glances at the evolution of social stigma during COVID-19 in India, the victims of it, and the impact of such a social evil on the Indian society at large. It then highlights the ways forward to mitigate this challenge in the Indian context.

## 2. COVID-19 Related Social Stigma in India: Why & How?

Fear is a primary response of human beings towards the unknown. Even after a year of its origin, the medical fraternity has not been able to come out with a vaccine or definitive cure for the virus, and this scares us in the real sense. A lot is still uncertain and intangible about this pandemic that is creating fear and consequently "anxiety and panic worldwide, due to its novelty, high infectivity, and absence of effective evidence-based treatment. Faced with this blurry and uncertain situation, fear and its associated behaviours are not uncommon human reactions" (Adikwu et al., 2020, p. 1). Holding others accountable through stigmatization for causing the distress due to the pandemic is one such behaviour that helps the society cope in times of such crises (Bhattacharya et al., 2020). The victim of this ‘othering’ is usually the socio-economically impoverished communities like the homeless, the age and gender minorities, etc. (discussed later).

Physical isolation and quarantine are among the most effective measures identified by experts in controlling the spread of the virus. But, the very act of these is once again inadvertently creating the “we versus they” bifurcation, where those who are physically isolated and quarantined readily become “the other”, and an easy target for stigmatization (Rubin & Wessely, 2020).

Another factor that has been shaping the perception of the public about COVID-19 is heavily influenced and coloured by the information portrayed in the mainstream and social media. Media indeed played an important role in educating the public about the disease, the measures taken by the government towards controlling the spread of it, or the “dos and don’ts” protocols. However, this pandemic has also been a witness to a sudden burst of misinformation being spread globally, as well as in India. Banerjee and Rao (2020) rightly pointed out:

> *As billions are being isolated at their homes to contain the infection, the uncertainty gives rise to mass hysteria and panic. Amid this, there has been a hidden epidemic of “information” that makes COVID-19 stand out as a “digital infodemic” from the earlier outbreaks. Misinformation and fake news are invariable accompaniments to this “information pollution” which can add to the anxiety, fear, uncertainty, and agitation and lead to faulty treatments, noncompliance to precautionary measures, prejudice, and stigma. (p. 131)*

Further, the use of inconsiderate and insensitive language to describe COVID-19 by print or digital media, social media and political leaders sometimes contribute to creating social stigma (Villa et al., 2020). Coining terms like “Chinese Virus”, “Chinese Syndrome” etc. to address COVID-19, or for that matter, any illness, widens the gap between self and others, instead of bridging it, and thereby fuelling social stigma. Such remarks also have the potential to stir global reactions and panic, contributing to national and international tensions as well as xenophobic attitudes.

## 3. Social Stigma induced Victimization during the COVID-19 Pandemic

Segregation normalizes stigmatization in a socially acceptable way. Unfortunately, segregation through physical isolation, quarantine, and social distancing has been identified to be most effective in checking the spread of the virus. Particular hospitals have been allocated to treat individuals affected by COVID-19, separate diagnostic laboratories have been assigned for conducting tests, quarantine and containment zones have been set, and based on incidence rates, the country has been divided into 'colour-coded zones'. While these are initiatives to flatten the ever-rising graph of a highly contagious outbreak, all these steps have their own social implications, one of them being fuelling social stigma.

### *A. Survivors*

Throughout the country, irrespective of socio-economic status, gender or other discriminatory factors that are usually seen in the diverse Indian society, incidents of social stigmatization have been reported towards those who are affected with COVID-19 (Sharma, 2020). Family members of those who survived or succumbed to the illness have also been discriminated against. Due to the fear of being affected by the virus, in many cases, families have refused to accept the bodies of those who succumbed to the disease and the state governments performed the last rites instead (Bajpai, 2020). Many instances have occurred where the survivors have been forcefully isolated by the neighbours and family members. Being labelled with tags like "super-spreader" worsened the experience of being ostracized (Ram, 2020). As mentioned earlier, the plethora of misinformation related to the spread of the infection, its pathogenesis, the necessary precautionary measures, rumour-mongering and lack of authenticity-verification has contributed to 'coronaphobia' (fear of COVID-19), that in turn have led to extreme safety-behaviours, one of which is the discrimination against those affected (Banerjee & Rao, 2020).

### *B. Frontline Workers*

For a long time, mental health professionals like mental health treatment facilities have often been stigmatized in India as *"paagolon ka doctor"* (doctor to the mad). Similarly, health professionals associated with the treatment of COVID-19 have been on the receiving end of such stigmatization. Bhattacharya et al. (2020) highlighted how doctors, nurses, paramedics have been forced to leave the neighbourhood, denied access to their houses and families been threatened. Instead of acknowledging the insurmountable atrocities, they have been undergoing, social stigma has overpowered the goodwill of those for whom they are fighting. A recent systematic review studying the psychosocial impact of COVID-19 in the South-Asian countries (Banerjee, Vaishnav, et al., 2020) has reported perceived stigma in frontline Indian health-care workers being related to depressive symptoms, anxiety, burnout, chronic stress and sleep disturbances. The authors further cautioned about the effect that such 'social outcasting' can have on the frontline physicians, who are the primary armament in battling the pandemic.

### *C. Marginalized Population*

A significant brunt of the COVID-19 has been experienced by the homeless and migrant workers in India. When they return home after being stranded isolated in their host cities, the migrant workers and their families have been singled out and harassed by the community members. Unlike their other visits, this time, they were received with suspicion and contempt from their family members and neighbours. In some instances, even after completing the mandatory 14 days' quarantine, they have been cast off (Kumar & Mohanty, 2020). As Banerjee, Kallivayalil et al. (2020) rightly identified, it was the "poor" migrants who were further marginalized and stigmatized compared to the non-resident Indians who too were travelling back from the foreign countries during the earlier phases of the pandemic and had equal chances if not larger of transmitting the virus. This marginalization among the already 'marginalized' population becomes vital during such a crisis, as it impairs their quality of life, social justice and rights further. For many of the homeless and migrant communities, social distancing is just a myth, as their daily existential struggle has been dire without the basic amenities of living.

***D. The Minorities***

The spurt of cases following a Tablighi Jamat event at Delhi, flooded the social media allegedly blaming the Muslim community for spreading the disease (Krishnan, 2020). For example, a video circulated in social media advising people not to buy vegetables from Muslim vendors. Similarly, posters on fruit shops in Jamshedpur to demarcate the faith of shopkeepers have singled them out communally (Singh et al., 2020). The Government rightly issued an advisory on April 8, 2020, directing its citizens to act more responsibly in such a time and to refrain from stigmatizing any community or area (The Economic Times, 2020). With a history of multiple communal riots even in the last decade, such stigmatization might bear significant consequences in India affecting public behaviour and socio-political dynamics. Ahuja et al. (2020) highlighted:

> *Due to various factors like fear of terrorism, the political dispute over Kashmir, international unrest and internal social dynamics, Islamophobia has emerged as a prominent xenophobic construct in India. Further bigoted opinions, fake news by media and viral videos have resulted in stigmatization of COVID-19 in India. It becomes all the more evident during such a public health crisis and adds to the psychosocial burden as well as quality of life. (p. 2)*

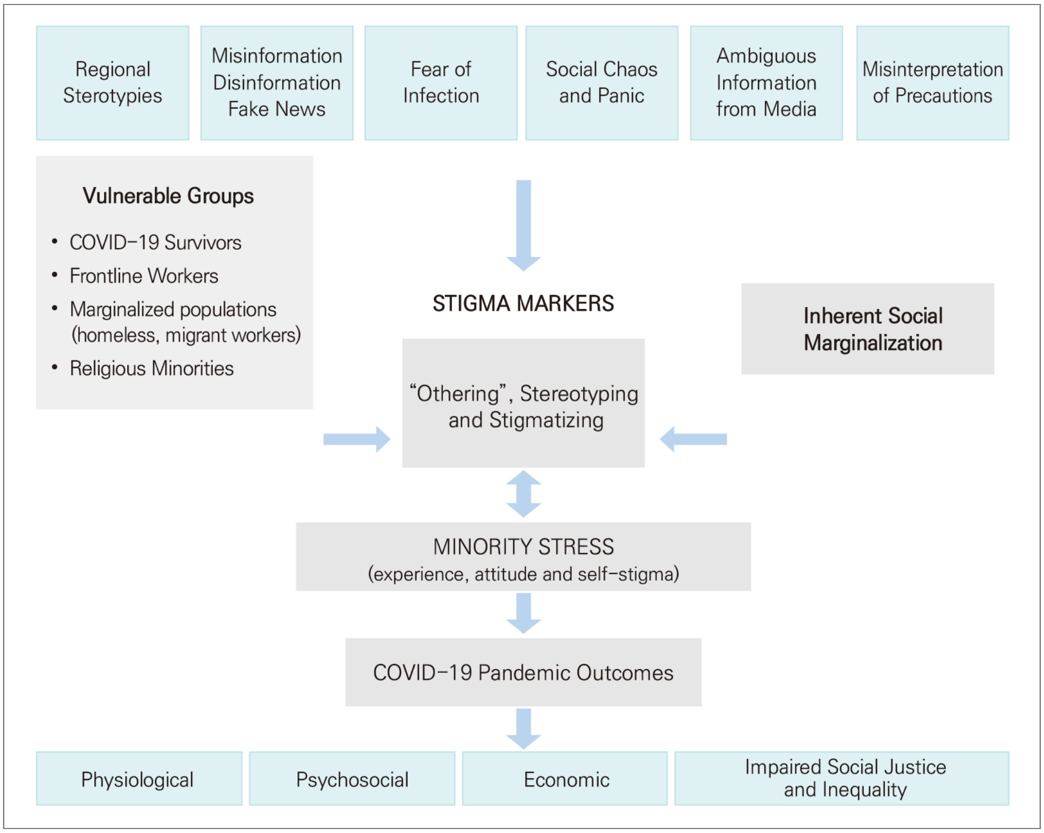
## 4. Impact of Social Stigma on its Victims during COVID-19

Social stigma during a pandemic like COVID-19 is acting as a deterrent to the effective management of the disease by acting upon social cohesiveness. Experiencing stigma and the 'apprehension of being stigmatized' is taking a heavy toll on the mental health of its victims. Banerjee and Bhattacharya (2020) highlighted common stress responses like sleeplessness, anxiety, worry about being affected, increased substance intake to be common in these trying times. But being socially stigmatized or apprehending the same might push the individual closer to the edge. Incidents have been reported in which individuals committed suicide apprehending social isolation. Experiencing social stigma, social boycotting, and religious discrimination from their neighbours, individuals who recovered from COVID-19 have also committed suicide (Times of India, 2020). While discussing the intersections between suicidal risk and the ongoing pandemic, Banerjee and Rao (2020) has highlighted the enhanced vulnerabilities of the minority groups and pointed out misinformation, fake news and social ostracization as vital contributing factors predisposing individuals to suicide during COVID-19.

Frontline-workers are also getting affected emotionally and psychosocially due to the stigmatization against them (Banerjee, Vijaykumar, et al., 2020). Peprah and Gyasi (2020) apprehended "COVID-19-induced stigma can profoundly plunge individuals especially, the health workers into isolation and worthlessness with respect to their inability to effectively contribute to the fight against the pandemic" (p.1).

Earlier this year when incidents of social stigmatization started surfacing, the World Health Organization (WHO, 2020 as cited in Singh et al., 2020) expressed its concern that due to the stigma, people might likely choose not to report the illness to avoid being discriminated against. That would delay access to health-care facilities and potentially increase the spread of the infection. Therefore, to avoid a high degree of stigma and othering associated with COVID-19, adequate and timely intervention from stakeholders is needed. There have been multiple instances reported in India where the history of foreign travel or symptoms of COVID-19 have been concealed due to the fear of experiencing social boycott and discrimination, leading to low testing and high mortality rates (Hindustan Times, 2020). India, being one of the worst affected nations in terms of COVID-19 caseload and the impending threat of 'second wave', such behaviour can be counter-productive to the required public health response. The various existing risk factors

Figure 1. Social Stigma, discrimination and othering during COVID-19, their bi-directional relationship with 'Minority Stress' and possible outcomes



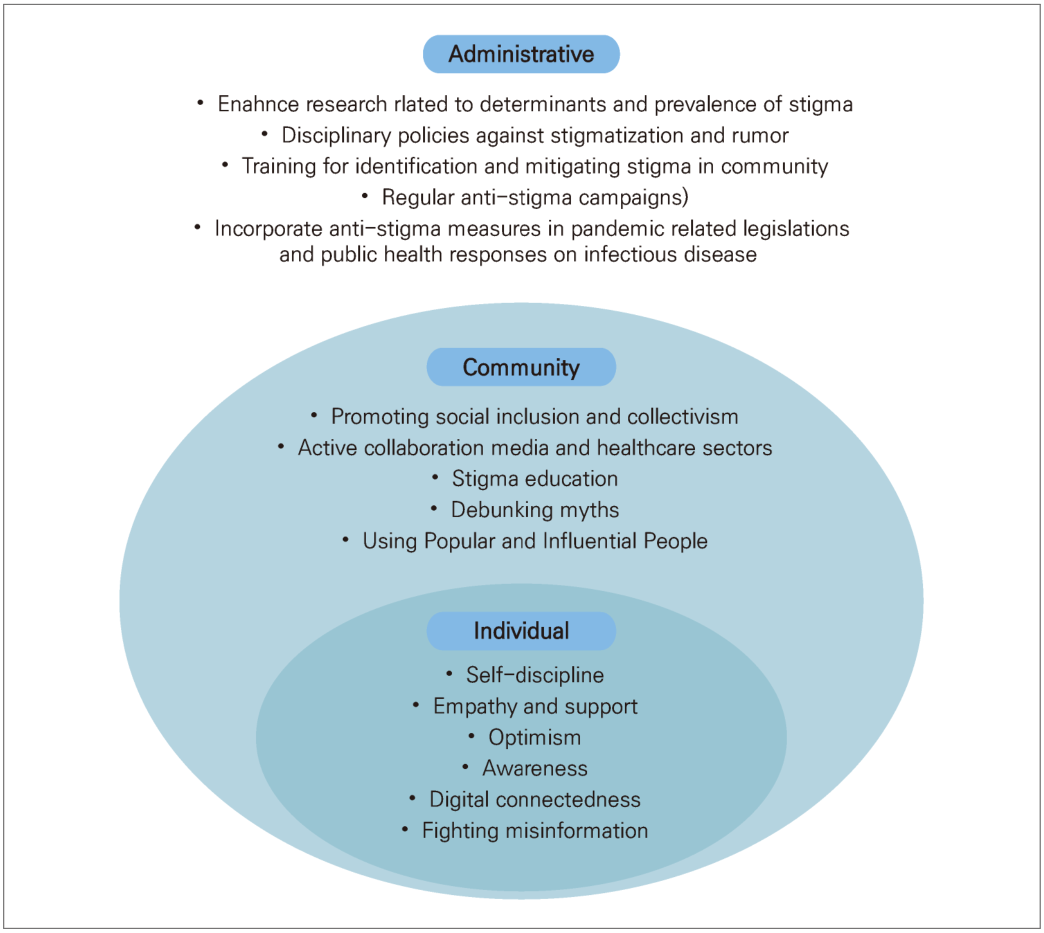

for social stigma together with the xenophobia and fear of infection during COVID-19 can further perpetuate self-stigma thereby leading to 'minority stress' that can have significant adverse outcomes in biopsychosocial dimensions (Figure 1).

## 5. Strategies to mitigate the social stigma: ways forward

Like any other mental health disorder, stigma can also be conceptualized as a biopsychosocial construct. Collective responsibility is warranted to fight it, at individual, social and administrative levels, with special focus on the vulnerable populations (Figure 2). Social stigma and consequent discrimination have shown to be perpetuated in a vicious cycle, being propagated by public beliefs that are unsubstantiated, stereotypes, and morbid fear of infection that maintains irrational safety behaviours and actions (Adiukwu et al., 2020). The role of effective health communication, mental health education and digital literacy is paramount in these cases. The pandemic and consequent lockdown have increased the global use of technology and virtual connectivity. Health and economy have benefitted from several digital improvisations. Social media platforms can be effective both for battling medical misinformation as well as health inoculation and fostering social inclusion (Banerjee & Rao, 2020). Bhattacharya et al. (2020) while discussing intervention strategies, focused on 'sensitive terminologies related to COVID-19', 'responsible public action' and 'amplifying the voices of the underprivileged' as vital to mitigate COVID-19 related social stigma in India. Of special relevance are the widely-used terms related to the pandemic, which are critical not only for the health professionals but also in public directives, promotional campaigns, political discourse, advertisements, media and also when used by global public health agencies like the WHO, UNICEF, etc. (The Economic Times, 2020). The most popular example is a "COVID-positive person" being rephrased as a "person being affected with COVID-19 infection". Based on social learning and attribution theories, persistent hearsay of pejorative terms in a daily discussion can lead to behavioural modelling and further anchor the harmful stereotypes and false beliefs (Corrigan, 2001). Such attributional models have been studied in stigma associated with HIV/AIDS which can affect the overall psychosocial well-being and functioning in those affected and can be countered by social support and public health education (Mak et al., 2017).

In a socio-culturally diverse and populous country like India, there cannot be a 'one-size fits all' approach to address the public misconceptions. Since the advent of the COVID-19 pandemic, various agencies like the BOOM, DATA LEADS, GOOGLE NEWS INITIATIVE, etc. together with the social media platforms like FACEBOOK, TWITTER, etc. have been working towards debunking the pandemic-related misinformation and

Figure 2. Different levels of suggested anti-stigma interventions during the pandemic




promoting health education (English Jagran, 2020). One such pan-Asian initiative, HEALTH ANALYTICS ASIA (HAA) has specifically worked extensively on COVID-19 related myth-busters and source-verified health education using the 'Train-the-Trainers' (ToT) approach, attempting to snowball the effects all over India (Krishnan, 2020). The Ministry of Health and Family Welfare (MoHFw), Government of India (2020), has adopted a firm standpoint and discouraged any form of stigma and discrimination against the health-care workers and those affected with COVID. It has called upon for nationwide civil responsibility and awareness to fight stigma during the pandemic. During the lockdown, spreading rumours related to the outbreak was also punishable by law. The implementation and outreach of these good-willed measures are, however, fraught with pragmatic challenges.

Keeping this in the background, Box 1 summarizes some of the basic facets of public-health communication that can help reduce the associated stigma.

## 6. Conclusion

COVID-19 infection can lead to immense morbidity and rising mortality irrespective of any socio-economic, linguistic, ethnic, racial or geographical divisions. In such an outbreak, where social distancing is the norm, that can significantly affect interpersonal relationships,

Box 1: Principles of public-health communication for social stigma reduction during COVID-19

- Simple and clear depiction of health-information (infographics, brief videos, messages, pamphlets, etc.)
- Contextualized and socio-culturally sensitive information
- Community Information-Education-Communication (IEC) approach
- Avoiding excessive 'numerical data / statistics'
- Raising awareness while minimizing fear and panic
- Sharing perspectives of vulnerable populations / "first-person accounts" from the frontline
- Eliminate practices of using negative, pejorative, discriminative terminologies and wordings (neutral terms are preferred)
- Frontline workers, minorities, those affected with COVID-19, people from high-risk regions and socio-economically under-privileged need special attention
- Adequate feedback from the rural communities related to health-risk understanding
- Misinformation, disinformation and fake news need debunking in various languages and cultural connotations
- Conspiracy theories to be promptly discouraged
- The modes of spread of the infection, pathogenesis, symptoms and necessary precautions need clarification in simple terms (targeting all communities and regions): this prevents harmful safety behaviours and avoidance
- Effective health-risk communication within the medical community
- Liaison with public figures, celebrities and all forms of media

any form of othering will only amplify these divisions contributing to loneliness, frustration, isolation and impaired emotional well-being. The success of any anti-stigma intervention depends on the collective will to understand the implications and implement it. Individual responsibility, constructive discourse and supportive attitudes are the basic requirements at all levels to mitigate pandemic-related discrimination. In a nation that comprises nearly 18% of the global population, reduction of such prejudiced behaviours is essential to improve health-care access, promote social inclusion and prevent under-reporting of symptoms, which can be a potential public health problem. Research has shown social collectivism to be inversely related to the xenophobic attitudes and fear of contracting COVID-19 in India (Ahuja et al., 2020). Though the mental health professionals, media, public health experts and policymakers need to take a lead role in promoting this collectivism, every individual is an equal stakeholder in this process. The COVID-19 pandemic in that way can serve as an eye-opening 'social experiment', lessons learnt from which can be used to fight infectious disease-related social stigma and othering during any such futuristic crisis.

## References


Adiukwu, F., Bytyçi, D. G., Hayek, S. E., Gonzalez-Diaz, J. M., Larnaout, A., Grandinetti, P., ... & Soler-Vidal, J. (2020). Global Perspective and Ways to Combat Stigma Associated with COVID-19. *Indian Journal of Psychological Medicine*, 0253717620964932.

Ahuja, K. K., Banerjee, D., Chaudhary, K., & Gidwani, C. (2020). Fear, xenophobia and collectivism as predictors of well-being during Coronavirus disease 2019: An empirical study from India. *International Journal of Social Psychiatry*, 0020764020936323.

Anderson, W. (1996). Immunities of empire: race, disease, and the new tropical medicine, 1900-1920. *Bulletin of the History of Medicine, 70* (1), 94-118.

Bajpai, N. (2020, May 13). Noida DM performs last rites of COVID-19 victim as relatives refuse to receive body. Retrieved November 27, 2020, from https://www.newindianexpress.com/nation/2020/may/13/noida-dm-performs-last-rites-of-covid-19-victim-as-relatives-refuse-to-receive-body-2142919.html

Banerjee, D., & Bhattacharya, P. (2020). "Pandemonium of the pandemic": Impact of COVID-19 in India, focus on mental health. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(6), 588.

Banerjee, D., & Rao, T. S. (2020). Psychology of misinformation and the media: Insights from the COVID-19 pandemic. *Indian Journal of Social Psychiatry, 36*(5), 131.

Banerjee, D., Kallivayalil, R. A., & Rao, T. S. (2020). The 'othering' in pandemics: Prejudice and orientalism in COVID-19. *Indian Journal of Social Psychiatry, 36*(5), 102.

Banerjee, D., Vaishnav, M., Rao, T. S., Raju, M. S. V. K., Dalal, P. K., Javed, A., ... & Jagiwala, M. P. (2020). Impact of the COVID-19 pandemic on psychosocial health and well-being in South-Asian (World Psychiatric Association zone 16) countries: A systematic and advocacy review from the Indian Psychiatric Society. *Indian Journal of Psychiatry, 62*(Suppl 3), S343.

Banerjee, D., Vijayakumar, H. G., & Rao, T. S. (2020). " Watching the watchmen:" Mental health needs and solutions for the health-care workers during the coronavirus disease 2019 pandemic. *International Journal of Health & Allied Sciences, 9*(5), 51.

Bhattacharya, P., Banerjee, D., & Rao, T. S. (2020). The "untold" side of COVID-19: Social stigma and its consequences in India. *Indian Journal of Psychological Medicine, 42*(4), 382-386.

Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science, 22*(4), 16-31.

Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia bulletin, 27*(2), 219-225.

English Jagran. April 13th (2020). https://english.jagran.com/lifestyle/fact-and-fit-initiative-dataleads-combating-medical-misinformation-in-partnership-with-boom-10010661 [last accessed on November 28th, 2020]

Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity, Prentice&Hall. *Englewood Cliffs, New Jersey*.

Krishnan, J. November 26th (2020). https://www.ha-asia.com/fact-checking-medical-misinformation-101/ [last accessed on November 28th, 2020]

Krishnan, M. (2020, May 14). Indian Muslims face renewed stigma amid COVID-19 crisis. Retrieved November 27, 2020, from https://www.dw.com/en/indian-muslims-face-renewed-stigma-amid-covid-19-crisis/a-53436462

Krishnan, M. (2020). Indian muslims face renewed stigma amid covid-19 crisis. *Deutsche Welle: Made for Minds [Internet]. May, 14*.

Kumar, C., & Mohanty, D. (2020, May 11). Migrant workers battle stigma, bias back home. Retrieved November 27, 2020, from https://www.hindustantimes.com/india-news/migrant-workers-battle-stigma-bias-back-home/story-0uuRSEZfoickVOrPU2agGL.html

Leavitt, J. W. (1996). *Typhoid Mary: captive to the public's health*. Beacon Press.

Mak, W. W., Mo, P. K., Ma, G. Y., & Lam, M. Y. (2017). Meta-analysis and systematic review of studies on the effectiveness of HIV stigma reduction programs. *Social science & medicine, 188*, 30-40.

Ministry of Health and Family Welfare (MoHFw). Government of India (2020). https://www.mohfw.gov.in/pdf/AddressingSocialStigmaAssociatedwithCOVID19.pdf [last accessed on November 28th, 2020]

Peprah, P., & Gyasi, R. M. (2020). Stigma and COVID-19 crisis: A wake-up call. *The International Journal of Health Planning and Management*.

Press Trust of India. (2020, April 8). Do not label any community or area for spread of COVID-19: Government. *The Economic Times*. Retrieved November 27, 2020, from https://economictimes.indiatimes.com/news/politics-and-nation/do-not-label-any-community-or-area-for-spread-of-covid-19-government/articleshow/75051453.cms?from=mdr

Press Trust of India. (2020, May 8). Social stigma, low testing behind WB's high Covid-19 mortality rate: Report. *The Hindustan Times*. Retrieved November 27, 2020, from https://www.hindustantimes.com/kolkata/social-stigma-low-testing-behind-wb-s-high-covid-19-mortality-rate-report/story-VGGBAEy2lXueEplUxOGX3N.html

Ram, T. (2020, April 13). Branded 'super spreader', family of Karnataka COVID-19 victim battles stigma. Retrieved November 27, 2020, from https://www.thenewsminute.com/article/branded-super-spreader-family-karnataka-covid-19-victim-battles-stigma-124482

Rubin, G. J., & Wessely, S. (2020). The psychological effects of quarantining a city. *Bmj, 368*.

Sharma, S. (2020, April 10). Kin of COVID-19 dead in Punjab refuse to attend last rites. Retrieved November 27, 2020, from https://www.downtoearth.org.in/news/health/kin-of-covid-19-dead-in-punjab-refuse-to-attend-last-rites-70379

Singh, S., Bhutani, S., & Fatima, H. (2020). Surviving the stigma: lessons learnt for the prevention of COVID-19 stigma and its mental health impact. *Mental Health and Social Inclusion*.

Van Wyngaard, A. (2014). Manifesting the grace of God to those with HIV or AIDS. *Verbum et ecclesia, 35*(1), 1-7.

Villa, S., Jaramillo, E., Mangioni, D., Bandera, A., Gori, A., & Raviglione, M. C. (2020). Stigma at the time of the COVID-19 pandemic. *Clinical Microbiology and Infection*.

World Health Organization. (n.d.). Weekly epidemiological update - 24 November 2020. Retrieved November 27, 2020, from https://www.who.int/publications/m/item/weekly-epidemiological-update---24-november-2020