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## COUNTERING STIGMATIZATION IN THE HUMANITARIAN RESPONSE TO COVID-19

Protection Working Group—With unique contributions from Humanity & Inclusion, HelpAge International, Jesuit Refugee Service, Refugees International, Translators without Borders, Save the Children, War Child Canada, SAMS, and InterNews.



## WHY SHOULD HUMANITARIANS PROACTIVELY COUNTER STIGMA?

The societal stigma attached to certain people or demographic groups based on their perceived attributes or their role in society leads to pervasive and overt discrimination. It can also lead to violence and exclusion that limits access to basic services and humanitarian assistance. During health crises, societal stigma often takes root and proliferates rapidly. This was the case during both past Ebola outbreaks and the HIV/AIDS epidemic.<sup>1</sup> Indeed, humanitarian and other first responders have identified stigma as a key challenge in the rapidly expanding global COVID-19 crisis. It is, therefore, critical that humanitarian organizations integrate strategies to counter stigma in the COVID-19 response. These strategies may also pave the way to improve how stigma is prevented and addressed beyond this pandemic.

The conceptualization of stigma identifies four interacting elements: anticipated, perceived, experienced, and internalized stigma.<sup>2</sup> COVID-19 has been associated with all of these elements of social stigma. People have modified their actions because of fear of being discriminated against, for example, by avoiding testing for COVID-19 (anticipated stigma); patients and their families have felt judged by others (perceived stigma); household and community members have excluded, isolated, or discriminated against infected or exposed persons (experienced stigma); and some patients have felt shame and self-rejection (internalized stigma).

Persons at risk of or infected with COVID-19 may experience intersecting stigma when they also belong to a marginalized community or group such as older people, persons with disabilities, women and girls, ethnic minorities, or displaced populations.<sup>3</sup> COVID-19 has an outsized impact on these groups. They often face compounded labeling, status loss, exclusion, and lack of access to services due to intersecting identities and harmful State policy and practice toward them. Harmful rumors, hate speech, false narratives propagated rapidly and widely via social media, and word-of-mouth often reinforce preexisting stigma. The rapid spread and the highly contagious nature of COVID-19 have further increased this xenophobia and stigma against marginalized populations.

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<sup>1</sup> Mariam Davtyan, Brandon Brown & Morenike Oluwatoyin Folayan. (2014). Addressing Ebola-related Stigma: Lessons Learned from HIV/AIDS, Global Health Action.

<sup>2</sup> Sotgiu, G., & Dobler, C. C. (2020). Social stigma in the time of coronavirus disease 2019. *European Respiratory Journal*, 56(2), 2002461. <https://doi.org/10.1183/13993003.02461-2020>.

<sup>3</sup> Ibid.

The complexities of humanitarian crises further exacerbate the impacts of stigma on these communities. During humanitarian crises, people’s vulnerabilities often stem from stereotyping, marginalization, and exclusion from care arising from discrimination along racial, ethnic, linguistic, religious, cultural, sexual identity, disability, and political lines.<sup>4</sup> Therefore, stigma will disproportionately affect people with intersecting vulnerabilities. The consequences of this stigmatization will continue long after the COVID-19 public health crisis ends.<sup>5</sup>

The following report highlights key findings and recommendations outlined in a webinar and roundtable event hosted by the InterAction Protection Working Group in July 2020.<sup>6</sup>

## IMPACTS AND CONSEQUENCES OF STIGMA

### OVERVIEW

As COVID-19 takes hold in countries worldwide, some measures governments and humanitarian organizations have put in place in response to the pandemic have created negative externalities. Several of the most pressing include the disruption of service provision, difficulty accessing healthcare, increased isolation of vulnerable individuals, and exacerbated societal stigma of older people, people with disabilities, and displaced communities—especially refugees and asylum seekers.

The spread of misinformation and the associated anxiety caused by lockdowns, and the many uncertainties related to COVID-19, have fueled discrimination and violence against vulnerable people.<sup>7</sup> For example,

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<sup>4</sup> United Nations of Human Rights Office of the High Commissioner. (1965, December 21). International Convention on the Elimination of All Forms of Racial Discrimination. Retrieved from <https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx>.

<sup>5</sup> Danzhen You, Naomi Lindt, Rose Allen, Claus Hansen, Jan Beise and Saskia Blume. (June 2020). [Migrant and displaced children in the age of COVID-19](#).

<sup>6</sup> In July 2020, members of the InterAction Protection Working Group organized a webinar [Countering Stigmatization in the Humanitarian Response to COVID-19] during which four panelists shared their expertise. More information on the webinar along with the [recording can be found here](#). Following the webinar, the Protection Working Group organized a roundtable event with the same title to provide a forum for InterAction members to discuss stigma more in-depth and further the findings of the webinar. The Working Group invited interested individuals and organizations working on the COVID-19 response to discuss how stigma is impacting humanitarian responses. Members expressed a desire to collectively discuss best practices, key challenges, and ways forward. Three breakout groups discussed: (1) Marginalized Groups (Older People and Persons with Disabilities) facilitated by HelpAge and Humanity and Inclusion; (2) Mental Health and Psychosocial Support facilitated by Jesuit Refugee Services (JRS) and Save the Children; (3) Misinformation and Language facilitated by InterNews and Translators without Borders (TWB).

<sup>7</sup> Sotgiu, G., & Dobler, C. C. (2020). Social stigma in the time of coronavirus disease 2019. *European Respiratory Journal*, 56(2), 2002461. <https://doi.org/10.1183/13993003.02461-2020>.

governments have scapegoated displaced people as political leaders seeking politically convenient distractions from domestic issues, thus increasing the risk of violence and discrimination against them. The “us versus them” type of fear-mongering is common in epidemics and is a key feature of the current COVID-19 pandemic. As a clear byproduct of this, governments have increased movement restrictions and access to asylum procedures, for example, in the United States, Lebanon, and Greece.<sup>8</sup>

The humanitarian community has learned from previous epidemics, such as HIV/AIDs and Ebola, that stigma contributes to a lack of access to health treatment and high isolation levels. This reality has already materialized for communities experiencing the COVID-19 pandemic. Stigma often drives people to hide illness and prevents them from seeking treatment. To address the spread of COVID-19 and support communities to manage and mitigate risk, it is essential that the humanitarian community—including governments, humanitarian organizations, civil society organizations, service providers, and other relevant stakeholders—take action against the dangerous spread of stigma. This cannot be done through punitive or aggressive approaches that further sow distrust and alienate communities. It requires engagement with vulnerable communities and a genuine openness to listen to their concerns and priorities. As one roundtable participant said, “We need to shift the power paradigm of programming, iterating in partnership with clients and reshaping how we design, implement, and monitor programs.”

In refugee and internally displaced persons (IDPs) hosting communities, societal stigma against displaced people has skyrocketed and become more deeply entrenched. One key reason is that COVID-19 is so highly contagious. The pandemic has exacerbated already existing xenophobia and fear of the “other.” In some circumstances such as in Bangladesh, host communities have blamed displaced communities for introducing the virus, thus exacerbating tensions in places that struggle to maintain social cohesion.<sup>9</sup>

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<sup>8</sup> Reidy, E. (2020, September 01). Briefing: The halting of asylum at the US-Mexico border. Retrieved from <https://www.thenewhumanitarian.org/news/2020/06/29/Mexico-US-coronavirus-mass-expulsions-asylum-halt>.

<sup>9</sup> Carvalho, R. (2020, September 13). Rohingya refugees in Bangladesh struggle with fear and stigma amid coronavirus. South China Morning Post.

The humanitarian ecosystem has widely recognized the phenomena of stigma, resulting in several strong guidance notes taking stigma into account in the COVID-19 response.<sup>10</sup> However, a more comprehensive effort is needed to address different manifestations and consequences of stigma at multiple levels. The only way the humanitarian community can effectively counter stigma is by anticipating and preparing for the potential ramifications.

## 1. Reduced Access: Changes in Health Seeking Behavior

Stigma toward vulnerable communities leads to a deterioration of the overall protection environment. It also disincentivizes people to engage in health-seeking behavior, which is crucial to controlling the pandemic. When people feel stigmatized or ostracized in their communities, they are less likely to seek out social services, humanitarian aid, or health treatments, including testing and care for COVID-19.

Access to stigmatized groups can be challenging in any humanitarian context and has become increasingly difficult due to pandemic related restrictions. Face-to-face mental health and psycho-social services (MHPSS) and protection services have declined or ceased due to a lack of adequate personal protective equipment (PPE) and movement restrictions. Remote services via radio or phone can serve as temporary solutions but limits comprehensive care, and many vulnerable populations lack access to a radio or phone. Further, when service providers cannot meet people in person, it is more challenging to detect protection risks, such as child abuse or exploitation and sexual and gender-based violence (SGBV).

Humanitarian actors are often unprepared to adapt existing services to be inclusive of persons with disabilities. In Jordan, for example, 88% of persons with a physical impairment and current medical needs reported that they could not go to the hospital for their regular checks or additional medical needs. Humanity & Inclusion has also reported that hospitals in Yemen can only accept emergency cases, so people with asthma or chronic heart disease cannot receive care.<sup>11</sup>

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<sup>10</sup> IFRC, UNICEF, & World Health Organization. (2020, February 24). Social Stigma associated with COVID-19: A guide to preventing and addressing social stigma. Retrieved from [https://www.unicef.org/media/65931/file/Social%20stigma%20associated%20with%20the%20coronavirus%20disease%202019%20\(COVID-19\).pdf](https://www.unicef.org/media/65931/file/Social%20stigma%20associated%20with%20the%20coronavirus%20disease%202019%20(COVID-19).pdf).

<sup>11</sup> Handicap International - Humanity & Inclusion. (2020, June 25). COVID-19 in humanitarian contexts: No excuses to leave persons with disabilities behind! Evidence from HI's operations in humanitarian settings - World. Retrieved from <https://reliefweb.int/report/world/covid-19-humanitarian-contexts-no-excuses-leave-persons-disabilities-behind-evidence>.

While already marginalized and stigmatized individuals are often unable or unwilling to access the services they need, COVID-19 has also disrupted global health systems overall. In humanitarian crises where health services are already limited and of low quality, the focus on COVID-19 will likely reduce other essential health services, especially for women and girls. These services, including family planning, clinical management of rape, and psycho-social support for survivors, should not be disrupted. Further, the risk of stigma leads people to be hesitant to seek health services regardless of their availability. Anecdotes from Iraq of people not being welcomed back into their homes after being tested or people facing violence for seeking COVID-19 related treatment send a dangerous signal.

## 2. Marginalization: Older People, Persons with Disabilities, and Women

COVID-19 has exacerbated the underlying vulnerabilities of marginalized communities. Older people and persons with disabilities often have intersecting vulnerabilities and face multiple levels of marginalization and stigma, which are further heightened in situations of displacement. De-prioritization of care, inaccessible information and services, and isolation are compounding existing discrimination toward these groups during COVID-19.

Older people, persons with chronic health conditions, and people of all ages with disabilities often have more health service and care needs than others. Therefore, they are more susceptible to the impact of low quality or inaccessible and inadequate medical care, in addition to the increased risk they face of contracting the virus itself. In a rapid needs assessment Humanity & Inclusion recently undertook in Haiti, households of people living with disabilities reported that the discrimination and stigma against them have been especially intense toward them and their families amid the pandemic.<sup>12</sup> For example, some Haitians refer to people with disabilities as “already being dirty and sick” (see more on linguistic markers of stigma in section 4).

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<sup>12</sup> Ibid.

Similarly, in China, a young man with cerebral palsy died when he was left alone for a week while his father and brother—his sole caregivers—were forced to quarantine in another location. Furthermore, women with disabilities already face higher rates of SGBV than their non-disabled peers. Lockdowns during the pandemic have forced women to stay home with their abusers and without access to protection.

Participants of the roundtable also shared examples of countries that have instituted harmful regulations targeting older people and people with disabilities under the guise of COVID-19 prevention. For instance, a regulation in Bosnia prohibits people over 65 years old from leaving the house. Age-based measures that isolate older people for long periods are harmful to their dignity and well-being. This can leave older people with little access to healthcare; care and support; work; food; and other means to support themselves.<sup>13</sup> Singling out older people and persons with disabilities reinforces ageist, discriminatory, and false stereotypes that they are weak and vulnerable. This impacts entire communities, preventing older people and persons with disabilities from performing the multitude of essential roles they have in society.

Economic factors are also inexorably linked to the continued isolation and marginalization of at-risk communities. Economic challenges can affect at-risk communities' ability to practice prevention measures because of the lack of adequate hygiene supplies and infrastructure and the inability to be socially distant because of living situations or other socioeconomic factors. When already marginalized communities do not take adequate COVID-19 prevention measures, backlash and stigma from the broader community increase, resulting in greater isolation.

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<sup>13</sup> HelpAge International. (2020). COVID-19: Age-based measures coming out of lockdown. Retrieved from <https://www.helpage.org/what-we-do/covid19-agebased-measures-coming-out-of-lockdown/>.

### 3. Isolation: Mental Health and Psycho-Social Distress

The COVID-19 pandemic has been widely described as a global mental health crisis, in addition to the

Sofia is a Syrian refugee in Jordan. She has back pain and severe knee pain, which limits her mobility. Sofia has developed new symptoms during the lockdown, such as hypertension. Her doctor attributes the degradation of her health to the stress she experienced during the lockdown period. She came to Jordan with her 21-year-old nephew, Ahmad, who has a psychosocial disability for which he receives psychosocial support and medication regularly from Humanity & Inclusion and partners. Since the lockdown, Ahmad has not been able to get this support, which has affected his stress and behavior.

physical toll it is taking. Stigma related to mental health and COVID-19 can exacerbate preexisting conditions or lead to new mental health and psycho-social problems for individuals, families, and communities. One of the biggest threats posed to people's mental health and psycho-social well-being is increased isolation because of COVID-19 related stigma. This is significant because isolation can exacerbate psycho-social problems and lead to mental health issues like stress, anxiety, and depression. This is increasingly problematic as people with mental health and psycho-social problems already faced access barriers pre-pandemic, including those

linked to stigma, which are now exacerbated. In most contexts, the social stigma of mental health problems exists due to a lack of awareness or understanding of the complexities and realities of mental health problems and cultural norms, resulting in isolation, increased vulnerability, and lack of support for people with mental health problems. This stigma has been exacerbated during COVID-19, as more people may need mental health or psycho-social support but cannot access it due to the cessation of in-person services and limited remote care options.

Furthermore, COVID-19-related stigma has the potential to create new mental health and psycho-social problems. Many humanitarian crises affect people on the move or who are displaced and already experience significant stigmatization from host communities where they reside. Host communities have often accused displaced populations of bringing crime and disease, isolating displaced populations, and leaving them more vulnerable to mental health and psycho-social problems. This can exacerbate perceptions toward those who have—or are believed to carry—the virus and may incite violence. Such was the case in South Sudan, where several United Nations peacekeepers were the first individuals to test positive for COVID-19 in the country. As a result, local newspapers ran articles with xenophobic headlines targeting U.N. workers, and Facebook posts urged citizens to act violently toward U.N. staff, accusing them



of bringing the virus into the country. The situation escalated as government soldiers surrounded U.N. bases and established refugee camps, restricting U.N. staff and refugees' movement. The U.N. responded and deescalated the situation by limiting staff movement. Other humanitarian actors followed suit, potentially increasing access barriers to services.

Those who do test positive and recover may experience challenges reintegrating with family, friends, and community, similar to what was experienced during the Ebola outbreaks. Despite testing negative or surviving COVID-19, people may remain isolated from their communities and cut off from the social connection that would allow them to better cope with the stressful and challenging situation. This also takes a toll on COVID-19 first responders and essential service providers, for whom community support is vital for mental well-being. First responders' risk of exposure to the virus is comparatively high, thus putting them at risk of social exclusion, isolation, and anxiety.

The closure of schools also greatly impacts the mental health and psycho-social well-being of students and their families. Schools often provide a safe space where social interaction can break down barriers and mitigate stigma among groups of peers and where important social

messaging is conveyed. As a result of COVID-19, children have limited access to social situations that would lead to social cohesion. Instead, social isolation can lead to the reinforcement of stigmas and negative perceptions of others.

In Palestine, Ihab, 28, lives with his wife and children. In 2019, he was injured by gunshot and had complex fractures in both legs. Since the injury, Ihab needs psychosocial support and rehabilitation services, as he feels anxious most of the time and cannot walk or stand for long periods. Since COVID-19, he cannot receive rehabilitation and medical services as he did before, as he is consulted only by phone for physiotherapy and wound care. He is worried that he does not have the skills to care for his wounds. The visits of the rehabilitation team were also an opportunity to meet and talk with people—now he feels very isolated.

## 4. Communication Barriers: Misinformation and Language

The spread of COVID-19 has been accompanied by what the WHO has termed an “infodemic”,<sup>14</sup> as rumors and misinformation about the virus abound. Whether intentional or unintentional, misinformation leads to

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<sup>14</sup> World Health Organization. (2020). Infodemic management of WHO Information Net Work for Epidemics. Retrieved from <https://www.who.int/teams/risk-communication/infodemic-management>.

the stigmatization of patients, doctors, immigrants, and other affected communities, both in-person and online. Misinformation affects both high-income and low-income countries and individuals, fueled by the languages and terminology used to communicate about the virus. In many cases, reliable health information is only available in official or dominant languages. This makes information exclusive and exacerbates the risk of stigma due to confusion and misinformation.

Marginalized language speakers in many locations have limited access to education and technology, meaning they are more likely to be information-poor and have less of a grasp of basic health information. Where speakers of marginalized languages also face other disadvantages—for instance, because of their gender, age, or disability—they are doubly excluded. For example, many governments and organizations are not disseminating information accessible to people with disabilities. A disturbing example of this occurred in Uganda, where a deaf man was shot in the leg by police when he was out after curfew because he had not received information about the curfew in sign language. His leg was later amputated.

Older people already face significant additional barriers to information due to different communication needs or low literacy rates—particularly among women, higher instances of disability or physical impairments, limited access to information due to the ability to speak only in local languages, and limited access to technology. Those who rely on personal and social interaction may find themselves in an information vacuum due to self-isolation and physical distancing.<sup>15</sup> Research among Rohingya refugees in Bangladesh in February and March—early on in the pandemic—found that older women had minimal independent access to information about COVID-19.<sup>16</sup> Male relatives controlled information flows and were often their only source of information.

The use of technical terminology, abbreviations, and dehumanizing terms prevalent in the humanitarian sector, such as referring to people as “cases,” are further examples of linguistic markers of stigma.

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<sup>15</sup> HelpAge International. (2020, June 15). Abuse and neglect of older people around the world intensified by COVID-19. Retrieved from <https://www.helpage.org/newsroom/latest-news/neglect-and-abuse-of-older-people-around-the-world-intensified-by-covid19/>.

<sup>16</sup> Translators without Borders. (2020, June 19). What Matters? Humanitarian Feedback Bulletin. Retrieved from <https://translatorswithoutborders.org/what-matters-humanitarian-feedback-bulletin/>.

#WuhanVirus trending on Twitter shows how sensational language can drive stigma, in this case affecting Asian people by insinuating that they are the source of the virus.<sup>17</sup>

While there are subtle but substantive differences between misinformation, disinformation, rumors, gossip, and myths, all forms of false content lead to stigma. The presence of bad actors and opportunists who use humanitarian or public health crises to drive discrimination is certainly not new. Neither is the fact that the existing lack of social cohesion is an exacerbating factor in emergencies. The COVID-19 pandemic is indeed strengthening xenophobia amid already rising nationalism in many country contexts. Technological platforms and social media play a prominent role in the spread of false information, increasing both the amount and the speed at which it spreads. Further, an increase in “fake news” accusations creates distrust of media and other information sources and makes it difficult to distinguish facts from untruths. Misleading or biased information has mutated across various platforms, been disseminated in multiple languages, and been attributed to different sources, including health professionals and humanitarian actors.<sup>18</sup>

“Social distancing” is a technical term that refers to a set of actions that reduce close contact between people in order to limit transmission of COVID-19. However, translating and ensuring people understand this term has been a challenge in many languages. Even in English, this term is problematic as “being socially distant” would normally read as a person who is not social, e.g., not friendly, not gregarious, shy, or even unfriendly. In this case, “physical distancing” or “keeping your distance from other people” are alternative phrases that can help convey as much of the meaning as possible across languages, with simple words that people understand.

The widespread availability and speed of social media have also been exploited to stigmatize some groups of people and deliberately and systematically orchestrate violence against them. As noted in a recent report:

*“Social media platforms amplify and disseminate hate speech in fragile contexts, creating opportunities for individuals and organized groups to prey on existing fears and grievances. They can embolden violent actors and spark violence—intentionally or sometimes unwittingly. The rapid proliferation of mobile phones and Internet connectivity magnifies the risks of hate speech and accelerates its impacts. Myanmar serves as a tragic example, where incendiary*

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<sup>17</sup> Worley, W. (2020, March 30). How do you say ‘social distancing’ in Swahili? Retrieved from <https://www.devex.com/news/how-do-you-say-social-distancing-in-swahili-96856>.

<sup>18</sup> (March 2020). Social Science in Humanitarian Action, Key considerations: online information, mis- and dis-information in the context of COVID-19.

*digital hate speech targeting the majority Muslim Rohingya people has been linked to riots and communal violence.”<sup>19</sup>*

Several existing best practices counter the spread of false content and thus limit its stigmatizing effect. Explaining the truth is preferable to debunking myths because addressing myths can increase their spread. Health actors should collaborate with media outlets to help counter misinformation. Organizations should work with traditional actors within the community and non-traditional actors, such as YouTubers or other influencers. Technological innovations can also help identify false content and provide accurate information, such as using artificial intelligence (A.I.) to monitor media or chatbots such as WHO’s Health Alert.<sup>20</sup> Messaging should provide factual information and seek to promote social cohesion and provide positive narratives that counter misinformation.

Ultimately, the most effective way to provide accurate information is to root programming in client preferences regarding language, how information is shared, and online versus offline means of communication. Previous disease outbreaks show that people want explanations and answers to their questions, not just instructions.<sup>21</sup> Community-driven models based on dialogue, empathy, colloquialism, and trust ensure that positive outcomes spread further through effective two-way communication.

## RECOMMENDATIONS

To successfully counter stigma and its impacts—including the mental health and psycho-social consequences—on older people, people with disabilities, women and girls, and displaced people during the COVID-19 pandemic will require a whole-of-system approach. This includes U.N. agencies, donors, government actors, NGOs—both international and national, service providers, civil society, and the affected community.

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<sup>19</sup> Mercy Corps. (2019, November). THE WEAPONIZATION OF SOCIAL MEDIA. Retrieved from

[https://www.mercycorps.org/sites/default/files/2020-01/Weaponization\\_Social\\_Media\\_Brief\\_Nov2019.pdf](https://www.mercycorps.org/sites/default/files/2020-01/Weaponization_Social_Media_Brief_Nov2019.pdf).

<sup>20</sup> World Health Organization: WHO. (2020, March 20). WHO Health Alert brings COVID-19 facts to billions via WhatsApp. WHO.

<sup>21</sup> Ibid.



### For Operational Organizations and Other Service Providers

1. Ensure the engagement and full participation of older people, people with disabilities, women and girls, and displaced people throughout the immediate, medium, and long-term COVID-19 response and recovery efforts. Governments and humanitarian organizations must include marginalized groups in rapid assessments, conflict assessments, information-sharing campaigns, assistance packages, and efforts to mitigate both the spread of COVID-19 and the negative effects of mitigation measures, including increased stigma.
2. Collect, monitor, and analyze incidents and trends of discrimination and exclusion. Use this data to support early warning, timely action, and effective responses to widespread harm—including the risk of targeted violence—at local, country, regional, and global levels.
3. Provide psycho-social support to people facing stigma as a result of COVID-19. Support should include accompaniment and reintegration support for people who survive COVID-19 and the direct provision of psycho-social care to people experiencing isolation and stigma. Prioritize collective and multi-sectoral approaches.



### For Actors Engaged in Strategic Communication and Community Engagement

1. Ensure that community engagement practices are evidence-based and consider language strategies and stigma-related risks in the design process. Ensure affected communities play a central role by elevating local voices and that people are involved in their own care. Listen to affected people's needs and preferences related to communication and information flows to and from communities and be responsive to changing needs. Harness technology such as multilingual messaging apps and hotlines to better engage less literate and less connected individuals.
2. Work with civil society and community-based platforms and networks—including community-based protection networks, social media, radio, and television—to support digital literacy and two-way communication. Inform communities of their role in preventing stigmatization, mitigating the spread of disinformation and misinformation, building community trust, and ensuring frequent

sharing of relevant and timely information. Incorporate messages aimed at mitigating the risk of violence against health workers.<sup>22</sup>

3. Provide multilingual trainings and resources for health communication actors. Offer trainings in non-stigmatizing communication and ensure resources are available in languages of the most-affected countries. Ensure that all communication is accessible for persons with disabilities. Support local influencers and capacities like trusted media outlets and grassroots groups as key health communication actors. Support disabled persons' organizations (DPOs) to work with these stakeholders, so that messaging includes persons with disabilities and does not exacerbate existing stigma.
4. Integrate stigma reduction messaging while disseminating clear and accurate information about COVID-19. Avoiding inflammatory, dehumanizing, or criminalizing language, such as “suspect case,” “dirty,” “sickly,” or “combating the virus,” is a critical first step. Media should promote ethical journalism, and humanitarian actors should encourage media outlets to explicitly resist repeating and amplifying misinformation.
5. Awareness-raising activities are proven to reduce stigma greatly—conduct them. By coming together for dialogue and community events, individuals can learn about available support services and marginalized groups' lived experiences. Community-level dialogue addresses misconceptions, which is important to reduce stigma during the pandemic. Communication strategies should be continually refined to enhance overall awareness.<sup>23</sup>



### For All Humanitarian Actors, including Donors, U.N. Agencies, and NGOs

1. Continue to strengthen the overall public health infrastructure. Evidence from the West Africa Ebola outbreak in 2014-2016 shows that the diversion of resources to the COVID-19 pandemic may hamper critical humanitarian assistance and have negative consequences on public health. It is important not to detract resources from other deadly and pressing diseases such as cholera, malaria, HIV/AIDS, and other life-saving health interventions such as sexual and reproductive health services and maternal health care.

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<sup>22</sup> HelpAge International. (2020). What We Do: Coronavirus (COVID-19). Retrieved from <https://www.helpage.org/what-we-do/coronavirus-covid19/>.

<sup>23</sup> International Disability Alliance. (2020). United Nations urged to lead action to end discrimination against people with disabilities in the response to COVID-19. Retrieved from <https://www.internationaldisabilityalliance.org/un-take-action-covid19>.

2. Prioritize information and accessible communication activities as a key area of humanitarian aid. Funding for community-driven two-way communication needs to be available to humanitarian actors as a cornerstone of effective programming and humanitarian accountability. Humanitarian actors—especially local actors—need more stable, predictable financial resourcing for communications expertise. Provide funding directly to civil society organizations, such as DPOs, to ensure that reliable information is provided in accessible formats and awareness is raised among otherwise-isolated populations.
3. Promote physical distancing and social connectedness in all services and information delivery, particularly for people at greater risk of isolation, while taking necessary preventive measures to reduce the spread of COVID-19. Service providers and local organizations should adapt service provision to maintain group engagement where possible, such as creating and maintaining WhatsApp groups for vulnerable individuals. Distribution of phone credit can also help vulnerable populations stay in touch with service providers and their social and community supports.

## CONCLUSION

COVID-19 is an unprecedented global public health emergency—already becoming a long term economic and social crisis. This crisis has exacerbated the vulnerability of the most marginalized and least protected people across the world. However, it is also an opportunity to confront challenges and weaknesses within the humanitarian system, which perpetuate some of the issues humanitarian actors are committed to combating—stigma being a prime example. This requires a real shift in power dynamics and collective action based on lessons learned during previous epidemics associated with significant societal stigma, particularly Ebola outbreaks and the HIV/AIDS epidemic. Governments, humanitarian organizations, and other service providers must place affected people—especially the most marginalized—at the center of COVID-19 response and recovery efforts to counter stigma now and in the future.



## ABOUT INTERACTION

InterAction is a convener, thought leader, and voice for nearly 200 NGOs working to eliminate extreme poverty, strengthen human rights and citizen participation, safeguard a sustainable planet, promote peace, and ensure dignity for all people.

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