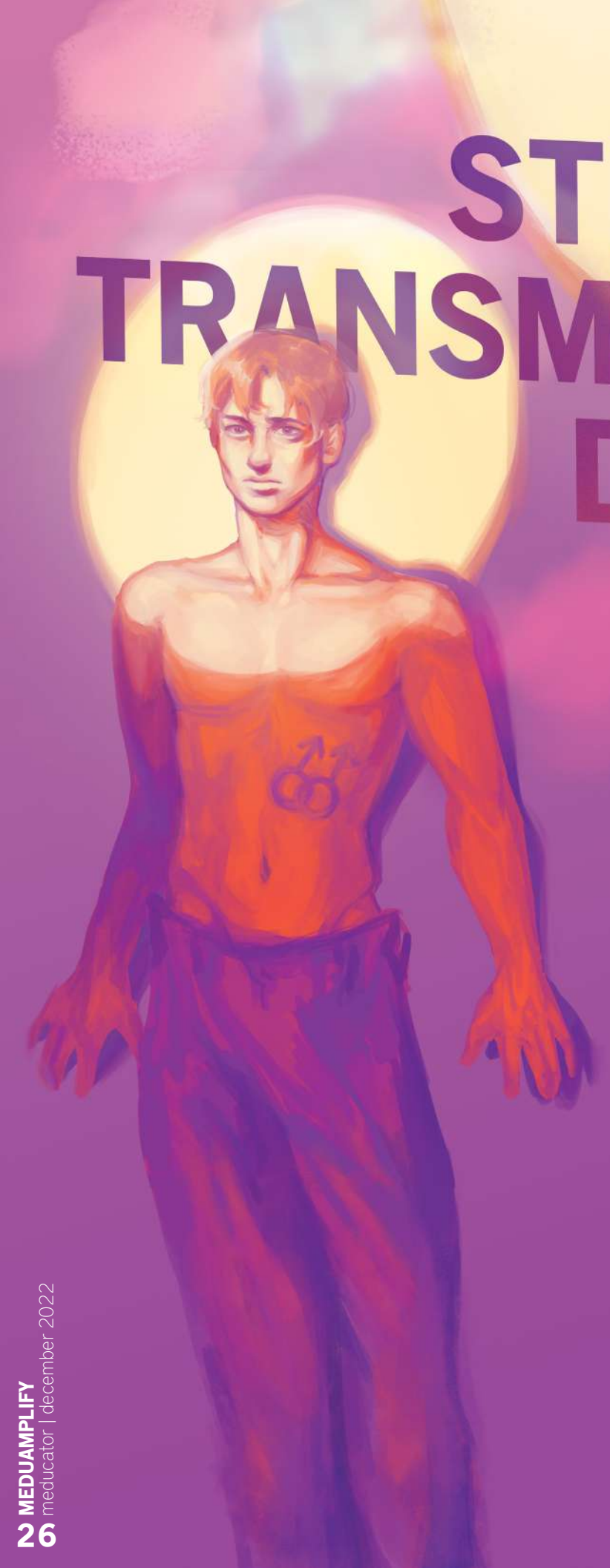
STIGMA IN TRANSMISSIBLE DISEASE



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AUTHORS:
ANNA MCCRACKEN [1], AUDREY DONG [2], & FLORENCE DENG [2]
[1] Bachelor of Health Sciences (Honours), Class of 2025, McMaster University
[2] Bachelor of Health Sciences (Honours), Class of 2026, McMaster University

ARTISTS:
MISHAL HOSSAIN [3] & ELAINE WANG [3]
[3] Bachelor of Health Sciences (Honours), Class of 2026, McMaster University

INTRODUCTION

In the context of public health, stigma is defined as a negative stereotype towards a group of people in relation to a disease. Stigma most often manifests as stereotyping, isolation, harassment, and refusal of service.[1] These behaviours are more likely to occur in pandemic and epidemic settings, as fear and anxiety perpetuate stigma during these times.[2] Beyond its social implications, stigma can have negative repercussions on disease mitigation strategies. This was highlighted by a meta-analysis of 21 studies which found that human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) stigma has an inverse correlation with HIV/AIDS disclosure.[3] Thus, stigma is a substantial obstacle in controlling disease outbreaks and significantly reduces compliance with public health measures.

AN OVERVIEW OF STIGMA

Stigma-imposed discrimination deprives an individual or group from full social acceptance. This limits one's access to resources, fuelling social inequalities.[4] A helpful way to conceptualise and apply the mechanisms of stigma onto past,

present, and future epidemics is to generate a framework that addresses both sociological and psychological contributors.[5] Through this method, intervention development, research, and public policy may be implemented to mitigate the detriments of stigma on society.[6]

Bruce Link and Jo Phelan conceptualise stigma using a framework that begins with labelling people based on their differences.[5] Observing differences is human nature, but the differences deemed societally notable are dependent on an individual's social environment. For example, sexual orientation is a noteworthy difference in the United States, whereas other differences —such as being double jointed— are less striking in our social context.[5] In the Link-Phelan framework, undesirable characteristics become attributed to certain groups. Especially in epidemic and pandemic settings, groups may become associated with the origin of disease, leading to marginalisation. The separation of "us" from "them" creates a dehumanising narrative, leading to status loss and discrimination.[5]

From a sociological standpoint, Stangl et al. provide another framework to conceptualise the stigmatization process by dissecting the phenomena into domains consisting of drivers and facilitators, stigma 'marking,' manifestations, and outcomes.[7] Drivers of health-related stigma consist of disease avoidance, social and economic reparations, judgement, and blame, and facilitators further enable stigma through cultural norms and health policy.[8] Individuals and groups are marked by their differences as health condition-related stigma intersects with race, gender, class, and sexual orientation-related stigma.[9] Labelling theory and social network theory could then manifest as discrimination, internalization, and prejudice.[10] As a result, stigma is ingrained within affected populations and institutions in the form of policies, accessibility to healthcare, and advocacy.[8]

Thus, stigma is crucially dependent on power as it enables the manipulation of resources and reliability to one's benefit.[4] Link-Phelan's framework summarises the intentions of stigma reinforcement as exploitation, norm enforcement, and disease avoidance.[5] The framework of Stangl et al. outlines the institutionalisation of stigma as being primarily reinforced by drivers and facilitators.[7]

STIGMA IN TRANSMISSIBLE DISEASE

Link-Phelan's framework can be applied to the emergence of HIV/AIDS —a disease with long-standing impact on the LGBTQ+ community— in the 1980's.[11] The Stonewall riots of 1969 and the modern gay rights movement led to the initial establishment and increased visibility of gay culture in the United States.[12] In accordance with the Link-Phelan framework, this interpersonal difference was deemed notable due to homophobia in the US.[5]

When HIV/AIDS was first clinically observed in 1981, it primarily affected homosexual men, and was briefly called gay-related immunodeficiency disease (GRID).[11] Some speculated that HIV/AIDS was caused by "lifestyle issues" that were being associated with homosexuality.[13] Marshall Forstein, a Boston physician and openly gay practitioner at the time of the first outbreak, served as Chair of the Steering Committee on HIV/AIDS for the American Psychiatric Association.[12] He recalls public figures engaging in extreme anti-gay discourse, funeral homes refusing the bodies of HIV/AIDS-positive men, and religious figures asserting punishment for "unnatural behaviour."[12] Over time, the case demographics of HIV/AIDS have changed. The stigma that homosexual men faced in the 1980's infiltrated communities who have been denigrated by society, often with discriminatory tone. Disproportionately affected groups include women of colour, gay and bisexual men of colour, and intravenous drug users.[11] It should also be noted that in 2018, 33.4% of all HIV/AIDS cases in Canada were a result of heterosexual sex, although stigma surrounding the disease remains.[14] This is illustrated by a study conducted in 2017, which found that 41% of healthy participants would feel ashamed upon an HIV/AIDS diagnosis, highlighting the dangerous outcomes associated with disease stigma.[15]

More recently, COVID-19 is an additional example of stigma associated with transmissible disease. COVID-19 first emerged in late 2019 in Wuhan City, China. In early 2020, the virus began spreading globally, transducing a wave of stigma with it.[16]

The media placed emphasis on Wuhan as the origin of COVID-19, establishing association of the disease with the Chinese community.[17] As the virus spread, non-East Asian people began openly expressing their xenophobia, attributing hate-driven characteristics to East Asian people. This subsequently isolated these communities from society, and in congruence with the Link-Phelan framework, separated "them" from "us."[5, 17] The result of this stigma was startling. In a Canadian statistical review with over 43,000 participants, it was found that perceived harassment and attacks based on race, skin colour, or ethnicity since the start of the COVID-19 pandemic were three times as frequent in visible minorities than in the rest of the population.[18] The reported increase in these discriminatory actions was most pronounced in Chinese (30%), Korean (26%), and Southeast Asian (19%) participants.[18] In Montreal, there were reports of Asian-Canadians being denied medical services with responses such as, "Go back to China," or "Take the virus back."[16] The thousands of anecdotal assaults in the literature highlight the discrimination and violence that afflicted the East Asian community as a result of social stigma.

CONCLUSION

Eliminating stigma requires both individual and institutional changes. The reconstruction of public health approaches towards transmissible diseases can target stigma occuring on a wider scale. Governments may collaborate with community-based advocacy organisations and social service providers to develop a comprehensive assessment of the structural, behavioural, and social vulnerability of marginalised groups.[19] First-hand insight from marginalised populations allows for the design and execution of case finding, contact tracing, and prevention to prioritise vulnerable communities.[19] In Canada, the Chief Public Health Officer, Theresa Tam, has taken initiative to address the prevalence of stigma. A 2019 report summarises the overall health of Canadians and how populations experience healthcare services differently as a result of stigma.[20] In sparking public discourse and awareness, first steps are being taken. Working jointly with community-focused groups will also increase accessibility of primary risk reduction programs for marginalised groups, many of whom also lack equitable access to healthcare resources.[19]

Individual mindfulness regarding the usage of more considerate and unbiased language when conversing about transmissible diseases can reduce segregation of a group of people, connection of them to a disease, and implication of blame on the stigmatised for their membership in the group and associated disease.[21]

Volunteering in organisational efforts to reform social and prevention programs can aid in the minimization of stigma in local communities through improving access to health services.[22] As the dynamic landscape of transmissible disease inevitably continues to shift, although stigma remains ingrained in healthcare systems and diseases, it can be rectified through institutional and personal efforts combined with proper education.

REVIEWED BY: DR. ALBINA VELTMAN (MD, FRCPC, M.A.)

Dr. Albina Veltman is Associate Professor of Psychiatry at McMaster University. From 2013–2016, she was the Inaugural Chair of Diversity and Engagement for the Undergraduate Medical Education Program at McMaster. Her clinical focus in psychiatry is on traditionally marginalised groups, including those with persistent severe mental illness, intellectual disabilities, and the LGBTQ+ community.

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