SOCIOLOGY | RESEARCH ARTICLE

Social Stigma as an outcome of the cultural repercussions toward COVID-19 in Saudi Arabia

Muna Abdullah Al-Ghraibi1 and Theeb M Aldossry1

Abstract: The current research paper explored the impact of social stigma on people infected with COVID-19 in Saudi Arabia and the factors that worsen the stigma against COVID-19 patients. The research sample consisted of fifteen Saudis recovering from COVID-19 aged 25–55; eight males and seven females. Using the purposive sampling method, the research utilized a guided interview consisted of four main sections. Following qualitative research design, the research administered the instrument to obtain and discuss the results. The research was conducted during the academic year 2020. The results showed that there was a positive association between social stigma and COVID-19 in Saudi Arabia. Additionally, there was no difference between the participants in the rate of social stigma according to gender. Moreover, this also highlighted that the experienced social stigma is varied in its form and in people’s behavior. Cooperation between society institutions and media is recommended to increase the awareness of rejecting discrimination and social stigma. Furthermore, stigmatized persons should be provided with early intervention and ongoing counseling programs.

Subjects: Sociology & Social Policy; Psychological Science; Health Psychology

Keywords: Social stigma; COVID-19 epidemic; cultural context; social support; collective society

ABOUT THE AUTHORS

Muna Abdullah Al-Ghraibi is an academic and a researcher in Political Sociology. She Works as an Assistant Professor in the Department of Social Studies at King Saud University. She is a board member of the Saudi Society for Social Studies, and a practitioner consultant at the Saudi Commission of Health Specialties. She received the PhD in sociology and social policy from the University of Sydney, worked as a researcher and assistant teacher at the University of Sydney for several years and received scholarships to contribute to international scientific conferences.

Theeb M Aldossry is an Associate Professor in the department of Social Studies at King Saud University. He received the PhD in philosophy from the university of Exeter. He was a head of the Scientific Research Unit at the College of Arts from 2017-2018. He is a researcher and social consultant in many fields since 2004 till now.

PUBLIC INTEREST STATEMENT

COVID-19 (novel coronavirus) has been reported to be the worst recent global pandemic that has caused a state of panic and serious cultural repercussions. Social Stigma is one of the cultural repercussions toward COVID-19 especially in a collective society. The community can highly form the ideology and identity of individuals. Social stigma is the disapproval of or discrimination against a person or group of people based on some perceivable social characteristics. This research explored the impact of social stigma on COVID-19 patients in Saudi Arabia and the factors that worsen the stigma against them. It revealed that the social stigma attached to COVID-19 patients harmed their social life even after they had recovered. The research highlighted that the experienced social stigma is varied in its form and in people’s behavior. Moreover, it is critical to provide COVID-19 stigmatized patients with appropriate ongoing support.
1. Introduction

Human societies are experiencing difficult times due to the outbreak of novel COVID-19 (corona-virus) epidemic all over the world. Countries are trying to manage this crisis by adopting several measures. They cancel all cultural and sports events, literary competitions, festivals, seminars, exhibitions, and others. This unprecedented situation of the current pandemic could be associated with cultural repercussions such as fears, isolation, stereotyping, discrimination and social stigma especially in collective societies.

The World Health Organization (WHO) has classified the novel COVID-19 as one of the fastest-spreading pandemics ever seen. COVID-19 is highly infectious. COVID-19 cause respiratory symptoms that can be fatal. According to the World Health Organization (2020),

“most people (about 80%) recover from the disease without needing hospital treatment. Around 1 out of every 6 people who get COVID-19 becomes seriously ill and develops difficulty breathing”. Since its emergence in Asia in late 2019, the virus has spread to every continent UNPD & Retrieved from, 2020). One of the major barriers to addressing the COVID-19 pandemic is the difficulty in reaching those who are at risk of infection. Because of the related stigma, people deny and fear disclosing their sickness status.

The social stigma of people diagnosed with the novel COVID-19 made it difficult to control the impact of the epidemic, especially in the collective society. It can result in a set of inhibitory responses that come from feeling threatened, anxious, and vigilant (Keltner et al., 2003). Because social stigma is an indicator of low social status, the social and psychological consequences of stigmatized people may in part be a personal response to the culture of shame.

Many studies provide evidence that the consequences of stigma are situational and suggest that stigmatized groups have different protective strategies (e.g., non-disclosure), which may vary in effectiveness (Cioffi, 2000). The Saudi Ministry of Health (MOH) announced the first case of COVID-19 infection on 2 March 2020, involving a person who returned from Iran via Bahrain but did not reveal his ailment at the Saudi port of entry. On 19 March 2020, the first case of COVID-19 infection drew media attention. Saudi Arabia showed a heavy progressive tendency, and the number of patients was not increasing extremely like other countries. In late July, the results of a multi-stage random sampling conducted by a group of authors illustrated that out of 1800 respondent, (74.6%) had negative feelings, such as anxiety, accompanied by sadness (43.4%), and stigma (23.0%) correlated with COVID-19 (El-Malky et al., 2020).

Both the overall public policy reaction and individual behavioral responses to an epidemic are shaped by cultural variations. The outset of COVID-19 put a strain on some Saudi people. Its accompanying cultural, social, and psychological influences were observable. Stigma, panic, and avoidance are among the main problems to be discussed and require raised awareness. Therefore, recognizing the impact of culture on the epidemic-related psychological behavior is highly important.

Following (Goffman, 1988), the social interaction process is the way individuals can defend and preserve their identity, through the construction and manipulation of information according to the expectations about it through the development of a strategy. (Goffman’s, 1963) study, Stigma, with its high heuristic potential (Serpa & Ferreira, 2020), provides one of the most notable studies on stigma manipulation, defined as the situation of the individual who is unable for full social acceptance (Goffman, 1988). The stigma situation is characterized by Goffman (1988) as follows: [...] an individual who could have been easily received in the daily social relationship has a trait that can be imposed on attention and alienate those that he meets, destroying the possibility of attention to other features he has. He has a stigma, a characteristic different from that which we had predicted (p. 14).
Stigma refers to a mark of humiliation and shame that sets a person apart from others (Pescosolido, 2013). There is an urgent necessity to recognize and acknowledge stigma as a considerable barrier to public health and global development (Das, 2020). As a result of others' discrimination and devaluation, social stigma has a variety of negative consequences that impede rehabilitation, such as shame and embarrassment (Corrigan et al., 2016). People who are stigmatized are seen to have an attribute that distinguishes them from others and causes them to be undervalued. Stigmatizing markings can be visible or invisible, controlled or uncontrollable, and connected to appearance (e.g., a physical disability), as well as conduct. Importantly, stigma is relationship and context-specific; it exists in a social setting rather than in a person. (Major & O'Brien, 2005). Thus, stigma is an attribution not a property of the person who is stigmatized. Further, fear of disease can lead to stigmatization and discrimination of cultural groups based on the virus outbreak's features (Prosen, 2020).

Most stigma researchers consider stigma to be a social construction and point to differences in stigmatization throughout time and cultures in terms of which characteristics, actions, or groups are stigmatized (Crocker et al., 1998; Jones et al., 1984). In the Saudi society, a cultural characteristic of stigma is that it tends not to accept diversity to some extent. Difference means social rejection, which denotes denial of social acceptance followed by the society pressure on the individual to integrate with the group. Although some groups of the society have gained a certain degree of knowledge, stigma has been associated with the growth of irrational and illogical fears of disease and its danger as well as the potential sources of infection. Thus, the infected was classified as different. Stigma was considered the major power that the society adopts to assert the reasons for group integration. Cultural stigma beliefs involve entire population groups, while personal stigma beliefs have an effect on the infected and close ones. The person infected with COVID-19 tends to hide in order not to turn into a stigmatized person who complies with the community principles and values.

Anxiety caused by lockdowns, many unknowns around COVID-19 and the fear of being infected have caused the rise of stigma in local communities (Sotgiu & Dobler, 2020). This research focuses on how COVID-19 is understood and responded to in Saudi Arabia. It investigates the adverse emotions against the infection of COVID-19, reports the features of social stigma, and makes recommendations to limit this wave in societies. Thus, the research seeks to answer the following questions:

1. What is the impact of social stigma on people infected with COVID-19 in Saudi Arabia?
2. What are the factors that worsen the social stigma against COVID-19 patients?
3. Is there a relation between social stigma and COVID-19?
4. Is there a difference in the rate of social stigma on COVID-19 patients according to gender variable?

2. Objective of the research
The research aimed to explore the related issues of social stigma as an outcome of the cultural repercussions toward COVID-19 in Saudi Arabia

3. Significance of the research
1. Discussing a recent critical social issue related to socio-cultural transformations in terms of both values and practices.
2. Helping in designing effective and tailored public health strategies.
3. Benefiting those who carrying out health care procedures for COVID-19 patients.

4. Background
Culture that related to a group of people could be defined as a set of shared rules or values (Lehman et al., 2004). Moreover, cultural variables have been found to have a considerable impact
on a wide range of behavioral phenomena (Bernhardsdóttir, 2015; Venkateswaran & George, 2020). Culture may lead to the stigmatization of certain communities or the blame of specific populations for their high incidence rate (Sovran, 2013). It may play a role in COVID-19 exposure, early detection, and therapy. When it comes to emerging diseases, epidemics, and pandemics, culture has a big impact on how symptoms are identified, how people get care, how they get treated, and how they feel about being stigmatized (Bruns et al., 2020). The general people’s perceptions of the pandemic, as well as public adherence to behavioral guidelines, differ significantly (Sabat et al., 2020).

Throughout the literature on infectious disease outbreaks, and particularly around quarantine procedures, stigma has been a major theme (Bruns et al., 2020). Erving Goffman (1963) defined stigma as a visible characteristic of individuals that causes society to devalue and dismiss them as unworthy for involvement in society. In the context of health, social stigma refers to the negative association that a person or group of individuals with certain qualities have with a specific condition. Stigma can cause people to hide their sickness in order to avoid prejudice, and it can also deter them from adopting healthy habits (Organization, 2020). The COVID-19 pandemic has resulted in a significant shift away from people’s need to live in close quarters and toward societal stigma (Bhanot et al., 2020).

In the 20th century, prejudice started to be seen as a major social problem (Miller, 2006). Crocker and Quinn (2000) conceptualized the self as a social construction developed through our perception of how others see us; therefore, since the social interaction between stigmatized groups and society is overwhelmingly negative, the victims of such stigmatization are likely to internalize social devaluation and develop low self-esteem. Goffman (1963) states that social stigma “makes [people] different from others in the category of persons available for [them] … an attribute that is deeply discrediting [and observable through] a language of relationships” (p. 3). Social stigma in the context of illness is the negative association between a specific disease and a person or group of people who have that disease. Link and Phelan (2001) define stigma as the co-occurrence of 1) labeling: the conflation of a condition with personal identity; 2) stereotyping: the conflation of a condition with socially undesirable characteristics; 3) separation characterized by an “us vs. them” social dynamic; 4) status loss, which is consistent with a decline in social network resources; and 5) discrimination, which incorporates a decline in access to financial resources or other power structures. A study in Saudi Arabia revealed the feelings of people living with HIV, including stigmatization, disclosure, fear and vulnerability, lack of psychosocial support, and religiosity. Societal prejudices against HIV/AIDS were a key factor in stigmatization (Omer et al., 2014).

Although solid social networks and high levels of interpersonal trust are advantages in the relationship between family members and friends, the individual’s behavior, values, beliefs, and way of life are subject to criticism by one’s social network (Alghuraibi, 2017). Despite education campaigns against judging others, progress in terms of social tolerance, and efforts exerted to achieve equality and encourage acceptance in Saudi Arabia, Saudi traditions have left remarkable fingerprints on law, education, mass media, and social media, as well as in traditions, cultural norms, and the way people are raised (Alghuraibi, 2017). Lack of societal awareness, on the one hand, and a combination of cultural beliefs and a deep suspicion of “the other”, on the other hand, have made people afraid to be tested or to disclose that they have been infected. People consider health infection as a defect that inflicts a stigma on affected people even after their recovery, and perhaps even after the end of the global health crisis. When HIV-AIDS spread, people who had the virus did not receive any sympathy (Zartaloudi & Madianos, 2010). Some Saudis considered the virus a moral punishment from God. Most of the literature on stigmas against people with health conditions in Saudi Arabia pertains to HIV and mental illnesses, such as schizophrenia (Koura et al., 2012; Wahass & Kent, 1997). Few studies were published on COVID-19.
COVID-19 is stigmatized not only because the epidemic is new and unknown, but also because many people are afraid of it or uninformed (UNICEF, 2020). It is easy to fear and blame people who have the virus. Several studies in Saudi Arabia suggest that: 1. neither religiosity nor worry about disease infection is related to stigmatizing others (Badahdah, 2010); 2. lack of knowledge about disease transmission and prevention forms negative attitudes against infected people (Raheel, 2016); 3. stigmatization can undermine social cohesion and lead to social isolation as people hide their illness and avoid seeking health care (Programs, 2020); (Raheel, 2016); 4. stigmatization leads to declining health status, poor access to health resources, and high rates of risky health behavior (Markowitz, 1998).

Kira et al. (2020) conducted a study to investigate how the COVID-19 pandemic is disproportionately affecting minorities’ discrimination victims, by investigating its impact as traumatic stress, along with intersecting discriminations, on socioeconomic position and well-being. A total of 1,374 people from seven Arab countries participated in the study (Egypt, Kuwait, Saudi Arabia, Jordan, Algeria, Iraq, and Palestine). COVID-19 traumatic stress, collective identity trauma (intersected discrimination), socioeconomic status, well-being, existential status and death concerns, posttraumatic stress disorder, depression, and general anxiety were among the variables examined. COVID-19 traumatic stress, when combined with collective identity traumas (intersected discrimination), increased existential status and death worries, as well as decreased social status and well-being, as well as increased posttraumatic stress disorder, anxiety, and depression. According to the findings, the route model of these interactions is strictly invariant across gender and substantially invariant among the nation groups studied.

Sulistiadi et al. (2020) conducted a qualitative study to examine some cases of stigma in Indonesia. The study highlighted the scarcity of personal protective equipment among health workers, the public's lack of knowledge of COVID-19, the media's distortion of news, and a lack of clarity among those in charge of education, information, and communication. Furthermore, the study found that the government has failed to act quickly enough to limit the spread of imported infectious diseases, resulting in local transmission and stigmatization among local communities.

Aliakbari Dehkordi et al. (2020) conducted a study to investigate the mental and social consequences of infected persons. Eight people (6 males and 2 females) with COVID-19 were included in the study. Interviews were used to collect data. Negative emotions such as fear of death, depression, and anxiety, decreased social activities, feelings of rejection by the community, decreased effective communication with family and society, and stigma experienced by the patient and her family are among the psychological consequences of this disease, according to the findings.

Karavdra et al. (2020) conducted a study to explore pregnant women's perceptions of COVID-19 and their healthcare experiences. Women who are pregnant or have given birth during the COVID-19 pandemic were asked to participate in a national online survey. One thousand four hundred fifty-one people responded to the online survey. Participants shared valuable information about the perceived hurdles to getting medical help during the pandemic.

“No wanting to bother anyone,” “lack of wider support from allied healthcare staff,” and media impact are only a few of them.

Ramaci et al. (2020) conducted a study to examine the effects of stigma, job demands, and self-esteem, and the consequences of working as a “frontline care provider” with patients infected with COVID-19. A total of 260 healthcare workers took part in the research (HCWs). A self-administered multiple-choice questionnaire, the Job Content Questionnaire (JCO), the Professional Quality of Life Scale (ProQOL), the Rosenberg Self-Esteem Scale, and the Rosenberg Self-Esteem Scale were used. According to the data, stigma has a significant impact on workers’ outcomes. Employee
compliance may be influenced by stigma, and management communication tactics regarding pandemic risk for HCWs may be influenced by stigma.

5. Research methodology

5.1. Research design
The current research adopted a qualitative research design (Sandelowski, 2000). It is a qualitative descriptive study as a type of social science research that utilized a guided interview to explore the impact of social stigma on people infected with COVID-19 in Saudi Arabia and the factors that worsen the stigma against COVID-19 patients. It followed a hermeneutical approach, using the authors’ knowledge of the Saudi cultural context, literature, cultural artifacts and practices, and information supplied by the research subjects. The hermeneutical approach is an appropriate research approach to interpret how people understand the construct and practice of judgment artistry (Paterson & Higgs, 2005).

Based on these considerations, the research followed the qualitative research design to suit its nature and objectives. Qualitative research emphasizes verbal rather than numerical data. As a research strategy, it is inductive, constructionist, and interpretive (Bryman, 2008).

5.2. Sampling
The research used the purposive sampling method. The research participants were fifteen Saudis who had infected and recovered from COVID-19, derived from Saudi community, aged between 25–55, eight males and seven females. This small sample was, of course, a limitation due to general social refusal. Participants were recruited through social media platforms. An important consideration in the selection of respondents was the diversity of the sample: respondents from several areas in various cities in Saudi Arabia were recruited to include a variety of social and economic strata. Regarding ethical consent prior to interviewing participants, the interviewees were approached and convinced to participate in the study by informing them the significance of this study and that their personal information and identity would be confidential as well as all the obtained information would only be restricted to scientific research purposes.

5.3. Instrumentation
The research implied an instrument designed by the authors which was a guided interview consisted of four main sections. The interview was administered to interviewees who have recovered from COVID-19. Before administering the interview, the authors obtained an approval from Saudi Social Studies Society of King Saud University. A guided interview was intended to ensure that the same general areas of information are collected from each interviewee. However, the format provides a degree of freedom and adaptability in getting comprehensive information from the interviewee. To ensure non-bias, the interview was recorded and transcribed verbatim, carefully reviewed and discussed between the authors.

The interviews can be characterized as a case study. Yin (2009) defined a case study as “an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (p. 18)”. This method is very useful for conducting research that crosses cultural boundaries. When conducting research as a Saudi citizen writing in an English academic setting, many of the culturally particular ideas discovered in the field must be interpreted, which necessitates interpretative effort. The authors are aware of the growing importance of many factors that might affect the stigma; however, they believe that this study offers an early warning regarding the importance of dealing with a social stigma.

The authors adhered to precautionary measures throughout the research procedures. Since there were a lockdown and no exit, the authors tried to contact some hospitals. Some of the people who were approached for interviews declined to talk to a stranger about their feelings
about stigma in their experience of the disease, but others wanted extra time to discuss it. The interview was conducted through calls, either by phone or on social media.

The interview guide content is designed to have four main sections: 1. Personal details (age, gender, how respondents caught the disease, how they discovered that they had been infected, How long they have been infected with COVID-19, What was the degree of their case severity? ). 2. Personal stigma (How the respondents felt when they first heard that they had tested positive? What was their reaction? Did they immediately tell their family? Have they had problems with their self-confidence or self-esteem? Is it embarrassing to be sick with COVID-19? Do they prefer that people do not know about the COVID-19 that they are experiencing? How do they perceive themselves and society as being formerly infected with Covid-19? What was their reaction in relation to the negative behavior or attitude of their friends and family? Have they felt during that period of great pressure and tension? Have they felt shy while answering the doctor’s questions?). 3. Social stigma (What was the reaction of respondents’ social networks? Have they been blamed for being infected? Have they discussed their medical condition with close friends or family? Have they ever felt or experienced that they were ignored, labeled, discriminated, or stereotyped for being infected with COVID-19? Have they been asked to stay away from work group? Do they feel that people avoid them because of their infection? Have people refused to visit their home because of this condition even after their recovery? Give an example. Do they think that patients with COVID-19 are rejected by society? Have healthcare workers stopped the attendants from seeing the patients with COVID-19? Did they get social support that helped them overcome this health problem? Have they exposed to bullying, physical violence or harassment? What were their family relations during their infection with COVID-19? Did they get any sort of support?) 4. Medical care (How have the patients been treated by the doctors and health practitioners? Were they provided with sufficient medical care?). Questions were asked about life after recovering from COVID-19 generally and in-depth questions about experiences of stigma in particular. The data were then organized into themes to derive the results to be discussed.

- Ethical Consideration

The study was approved by the Saudi Social Studies Society of King Saud University: Ksu-ssss-20-01.

6. Results

For assuring objectivity and avoiding subjectivity, the participants’ responses were peer reviewed. Arranging qualitative interviews, providing analyses, and relating the findings to the literature on other viral diseases revealed four aspects: The impact of social stigma on people infected with COVID-19, the factors that worsen the social stigma against COVID-19 patients, the relation between social stigma and COVID-19, and social stigma on COVID-19 patients in terms of gender.

6.1. The impact of social stigma on people infected with COVID-19

It is hard to compare people with COVID-19 to those with AIDS or HIV because these

conditions are associated with different behaviors. With COVID-19, the stigma manifests when people do not comply with recommendations to stay at home and practice social distancing. One interviewee talked about how he saw himself after being infected with COVID-19 from his brother who had just come back from abroad:

I did not take it seriously, and it was a shock to know that I was infected. How did it happen just like that? I guess it is not my fault nor my brother’s—it is Allah’s will. I was hurt more when I knew that people were after the story, and this was all they cared about. This is a disease, there is nothing wrong about it and there is nothing religiously shameful for me.
Another view was presented by an interviewee who was more confident:

All praise goes to Allah. I was committed to all the announced precautions and I have received care and treatment by the government, but this is Allah’s will. I am clueless why people are embarrassed by it as if they have done something wrong or something that harms their reputation. I see myself as innocent, but if others do not accept it, it is their problem.

It was clear from the interviewees’ responses that social stigma is related to shame, immorality, or lack of religiousness. Many of them insisted that “we have not done anything religiously prohibited”, implying that only religiously prohibited actions are shameful. Moreover, the root of this social stigma may be a result of the society, whereas people attribute illnesses to pre-existing cultural and social attitudes and perceptions of catching the disease. Moreover, with the spread of rumors that created new fears, the reactions ranged from intense fear to denial. Considering the Saudi community as one of the societies that acknowledge death and the limited human abilities to face death, social stigma has become a means to express the inability to face death. There has been focus on the person to evaluate their actions since the Saudi society has explicit cultural beliefs regarding social stigma. This characteristic stems from the culture of social judgment, which is based on assessing others according to the prevailing social standards considering that the society adopts the concepts of the good and bad person in accordance with the ethical standards, norms and social values. Hence, the person infected with COVID-19 is considered a bad person. Common values serve as the only channel for group communication, leaving limited space for individuals to justify their infection and behaviors, which prevent them from disclosing the disease so as not to face more cultural obstacles. Koschorke et al. (2017) state that the meanings, behaviors and results of stigma varies across cultures. In various contexts, social stigma can take on different forms.

Social stigmas are culturally devalued distinctions that result in the formation of negative inferences, often leading to prejudice and discrimination (Dovidio et al., 2000). Social psychologists have long been interested in prejudice and stereotypes. However, it is only recently that the field has devoted substantial attention to the targets of stigma and the psychological consequences of stigmatized identity (J. Cracker et al., 1998; Kaiser, 2006; Mendoza-Denton et al., 2006).

There is evidence of prejudice among health care workers who are uninformed about the transmission of HIV (Memish et al., 2015). It would not be surprising, therefore, if patients in this study were to report prejudice among doctors with poor knowledge of COVID-19. This might be a consequence of the cultural acceptability of prejudice against COVID-19, which is often associated with not taking necessary precautions. First-line health care workers’ lack of knowledge of COVID-19 transmission may be a barrier to the development of preventive interventions or therapeutic programs for COVID-19. However, the interviewees were satisfied with their health care workers, describing them as understanding their needs and providing them with special care.

There is no reason for the study’s interviewees to blame themselves for having been infected with COVID-19, even if other people do so. Other people might assume that they would pass on the infection or that they did not stay in quarantine as instructed by the Saudi government. An official in MOH stated:

There is a difference between being infected after traveling and after mixing with people. Someone infected during travel did not feel embarrassed or blamed at the beginning of the outbreak. But people mixing with others received a great deal of blame because they had not taken the necessary precautions to apply social distance and to go out only when they had to.
The participants have different opinions of the harm caused by not abiding by the government’s instructions. People think the infection is caused by violating religious and cultural obligations. Many stories were published in the Arab news accusing people with COVID-19 of not staying in quarantine. A participant described the reactions of society stating:

When I was first diagnosed with coronavirus, people have changed dramatically. My family and I have a story to tell as if I have done something wrong, although I was infected by a co-worker. Many people created false stories as if I am a criminal. I felt worthless to others after getting infected.

The cultural environment defines how we construct and confront fear. The culture of the community is the foundation of the logical daily life, where experiences, beliefs, religion, habits, ideas and memories are stored and adopted in various situations. Culture warns against danger and poses the alternatives and methods that overcome it. Methods of fear expression may create new fears that spread in a short time. During COVID-19 pandemic, religious and ideological interpretations and visions appeared at the individual level, as they explained the closure of worship places as an indication of the approaching of the Day of Resurrection. Thus, they adopted ideological methods to get closer to Allah.

Social support is beneficial to one’s health. Access to resources is improved, the immune system is strengthened, and health-related behaviors are improved. Integration into supportive networks can help people improve their mental and physical health by lowering stress and shielding them from stresses that can harm their health and well-being (Cohen & Syme, 1985; House et al., 1988; Turner & Turner, 1999).

How was it after coming out of the hospital?

Even after that, some of my friends keep joking about the incident. I am cured, but some people still doubt it. People treat me cruelly, which is totally the opposite of the Ministry of Health. I am speechless about the MOH: They gave me the care I need. I think my family has struggled more than I did with people’s stories and the spreading of rumors on WhatsApp. They tried not to tell me, but they reached me in one way or another.

This social stigma may hinder the Saudi government from offering coronavirus tests and medical care. People fear being stigmatized by the virus and then being abandoned by others. Fear of infection has become a social concern. Avoidance of those who are perceived to carry a risk of infection and the subsequent bullying, which can reach the level of cursing and castigation, lead us to pose questions about the social impact of contracting COVID-19.

6.2. The factors that worsen the social stigma against COVID-19 patients

The authors acknowledge that it is hard to cover all the social impacts of contracting COVID-19 in Saudi Arabia. One reason is that the social impacts require long-term monitoring. Another reason is that the COVID-19 pandemic is so recent. Therefore, the authors introduced and interpreted the most significant remarks from administering the interview.

People with COVID-19 feel awkward about being accused of infecting other people, especially the elderly, which has exacerbated and worsen the social stigma against them. This judgment, along with rumors and cursing, affects relationships with society, relatives, and friends. According to an interviewee who had recovered from COVID-19,

It is strange to get this amount of rumors and curses, as if I am the only one to be infected or as if I am responsible for the outbreak. I got infected like many others and I did not infect or kill anyone. I am sick of telling people that; it is just impossible—how come I am the cause of it all?
I am disgraced towards friends and colleagues. Instead of giving me their support, they have become more hurtful than corona. I do not know if I transmitted it to others, and actually, I no longer care. I do not like to be in places where there are a lot of people and I would rather be alone.

Since the virus easily spreads, people with the infection need to comply with quarantine and seek treatment, but they should not be treated by others as a symbol of death. Many people confuse COVID-19 with other viruses, denying that COVID-19 can be transmitted simply through the air, or by touching surfaces that have been contaminated, and not by unethical relationships. A confident return to normal life among people in Saudi Arabia who have recovered from the coronavirus has become unlikely as a result of the many rumors and curses that abound. There are two paths for a cured patient to take: either to ignore the issue or to deny being infected. According to another participant,

I was embarrassed to admit my infection; I would even prefer to hide the fact. I was worry about people’s reaction.

Why?

Unfortunately, many people have fear of disease and have no sympathy for patients. A patient is now judged for neglect and causing harm to others. Certain groups, not all, of infected and people who have recovered from the coronavirus are afraid to disclose their health status because of the way people would treat them and out of fear of transmitting the infection to others.

This social stigma can lead to withdrawal from society and the inability to communicate with others, which might persist after the pandemic ends. This epidemic is having social effects, especially in Saudi society where there is a great deal of social movement in gatherings and direct social relations. However, in the aftermath of the epidemic, there is likely to be more social distancing than before as people might be cautious about attending celebrations and family gatherings or meeting other people. These practices may explain the behavior of people who have recovered from the coronavirus as a result of other people's reactions to their infection.

6.3. The relation between social stigma and COVID-19

The benefits of social networks were examined in public health and other fields. Kawachi et al. (1996) claim that strong social networks are associated with reduced incidence of many diseases. Connections to sources of social support can reduce the spread of illness, limit risky behaviors, and increase emotional bonding, while improving the provision of information and advice and positive peer influence, as well as promoting health-seeking behavior (Cohen &Cohen & Syme, 1985); (Ennett et al., 1999); (House et al., 1988). In many cases, infected people try to gain support from their social networks only to find themselves isolated. Even when people have recovered, they are still accused of spreading the disease.

Another participant says:

It is painful when people congratulate me on recovery, but then comes the inevitable question: with whom did you meet lately? And how can I be sure you did not meet people close to me? Questions go on, and at that point, I realize that they care only about themselves and they are not checking on me at all. Distant others spread rumors or keep saying Allah is sufficient. I read posts in some groups of people, whom I once thought friends, making prayers against me. I was taken by surprise when I saw their reactions while I was sick. Believe me, people's reactions to my sickness are something that I cannot forget; it was harsh. In the beginning, I kept apologizing; but
in the end, I stopped caring. Furthermore, I can tell now false friends from true friends, and they are many.

It can be inferred from this interview that there is confusion in the way Saudi society sees people with COVID-19. Worry prevails because so little is known about the disease. This is evident in the way in which people who have survived the infection are interrogated.

Among people infected with COVID-19, efforts to conceal their disease from other members of their network can reverse the positive association between social support and health outcomes. People who hide their disease status from friends and family while continuing to interact within those networks deny themselves access to beneficial social resources. They may also forgo medical treatment for fear of being found out or discredited (Goffman, 1963).

Social reactions can be quite justifiable as a result of the powerful media coverage of the pandemic. Watching the news and keeping track of the rising COVID-19 death toll have caused panic in Saudi Arabia. In an opposing view, a participant says:

Upon arrival at [King Saud Airport], I was held in quarantine. Two days later, I was informed that I had the coronavirus. Actually, everyone around me, my relatives and friends, was checking on me. I had a hard experience, but the reactions of others were encouraging and filled me with hope.

But why do you think others are bullied?

I believe you mean people infected through mixing with others and not during travel. Yes, it happens because there are instructions to stay at home, and people who do not comply are accused and attacked. You should not disregard people’s fear of the virus and the amount of information on social media, which has increased bullying. We need to be more aware of and sympathetic towards patients and less fearful by attacking, making up rumors, and accusing people of lack of awareness. We need to be more supportive and compassionate than ever before.

These statements show a tendency to feel compassionate. This compassion arises from a concern for the person with the infection. However, such compassion does not extend to people who disregard social distancing and public quarantine. Therefore, some individuals view people with COVID-19 as a threat to themselves, their families, and society. Moreover, this indicates a positive association between social stigma and COVID-19 in Saudi Arabia.

Compassion is extended to people who were infected during travel and at the beginning of the epidemic. Social media have circulated images of people being infected through gatherings.

Some Saudi citizens have been aggressive towards people who are not observing social distancing or quarantine. However, many people who have recovered from the coronavirus disagree with this. If people’s reactions towards those with the infection are negative, they have justifications for this as we see in social media. Thus, we seek ways to overcome this negative image from the perspective of those who have recovered from the coronavirus.

6.4. Social stigma on COVID-19 patients in terms of gender

Since COVID-19 is still spreading, we need to know how to reduce the bullying and stigma that people with the virus face. According to one of our female interviewees,

Instead of gloating or cursing the infected, people should be more sympathetic even after recovery. We, as patients, want to leave behind the pain of illness and the pain of stigma, as it is called. After recovery, we need social rehabilitation from the shock of being infected. People should stop blaming patients for what happened or reminding them of the number of infections
and deaths. We are Muslims, we believe in Allah’s (God’s) will, and it is impossible to be responsible for all the drama when I do not even know how I got infected in the first place.

When someone with COVID-19 is stigmatized, so too is his or her family. A woman who recovered from the virus said that rumors and posting of news of infection on social media must stop. It is better to offer care and sympathy. This can be achieved through social media. Disparaging people with COVID-19 should be replaced with help and sympathy. This is better than speculating about the cause of infection, how it was transmitted, and how many other people might have been infected.

A health care provider states:

We are experiencing a media crisis that manifests itself through social media. There are many rumors and many more comments, where everybody seems to say what they think without real experience or knowledge and to consider the patients as criminals. Now, the media trend should be oriented towards ways of protecting yourself, how to deal with a coronavirus patient, and how to alleviate the impact on patients in one way or another.

As for the communicative and informational dimensions of the societal struggle against the pandemic, it was embodied, in our opinion, in the negative role played by social media, especially “Twitter” in increasing the impact of social stigma. During the lockdown, social media sites alone remained the window through which the different social and cultural strata overlooked their social worlds. With the decrease of connectivity with actual reference groups of family, peers, real friends, partners, and colleagues, social media alone secure the direct and live broadcast of the diaries of the general public of people, influencers, artists, and religious scholars (sheiks). These actions offered more space to disseminate their believes and ideas that carried implicit messages incriminating infected with COVID-19 with no boundaries.

The COVID-19 outbreak has led to stigmatization and discrimination against people of certain ethnic backgrounds, such as Asian workers, and against people thought to have been in contact with the virus or spread it to anyone in Saudi Arabia. Media have increased the stigma by labeling, stereotyping, discriminating, and bullying people with the virus. They have also failed to inform the population about treatment.

Social media urge people to avoid possible hotspots, but these campaigns might have cultivated a sense of cruelty against people with COVID-19. People with the virus are mistreated and discriminated against. The stigma surrounding COVID-19 should be addressed in the media in order to promote a positive attitude about the condition, dispel myths, and modify public behavior. Mass media intensified the fear of HIV when the first case was reported in Saudi Arabia in 1984. The same is happening today with COVID-19. The media mischaracterized the disease and the people living with it. At the same time, authors claim that the potential negative impacts of coronavirus may be exacerbated by fear, self-isolation, and social distraction. The risk of suicide among people with COVID-19, their families, and health care providers may increase because of the stigma. For overcoming social stigma, a male participant suggests:

Active bullies on social media should be punished. It is unacceptable, whether on social media platforms or in private WhatsApp groups, to publish false news about a person who is infected for not staying in quarantine and claim that they transmitted it to the family of another person. The patient is in a critical state and needs support, rather than judgment, stigma, and being cut off. I call for punishment for people who publish lies and rumors. Even if the news later proves to be true, they do not have the right to spread it in public. Nobody knows exactly the circumstances of infection; therefore, we need to put an end to those rumors.
Both male and female interviewees viewed themselves as having been treated unfairly. People in positions of social power denied being infected with COVID-19 to avoid questions. People who have recovered are looked down upon, so they do not mention that they have had the virus. Obviously, there was no difference between the participants in the rate of social stigma according to gender. Although that the Saudi society culture distinguishes between males and females, no individual differences appeared in dealing with the cases according to gender. This may be because confrontation with the possibility of death, which is a very sensitive issue, can remove most marginal cultural differences. From the perspective of sociology of fear, fear is considered a social act within a cultural matrix that controls public awareness of dangers and influences its prevailing sense. The intensity of fear varies according to the nature of the interactive relationships between the community segments. The persons’ trust and emotional connection with others directly affect the intensity of fear and empathy towards the other that does not consider the participants’ gender when facing death.

People who have recovered from COVID-19 believe that the government should punish those who accuse them on social media of spreading the infection. This belief, as explained by some interviewees, reflects the carelessness of mass media in contrast to the efforts from Ministry of Health. The tension between people with the virus and society regarding responsibility for the outbreak has to be reduced by not treating infected people as criminals.

7. Discussion
The current research aimed to investigate the influence of COVID-19 in relation to social stigma against people who have been infected. Data were collected from recovered patients. Four important findings warrant consideration. Firstly, the experienced social stigma is varied in form and people's behaviors. It is important to address the fact that first-line health care workers did not experience any form of associative stigma, as reported in some mental health studies. Verhaeghe and Bracke (2012) revealed that professionals from diverse mental health services had an associative stigma that was related to emotional exhaustion and reduced client satisfaction. Secondly, the root of this social stigma emanates from pre-existing cultural and social attitudes, perceptions, and knowledge about catching diseases, such as HIV. Thirdly, despite the feeling of social stigma, most interviewees described their relationship with the health care workers as non-stigmatizing and non-discriminatory. Fourthly, although authorities in Saudi Arabia have made genuine attempts to raise COVID-19 awareness through official media and social channels, these efforts are comparatively meager or negatively influence the rise of the forms of labeling, stereotyping, discriminating, and bullying. There was a strong predictor that they would fail to provide the population with information about the Covid-19 treatment protocol and to send key messages to the public. It is important to raise the awareness that people who are diagnosed with COVID-19 have not done anything wrong and they deserve to be treated with compassion and kindness, and not to be stigmatized.

The research clarified that social stigma is a problem because it disrupts social relationships and causes psychological suffering, which can harm patients’ quality of life, especially after an illness. The media’s attention on de-stigmatizing words can assist eliminate stigma in other areas (Budhwani & Sun, 2020). COVID-19 misinformation has quickly circulated around the world thanks to social media (Molecki et al., 2021). Accordingly, providing accurate information about the virus’s biology and spread can be a good way to eliminate stigma (Sotgiu & Dobler, 2020). Fear and blame were drivers of COVID-19 stigma (Parker & Aggleton, 2003).

Although a large body of research points to the positive association between social stigma and HIV because of how the disease is transmitted, it is uncertain whether this association can be applied to COVID-19. Individual behavior is very significant to control the spread of COVID-19 (Keltner et al., 2003). This research accomplished its objectives: The findings support a positive association between social stigma and COVID-19 despite the limitation of the research. The
authors found evidence of labeling, stereotyping, and discrimination, either verbally or behaviorally. At the cultural level, the research examines whether the culture of society influences social stigma. Supportive evidence was found that culture plays a vital role in social stigma. Most participants were aware of the cultural background regarding reputation. In Saudi Arabia, most people know each other by their family names. The reputation of the clan is basically built over centuries and individuals are responsible for keeping this reputation highly respected. Therefore, an affected person tends to hide their health situation to be respected among the clan’s members. Solid scientific evidence shows that social relationships, in terms of both quality and quantity, are essential for emotional support in a range of health outcomes, but in some cases, social relationships can be stressful for individuals (Umberson & Karas Montez, 2010). The bonding social capital in the Saudi cultural context plays an essential role in people’s social behaviors, in general (Alghuraibi, 2017), and social stigma and hiding the illness, in particular. 3. In many cases, social stigma drove people to hide their illness for two reasons. The first is the increased value of personal privacy, which means that people find it difficult to speak about being diagnosed with COVID-19 or even to tell others that they are in isolation due to experiencing symptoms. The other reason is feeling ashamed of telling others in order to avoid discrimination which prevents them from seeking instant health care and discouraging them from implementing healthy behaviors. This shame results in more serious health problems, difficulties controlling a disease outbreak, and crushing a country’s economy. According to most participants, this finding confirms previous studies (Programs, 2020). The severity of the COVID-19 patient’s case and the length of the disease have an impact on the social stigma. Furthermore, the results indicated that there was no difference between the participants in the rate of social stigma according to gender variable. Nevertheless, this contradicted with González- Sanguino et al. (2020) who refer that spiritual well-being is another characteristic in which men and women differ, with women reporting the lowest levels of well-being during the COVID-19 pandemic.

The results of the research cannot be generalized due to the limited number of participants. Thus, the study can be replicated on a larger sample as a recommendation. The limitation of the research can be divided into two categories: The sampling methods and the size of the sample. Firstly, the sampling method: Purposive sampling was used for this study, which could lead to research bias. The authors were aware that it is not possible to defend the representativeness of the sample, which makes it difficult to make a logical generalization of the results. Though, they dealt with it in two ways; a. supports the study of COVID-19 stigma by comparing the participants’ responses to earlier researches of HIV social stigma and the results of these studies in Saudi Arabia to have a complete understanding of health-related stigma. b. The authors were also aware of the timing. This research was conducted after COVID-19 hit Saudi Arabia, which means that it was difficult to reach the population to sample using other sampling methods because of the lockdown and precautionary measures applied in the country. Secondly, sample size, like most qualitative studies in which authors normally focus on the participants’ perceptions in order to draw conclusions that meet the research objectives, the present research focused on the patient’s responses and health care providers who proved to observe people’s reactions in the matter of social stigma during the period of testing and treatment. Participants posed problems that could help health care workers, governments, and media to provide a better understanding of the negative impact of COVID-19 related stigma. Future research is necessary to ascertain whether the findings yielded in the present research are reflected in the majority of the Saudi population. Additionally, it is recommended to investigate the relation between COVID-19 social stigma and the socio-economic status. This research focuses on basic points. For example, preventive protocols and information dissemination about the epidemic must take into account the culture of the society. In a faithful society, relying on God without prevention will not reduce the spread of disease. There must be some form of official censorship over what is posted on social media to minimize social stigma. Finally, spreading more educational instructions in communities is needed to distinguish between diseases that are transmitted as a result of unethical practices and other sorts of diseases to reduce social stigma.
8. Conclusion

Despite the current research limitations regarding the sampling methods and the size of the sample, social stigma in Saudi society has a noticeable impact on individuals, families, and communities. The research paper revealed that the social stigma attached to people with COVID-19 harmed their social life even after they had recovered. It is critical for the media to emphasize self-protection and prevention of COVID-19 infection because their actions to date have given some people an incentive to spread rumors and to bully people with the virus instead of sympathizing or offering support. Although these campaigns were not intended to cause harm, they shaped public reaction towards the virus and people who had contracted it. It is better to limit media discussions of COVID-19 to allow everyone to understand what the virus is and what its effects are. There is a considerable correlation between fear of COVID-19 in Saudi society and social media campaigns, which has led people who have recovered from the coronavirus to insist that they are victims. In conclusion, social stigma in a traditional society like Saudi Arabia may depend on families and the community. Its effects can be long-lasting, making it difficult for people who have recovered from COVID-19 to re-join society or regain self-confidence and trust in others. Communities should identify negative behaviors in order to support stigmatized people. Patients are at risk of experiencing social stigma and bullying should be provided with adequate social, psychological and medical support as well as appropriate means of protection. Media has a major role in reducing the stigma imposed on people infected with COVID-19 and their families. Thus, the information from media and social networking should be well controlled and emphasize the rejection of bullying, discrimination and social stigma.

Acknowledgements
The authors thank the Deanship of Scientific Research and RSSU at King Saud University for their technical support. The authors also thank Saudi Social Studies Society for its support.

Funding
The authors received no direct funding for this research.

Author details
Muna Abdullah Al-Ghuraibi1, Theeb M Aldossery2
E-mail: didtheeb174@gmail.com
1 Assistant Professor of Social Studies, College of Arts, King Saud University.

Disclosure statement
No potential conflict of interest was reported by the author(s).

Ethics statement
Social Research Ethics Committee approved to conduct this research.

Citation information
Cite this article as: Social Stigma as an outcome of the cultural repercussions toward COVID-19 in Saudi Arabia, Muna Abdullah Al-Ghuraibi & Theeb M Aldossery, Cogent Social Sciences (2022), 8: 2053270.

References
Alghuraibi, M. A. (2017). The Role of Social Capital in the Formation and Activation of Civil Society Organisations in Saudi Arabia. (PhD dissertation). University of Sydney, http://hdl.handle.net/2123/17686. Available from The University of Sydney eScholarship database.
Aliakbar Dehkordi, M., Esrazadeh, F., & Aghojanibigloo, S. (2020). Psychological consequences of patients with coronavirus (COVID-19): A qualitative study. Iranian Journal of Health Psychology, 22(2), 9–20. doi:10.30473/ijoph.2020.52395.1074.
Badahdah, A. M. (2010). Stigmatization of persons with HIV/AIDS in Saudi Arabia. Journal of Transcultural Nursing, 21(4), 386–392. https://doi.org/10.1177/1043659609360873
Bernhardsdöttir, Á. E. (2015). Crisis-Related decision-making and the influence of culture on the behavior of decision makers. doi, 10, 978-973. Cham: Springer International Publishing.
Bhanot, D., Singh, T., Verma, S. K., & Sharad, S. (2020). Stigma and discrimination during COVID-19 pandemic. Frontiers in Public Health, 8(829), 1–11. https://doi.org/10.3389/fpubh.2020.577018
Bruns, D. P., Krogljac, N. V., & Bruns, T. R. (2020). COVID-19: Facts, cultural considerations, and risk of stigmatization. Journal of Transcultural Nursing, 31(4), 326–332. https://doi.org/10.1177/1043659620917724
Bryman, A. (2008). Social research methods (edn ed.). Oxford University Press.
Budhwani, H., & Sun, R. (2020). Creating COVID-19 stigma by referencing the novel coronavirus as the “Chinese virus” on twitter: Quantitative analysis of social media data. Journal of Medical Internet Research, 22(5), 19301. https://doi.org/10.2196/19301
Cioffi, D. (2000) The social psychology of stigma In T. F., Heatherton, R.E., Kleck, M. R., Hebl, J. G., Hull (Eds.), The looking-glass self revisited: Behavior choice and self-perception in the social token.). : Guilford Press (pp. 184–219).
Cohen, S. E., & Syme, S. (1985). Social support and health: Academic Press.
Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2016). What is the impact of self stigma? Loss of self-respect and the "why try" effect. Journal of Mental Health, 25(1), 10–15. https://doi.org/10.1080/13652850.2015.1021902
Crocker, J., Major, B., & Steele, M. (1998). Social stigma. In The handbook of social psychology (4 ed., pp. 504–553). McGraw-Hill.
Crocker, J., & Quinn, D. M. (2000) The social psychology of stigma In T. F., Heatherton, R. E., Kleck, M. R., Hebl, J.
Majer, B., & O'Brien, L. T. (2005). The social psychology of stigma. Annu. Rev. Psychol., 56(1), 393–421. https://doi.org/10.1146/annurev.psych.56.091003.070137

Malecki, K. M., Heating, J. A., & Safdar, N. (2021). Of Crisis communication and public perception. Markowitz, F. E. (1998). The effects of stigma on the psychological well-being and life satisfaction of persons with mental illness. Journal of Health and Social Behavior, 39(4), 335–347. https://doi.org/10.2307/2676342

Mernish, Z. A., Filmian, S. M., Bambboyel, A., Al Hover, R. F., Eltrashied, S. M., & Al-Towfiq, J. A. (2015). Knowledge and attitudes of doctors toward people living with HIV/AIDS in Saudi Arabia. JAIDS Journal of Acquired Immune Deficiency Syndromes, 69(1), 61–67. https://doi.org/10.1097/QAI.000000000000550

Mendoza-Denton, R., Page-Gould, E., & Pietrzak, J. (2006). Mechanisms for coping with status-based rejection expectations In S., Levin, C., van Loar (Eds.), In Stigma and group inequality (pp. 165–184). Psychology Press.

Miller, C. T. (2006). Social psychological perspectives on coping with stressors related to stigma In S., Levin, C., van Loar (Eds.), In Stigma and group inequality (pp. 35–58). Psychology Press.

Omer, T., Lovering, S., & Shomrani, M. A. (2014). The lived experience of living with HIV/AIDS in the western region of Saudi Arabia. Diversity & Equality in Health and Care, 11(6), 215–223. https://doi.org/10.21767/2049-5671.1000022

Organization, W. H. (2020). A guide to preventing and addressing social stigma associated with COVID-19. World Health Organization, https://www.who.int/publications/m/item/guide-to-preventing-and-addressing-social-stigma-associated-with-covid-19

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. Social Science & Medicine, 57(1), 13–24. https://doi.org/10.1016/s0140-6736(02)00304-0

Potterson, M., & Higgs, J. (2005). Using Hermeneutics as a Qualitative Research Approach in.

Pescosolido, B. A. (2013). The public stigma of mental illness: What do we think; what do we know; what can we prove? Journal of Health and Social Behavior, 54(1), 1–21. https://doi.org/10.1177/0022146512471197

Programs, J. H. C. (2020). COVID-19 resources. Obzornik zdravstvene nege, 54 (2), 100–103. https://ccp.jhur. eu/resources-3/covid-19-resources/ Prosen, M. (2020). Social stigma in the time of coronavirus (COVID-19): an epidemic we must not remain silent about.

Raheel, H. (2016). Stigma towards people living with HIV/AIDS (PLWAs) among adolescents of Riyadh, kingdom of Saudi Arabia. Journal of AIDS & Clinical Research, 7 (9). https://doi.org/10.4172/2155-6133.1000049

Ramaci, T., Barottucci, M., Ledda, C., & Rapisarda, V. (2020). Social stigma during COVID-19 and its impact on HCWs outcomes. Sustainability, 12(9), 3834. https://doi.org/10.3390/su12093834

Sabit, I., Neuman-Böhme, S., Varghese, N. E., Barros, P. P., Brouwer, W., van Exel, J., Schreyögg, J., & Stargardt, T. (2020). United but divided: Policy responses and people’s perceptions in the EU during the COVID-19 outbreak. Health Policy (Amsterdam, Netherlands), 124(9), 909–918. https://doi.org/10.1016/j.healthpol.2020.06.009

Sandefors, M. (2000). Focus on research methods: Whatever happened to qualitative description?
Sulistiadi, W., Slamet, S. R., & Harmani, N. (2020). Kesmas: Jurnal Kesehatan Masyarakat Nasional (National Public Health Journal). 1(1) 70–76. doi:10.21109/kesmas.v1i152.3909.

Umberson, D., & Karas Montez, J. (2010). Social relationships and health: A flashpoint for health policy. Journal of Health and Social Behavior, 51(1), 55–86. https://doi.org/10.1177/0022146510383501

UNICEF. (2020). Social stigma associated with COVID-19. https://www.unicef.org/media/65931/file/Social%20stigma%20associated%20with%20the%20corona%20virus%20disease%202019%20(COVID-19).pdf

UNPD. (2020). COVID_19 pandemic: Humanity needs leadership and solidarity to defeat COVID-19. https://www.asia-pacific.unpd.org/content/rbap/en/home/coronavirus.html

Venkateswaran, R. T., & George, R. (2020). When does culture matter? A multilevel study on the role of situational moderators. Journal of Business Research, 116(3), 99–122. https://doi.org/10.1016/j.jbusres.2020.04.052

Verhoeffe, M., & Brocke, P. (2012). Associative stigma among mental health professionals: Implications for professional and service user well-being. Journal of Health and Social Behavior, 53(1), 17–32. https://doi.org/10.1177/0022146512439453

Wahass, S., & Kent, G. (1997). A comparison of public attitudes in Britain and Saudi Arabia towards auditory hallucinations. International Journal of Social Psychiatry, 43(3), 175–183. https://doi.org/10.1177/00207640970430030

Yin, R. K. (2009). Case study research: Design and methods. Sage.

Zortaloudi, A., & Madianos, M. (2010). Stigma related to help-seeking from a mental health professional. Health Science Journal, 4(2), 77–83 https://www.hsj.gr/medicine/stigma-related-to-help-seeking-from-a-mental-health-professional.pdf.