Discourses around Stigma and Denial in the COVID-19 Pandemic
A Case Study from Tamil Nadu

S KRITHI, KALPANA KARUNAKARAN, J JEYALYDIA, R PARTHESARATHY, T SUNDARARAMAN

A widespread but underexplored aspect of the COVID-19 pandemic in India has been the prevalence of stigma and denial at different levels in the community mediated by state policy and actions. Based on a field study in three districts of Tamil Nadu between the two waves of the pandemic, this article explores the nature of stigma and denial and their consequence for health-seeking behaviour and access to healthcare.

The authors are grateful to the health activists of Tamil Nadu Science Forum, Pondicherry Science Forum and Makkal Nalvazhvu Iyakkam, especially R Ramesh, Poongothai, Parameswari, S Mohana, and T Santhi for their assistance in the field study. The authors thank the anonymous reviewer for their helpful comments.

S Krithi (*sskrithi@gmail.com*) teaches at TISS Hyderabad. Kalpana Karunakaran teaches at IIT Madras. J Jeyalydia is an independent consultant. R Parthesarathy is with the Heidelberg Institute of Global Health, Heidelberg University. T Sundararaman (*sundar2016@gmail.com*) is the global coordinator, People's Health Movement.

According to official statistics, on 30 April 2021, over 4 lakh COVID-19 infections were recorded in India. In Tamil Nadu (TN) alone, since the onset of the pandemic, more than 11 lakh cases and 13,933 deaths were reported as of 30 April 2021. Yet, in December 2020, when undertaking a COVID-19-related field study in rural TN, one could be asked, "Is there really a disease called COVID-19? And even if it exists somewhere in the world, has it really affected us or is it all an exaggeration, a fabrication, or even a conspiracy?" While an outright denial of the pandemic may not have been so apparent in Chennai, conspiracy discussions were not uncommon among the urban sections either. This article discusses the widespread COVID-19 denial uncovered in a field study in TN and explores its relationship to an equally pervasive social phenomenon, namely stigma.

The ugly underbelly of stigma has long been associated with infectious diseases, most notably leprosy, HIV/AIDS, and tuberculosis, and such stigma was associated with increasing vulnerability of those infected as well as rendering ineffective disease control and public health initiatives (Chandrashekhar 2020; Gilbert 2016). Theories of health-related stigma define it as a social process in which illness is constructed as preventable or controllable, certain "immoral" behaviours causing the illness are identified and existing social constructions of the "other" are usually displaced onto the "carriers" of disease (Deacon 2006). An important part of this process is that people are blamed for their own infection, with some categories of people singled out for such blame. A classic case in point is the blaming, shaming, and othering of population groups that are perceived as being at greater risk of contracting HIV/AIDS, such as gay men, "promiscuous" people, and commercial sex workers in diverse regional contexts (Deacon 2006). In the early months of the pandemic, news reports highlighted the stigmatising and discriminatory treatment meted out to doctors, nurses, flight attendants, police, and a range of other frontline workers across the country (Ganapathy 2020; Mantri 2020). Healthcare workers and even patients recovering from COVID-19 in India and elsewhere were asked to vacate rented homes, denied access to public transport and other essential services, subjected to physical assault, and stalked and abused on social media (Bagcchi 2020).

While stigma has been foregrounded as an urgent issue that must be tackled alongside the current pandemic (WHO 2020), relatively little is known about how the COVID-19 stigma manifests within communities or how it is perceived and experienced by COVID-19 patients and their family members, infected or not. Denial, on the other hand, has largely been studied as a mechanism for individuals to cope with stressful life situations and is well described in cancer and other serious illness. While it may serve to reduce anxiety, it also disrupts treatment and interpersonal relationships, and may even lower immune-competence and compromise longer-term coping (Kreitler 1999). This article aims to study the manifestation of denial in the context of COVID-19 and the nature of shame and social suffering stigma begets. It also seeks to understand how stigma and denial mediate health-seeking behaviour and access to healthcare. In this article, we attempt to address this gap by drawing insights from a field study conducted by health movement activists in TN.

The study was undertaken by the Tamil Nadu Science Forum and the Pondicherry Science Forum, which are non-government agencies working as part of a civil society network, known in Tamil as the Makkal Nalvazhvu Iyakkam

or People's Health Movement. The field study was conducted between November 2020 and February 2021 in Chennai, Cuddalore, and Pudukkottai districts of TN. It documents the COVID-19 journeys of individuals and communities and how they experienced the pandemic and its consequences on their health, lives, and livelihoods. In order to include population groups with varying degrees of vulnerability, the study was conducted in village panchayats, a city slum or urban informal settlement and urban middle-class residential areas (both lower- and upper-middle class) in each district.[1] The field study consisted of structured interviews with families whose members had tested positive and had been treated for COVID-19, as well as semi-structured and open-ended group discussions with other members of the village or the urban residential area. The study was carried out with the help of local volunteers and activists who volunteered time and effort for data collection and used their grassroots contacts to identify families who had undergone treatment for COVID-19 and were willing to share their experience with the study team.

Stigma in Life and Death

Stigma experienced during the COVID-19 pandemic seems to stick to persons and spaces in a stark, visceral manner, enabled by fear let loose in the pandemic and a lack of information on the nature or duration of infectivity. This was initially reinforced by the government marking households with COVID-19-infected persons and isolating them, with restrictions often enforced by the police department. In all our study areas, a key mode of transmission of stigma in the community was through the identification of the infected persons' house via stickers, tape, or even steel barriers to prevent the residents from leaving the premises. For instance, according to the mother of Amal,[2] an information technology employee in south Chennai whose family lived in a lower middle-class neighbourhood, "Our house was the first in the area to be notified as infected. A sticker was pasted on the main door and an iron grill installed in front of the door." The physical marking of houses left an enduring impression of soiled or contaminated spaces that evoked fear and disgust even after the recovery of the infected persons. Such houses were labelled "Corona *Veedu*" (house). When the residents vacated these houses owing to the stigma they had faced in the neighbourhood, they remained unoccupied for months.

Identified by the community as the bearer of the virus, patients with mild symptoms emphasised suffering from the stigma more than the virus itself. In a middle-class apartment complex in south Chennai, two members of a relatively well-off family were diagnosed as COVID-19 positive. An engineering student Ramesh, who was diagnosed first and his mother, diagnosed a few days later, were greatly relieved when they were allowed home isolation. However, their relief was short-lived. As the mother and son described it, the walk from the main road (where the ambulance dropped them after the initial tests) to their house was akin to a walk of shame, in which they were the object of everyone's fear-filled gaze. The case of Ramesh's family illustrates how COVID-19-containment strategies play out in shared living accommodation such as multistoreyed apartment complexes. When a brown sticker pasted on the front door of their apartment signalled that COVID-19 was suspected based on their symptoms, four families in the apartment complex left immediately for their home towns. When COVID-19 was confirmed, a green sticker pasted on their door and white stickers on the doors of the other apartments (signalling proximity to a COVID-19-infected person) contributed to an atmosphere of fear and panic.

AR, a rice merchant and a political party worker residing in a village in Pudukkottai district, was admitted to the government hospital in Pudukkottai along with three of his family members; he declared that the food and medical facilities were excellent. All treatment costs were borne by the government. The family's ordeal began only after their return from the hospital. As AR said, "Our street was sealed. Nobody visited or enquired about us. This hurt me very much as people were treating us like refugees." The sudden rupture in long-cultivated social ties of reciprocity and civil exchange among kith and kin and between neighbours dealt a blow that was hard to stomach for anyone who endured it. Kalai, who managed a small medicine shop in a village in Panrutti block (Cuddalore district), found that no one, not even her brother, would drive her husband, who had difficulty breathing, to the hospital. Malliga, a domestic worker and resident of a slum in south Chennai, underwent a month-long institutional confinement. She was shaken when she realised that her relatives and neighbours would not even offer verbal acts of commiseration and friendly exchange after she was cured and discharged.

The experience of stigma only worsened when there was a COVID-19-induced death in the family. Resident of a village in Pudukkottai district, Ramani was an office-bearer of the ruling political party at the administrative block level. After her death in the hospital, a state cabinet minister visited the household to condole with the family. Yet, according to her family members, local party workers did not call on them, while neighbourhood residents avoided walking in the direction of their house. In the case of Kalai (a case cited earlier), when her husband died of COVID-19, she had also been diagnosed with COVID-19 and was isolated in the hospital ward. Her distress at being unable to attend her husband's funeral was increased by her fellow COVID-19 patients avoiding interaction with her even when she remained asymptomatic. In both these cases, the absence of the community's support and empathy was particularly galling given the customary significance attached to expressing sympathy with the bereaved in a household where a death has occurred. In the Tamil cultural ethos, ignoring a death in the family of a friend, relative, or acquaintance is generally regarded as a breach of the moral/social order worse than failing to mark attendance at a wedding.

In all the instances that we observed, besides public stigma directed at the person known to be infected, their family members, including those who had tested negative, were subject to stigma by association (Bos et al 2011). These families

had undergone an "othering" experience that was as cruel and inexplicable as it was sudden and unexpected. To be treated with hostility and suspicion as an "outsider" (like "refugees" as AR said) has obvious implications in a caste society. The isolation verging on social boycott that our respondents had endured corresponded to the loss of face and status that befalls those whose position within their social (caste-ordered) universe is suddenly overturned. Our respondents' narratives suggest that they had made sense of the social isolation they experienced through the caste-mediated lens they were most familiar with.[3] As Amal described it, "Our neighbours would slam the door if they saw us. They looked at us as if we were untouchable." Even when those infected were prominent members of the community, the repercussions of a COVID-19-positive diagnosis mimicked in a frightening manner the loss of social respectability and "insider" status accorded by a hierarchical society. So traumatic was this experience that some of our respondents remained house-bound for several weeks or even months after recovery in a manner suggestive of self-stigma or the internalisation of shame and devaluation, the diminution of self-worth, and the associated psychological distress (Bos et al 2011).

The message conveyed by the actions of the government during this period did not help mitigate this sense of self and community blame. The perception that the infected person has done something wrong and invited the disease on him/herself, thus putting the larger community at risk, fuels stigma and discrimination (Weiss et al 2006). Yet, the heavy-handed role of the police in enforcing the lockdown across the country reinforced the impression of reckless and irresponsible behaviour on the part of the public as the main reason for the spread of the disease. This impression was likely further strengthened by the state's constant reminders to individuals to mind and reform their personal behaviour, the filing of the first information reports against "spreaders," and the public shaming of those caught violating prohibitory orders by the police. A news report estimates that from 24 March to 10 June 2020, the police arrested 6.11 lakh people for violating prohibitory orders (*Hindu* 2020). In TN, the presence of the police was ubiquitous even when escorting those found COVID-19 positive (through screening tests) to treatment centres. Commenting on the "rounding up" of those who had tested positive from their localities, a Chennai-based respondent of this study said, "Officials and volunteers came in groups … The police came with the lathi, as if they were taking a criminal!"

The victim-blaming and vilification of the infected was strikingly visible in the central government's response to the Tablighi Jamaat congregation in Delhi (Jain 2020). The scapegoating of the Tablighi Jamaat attendants was swiftly followed by the arrests of the foreign nationals who could be targeted (as "outsiders") in a manner that conveniently deflected the focus from the local/community sources of the COVID-19 transmission. The likely effects of this "blame and shame" discourse in shaping public perceptions of individual culpability and willed intent in disease transmission cannot be ignored.

'This Is Not COVID-19'

Given the association of criminality with the disease and virulent social stigma, it is not surprising that some chose to hide it and others relied on forms of denial. At the individual level, denial commonly took the form of hiding symptoms from one's family or even oneself and refusing to get tested. Our respondents had been exposed to media images of patients dying alone in hospitals and strapped to ventilators. Malliga, the domestic worker in Chennai, simply said, "I was hesitant [to test] because I did not want to know that I had COVID-19." For some, it was difficult to countenance the idea of being taken away from family when one was ill, vulnerable, and in need. In low-income colonies, for people accustomed to crowded living spaces, the sheer idea of physical isolation was unnerving. Among our respondents, women were more likely to openly express this fear. Malliga, who lived in a single-room thatched hut with her son, had stayed alone in a one-bedroom flat in the low-cost housing board tenement that had been repurposed as a COVID-19 care facility. She said,

> I had the worst time. Never before in my life have I stayed alone. I was scared of the dark. I kept the room light switched on, stayed awake through the night and slept during the day.

When those with symptoms overcame their hesitation and came forward to get tested, their family members sought to dissuade them. Trying to convince her son that it was an "ordinary fever," Amal's mother had offered to brew home-made tonics and pleaded with him to not get tested. When Arul, a tenant farmer in a village in Cuddalore, tested positive, an ambulance was sent to pick him up about 2 kilometres outside the village, since the ambulance coming inside the village was taboo. Yet his relatives gathered at the pick-up site and pressured him (unsuccessfully) to return home. His persuasion and the persistence of healthcare workers subsequently brought his reluctant family to the COVID-19 care centre. On seeing him, his furious daughter reportedly grabbed hold of his shirt and shouted, "It is because of you that we had to come here." It was common practice in other villages too for the ambulance to pick up COVID-19 patients outside the village.

Denial also manifested as refusal to believe one's own or a family member's COVID-19 diagnosis. According to Kalai, circulation of news that her husband had most likely died due to jaundice (and not COVID-19) made it more acceptable to others in her village. She drew comfort from this narrative and claimed that she found strength and hope during her own recovery through a similar process. As she said, "I was very worried. Then I told myself—'this is not COVID-19, the doctors have got it wrong.' Immediately I felt better." In the case of Ramani who died in Pudukkottai, the breach of protocol in the private medical college hospital compounded her husband's suspicion that she had not died of COVID-19. The doctors treating his wife had worn only a face mask and not the body-covering protective suit, while his daughter-in-law had been allowed to attend to his wife in the

COVID-19 ICU. In this case too, his negation of his wife's diagnosis was fuelled by the overwhelmingly negative response to it.

Our discussions across respondents found that the public health messages of the state had failed to find resonance among the people. Respondents raised concerns such as "why are close contact/ family members tested in the fifth or sixth day? Why cannot they be tested along with the patient?" These concerns indicate insufficient institutional efforts to explain the underlying rationale of different control measures. At the same time, instructions to light diyas (lamps) and clang plates, customarily associated with measures to drive away evil spirits, did little to enhance knowledge of the disease. Our respondents' reliance on home remedies and traditional practices should be viewed in a context where public messaging was emphasising absence of any cure. Not surprisingly therefore, traditional health foods such as *kasayam* (home-made health drinks) and *kabasura kudineer* (a tonic that is reputed to have immunity-boosting properties) were seen as sufficient protection against infection.

The COVID-19 denial at the community level took the form of downplaying the disease or grossly under-reporting its prevalence.[4] In one of the villages in Cuddalore, even the local health activists participated in the denial discourse and claimed that there had been no more than one or two COVID-19-positive cases in the village. However, the study team found more than five affected individuals (three households) in the village on the same day, with clear indication of there being more of such cases. The general perception in the villages we visited was that the disease had not spread in their villages and that some residents were found positive because they tested for COVID-19. To test was seen as a reckless and irresponsible act that invited trouble and unwarranted attention. In the community's perception, the problem was situated in the disclosure, not the concealment of symptoms. Here, we would do well to recall that central and state governments too had persistently denied community transmission during the early months of the pandemic. As part of this culture of denial, government school teachers, who were assigned the task of contact tracing in Chennai, informed us that health officials sometimes mapped newly infected COVID-19 patients with an already affected person in order to deny community transmission.

Stigma, Denial, and Access to Healthcare

The repercussions of denial and stigma in disabling access to timely medical care were mediated by income, social class, and occupational differences among our respondents. A retired police officer and his wife, living in an independent house in south Chennai, had been hospitalised and treated for COVID-19. As no one even knew they had contracted COVID-19, they had no experience of stigma. They could confidently express the view that "safety matters first." A striking contrast was the case of the engineering student Ramesh of south Chennai (case discussed earlier) whose apartment block was sealed when he and his mother were diagnosed positive. The public embarrassment his family had suffered prevented his father and sister from getting tested at a government facility, when they too developed high-grade fever the following week.

Another important factor mediating access to healthcare was found to be the nature of occupation and conditions of work. All 25 employees of a thrift and cooperative society in Neyveli township were tested shortly after the death of a co-worker with COVID-19 symptoms. When six were found positive, they were immediately admitted in COVID-19 care centres and the outbreak was effectively contained at the workplace. Importantly, the decision to test (or not) and the follow-up action was not left to the workers or their families to manage. While stigma may have been present in the community, the process of testing in the workplace, supported by the local trade union, ensured access to healthcare for all employees. Full wage protection during their prolonged absence from work also meant that they had an economic buffer against the costs of the disease.

The case of the organised workers in Neyveli stood in stark contrast to the daily wagers and self-employed petty commodity producers among our respondents. Malliga, the domestic worker in Chennai, found that no one would hire her post-recovery. After it was known that his mother had tested positive, her son, who worked as a driver, lost his job and could not find employment for over six months. A family involved in the dairy business in a study village in Pudukkottai faced financial ruin after a COVID-19-induced death in the household. No one would buy milk from them. The residents of Malliga's slum in south Chennai said that they avoided government facilities and managed COVID-19-like symptoms with to traditional medicine. Some of them resorted to private clinics in their neighbourhood, which treated patients with fever lasting more than a week without referring them for COVID-19 testing. Residents of a nearby poorer slum area said that they could not imagine falling sick as they would not be able to work. For these daily wage-earning workers in the informal sector, almost all the social distancing measures propagated were not feasible. Denial worked as a form of coping with this helplessness. Under these circumstances, COVID-19 stigma could cost much more than the loss of face or status in their community. Survival imperatives and the terrifying prospect of losing jobs and livelihoods made it prohibitively costly to seek treatment from government facilities even where it was freely offered.

Health-seeking Behaviour

The perception of the government health services as compared to private providers came up repeatedly in our respondents' narratives across different classes and sections in Chennai, Cuddalore, and Pudukkottai districts. Arul (Cuddalore) expressed the prevalent understanding in his village saying, "Nowadays, if a patient with fever goes to a private hospital, they get medicine and come back. But if you go to a government hospital, they capture you as a Corona patient and admit you." A number of bystanders confirmed this perception. In an urban slum in Panruti, a young pregnant woman

had tested positive. The family was fully satisfied with the quality of medical care she had received in the government-run COVID-19 care centre. Yet, they strongly believed that she had been admitted since the "doctors want to show admission of so-called COVID-19 patients to the authorities in order to earn money." In Chennai too, there was a proliferation of stories on the "cut" and the "commission" per COVID-19 admission in a care facility or government hospital that the highest rungs of the state executive were supposedly earning.

Our case studies reveal that these money-making stories served to give credence to denial ("this was not COVID-19, the diagnosis only served to 'catch' a case"). The denial, in turn, helped mitigate the stigma, shame, and social suffering endured by families publicly tainted by the COVID-19 brush. In a few of our cases, the denial enabled families to cope with grief and loss after the inexplicable death of a family member, as seen, for instance, when one person died and the other remained asymptomatic. At the community level, denial served to help recover the self-respect of a village community after a few cases of COVID-19 had been "outed." Arguably, this accounts, in part, for why the money-making narratives remained so entrenched and pervasive, despite a general level of satisfaction with COVID-19 treatment at government hospitals.

If the private sector generally fared better in this popular construction of a COVID-19-obsessed health sector, our respondents' actual experiences with it left much to be desired. While Ramani (Pudukkottai) who died in a private hospital had the chief minister's comprehensive health insurance card, the hospital refused to accept the card and made the family pay close to ₹4,00,000. This card carries a promise of providing completely free care without payments to its holder, up to a sum of ₹5,00,000. When Ramesh's father and sister also developed unmistakable symptoms, they got tested at a private facility in Chennai. The doctor at the clinic convinced them to take an injection costing ₹50,000 that would ostensibly prevent the relapse of COVID-19. The social ostracism they had faced induced his parents and sister to take the injections at a total cost of ₹1,50,000. The only evidence of money-making that we uncovered, as distinct from hearsay stories and viral rumours, pertained to the extortionate behaviour of the private (not public) sector.

As part of an effort to encourage disclosure of symptoms and testing, the Greater Chennai Corporation (GCC) initiated a system of door-to-door fever survey volunteers in all the 15 zones of the city. This study included interviews with a fever survey volunteer and some of the residents of low-income neighbourhoods in south Chennai that she had helped gain access to healthcare and other essential services like rations. While she (like the other volunteers) was initially met with suspicion and distrust and perceived as an infective agent, her continued visits to the neighbourhoods and support to needy households helped her build a rapport with the local communities. This was a positive case of outreach making a difference by mitigating distrust of public services and suggesting possible ways of addressing denial and stigma through community health workers.

Discussion

As this study found, stigma caused enormous pain and suffering among our respondents, with many reporting that they suffered more from the stigma than the disease. The extent of denial and the use of non-religious reasons like blaming the media, medical system, government, etc, for creating a perceived "artificial scare" is a rupture from past experience. Historically, community-level coping mechanisms were often based on attributing pandemics to the visitation of a goddess or other supernatural forces. Community denial, in the forms seen in our case studies, is more recent and has been noted in the case of the recent Ebola outbreaks in Sierra Leone as well. Similar to the cases here, communities were found to actively reject the existence of the disease or its danger to them and chose to call it a "man-made disease, linked to political and moneymaking schemes." Studies have linked such denial to fear, uncertainties, lack of community trust, and misleading or confusing messaging about the disease (Gray et al 2018; Yamanis et al 2016).

The inter-related phenomena of stigma and COVID-19 denial were seen to have serious adverse repercussions for individuals and from a public health point of view in our context. They effectively impeded both contact tracing and early case identification as essential disease containment measures. As the fever survey volunteers of the GCC explained, even when trust was established, the overall environment of stigma was such that, politely but firmly, families would refuse to name contacts or altogether deny having made any close contact. Contact tracing was therefore de facto abandoned at the field level. Barring a few upper middle-class households, the close contacts of our respondents had seldom volunteered for testing. In most cases of death and hospitalisation, medical consultation was postponed till symptoms were grave. The lower the socio-economic category of the respondent, the more likely we were to see this. Another section that is negatively affected in this context is the elderly, as COVID-19-induced deaths among them could very easily get missed due to already high mortality in this age group.

This study also finds that the stigma associated with designated COVID-19 centres and public hospitals forced many to avoid them in favour of private providers. For some segments of the population, this reinforced health-seeking behaviour was established well before the pandemic. However, in the case of more marginalised sections, this was a new compulsion. The move to the private sector was also influenced by a denial-effect, namely the perception that the public sector is obsessed with COVID-19 and will not diagnose non-COVID-19 illness, which is what one has because "COVID is not real." The consequences were huge expenses in the private sector for irrational remedies and in the case of worsening illness, the delayed dumping of patients in public hospitals.

By impeding disease surveillance, stigma and denial may well have precipitated subsequent waves of the pandemic. In November–December 2020, when the field study was ongoing, the number

of daily new cases had come down dramatically. However, it was clear that case incidence continued at low levels. Potentially, when case incidence was low, a robust countrywide disease surveillance system that responds to every suspected case and local outbreak and a population willing to come forward for testing and contact tracing could have contained the pandemic and pre-empted a disastrous second wave. When planning for future waves of the pandemic, there is a need, therefore, to factor in both the roles of stigma and denial in the failure of the disease surveillance system.

Conclusion and the Way Forward

This study brings important insight into the experience of the pandemic thus far, with implications for planning better community response and state action. Some of these lessons relate to the social determinants of health and others to the strategies of pandemic management.

An important lesson is that there is a need to re-examine the entire health communication strategy and replace simplistic, sweeping top-down messages with more appropriate messaging specific to each audience segment and informed by evidence. Central to this rethink should be an understanding (i) that while individual behaviour change reduces risk, it will not eliminate it altogether and (ii) that behaviour change has to be addressed at the interactions/activities, which have the highest probability of spreading infection and not try to cover all possible interactions between people. The persistent approach of criminalising the people in the name of enforcing "appropriate" behaviours is a losing scenario. Instead of an authoritarian law and order approach to a lockdown, one requires a separate strategy of health communication that in the case of more marginalised populations takes into account their conditions of living and work.

While the violations of people's dignity and basic rights are a problem in their own right, this study has shown their contribution to stigma and denial and the consequences for pandemic response as well. The COVID-19 denial is not a consequence of stand-alone individual behaviours. It is a response that is socially determined, and for millions of temporary or contract workers, their precarious terms of employment are further aggravated by stigma. It is important for workers to have a guarantee of employment and paid leave if spread in the workplace and subsequently in the home and community is to be prevented. As seen in the case study, an active trade union also plays an important role, in both intervention and negotiation with the employer and the state, while providing solidarity among affected workers.

Finally, the government has to relook at its own forms of denial and rethink how its strategy allows the perpetuation of stigma. This study must be seen in light of the high degrees of inequity in the COVID-19 response and its relation to how power and politics play out in public policy and discourse. In response to the Tablighi Muslim case, the Aurangabad High Court order observed that

> A political government tries to find the scapegoat when there is pandemic or calamity and the circumstances show that there is probability that these foreigners were chosen to make them scapegoats. (Saigal 2020)

Stigma and denial could have also been convenient in under-reporting cases and deaths and therefore sustaining the narrative of India as a "high achiever" in pandemic control during the first wave. The link between denial at the community level and denial as a consequence of the government narratives on success at policy levels needs to be explored further. What is certain is that there has been insufficient recognition in the government policy of the existence of both stigma and such widespread denial of the problem, thus resulting in the lack of effort to address this critical angle to the pandemic.

NOTES

1 The study was conducted in two village panchayats each in Cuddalore and Pudukkottai districts. In all three districts, the study was conducted in urban residential areas, both middle-class neighbourhoods and slum settlements. None of the neighbourhoods or villages are identified by their names in this article.

2 The names of all respondents have been changed.

3 The experience of stigma was reported by our respondents who belonged to diverse caste communities, including Scheduled Castes, Other Backward Classes, Most Backward Castes, and the general (unreserved) category. Socially pervasive caste norms of purity and pollution, internalised across castes, very likely reinforced the perception of the infected and their household members as "diseased" and "unclean."

4 Discussions were held at different habitations, targeting diverse caste groups. In rural Tamil Nadu, residential settlements are usually structured along the lines of caste.

REFERENCES

Bagcchi, Sanjeet (2020): "Stigma during the COVID-19 Pandemic," *Lancet Infectious Diseases,* Vol 20, July, https://www.thelancet.com/pdfs/journals/laninf/PIIS1473-3099(20)30498-9.pdf.

Bos, A E R, John B Pryor, Glenn D Reeder and Sarah E Stutterheim (2013): "Stigma: Advances in Theory and Research," *Basic and Applied Social Psychology*, Vol 35, No 1.

Chandrashekhar, Vaishnavi (2020): "From Leprosy to COVID-19, How Stigma Makes It Harder to Fight Epidemics," 16 September, https://www.sciencemag.org/news/2020/09/leprosy-covid-19-how-stigma-makes-it-harder-fight-epidemics.

Deacon, Harriet (2006): "Towards a Sustainable Theory of Health-related Stigma: Lessons from the HIV/AIDS Literature," *Journal of Community & Applied Social Psychology*, Vol 16, pp 418–25.

Ganapathy, Nirmala (2020): "Healthcare Workers in India Face Stigma amid Fight against Coronavirus," *Straits Times,* https://www.straitstimes.com/asia/south-asia/healthcare-workers-face-stigma-amid-fight-against-coronavirus.

Gilbert, Leah (2016): "The Mercurial Piece of the Puzzle: Understanding Stigma and HIV/AIDS in South Africa," *SAHARA-J Journal of Social Aspects of HIV/AIDS*, Vol 13, No 1, pp 8–16.

Gray, N, B Stringer, G Bark, A H Perache, F Jephcott, R Broeder et al (2018): "When Ebola Enters a Home, a Family, a Community': A Qualitative Study of Population Perspectives on Ebola Control Measures in Rural and Urban Areas of Sierra Leone," *PLoS Neglected Tropical Diseases,* Vol 12, No 6, p e0006461.

Hindu (2020): "Lockdown Violations in Tamil Nadu Touch 5.6 Lakh," Special Correspondent, Chennai, 10 June, https://www.thehindu.com/news/national/tamil-nadu/lockdown-violations-in-tamil-nadu-touch-56-lakh/article31793163.ece.

Jain, Ritika (2020): "How Fake News and Modi Government Messaging Fuelled India's Latest Spiral of Islamophobia," 21 April, *Scroll.in*, https://scroll.in/article/959806/covid-19-how-fake-news-and-modi-government-messaging-fuelled-indias-latest-spiral-of-islamophobia.

Kreitler, S (1999): "Denial in Cancer Patients," *Cancer Invest,* Vol 17, No 7, pp 514–34.

Mantri, Geetika (2020): "Indian Flight Attendants Are Being Harassed and Ostracised Due to Coronavirus Fears," *News Minute,* https://www.thenewsminute.com/article/indian-flight-attendants-are-being-harassed-and-ostracised-due-coronavirus-fears-121015.

Saigal, Sonam (2020): "Bombay High Court Quashes FIRs against Foreigners Who Attended Tablighi Jamaat Congregation," 22 August, *Hindu*, https://www.thehindu.com/news/national/bombay-hc-quashes-firs-against-foreigners-attending-tablighi-jamaat-congregation/article32419331.ece.

Weiss, M G, Jayashree Ramakrishna and Daryl Somma (2006): "Health-related Stigma: Rethinking Concepts and Interventions," *Psychology, Health and Medicine,* Vol 11, No 3, pp 277–87.

WHO (2020): "Social Stigma Associated with COVID-19," World Health Organization, https://www.who.int/publications/i/item/social-stigma-associated-with-covid-19.

Yamanis, T, E Nolan and S Shepler (2016): "Fears and Misperceptions of the Ebola Response System during the 2014–15 Outbreak in Sierra Leone," *PLoS Neglected Tropical Diseases,* Vol 10, No 10, pp e0005077.