

CRISIS+EMERGENCY RISK COMMUNICATION

CDC CERC Best Practices: Stigmatization

When new infectious disease illnesses emerge, the potential to stigmatize people, places, animals, or products exists. If a particular parasite, virus, bacteria, or toxin evokes an instant negative association with a particular ethnic/racial/age/gender group—stigmatization is already occurring.

Early in an outbreak, such as the 2009 H1N1 outbreak, groups of people, places, and animals can be singled out and will be at risk of being stigmatized by association with the threat this virus poses. Groups are stigmatized by an infectious disease when the risk of infection to others is not present or remote but the association of the risk is magnified by others for that population group, or place or animal.

Stigmatization is a psychological short cut or stereotype used by people who are concerned about their wellbeing. People naturally want to protect themselves and when a situation is evolving or uncertain, they may revert to visible markers to infer risk. Stigmatization occurs when the people associated with the risk, based on outward appearance, are shunned or excluded from societal benefits.

Communication professionals must work to communicate the real risks that exist without needlessly associating an identifiable group of people with that risk. For example, state clearly the risk is associated with travel and potential exposure through close contact with people who travel to affected locations, not merely because one shares a racial or ethnic heritage from the affected area.

Stigmatization's toll

Other than obvious societal reasons, stigmatizing groups during an outbreak can be harmful in many ways. Members of the stigmatized group may literally hide their illness to avoid the stigma, which could hamper response and community mitigation measures. Also, stigmatized individuals may experience emotional pain from the stress and anxiety of social avoidance and rejection. This stress may make them more susceptible to illness. In rare, but documented, instances group conflict may arise and important community resources withheld from those stigmatized.

There are steps response officials and communication professionals should take to reduce stigmatization. A checklist for before, during, and after an outbreak follows:

Checklist: Inhibiting and countering stigmatization

Before

- Remember: products, animals, places, and people can be stigmatized.
- Avoid constant use of visuals that portray only one ethnic group in briefing and education/outreach materials. (Media reports are different and set in time.)

- Avoid geographic mentions of past infectious disease outbreaks, instead substitute dates (e.g., Toronto SARS outbreak versus the 2003 SARS outbreak; the Spanish Influenza Pandemic versus the 1918 Influenza Pandemic)
- Avoid typefaces and symbols that evoke a specific ethnic group (subconsciously you may think it's relevant when it's not).
- Ask staff who share the ethnic background of persons experiencing the earliest outbreaks whether the proposed materials are offensive (if no staff share the ethnic background, reach out to trusted partners).
- If a particular parasite, virus, bacteria, or toxin evokes an instant association with a particular ethnic/racial/age/gender group—stigmatization is already occurring.
- Teach response officials and communication staff as broadly as possible about the harm that results from stigmatization—people may literally hide their illness to avoid the stigma, which could hamper infection control and community mitigation measures.
- Share with media the concern about stigmatization and work together to create visuals that tell the story without targeting one group.
- Address the issue in preplanning community checklists and guides. The more people are aware that this could occur, the more people can help guard against it.
- Have a mechanism in place that allows people to seek the help of public health experts in determining real risks versus imaginary or theoretical risks.
- Have a mechanism in place to allow people who are feeling stigmatized to express their concern and ask for help.

During

- All of the above continue to apply.
- Ensure the environmental scanning process being used is able to discern and alert communication staff to stigmatizing visuals, statements, or behaviors.
- Monitor misperceptions in the community regarding real risks versus imagined or theoretical risks in relationship to products, animals, places, and people.
- When stigmatization occurs in the community, counter it immediately with emotional appeals for fairness, justice and sound scientific facts. For example: When nail salon owners who were Vietnamese appealed for help from the health department during the SARS outbreak because women feared they would get SARS at the salons, the health department was able to allay public concern about increased risks and shorten the negative emotional and fiscal impact of the stigmatization).
- Engage respected political and civic leaders in countering stigmatization (e.g., the governor of Hawaii visited Honolulu's Chinatown during the SARS outbreak).

After

- Continue to do all the activities above.
- Ensure that historical accounts of the event do not unfairly show any one ethnic group. The potential is high for historical accounts that cover the early part of the outbreak to unintentionally perpetuate the stigmatization.
- If stigmatization does occur in the community, reach out to the stigmatized community to learn – believe me, they will know – when it started, what led to it, how it manifested, and how they coped or countered it themselves. Learn the lessons and engage them in the future for help.

Note: As an infectious outbreak becomes much more widespread and people cannot distinguish themselves from others who are becoming sick (everyone is sharing the risk equally), stigmatization will decline. However, it can erupt as new developments occur or new data emerge.

For information about this and other Crisis and Emergency Risk Communication best practices and free CERC materials/tools, please contact CDC's Barbara Reynolds, Ph.D., at CERCrequest@cdc.gov 3/30/2009



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