**“As if we have the mark of Cain”: Stigma, guilt, and shame experienced by COVID- 19 survivors in Israel - A qualitative study**

**Abstract**

The literature on stigma in medical sociology usually addresses the stigmatization of people with disabilities (Jansen-van Vuuren & Aldersey, 2020; Rubeis & Steger, 2019; Sabatello, 2018), chronic or mentally ill patients (Azlan et al., 2020; Oexle & Corrigan, 2018; Woo, Zhou & Larson, 2021) and minority groups (Cheng, Kwan & Sevig, 2013; Horowitz et al., 2017). Hatzenbuehler et al. (2013) argue that stigma overlaps with many other constructs, such as racism and discrimination. It is defined as “the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised.” It has a significant influence on many aspects of a person’s life, such as social relationships, coping mechanisms, access to resources, stress, psychological and behavioral responses. It encompasses statuses such as disability, HIV, sexual orientation, etc.; and it incorporates elements including othering (Logie & Turan, 2020), labeling, stereotyping, prejudice, and discrimination (Corrigan & Penn, 1999). Stigma poses a barrier to “health seeking behavior,” including engagement in care and adherence to treatment across a wide range of conditions (Lan, Lin & Thanh, 2018; Stangl et al., 2019; Stringer & Baker, 2018; Wainberg et al., 2017). Studies have consistently found that stigma is associated with harmful health outcomes (Budenz et al., 2020; Budhwani & De, 2019; Pachankis et al., 2018). Additionally, it fuels social and health inequalities.

While stigmatization is often studied in medical settings where the stigma is associated with stable, existing conditions, such as disability or chronic illness, this study broadens the scope of stigma analysis and explores the dynamics of stigmatization during epidemics. The COVID-19 pandemic has provided an ideal opportunity to investigate the emergence of stigmatization of COVID-19 patients during the first wave of the pandemic in early 2020. Specifically, we were intrigued by the fact that although vulnerability to COVID-19 was universal (before vaccinations were introduced) and the risk of being infected was shared by all members of society, it was stigmatization rather than a shared feeling of vulnerability that prevailed in the attitudes toward COVID-19 patients during the initial stages of the pandemic outbreak. In this study, we delve into the stigmatization experiences of recovered COVID-19 patients.

**Covid– 19 and Stigmatization**

According to the World Health Organization (WHO, 2020), current COVID-19 stigmatization has been driven by three main factors. First, it is a new disease about which much remains uncertain. Second, it is common to be afraid of the unknown, which leads to the third factor: a sense of fear towards “others.” These three factors induce confusion, anxiety, and worry in the public, leading to the creation of harmful stereotypes. Stigma can undermine social cohesion and encourage social exclusion of groups, which may contribute to a situation in which the virus will spread further and it will become more difficult to control outbreaks of the disease.

Moreover, during the COVID-19 pandemic, many acts arising from stigmatization have come to light around the world, involving patients, doctors, and survivors.. In late January 2020, when the COVID-19 pandemic was still primarily confined to China, verbal and physical attacks against Chinese or people of Asian descent were documented in many countries. In Italy, for example, many racist and violent acts took place (Muzzi, 2020). There have been cases of people refusing service to Asians in shops and restaurants, and in the United States, during one week in March, 650 racist acts were committed against Asian Americans (Yoshiko, 2020). Recovered patients also had to face stigmas, especially from neighbors. Given the shortage of test kits and laboratories, it was not always possible to test recovered patients to determine if they had been totally cured. This has led to avoidance and social isolation due to others’ fear of being infected (*The New York Times*, 2020). Bagcchi (2020) reports many stories involving stigma surrounding COVID-19. Doctors, nurses, and healthcare workers from Malawi, Mexico, and India have reportedly been denied access to public transport, physically assaulted, and evicted from rented homes. Similarly, COVID-19 patients have also suffered from stigma associated with the virus. For example, a woman in India was abandoned by her family after giving birth to her child and testing positive for the virus. Another striking example took place in Harare, Zimbabwe, where the street in front of a recovered patient’s house was named “Corona Road,” and neighbors avoided using that road for fear of getting infected. We can say that the substantial stigma related to COVID-19 derives from a lack of understanding and incorrect information surrounding the virus.

Most countries have difficulties preventing stigma attached to the COVID-19 pandemic. The role of stigma and discrimination in spreading the infection has been repeatedly emphasized (Smith & Hughes, 2020). Stigma caused sick people to hide their symptoms in an attempt to avoid exclusion. This behavior enabled the spread of infectious pathogens, especially among those suffering from mild symptoms who avoided seeking medical attention and continued with their routines so as not to raise suspicion regarding their condition. In addition, such behavior can contribute to the deterioration of clinical situations and may have psychological consequences. On the other hand, patients with a diagnosis of COVID-19 often suffer from anxiety and depression, mainly due to hospitalization or home quarantine, or because of guilt toward family members or acquaintances (Rong et al., 2020; Villa et al., 2020). Overall, there is limited research on the effects of the stigma regarding COVID-19. However, it is essential to note that the stress surrounding it may have a considerable impact on those affected.

In this study, we tried to understand the experiences of COVID-19 survivors. The subject of bearing a stigma and experiencing feelings of guilt and shame after contracting the disease was often raised spontaneously during the interviews, emerging as a significant theme. Based on the personal stories, we tried to examine how these experiences made them feel and how they dealt with the environment’s attitude toward them. Other common health conditions associated with social stigma are AIDS (HIV), mental illness, tuberculosis, drug use, leprosy, and cancer (Nyblade et al., 2019). COVID-19 is not a chronic condition but is accompanied by guilt, shame, and social sanctions both in the infection stage and in the post-recovery period. The study aims to expand the knowledge about the stigma surrounding the COVID-19 pandemic using personal narratives to examine feelings of shame, guilt, and exclusion caused while interacting with the environment.

The Israeli response to the COVID-19 pandemic has become a model for many other countries. The virus initially began spreading in Israel in February 2020 and has not yet completely disappeared. Israel was one of the first countries in the world to decide on adopting a series of closures and shutdowns, and in March and April 2020, severe limitations were imposed on movement and gatherings. In May, the limitations were relaxed, but a spike in the morbidity rate led to a partial reimposition of the limitations. This study addresses the phenomenon of the stigmatization of individuals recovering from COVID-19 manifested during the first three months of the pandemic’s outbreak. Persons infected with COVID-19 were sent into isolation outside their home, to hotels specially converted into isolation complexes. They were required to remain in the isolation hostels for two weeks, not to leave their rooms, nor be in contact with the public. Only after two weeks and a negative COVID-19 test were they allowed to return to their routine lives. The Israeli authorities applied a variety of measures to contend with the COVID-19 outbreak: a series of emergency regulations and establishing a special government team headed by the prime minister as well as special expert teams. They even turned to the Israel Defense Forces (IDF) and other security services in the race to obtain lacking ventilation equipment and COVID-19 test kits. The Israeli effort has been reviewed in the professional literature (Mizrahi, Vigoda-Gadot, & Cohen, 2021), which has suggested that the public health system in Israel, mainly the extensive system of health maintenance organizations (HMOs), may have helped Israel obtain vaccines from Pfizer and thus reach a relatively high level of vaccination within the population, about 60% vaccinated with two doses (as of July 2021). However, alongside the measures adopted to contend with the pandemic at the organizational and institutional level, we wish to examine the implications of the rapid shift from a routine situation to a medical emergency scenario on the stigmatization processes of people recovering from COVID-19.

**Method**

The study received the approval of the Ashkelon Academic College Ethics Committee (Approval no. #25-2020).

**Participants**

The participants were 20 COVID-19 recovered patients (13 women and 7 men) between the ages of 22–56 (mean age 44.45±10.35). The period of time that elapsed between their recovery and the interviews ranged between 40–200 days (a mean time of 92±47.36 days). Two interviewees were unmarried (10%), two were divorced with children (10%), and 16 were married with children (80%). Twelve of the interviewees were secular Jews (60%) and eight were religious Jews (40%). There were 18 Jews (90%) and two Muslims (10%). Two interviewees (10%) had not worked prior to the disease, and among the remaining 18, three (17%) did not return to work at all for several months and were still recovering, others took between two weeks to two months to return to work following isolation, and half of them claimed that they did not yet feel ready for work but were obligated to return. Five of the interviewees had not been hospitalized nor confined to an isolation hostel (25%), but remained in home isolation for a long period (between one to two months), as the severe symptoms had not disappeared, and they were unable to properly function. Fifteen (75%) were hospitalized for between one week to several months, four of whom were hospitalized together with other family members (parent/child/sibling).

The interviewees were sampled using a combined purposeful and snowball sampling approach common to qualitative research. In the purposeful sampling, the interviewees were selected based

on their serving as potential sources of rich information to serve the study objectives. In addition, we asked the interviewees to approach their friends and acquaintances who met the inclusion criteria, and to ask if they were prepared to be interviewed.

Inclusion criteria:

* COVID-19 recovered patients for whom six weeks had elapsed since receiving notification of leaving isolation.
* Hebrew speakers.
* Adults.
* Recovered patients who had suffered from severe symptoms/a long period of illness/required hospitalization.

Exclusion criteria:

* Patients with suppressed immunity, such as cancer patients, patients with organ implants, etc.

Table 1: Individual interviewee characteristics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Interviewee**  **(M-male, F-female)** | **Age** | **Marital status** | **Religion & religious devoutness** | **Relatives infected** |
| M1 | 33 | Married+3 | Muslim, religious | None |
| M2 | 55 | Married+1 | Jewish, religious | Entire nuclear family |
| M3 | 55 | Married+6 | Jewish, religious | Wife |
| M4 | 41 | Unmarried | Jewish, religious | Both parents.  The father died |
| M5 | 53 | Married+4 | Jewish, religious | Son & daughter |
| M6 | 54 | Divorced +2 (lives with a partner) | Jewish, religious | None |
| M7 | 50 | Married +4 | Jewish, secular | Husband & 3 children |
| F1 | 28 | Unmarried | Jewish, secular | None |
| F2 | 22 | Unmarried | Jewish, secular | None |
| F3 | 50 | Divorced+3 (single parent family) | Jewish, secular | Daughter |
| F4 | 42 | Married+2 | Jewish, secular | Husband and two children, siblings and nephews |
| F5 | 45 | Married+3 | Jewish, secular | Son (source of infection), two brothers and ten additional relatives. |
| F6 | 39 | Married+3 | Jewish, secular | Two children |
| F7 | 47 | Married+4 | Jewish, secular | None |
| F8 | 44 | Married+4 | Jewish, religious | Husband and two children |
| F9 | 49 | Married+2 | Jewish, secular | Two children |
| F10 | 56 | Married+5 | Jewish, religious | Her husband & 3 children |
| F11 | 56 | Married +2 | Jewish, religious | None |
| F12 | 26 | Married +1, pregnant | Jewish, religious | Sister and mother |
| F13 | 44 | Married +4 | Muslim, religious | Daughter |

**Recruitment of the Participants**

In order to locate potential interviewees, we entered the Facebook group, “The First Official Forum in Israel for COVID-19 Patients and Recovered Patients.” The members of this group recount how they experienced the disease and the symptoms from which they suffered. We read 23 posts that were published, and from these, we tried to locate those cases that met the inclusion criteria, based on consultation with the study advisors. We initiated contact with 13 recovered patients via a private announcement posted on Facebook. We introduced ourselves and presented the study objectives and asked if they were prepared to be interviewed. Four of them did not respond at all, four did not meet the inclusion criteria, and five agreed to be interviewed, and we scheduled dates following a short session of questions to ensure that they did indeed comply with the inclusion criteria. One interviewee changed his mind and canceled the interview out of concern about being identified.

At the same time, we published a short announcement in the Facebook group regarding the study, its objectives, and the inclusion criteria, together with our phone numbers. Eight recovered patients contacted us and expressed their willingness to be interviewed. Three of these met the criteria and were interviewed.

We reached five of the interviewees via the snowball method based on the recommendations of other interviewees. They approached friends who had been ill and who met the inclusion criteria and asked them if they would be prepared to be interviewed. All five who were contacted met with the criteria and were duly interviewed.

In addition, we approached individuals we knew, and they in turn contacted friends who had been ill and who met the inclusion criteria and asked them if they would be prepared to be interviewed. We received the details of 12 recovered patients who agreed to be interviewed. One of these did not meet the inclusion criteria, while two others changed their minds and canceled the interviews as they did not want to be reminded again of that difficult period.

In summary: four interviewees were located by an initiated approach via Facebook, three who replied to the announcement we published, five via the snowball method (recommended by other interviewees), and eight via common acquaintances. Only three candidates who scheduled interviews eventually canceled.

All the interviewees were very open and eager to share what they had gone through. Some of them were motivated to help others understand just what it means “to be ill with COVID-19,” and thereby convince them to be careful and adhere to the rules. Some participated so enthusiastically in order to process retrospectively what they had been through and to understand the sources of strength that had helped them contend with the disease. Others regarded the interview as a form of “therapeutic” discussion, in which they could share their experience with another person who does not know them, who listens and is not judgmental.

**The Interviews**

The interviews were conducted by telephone in Hebrew on a convenient date for the interviewees during November 2020. The interviews were in-depth and semi-structured, allowing for flexibility and posing other questions in addition to those that had been prepared in advance. On occasion, we changed the wording and order of the questions in accordance with the dynamics of the interview so as to maintain the flow of discussion and encourage openness amongst the interviewees. During the interviews, we examined the experience of suffering from the stigma from the moment they became aware of being ill, throughout the course of the disease, and during the recovery period. The interviews were conducted by the second and third authors, BA graduates in Public Health. They were trained to conduct the interviews by the first and the last authors, and each one conducted two pilot interviews for the purpose of training, which were not included in the study. The interview guidelines were written by the authors with the aid of two recovered patients and were validated during the pilot. The length of the interviews ranged between 25–60 minutes (a mean duration of 40±11 minutes). Prior to commencing the interview, we explained the nature of the study and its objectives to the interviewees, and they were asked to sign a consent form for taking part in the interview and having it recorded. We explained that they were entitled to stop the interview at any stage they wished, and that they were not required to answer all the questions. The interviews were recorded and then transcribed using a professional transcriber.

The first half of the interview dealt with the story of being infected, the symptoms, the test and then learning of the positive result and notifying their acquaintances that they must enter isolation, as they were able to recall all this from their personal experiences. The second half of the interview dealt with the experience of being ill and then recovering, as well as the response of their surrounding environment to them after they had been defined as having recovered from COVID-19.

**Analysis of the Interviews**

The interviews were recorded and transcribed and then analyzed using the thematic analysis method (Shkedi, 2003). A theme expresses a broad central idea that tends to appear and reoccur in the analytical material in different forms of expression. The analysis included both deductive themes arising from the study topic and a review of the literature, as well as inductive themes that arose from the data (Charmaz, 2002). Analysis of the interview contents was carried out in several stages according to Shkedi’s method (2003): at first, the focus was placed on gaining in-depth and comprehensive familiarity with the data by lateral reading of all the interviews. The next stage involved identifying ideas, categories, and themes connected to the study questions. During the third stage, the specifications and ideas were discussed while engaging in repeated reading of the transcriptions until the final wording of the themes.

In order to identify structures of stigma and contending with it, two raters from the field of health sociology initially read the interviews and attempted to locate the feeling of stigma and the tactics of contending with the experience of suffering from the stigma, as described by the interviewees. The process of analyzing the texts included three stages. During the first stage, two independent coders determined if processes of imposing stigma and feelings of shame and guilt were described in the interview. The inter-rater reliability level according to the kappa index was maximal – Cohen’s *kappa* = 1.0. In the second stage, we defined nine themes according to three stages of the experience of illness (discovery of the disease, the duration of the disease, and recovery) as these arose from the interviews. In the third stage, we reread the interviews to code each one in accordance with the themes described in them. The inter-rater reliability level was high – Cohen’s *kappa* = 0.88.

**Findings**

The findings section is divided into three stages: The first, discovery of the disease, the second, the duration of the disease; and the third, the recovery period. Table 1 presents the division into themes and sub-themes, as they arose from the interviews according to each stage.

Table 1: Mapping out themes and sub-themes according to stage

|  |  |  |
| --- | --- | --- |
| Stage | Themes | Sub-themes |
| 1. Discovery of the disease | 1.1 Shame and the desire to conceal the disease |  |
| 1.2 Guilt |  |
| 1. Duration of the disease | 2.1 Shame and humiliation in hospital |  |
| 2.2 Stigma | 2.3.1 Stigma and fear of the patient  2.3.2 Contending with the stigma and the guilt |
| 1. The recovery stage | 3.1 Shame and guilt | 3.1.1 Guilt at the harm caused to the family  3.1.2 Increased use of the health services |
| 3.2 Stigma | 3.2.1 Exclusion of the recovered patient  3.2.2 Contending with the stigma - attempt to return to normal life |

**1. Discovery of the Disease**

All the interviewees described the moment of receiving the answer as a moment of dread, great confusion, and tremendous fear of the unknown. Interviewee M1, a physician, described this moment as follows: *“I became extremely stressed out. Everything was black in front of my eyes. I was unable to think or speak. I asked myself, how will I be able to continue?”* Interviewee F2, a young woman who still lives with her parents, felt that at the very moment she most needed support, she was being pushed aside: *“When I received the answer, I was seized by an anxiety attack. I began to shake and cry. They threw me into a room straight away.”* While interviewee F10, an ultra-orthodox Jewess, told us of a crisis of faith:

*I refused to accept that I was ill with COVID-19. It was very hard for me to accept. I went to pieces. I had the sense of failing God, and this was too much for me. I cried all night long and I refused to calm down. I am a very strong woman with great faith. I never suffer from any breakdowns. And at that moment I sensed an emotional breakdown.*

The great crisis, the fear of the disease and the concern over the response of the surrounding environment evoked a feeling of shame and a desire to hide their disease in the interviewees.

## 1.1 Theme: Shame and the Desire to Conceal the Disease

Most of the interviewees were ashamed at having contracted the disease; they felt “singled out” and sensed that this had a negative impact on the value attributed to them by their surroundings. As interviewee F10 described it:

*We were greatly ashamed. We live on a moshav and we are a community, and suddenly you feel that you are ill with COVID-19, it feels like such an embarrassment.* *As if we are branded with the mark of Cain. I was utterly ashamed. We are an esteemed and well-known family.*

There were interviewees who sought to conceal the fact that they were ill due to fear of how their surrounding environment would react, and they preferred to avoid encountering any such hatred. Thus, interviewee F6 (a teacher) recalls:

*I caused lots of people to go into isolation before Rosh Hashana (the Jewish New Year) and I felt ashamed. I did not think that I was the verified COVID-19 case. To this day, my pupils do not know that I am the COVID-19 case, as the reactions were extremely harsh and extreme: How irresponsible! What sort of a school are you? You should be ashamed! I had a terrible sense of guilt.*

Interviewee F9 asked her children to hide the fact that they were ill: “*I’m sure everybody knew why the children were absent from school, but I concealed the information. In June, I was still greatly ashamed of this.”* Interviewee F11 explained the shame she felt when all her neighbors looked at her being taken away by ambulance. She even compared being ill with COVID-19 to having AIDS, which is known to be a disease most associated with stigmas and social sanctions:

*I will tell you why I was ashamed. I had neither stolen nor murdered. I was ashamed of the situation. As everybody began: “Wow, who is it? Wow, does she have children in the kindergarten?” Lots of questions. In the building opposite me there was a woman who was being taken away by ambulance and everybody said: “Wow, there is a woman with COVID.” Do you know what reactions? It is humiliating. I saw unbelievable responses in the WhatsApp group. It was as if she had AIDS. The neighbors came down to watch.*

In contrast to the previous interviewees, although Interviewee F12 was afraid of the response, in the end, she felt it was her duty to tell and was forced to contend with difficult reactions:

*I was afraid of telling, especially when I found out that people do not react to it in a very positive manner*. *They accuse you, as if you were really to blame. They accused me of having known that I was sick and having come and sat with them deliberately. It really frustrated me, so much so that even now I am unable to look those people in the eye. Even after I received confirmation from the doctor that I had recovered, I still chose not to go out and stayed at home.*

In contrast, a number of interviewees, usually men, like M6, declared: *“I had no reason to be ashamed. I was up the creek. What could I do?”*

1.2 Theme: Guilt

All the interviewees expressed feelings of guilt toward those close to them when they told them that they had to enter isolation and be tested. They felt as though they had done something bad, that they were criminals who had broken the law. Eventually, their friends and family did actually cause them to disobey the directives, as many interviewees told us that they did not “give up” many people who had come into contact with them, as these individuals asked that their name should not be mentioned during the epidemiological investigation, to avoid having to enter isolation. Everybody was afraid that they might have infected others and reported a sense of relief when they found out that this was not the case. Interviewee F6 shared these thoughts with us:

*When I found out the result I really began to cry. It is extremely emotionally difficult to accept this. First, that I am ill, and have caused three classes to enter isolation before Rosh Hashana, and affected lots of friends and family. So that my most prominent feeling was one of guilt. I felt terrible that because of me people would have to enter isolation on the day before Rosh Hashana. At least I did not infect anybody. But the feelings that engulfed me the most were of guilt and shame. Not the fact that I was ill, as being ill with corona is nothing to be ashamed of. It is your surroundings which cause this. Every message of, “Oh, how I would love to celebrate Rosh Hashana with my mother.” You are ashamed that this is because of you. So that this is both guilt and shame rolled into one.*

Interviewee F10 told us: *“I felt as though I had broken the law. That people had gone into isolation because of us. We were lucky that everybody tested negative.”* Interviewee F12 shared these thoughts:

*A sense of guilt that maybe I had infected somebody... I was so afraid that I was unable to sleep at nights until I found out that I had not infected anybody. When I told everybody, I didn't feel good, because it means that you are about to bring people’s lives to a halt. Lots of people who had been in contact with me were mad at me: “What? You were ill and sat with us, don't report us!” They really blamed me. And in fact, I didn’t report them. Only my close family. Even though I was afraid that maybe they had been infected and would infect others.*

Interviewee F3 told us of the feelings of guilt after finding out that she had infected her daughter:

*I suffered from severe feelings of guilt that I had infected my daughter. When she became ill, what is the first thing that comes to mind? Maybe she contracted the disease when I cooked with COVID-infected hands. I blamed myself. I began to become afraid of my body, my hands. Afraid to breath. I walked around my house with disinfectant spray. This is a really difficult issue. People are unable to understand if they do not have firsthand experience of it.”*

Interviewee F2 infected a work colleague:

*One minute after I discovered that I was ill and I was hysterical, I phoned my manager in tears, I couldn’t stop apologizing. I caused all those at work to go into isolation. I felt that this was my fault. That I had done something bad... On the one hand, I felt slightly guilty about my friend whom I had infected, but on the other hand, I also felt some degree of happiness. It might be bad to say this, but I was happy to an extent that I was not alone.*

**2. Duration of the Disease**

One half of the interviewees, mainly parents with children, returned to that moment when they were certain that they were about to die, whether this was at home, in the ambulance, in the COVID-19 Emergency Room (ER) or during hospitalization. Interviewee F7 had already envisaged her own funeral: *“They had me hooked up to a ventilator and my entire body recoiled out of fear. The entire time I was imagining death. My own funeral. The immense fear that my children would be left alone.”* They felt a sense of helplessness due to the disease, and they told us of the humiliating experiences they had undergone in hospital.

# 2.1 Theme: Shame and Humiliation in Hospital

Interviewees who were hospitalized described humiliating experiences in hospital, which, on the one hand, caused them to feel a greater sense of shame, but, on the other hand, helped them understand the situation. IntervieweeM2 described the following:

*At that time, the corona virus outbreak had just begun, and people were becoming extremely afraid of it. So, when I arrived at hospital and I said I might have corona, everybody around me ran away. What annoyed me the most was that when they took me for a CT, they evacuated everybody. Lots of security guards along the way, as if a leper was entering. On the other hand, I don’t blame anybody, that’s the situation.*

Interviewee F3 added:

*I arrived at hospital in a very severe condition. Two doctors and three security guards took me to the MRI, and all along the way they were trying to brush people aside, shouting keep away, keep away, this is a corona patient. And as if in a horror movie, people were jumping up, frantic. I have a really strong memory of this. I felt absolutely terrible. Shame. Medical exposure. Insecure. When I came back, I called the doctor and told her that I am simply taken aback. I have been utterly humiliated and if you are unable to schedule a test for me in a manner that safeguards my rights as a human being, then don’t take me for a test or take me at night. By the way, the COVID-19 Department is a closed department. All the doctors are like aliens, you can't even see the doctor. You don’t know who is standing in front of you. You can’t talk on the phone as there is no privacy. They speak with the patients via intercom. And if no doctor or nurse enters the department, you can remain there suffering for a number of hours until somebody comes to you. This experience is something terrible. Horrible. It is a scar that will remain with me for my entire life.”*

Interviewee F10 reinforced this:

*Until the ambulance finally arrives to take me home from hospital, the driver shouts to everyone to stay clear, COVID-19 patient, COVID-19 patient. Steer clear. People run away. People running. Do you know how embarrassing this is? You say what? All of this because of me? In what terrible dreamworld am I?*

2.2 Theme: Stigma

Interviewee F10 aptly reflected the stigma regarding COVID-19 patients when she described her stay in the COVID-19 ER:

*In the Torah there is a situation whereby somebody who does something bad is sent away from the community to where the lepers are. I looked around at all the ill people and said to myself: We are just like lepers. They are isolating us from the public.*

Interviewee F9 reiterated:

*Once people would hide the fact that they are ill. They felt as though they are lepers. This is the issue with the hostel. While there is something good about it, , you feel like the leper colonies that used to exist, or like those infected with the plague in the Middle Ages.*

Later, this theme was divided into two sub-themes: The fear of the patient and the effort to contend with the stigma and the guilt.

2.2.1 Fear of the Patient

The interviewees shared with us how their immediate surroundings distanced themselves from them. Interviewee F1 recounted:

*Everybody was very scared. They were afraid of me and afraid of dying. It was stressful. Extremely stressful. They asked what I was feeling so that they would know if they have it too. They asked if they can be infected. But apart from one, they all tested negative. My cousin tested positive. It was most unpleasant.*

Interviewee F2 shared the following thoughts with us*:*

*I was completely stressed out. I had anxiety attacks. So, in the first few days you cry and nobody can touch you. They treat you as if you were a leper. I felt completely alone. That I am repulsive. That nobody wants to touch me. As if anybody who would touch me would also become a leper. That’s how I felt. At the hostel I received many phone calls, including from people with whom I was not particularly close. It was really weird. I felt that people were treating me as if I was going to die. They came scuttling out from their hiding places because they thought that if she dies, then afterwards I will regret not having spoken with her.*

Interviewees complained that at the hospital, the staff was afraid of patients with symptoms; therefore, patients were discharged and sent them home without getting checked, which impeded the ability to diagnose them on time. Interviewee M5 said:

*My wife took me to the ER. They didn’t give me a COVID-19 test. They conducted blood tests. They were afraid of touching me at all. They put me in some room out of the way. They discharged me in this condition. In the hospital they are afraid of approaching you, and so they don’t diagnose on time.*

2.2. 2 Theme: Contending with the Stigma and the Guilt

While they were ill, the interviewees were less conscious about contending with the guilt and anger from their surroundings, as they had to focus all their remaining strength on fighting the disease and getting better. This is how interviewee F1 described this:

*When they told me that my cousin had tested positive, at that moment I was just in the hospital with a high fever. At that particular moment, I really wasn’t interested. But she was mad at me. At that time, I felt really ill, and you get to a stage where you have no strength to deal with others. You don’t feel good, your entire being is focused on recovering.*

Interviewee F13 found another way of dealing with this:

*I come from the world of treatment, so I wasn’t concerned about what other people would think. At the beginning of the pandemic, the issue of the stigma was more present. For example, at the beginning, as a caregiver, I phoned people to see how they were. They replied: “I didn’t want to cause anybody to go into isolation, I am sorry that I caused people to enter isolation.” But it wasn’t your choice. You were infected. You are ill. This is not something that you order. There are people surrounding you that give you this feeling. For example, people say, “don’t make me go into isolation, don’t mention our names,” all these things. I think that a person should be extremely calm and in harmony with himself and should really know how to stand up to such statements. And we need to support the patients. We shouldn’t be accusing them. In the end, the sick will prefer to stay at home and will not go to be tested so that people won’t then say: “That family is a sick family.”*

**3. The Recovery Stage**

The interviewees who spoke of the recovery stage, some of whom even did so several months after being defined as “recovered patients,” talked about their lives having completely changed. They talked about a different reality. Most of them remained in a difficult state of mental health, beyond the physical symptoms that they were suffering from. They found it difficult to return to the life they had enjoyed before the disease. The disease had left them with traumas and scars, and half of them were trying to recover through emotional treatment and the use of anti-anxiety medication. The situation affects the family members, and above all the children. In this context, Interviewee M1 related:

*There is no such thing as a “recovered patient.” I still suffer and anyone who was infected suffers from dizziness, weakness, muscular fatigue, a sore throat, and breathlessness. Nowhere have I heard mention of the fact that people become depressed. I am still depressed. And people are not aware of this. This really must be made public. At night I feel a sense of pressure in my chest. This is the first symptom I felt when I was tested for corona. I still feel it, so much so that it wakes me from my sleep. So, when I go to work, I take Cipralex because I suffer from anxiety and fear becoming infected again.*

Interviewee F8 shared with us the anxieties she suffers from since having recovered:

*I explained to the doctor that these are not a case of anxiety. This is simply a person who is experiencing it, so he is afraid. I took all sorts of sedatives. I turned on the television and heard that somebody had been infected for a second time, and suddenly I felt a sensation of breathlessness. Consequently, I began to become depressed and afraid.*

Interviewee F3 consulted a psychiatrist:

*I was an extremely meticulously dressed woman. I used to go out and work, I was very active and never asked for help. So, I did not get embarrassed and went to see a psychiatrist. He said to me: “Listen, you are undergoing a very severe trauma and you need to get treatment for it. You are in a state of dependency that you need to accept and to process.”*

Interviewee F5 expanded on the trauma she had experienced and tried to explain the reasons for her anxiety:

*When I was in the hospital department, there was a woman next to me who died of corona. She died next to me. They left me with a dead woman in a closed room. And when you come back from a place like that... I was really down, I needed anti-anxiety medication. I was a very lively and happy girl. Not everybody would have been sufficiently mentally strong to remain alone for two and a half weeks in a room and listen to all the screaming and suffering. That is why there are so many people who still suffer from anxiety and fears.*

3.1 Theme: 3.1 Shame and Guilt

During the recovery stage the feelings of guilt and shame were transformed, as the interviewees begin to reflect about themselves and express regret for the harm caused to their family, and, above all, their children.

3.1.1 Guilt at the Harm Caused to the Family

Interviewees mentioned the feeling of guilt due to the harm caused to their family members. Interviewees M3, the head of a family who was ventilated and sedated told us:

*What hurts me the most is the family angle. The fact that several months went by without my family, the children slightly went off track, and this wouldn’t have happened if their father would have been at home. “They took advantage” of the fact that their father wasn’t home. Discipline was very lax and this hurts me the most. I don’t blame them. Being without a father and a guiding hand. They aren’t to blame and neither am I. It just came upon us, and it is hard.*

Interviewee F3 did not accompany her son on his induction to the army and she was unable to even find the strength to support him by phone.

*I was in isolation for two and a half months. I wasn’t with the children, I wasn’t with the family, I wasn’t with people at all. My son joined the army at that time. He told me just how difficult it was for him to understand that I wasn’t even available to answer his phone calls. He went to the IDF induction center alone, his little 11-year-old brother went with him... My little son grew up without a father. I am his entire world. He was unable to approach me for more than two months. I have no strength to speak to him on the phone. I lied to him that I am in hospital. Go and explain this to a kid: You cannot enter your house to be with your mother. I want to see what all the psychologists have to say about what you do in a situation like that.*

Interviewee F8 told us how her anxieties had an impact on the other members of the family:

*I am certain that I have caused damage to my children. As a result of the disease, I won’t let them bring friends home or go to their friends. My youngest son at kindergarten is automatically unwilling to play with friends because I was constantly convincing him that this was forbidden. My 18-year-old son wants to celebrate his birthday, he asked to sit with one friend in the garden. I told him that I won’t allow even half a friend to come here. And once my house was the most open house you could find. There were always guests at home. We were always awake. All the time laughing and having fun. Today, there is absolutely no way I will go out of the house.*

3.1.2 Increased Use of the Health Services

Many interviewees stated that before they became ill with COVID-19, they never even went to the clinic, and that COVID-19 had made them extremely anxious about their state of health. For example, interviewee M4 related that prior to contracting the disease, he was not even aware that a branch of the HMO had opened up near his home, and now he is fully familiar with the entire staff at the clinic:

*I have now become aware that we have a clinic near our house. That a branch opened under my very nose and I knew nothing about it. And why wasn’t I aware of it? Because I wasn’t in a situation in which I needed to know. I didn’t know who the people were who worked there, and now I know them only too well.*

Interviewee M6 added that now he constantly undergoes tests, some of them probably out of anxiety: *“Before the corona, I would hardly ever go to the doctor. And today, for every stupid little thing I phone the doctor, I ask him, and take tests. I am stressed out. I check myself all the time.”*

Interviewee F8 now feels uncomfortable about going to the clinic:

*On many occasions I say enough, I really have had enough. I feel extremely uncomfortable about going to the clinic. They must think that I am stupid. That I am bothering them once again [laughing]. But it really does hurt me. I go to the clinic every week. I think that I am having a heart attack. Each time they have to give me an ECG test. They tell me that there are palpitations but nothing is wrong with you. Today, I scheduled an appointment for a mammography, for no reason, I am 44. I schedule appointments for no real reason. I am dying to go to the gynecologist, but I won’t go due to the fear that she might have touched somebody with COVID-19... I wake up a lot at night. Once, I used to be a real sound sleeper. Nowadays, all you have to do is go “like this” and I wake up. All this is due to anxiety.*

3.2 Theme: Stigma

3.2.1 Exclusion of the Recovered Patient

Most of the interviewees (90%, n=18) reported that they felt stigmatized and excluded by their surrounding environment after they had recovered. They described how people were reluctant to be in contact with them and stayed away from them. They used descriptions of people who were “socially shunned.” Ostracized, shaming, fear, escape, repulsion, distancing, shame, and the phrase that was repeated by all of them: “They turned me into a leper.” Notwithstanding, the interviewees understood the feelings of those surrounding them and regarded them to be “natural” and tried not to be judgmental:

*People were afraid of being around me. I was like a leper for many people. They were scared. Keep your distance from me just a bit. Or they didn’t want to touch things that I had touched. That is natural, but it is an extremely unpleasant feeling all the same. Of being a leper. They don’t want to get close to you. Because nobody knows what this disease is. So people are really scared. Truth be told, I did understand them.* (M6)

Interviewee F4 told us of the need to be on the defensive all the time and to “take preventive action”:

*Lots of people won’t come near me. When I came out of isolation and everything, people still maintained their distance. They were afraid that I was carrying corona around with me. And I would say: Hey everybody, I am after two negative tests. Unfortunately, I automatically felt the need to be on the defensive. You can’t be otherwise. There are many recovered patients who feel like lepers. Who take it very hard. I immediately tell them, listen up everybody, I am negative. But this is legitimate. I understand them. No one wants to get in trouble or lose a relative or enter isolation.*

Interviewee M7 told us of the children’s experiences, and stressed the need for explanatory publicity:

*I know a girl who contracted COVID-19 and they subjected her to shaming and sent her WhatsApp messages, and I think that much more positive, explanatory publicity is needed for children. Adults can cope with this. Children who are the victims of shaming and ostracization find it difficult to cope. It is necessary to engage in a program of explanatory publicity in educational institutions to underscore the fact that those children are not guilty. Whoever is infected did not want to be. That is fate. It is not something done on purpose. And he is not ill with leprosy. He is ill with corona*.

Interviewee F12 did not leave her home for a long period of time after she recovered, due to fear of the response of those surrounding her. Precisely where she needed support, she felt rejected. This caused her to reflect and think how she had judged COVID-19 patients and had accused them before she became ill herself.

*It took me time to leave home because I was afraid of people’s reactions. And even after I left, people still looked at me in a weird fashion and stayed away. It was very unpleasant. They look at you as though you are defective. People were still concerned about being around me. I felt spurned. As if all of a sudden these are not the people that I know. Instead of support and understanding, I felt rejected by people and shame. I began to think how I had reacted to COVID-19 patients before I became ill and just how wrong it is to look at an ill person and blame him for this, as you can never know where it will take hold of you during your lifetime.*

Interviewee F2 told how she herself had kept her distance from people after she recovered:

*I was scared to death of leaving the hostel. The day before I left, I couldn’t stop crying. I received all sorts of responses, ostensibly as a joke: “I won’t risk meeting with you, sorry sister, if I have to go into isolation one more time, they’ll have to put me in Abarbanel (mental hospital).” So why should I go out if people don’t want to get close to me? It made me feel really bad. Wasn’t it enough that I was 17 days alone, away from everybody, now I have to continue with my “aloneness” outside? And then, when I came home, I kept my distance from my parents and brothers. I myself didn’t want to come near to them. I was afraid for them. People made me stressed. It was also strange for me suddenly to come near them. In the hotel, everybody was ill, and we were very close, hugging each other... But outside, I still felt bad. I did not return to work straight away. I spent another month at home. I was afraid to return, and the truth is that they didn’t want me back there either. Legally speaking, they simply can’t tell me not to come back to work. But I sensed a vibe of “stay at home and rest.” I took it really personally, I was very emotional and I took everything to heart and cried over everything.*

She continued to share with us tangible experiences of shaming that she experienced.

*A male friend saw me at a cafe, I was waiting to go in with a girlfriend who is also a recovered patient and then he said to me: “What, that’s it? You’re negative?” I didn’t lie. I told him in a positive tone: I am not negative, but I am not infectious... He shouted at all those waiting to enter the cafe, “what do you mean positive but not infectious?” I saw people sitting on the sofa, they lifted up their mask and moved to the other side of the room. I started to cry. That really finished me off. I said that I don’t want to talk. I left him. Afterwards we went to the restaurant where I work, and my manager joked: “So you’ve come here again to infect everybody?” I didn’t really think it was amusing, so I ignored him. Then, one of the waitresses saw me at the entrance and said, “Oh my God”, she put her hand on her chest and took three paces back. I said to her: Have you seen a monster here? I couldn’t understand her exaggerated response and her cry of “Oh my God.” I sat at the table crying, tears in my eyes. A girl friend who works at the restaurant came over and hugged me. She said to me: “Don’t pay attention to that stupid girl, everything is fine.” At that moment I said that I wanted to return to the hostel. There nobody related to me in that way. At the end of the day, all that had happened was I contracted COVID-19. I hadn’t sprouted antennae or something like that.*

Interviewee F3 shared with us how the stigma was even passed on from her to her young son, as now other mothers are deliberating as to whether they should invite him over to their homes.

*Everybody saw how a large number of ambulances came to this house, so they clearly understand that there was a problem here. So, the neighbors keep their distance. And close friends also stay away. I wanted to speak with a neighbor, and I saw that he began to retreat. I want to run my child over to a friend, but his mother says: “I understand that you were ill, I’m not really sure.” Then I realize that I myself have a problem as I begin to panic that the children should not be infected nor infect me once again.*

Interviewee F7 was filmed for a Ministry of Health publicity campaign broadcast and was subsequently the victim of shaming on the social media:

*I was filmed for a Ministry of Health publicity broadcast that was extremely successful and advertised everywhere. There was an abundance of nasty responses: “You are an actor, you are a liar, you are reading from a text, it*’*s all nonsense, you must have received lots of money. At the beginning, all this really made me cringe. I thought that everybody would say, well done! In retrospect, it turns out that on the day the advert shooting was to take place, there were a number of people who canceled, because they heard that following the previous campaign, those who took part suffered from much abuse and shaming.*

* + 1. 3.2.2 Contending with the Stigma – Attempt to Return to Normal Life

Eventually, the interviewees managed to gain some closure. Although they still suffer and experience anxiety, they are trying to rehabilitate themselves in various ways and mainly seek to break free from the thoughts of “Why of all people did this happen to me?” They are trying to return to normal life and remain that way, to break free of the shame and the guilt, even if most of them are still in a state of trauma. For example, interviewee F2 shared the following with us: “*I changed my approach. Whoever does not wish to come near me, may stay away. I will go wherever I desire, if you do not want to go to those places, go into my story and you will be able to see that I am there, so’just don*’*t come by.”*

Interviewee F10 added insights regarding the COVID-19 pandemic, that occurred mainly among religious interviewees. Insights regarding God’s role in bringing the pandemic into the world so that people should gain proportions and become better persons.

*The fact that people kept their distance had a greater impact on my husband than on me. I am not a judge. While it does hurt, I understand that people are afraid of you. Today I no longer let this preoccupy me. Two months really finished me off. I was completely crushed. I would see just how people look at me outside. People were shocked to see that we were ill with COVID-19. It was a real slap in the face for everybody. For anybody who contracts COVID-19, it is like being punched in the face. But I think that for us, it is a much more powerful blow. It’s as though we have a sort of slight superiority, a type of hidden pride that it won’t happen to us. And then, when it does occur, it spins you around 360 degrees. I will tell you: You are nothing, you are absolutely not like everybody. Even if you are an observant Jew and genuinely a good and very spiritual person. It still made all of us delve down extremely deep to engage in profound contemplation. It was both Yom Kippur (the Day of Atonement) and Sukkot (the Feast of Tabernacles) wrapped into one; these are the festivals of introspection and soul-searching. What you’d call really deadly timing... We are people with profound belief, we believe that it is from God, that we had to undergo this and say thanks to our Maker. If we really want to take the good things that the corona has brought with it, we need to understand that this was an act of God. The Jewish people did not experience this for no reason. The entire world did not experience this for no reason. God brought the corona to make a better world.*

Interviewee F8 shared with us how, despite her fears, she is trying to cling on to life, so as not to let her anxieties take over her and kill her from within.

*Everybody thinks that I am undergoing a trauma because of this and that I have gone mad, but this is not the case. It is because of what I went through that I am scared to death. The kindergarten teacher told me to cut the child some slack, so yesterday, I took him to the park. I am trying. I am working on myself a lot. I say that whatever will be will be. You can’t just stop living. It is either you actually die or you die inside.*

**Discussion**

The isolation required from people infected with COVID-19 is not only a physical barrier, but one leading to social isolation and stigmatization. As a result of the physical limitations imposed on those contracting the disease, the accompanying process of stigmatization is all-encompassing and begins at the stage of discovery of the virus, and continues throughout the duration of the disease and the recovery stage. The social dynamics accompanying the process of stigmatization include feelings of guilt, shame, exclusion and, on occasion, even humiliation. These findings are consistent with the discussions in the literature on the implications of the stigmatization processes for people with disabilities or suffering from chronic diseases (Whittle et al., 2017). The literature indicates that stereotypes are a means of reducing the cognitive burden of dealing with complex situations. They help their holders reduce perceived information into manageable information, thereby helping to understand a predictable social world (Snyder & Miene, 1994). Throughout all the interviews, it could be seen that during interaction with the environment, the interviewees internalized the stigma imposed on COVID-19 patients. In the process of self-stigmatizing, they feared the reactions of the environment and feared sharing that they had contracted the disease. The duty to report this to others so that they might enter isolation forced them to deal with the environment, and caused them feelings of shame and guilt. Even if they did not necessarily experience direct and abusive negative reactions, they internalized the reactions they feared; so, whoever was able to hide the fact that he or she was the one responsible for causing others to enter into isolation, duly hid it.

But the COVID-19 pandemic and the findings in this study indicate the existence of stigmatization and stereotyping also in the case of an emerging pandemic. In contrast to stigmatization of stable medical conditions, such as chronic or mental illness, those people suffering from the stigmatization from falling ill with COVID-19 had nobody to turn to who would take care of their emotional welfare. There were no support groups and no public mechanism that tried to balance the fear from infection and being located near people suffering from COVID-19 with an emotional and social publicity campaign. In fact, we might have expected that the very issue of universal exposure and the vulnerability of the entire population to the pandemic would actually lead to greater understanding and acceptance of those who had been infected. The shared, common fate did not lead to the development of feelings of social solidarity and support for the sick and those infected. Classic theories of social solidarity indicate that it is precisely during times of emergency that social cohesion is created, a feeling of a common fate and mutual responsibility (Durkheim, 1897). The outbreak of the COVID-19 pandemic led to the opposite result. It was precisely during the COVID-19 pandemic that the lines of social difference became stronger and clearer. This lack of a feeling of solidarity might have also derived from the approach at the state level that adhered to a policy dubbed “**vaccination nationalism**” (Wong et al., 2021), whereby instead of contending with a global pandemic on the level of the shared international fate, competition was generated among the various states, a sort of “arms race” to obtain the vaccine. This policy characterized the Israeli approach even before the vaccines had been developed and it was manifested, for example, in the clandestine efforts to obtain medical equipment after the onset of the pandemic without taking into consideration its international dimensions, by making a distinction between the situation in Israel and the situation in the territories under Israeli control in Judea and Samaria. Such a policy, though perhaps not directly, eventually leads to a concept of “Me and nobody else,” the atomization and disintegration that constitute fertile ground for processes of stigmatization and othering. At the beginning of the pandemic, in Israel, just as in other countries around the world, the stigmatization process underwent changes and was dynamic. If at the beginning, the disease was perceived as having been imported from abroad, it was foreign patients mainly from the Far East who were exposed to the experience of stigma and racism. The more the disease spread across Israel, the more the stigma began to undergo transformation, as we have seen in the results of the study before us.

**Limitations of the Study**

Despite the limited sample due to the difficulty in reaching interviewees, we did manage to maintain a mix of interviewees of different ages, marital status (unmarried, married and one-parent families), different geographical areas within Israel, different levels of religiosity and different religions. Moreover, as is the accepted norm in qualitative research, we completed the interviews once we had reached theoretical saturation.

**Conclusions**

The COVID-19 pandemic led to the announcement of global health-related states of emergency. The outbreak of the pandemic, coupled with the rapid pace of its spread and the damage it caused to the overall population, constitutes a catalyst for the feelings of fear and dread. History teaches us that pandemics were the cause of pogroms and atrocities against minorities, particularly those suspected of having spread the disease. The COVID-19 pandemic, too, generated ugly phenomena of racism (“the Chinese flu” as President Trump referred to it), and exclusion. The condemnation of these phenomena was extensive and comprehensive in many places around the world. However, along with these severe phenomena, a much “quieter” process of stigmatization of COVID-19 patients and recovered patients themselves took place. This process is the result of the totality and dramatic nature of the emergency measures adopted by the state and its authorities to contend with the spread of the pandemic. However, the study here indicates that the phenomena of stigmatization are broader and more all-encompassing, and the damage they cause is greater. We are optimistic that additional studies of a broader scope will be conducted in other countries as well and will thus be able to raise awareness among decision-makers as to the cost of emergency measures adopted to safeguard public health. Alongside such measures, the authorities should also offer emotional support frameworks for the victims of those stigmatization processes that accompany outbreaks, such as that of the COVID-19 pandemic.

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