RESEARCH ARTICLE

Stigma and Solidarity Among Covid-19 Patients in the Philippines

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Abstract: Pandemic management strategies often reinforce the trope of the uncooperative and disease-spreading poor; they who are to be blamed for transmission and therefore must be subdued to protect the population. Although counternarratives to this proposition seek to explain from the lens of political economy why people who are poor behave the way they do, they do not, at the bottom, assail the central idea that the poor behave in ways inconsistent with the aims of public health. The interrogation of this central idea is what this research aims to contribute towards using original data from interviews with 21 COVID-19 survivors in the urban poor areas in the Philippines. This research captures experiences in the stigma of COVID-positive individuals during the early stages of the virus in May-June 2020, and investigates how these experiences might impact views on the duty of the infected to voluntarily disclose their infection status. It finds that despite painful stigmatizing experiences both within their communities and in interactions with actors in the public health care system, an overwhelming majority of participants still felt that they had a duty to voluntarily disclose their COVID-positive status to protect their community—offering another possible critique to mainstream narratives that blame the poor for pandemics and other crises.

Keywords: COVID-19, solidarity, stigma, pandemics, Philippines

The Filipino word *pasaway* has no precise English translation that captures its complex pejorative nuances, but it roughly translates to the "irrationally stubborn" and "uncooperative" and is often used in an infantilizing fashion for children and inferiors. The word has taken on a class dimension in the early months of the COVID-19 pandemic in the Philippines, as it was used by Filipino government officials to describe ordinary Filipinos whose supposedly cavalier attitudes caused the spread of the virus. Despite being unsupported by data (for example, Punongbayan, 2020) and agnostic to the pandemic's uneven impacts, perceptions of the cavalier attitudes of the poor reflect dominant middle-class narratives that depict working-class or poor Filipinos as undisciplined disease-spreaders. The scapegoating of the "*pasaway* poor" did not just surface in discourse, it has also shaped government policy on COVID-19 management (Sapalo & Marasigan, 2020). Although stigma on the basis of class stereotypes is markedly different from the stigma faced by lower-class COVID-19 quarantine patients, the intersection of these stigmas creates significant differences in the way COVID-19 is experienced between and among social classes.

In April of 2020, for instance, the Philippine government announced that COVID-19 positive individuals would be required to disclose their identities for contact tracing procedures to be undertaken (Cepeda, 2020). Public officials rallied behind this measure, saying that mandatory disclosure would ensure better contact tracing (Mercado, 2020). The underlying premise and the intuitive assumption behind this was that the coercive power of the State was necessary because, faced with the stigma and discrimination from their communities as well as the possible economic consequences of stigmatization, COVID-19 patients would be afraid to disclose their status and cannot be called upon to consider the interests of public health and the wider community.

Similar to other populist leaders all over the world, Duterte has been drawing from an arsenal of strongman tactics described as punitive (Beltran, 2020), and disproportionately burdensome to the poor (Bainbridge & Vimonsuknopparat, 2020; Santos, 2020). In July of 2020, for example, the government announced that COVID-19 asymptomatic patients would be tracked down by law enforcement forces and be bodily brought to public quarantine facilities (Jazul, 2020). Although emergency measures are understandable during a public health emergency, the application of these measures in the Philippines has, for the most part, been uneven. The militarized lockdown response has largely impacted those in the urban poor communities (Recio et al., 2020) and has tended to reinforce the trope of the uncooperative infantile poor—they who cannot be called upon to take the interests of public health into consideration and must be "controlled" to protect the rest of the population. As described by Bhattacharya et al. (2020), "transmissions of infections has always been associated with poverty, filth and class to maintain a false sense of assurance and safety for the higher sections of society" (p. 382).

Several critiques and counternarratives have been offered to this supposition, critiques and counternarratives that speak to the uneven economic impacts of the pandemic, both global (Davis, 2020; Klein, 2020) and local (Recio et al., 2020), and the extraordinary pressures that bear down upon the poor and influence their choices. Although these counternarratives explain from the lens of political economy why the poor behave the way they do, they do not at bottom assail the idea that the poor behave in ways that are inconsistent with the objectives of public health. It is here that this study offers its modest contribution.

Purpose of the Study

This research aims, through empirical data from interviews with 21 COVID-19 positive individuals in the urban poor areas in Quezon City, Philippines, to investigate experiences with stigmatization and discrimination within their community as a result of the virus and how these experiences impact their actions and decision-making. Predicating on the premise that pandemics are not just biophysical phenomena but epidemiological events aided and mediated by economic and political processes, both global and local, with disproportionate impacts on vulnerable social groups, the following key questions were asked: firstly, whether or not, and how, do COVID-19 positive individuals from urban poor areas experience stigmatization within their immediate communities; secondly, how do COVID-19 positive individuals from urban poor areas link COVID-related stigmatization to broader issues of class and differentiation; and thirdly, to what extent do these experiences with stigmatization influence perceptions on the duty of a COVID-19 positive individual to disclose his or her infection status?

This research was conducted in the early stages of the pandemic, and it may be possible that experiences of stigma and discrimination were made more acute by the lack of knowledge of the disease and the extreme fear of contraction.

Review of Related Literature

Blaming the poor for adverse conditions, such as pandemics, is by no means a new phenomenon. A latent hostility towards the poor has, in large part, been responsible for an acceptance of inequality (Dorey, 2010) and has, in myriad ways, shaped policies meant to benefit them (see Unterhalter et al., 2012). Mary Douglas (2013) suggested that blaming demonstrates how a society is organized and that a major crisis—such as a pandemic—exposes cleavages that are already there. This research draws from this rich analytical well as a starting point of analysis on whether or not the poor may be blamed for the spread of the disease, and to interrogate the supposition

that militaristic and punitive solutions are warranted because the poor and the working class do not act in ways that promote public health.

Narratives and policies that blame the poor for the spread of COVID-19 did not surface at the same time the novel coronavirus was discovered in Wuhan Province, China. Rather, it draws from a long and complicated history of pandemics, social cohesion, and scapegoating (Jedwab et al., 2020). Blaming the poor for the spread of disease is tethered to the idea of poverty as a moral deficit—the poor are the way they are because of some personal failing, and not because of the constellation of political and economic forces that determine one's inclusion or marginalization. The poor are often associated with making irrational decisions, and in the context of COVID-19, they have been chastised for breaking quarantine rules and spreading the virus (*pasaway*). Hapal (2021) argued that the government response relied on the creation of oppositional archetypes—law-abiding citizens on the one hand and the *pasaway* on the other, consistent with and continuing from the political discourse of Duterte-era authoritarianism. Lasco (2020b) added to this by demonstrating how these divisions are sustained and nurtured through the invocation of suspect knowledge claims by populist leaders. Although the coercive powers of the State are felt by all citizens across classes during this extraordinary historical conjuncture, experiences of the poor reveal a grotesque unevenness in how these powers are applied.

Coming now to the main point of inquiry, how do COVID-19 positive individuals from poorer households experience stigma, link disease-related stigma with issues of poverty and power, and perceive the duty to disclose? Stigmatization refers to the social process of devaluing individuals or groups of individuals based on a perceived or actual difference, whereas discrimination is this devaluation when carried out in action or behavior such as exclusion or rejection (Abbey et al., 2011). Discrimination, therefore, is understood to be an outcome of stigmatization, and stigma is articulated through discriminatory behavior. By differentiation, we speak of inequalities in access, privilege, or deprivation, whether in a zero-sum game or along a gradational scale.

There have been some studies on stigma in coronavirus survivors. Pandemics and epidemics typically give rise to fear within the community and experiences of stigma among those who are carriers or believed to be carriers of the infectious disease. The COVID-19 pandemic is no different. The literature suggests that health care workers (Bagchhi, 2020), Chinese people and those of Asian descent (Misra et al., 2020), and infected or previously infected individuals (Sotgiu & Dobler, 2020) have been especially vulnerable to COVID-related stigmatization.

Research conducted among 91 coronavirus survivors in Kashmir, Pakistan, corroborates informal reports of social isolation and prejudice arising during the pandemics and raises concerns that those with the disease may hide symptoms to avoid discrimination or conceal travel history and prevent effective contact-tracing (Dar et al., 2020). Villa et al. (2020) suggested that experiences with stigma can lead people to hide symptoms and avoid seeking medical attention to avoid marginalization and social isolation—behavior that may exacerbate the spread of the pathogen.

From a long view of past pandemics and epidemics, the evidence on the facilitative effects of stigma on disease transmission is rich. For the HIV epidemic, for example, HIV-related stigma—discrimination against populations perceived to have higher rates of HIV infection—has been noted to be one of the "most enduring barriers to HIV prevention" (Petros, 2006). An obvious reason that has surfaced is that because of the stigma, fewer individuals are likely to disclose their infection status, thereby allowing the disease to spread. This is corroborated by several studies. Research involving HIV-positive African-American women between the ages of 18 and 50 revealed an inverse relationship between the level of stigma and the degree of disclosure, such that when the level of perceived stigma increased, the degree of disclosure decreased (Clark et al., 2004). Further complicating the discussion, according to Sowell et al. (1997), individuals who already perceive a high degree of stigma in other aspects of their lives—such as due to race or poverty—may be even more unwilling to disclose HIV seropositive status, even if disclosure brings forth benefits like social services or access to health care. Sowell & Phillips (2016), while demonstrating that women in rural communities had a high pattern of disclosure to health service providers across all stages of their illness, asserted that analyzing stigmatization and disclosure patterns points to a compelling need for continuous education and risk reduction messages within communities and the development of supportive community networks.

Emlet (2006), comparing stigma and disclosure patterns between older and younger adults living with HIV/AIDS, showed that older adults were less likely than their younger counterparts to disclose their HIV status to relatives, neighbors, and church members, than those in the 20–39 age range.

This research also draws from research on solidarity among the poor. James Scott (1977) set the stage for contemporary thinking in this field of study in his important work, *The Moral Economy of Peasants,* where he demonstrated how values of reciprocity and the right to subsistence undergird the solidarity systems that bind peasants in Southeast Asian societies. Deepening the analysis, the evidence from the literature establishes a clear relationship between solidarity mechanisms and "the extreme precariousness of life" (Fafchamps, 1992, p. 148). This is also supported by more recent research arguing that substantial solidarity behavior among the poor is an outcome of lesser wherewithal to insure against everyday risks (De Oliveira et al. 2014). Fafchamps (1992) appeared to qualify this position by suggesting that solidarity systems work better when that precariousness is distributed uniformly and raises doubts on these systems' abilities to address the needs of the particularly weak, such as the sick or the poorest of the poor. Drawing on the early literature on solidarity and solidarity systems, Kusaka (2020)—using first-hand data from his experience in Bohol, Central Philippines, during the heavy lockdowns of 2020—demonstrated how ordinary Filipinos undermined the "good vs. bad" narrative through mutuality, cooperation, and community in support of the logic of their everyday lives.

Methods

Methodological Approach

The research relies on qualitative data drawn from semi-structured open-ended interviews with 21 individuals who tested positive for COVID-19. The open-ended interview method was used, which according to Stuckey (2013), "elicit(s) responses that are meaningful and culturally salient to the participant; unanticipated by the researcher; rich and explanatory in nature" (p. 56, but it was semi-structured in that I followed a set of guide questions.

I disclose my own status as a formerly COVID-19 positive individual, which was what made it possible to access the participants and secure these interviews. I was included in an informal chat group with members who had tested positive for COVID-19 and, from there, established social connections. When the idea for the research occurred to me because of conversations in these chat groups, I approached each participant individually to seek permission for the interview. Although the initial list of willing interviewees included individuals from other quarantine facilities, a decision was made to limit to those from Hope 2, which constituted the biggest group, so that experiences are more or else uniform and the backgrounds of the participants would be more or less similar. The qualitative data for this paper is part of larger material collected from the same participants via the same interviews I used to document the class-differentiated ways COVID-19 interventions are experienced (Bekema, 2021). Ethical protocols in health research were also complied with, with due consideration to the fact that health research can be more sensitive to issues of patient privacy and informed consent (Benton et al., 2017).

Selection Criteria

The individuals were selected based on their willingness to participate in the study, their capacity to be interviewed via an online platform, and with a view toward an even distribution between men and women. I identified the target sample size of 20 or 21 by looking at previous peer-reviewed qualitative studies examining stigma among a patient population, such as stigma among California's medical marijuana patients with a sample size of 18 (Satterlund et al., 2015), weight stigma among physiotherapy patients with a sample size of 15 (Setchell et al., 2014), and stigma among tuberculosis patients in Nepal with a sample size of 34 (Baral et al., 2007). This was made the basis on which the participant numbers were chosen.

Interview Format

Interviews were conducted via Voice Over Internet Protocol (VoIP) technologies, specifically Facebook messenger with the video on. The lockdown that was in place in Manila, Philippines, during the data-gathering period did not allow for face-to-face interviews, and the interviewees preferred Facebook messenger over other VoIP technologies. Studies have shown that while VoIP-mediated interviews cannot replace face-to-face interactions, they are a viable

substitute for qualitative researchers and may be used with confidence (Lo Iacono, 2016), particularly if the interviewer and interviewee are both comfortable with the communication medium (Barratt, 2012). If a web camera is used, the interaction is comparable to an on-site interview in that non-verbal and social cues may be discerned (Sullivan, 2012). Conscious of the risks a disruptive environment may pose to the interviewee's concentration and the quality of data obtained (Deakin & Wakefield, 2014, the interviewer made sure that the interviewee had time for the conversation and was free from disruptions. Many of the participants were still in the quarantine facility during the interview, and there was sufficient time and privacy, as well as a stable connection that would allow a clear and unimpeded interview session. Two of the participants asked to reset the interview session because of sudden schedule conflicts, and the new schedule allowed for a better interview. Hour-long remote interviews in Tagalog were conducted with each of these 21 participants (see Table 2) from May 27 to June 2, 2020. Consent of these participants was sought before the interviews, and the participants were clearly informed as to where the data collected were going to be used. All interviews were confidential, and identifying details were removed from the transcript.

The participants were asked whether or not they experienced some form of stigmatization or discrimination within their communities, and they were asked to recount, describe, and enumerate the same. The participants responded more to the word "discrimination" or to its phonetically-similar Tagalog translation *diskriminasyon* and did not need further explanation of the question when asked if they experienced the same. This question was asked in an open-ended manner that allowed the participants to respond in their own words and recount their experiences using their own language. The interviewer followed up by asking how the experiences made them feel, prompting descriptions of feelings and emotions. Then they were asked whether or not they believed stigma is the same for poor people with COVID and rich people with COVID. The purpose of this question is to prod them to reflect on possible linkages between COVID-related stigma and other stigmatizing conditions, specifically poverty. After that, they were asked whether or not they believed that COVID-19 positive individuals have the duty to disclose their infection status to the community. This sequence was not interchanged. The interview was then transcribed, translated into English, and then coded manually. Main categories and sub-categories were identified and then linked to identify patterns for analysis. To enhance credibility, a second researcher who was not present during the interview was asked to independently validate the categories that emerged, looking at both the raw transcript in the original Tagalog language and its translated version. Table 1 shows the interview questions used for this paper's data.

Table 1

Research Questions

Q1	Have you experienced discrimination, and if so, can you tell me about these experiences?
Q2	How did these experiences make you feel?
Q3	Do you think experiences of stigma are the same for rich people who have COVID and poor people who have COVID?
Q4	Do you think COVID-positive individuals have a duty to disclose their status to the members of the community?

Data

Profile of the Participants

All of these participants had stayed or were staying in Hope 2 facility at the time the interview was done. Hope 2 is one of three public quarantine facilities in Quezon City, the largest city in the Philippines in terms of population and, during the period the interviews were taken, the city with the highest number of COVID-19 cases. Hope 2 is also the biggest of the three public quarantine facilities run by the local government, the other two being Hope 1 and Hope 3. Of the 21 participants, eight were male, and 13 were female. All of the participants were asymptomatic or had mild symptoms. The youngest was 16 years old, and the oldest was 57 years old (Hope 2 facility does not accept individuals above the age of 60). The 16-year-old was interviewed in the presence of her mother, who gave her express consent. Of the eight males interviewed, only one was jobless. The other seven were employed in blue-collar occupations: house painter, security guard, factory worker, bet collector at cockfighting den, cook at a roadside eatery, messenger, and a coffee shop barista. Of the 13 females interviewed, four were housewives, two were domestic

helpers, two were students, one was a seamstress, one was a vendor at a small street kiosk (*sari-sari*), one was a lessor of a row of apartments, one was a farmer who was only visiting family in the city when the lockdown prevented her from going back home, and another one was a community health worker. One of the housewives was married to a used car salesman, and the other three housewives were married to men with blue-collar jobs.

All but three of these recipients were indigent. The metric used for indigency is their status as beneficiaries of the government's Social Amelioration Program (SAP), which is an emergency cash transfer program provided to households that have been identified as poor and vulnerable by the Department of Social Welfare and Development. The wife of the used car salesman, the lessor of apartments, and the community health worker did not receive any cash grants. Hope 2 Facility does not impose an income requirement, but since it accommodates individuals who are not able to do home quarantine, its patients are often those living in smaller dwellings or in densely-populated communities.

At the time the interviews were collected, the Philippines was experiencing a dearth of testing kits and laboratories. This meant that a very rigid criterion was imposed before an individual could qualify for RT-PCR or nasopharyngeal testing. Of the 21 participants in the study, 14 qualified for swab testing because of direct contact with a positive case. Five of the participants presented themselves for swab testing after experiencing symptoms and passed the triage requirement at the testing center. Common symptoms experienced are headache, shortness of breath, stomach ache, dry throat, fever, extreme fatigue, body pain, and diarrhea. Two of the participants were already in a medical facility for an unrelated or initially-unrelated medical situation. All of the participants responded with candor and openness, with a few getting emotional while recounting their experiences. It was clear that their experiences with stigma and discrimination were significant and, for others, a major part of their entire experience with the illness.

Experiences with Discrimination in the Community

The participants who are already back in their communities and whose neighbors are aware of their COVID-19 positive status (all participants except for Male 2, Female 2, Female 3, Female 7, and Female 10) experienced some form of discrimination from their neighbors and members of their immediate community.

The cases of discrimination within the community may be clustered into three categories: hostile avoidance (experienced by 16 participants), gossiping and spreading rumors, whether in person or on social media (experienced by 10 participants), and overt acts, such as throwing objects, vandalizing, and cursing (experienced by four participants). Hostile avoidance is not to be understood in this case as merely the opposite of socializing or fraternizing but is characterized by undisguised repudiation and disgust.

Two participants were able to hide their COVID-19 status from their neighbors. One is not yet back in her hometown of Capiz (in Central Philippines), so she has no knowledge yet as to how she will be treated.

An example of hostile avoidance was described by a male participant in this wise: "We felt the revulsion of our neighbors. My 11-year-old overheard the parents of her playmates tell them not to play with her." A female participant shared that a neighbor told her, "you are the virus! Why did you go home? Stay in Hope!" Another woman had to close down her small store because no one was buying from it.

Gossiping was another common experience. A participant whose parents passed away from COVID-19 stated: "I have not heard anything face to face, but I have seen a photo of my father and mother being spread on social media and Facebook messenger by those in the outer street saying, 'this is the COVID positive couple in the inner alley (*looban)*, we have to be careful of the inner alley'." A female participant shared: "they said my father is dead even during the time he was still alive. They made posts on social media saying my name and to avoid me." They are also socially ostracized, as in the account of another female participant: "We are not allowed to buy in the stores. On social media, there are posts warning people about us. Even the barangay workers also discriminate against us. We feel like a virus."

Overtly hostile acts were less common but still experienced by some. According to a male participant, "someone vandalized the front of our house and another one also threw garbage and objects." A female participant recounts being cursed at and threatened. Yet another found herself at the receiving end of verbal harassment. "They said I am unlucky. That I bring misfortune to our town. And because of me, they will

Table 2

Demographic Profile of Participants

Code	Age Range	Gender	Occupation	Reason for testing
M1	30-40	M	House painter	Sister (F13) tested positive.
M2	50-60	M	Security guard	Went to the health center after two weeks of persistent symptoms (extreme fatigue, shortness of breath, dry throat, stomach ache)
M3	40-50	M	Bet collector at cockfighting den	Mother-in-law died and a positive COVID-19 result was received post-mortem
M4	30-40	M	Factory worker (making nets for fishermen)	Mother died and a positive COVID-19 result was received post-mortem
M5	20-30	M	Jobless	Grandmother (mother of M4) died and a positive COVID-19 result was received post-mortem
M6	50-60	M	Cook (roadside eatery)	Went to the village leader after 3 weeks of persistent and severe symptoms
M7	30-40	M	Messenger	Father died and a positive COVID_19 result was received post-mortem
M8	20-30	M	Coffeeshop “barista”	Mother tested positive
F1	30-40	F	Sarisari store vendor	Mother died and a positive COVID-19 result was received post-mortem
F2	40-50	F	Housemaid	Male employer died of COVID-19
F3	40-50	F	Housewife/wife of migrant worker	Went to the hospital after two weeks of persistent symptoms
F4	50-60	F	Housewife/owns a row of apartments	Father died with a confirmed COVID-19 diagnosis
F5	50-60	F	Housewife/wife of welder	Went to a private hospital after ten days of symptoms
F6	50-60	F	Community health worker	Health facility frontliner. Went to the health center after one week of symptoms
F7	50-60	F	Housemaid	Brought to the hospital due to hypertension. Tested because of minor symptoms
F8	20-30	F	Student	Father died and a positive COVID-19 result was received post-mortem
F9	40-50	F	Seamstress	Mother died with a confirmed COVID-19 diagnosis
F10	40-50	F	Housewife (husband buys and sells used cars)	Brought to hospital for hypertension. Experienced diarrhea for one day, so was tested for COVID-19.
F11	30-40	F	Farmer from Bicol (visiting family in Quezon City)	Sister tested positive
F12	15-20	F	Student	Auntie (F13) tested positive.
F13	30-40	F	Housewife	Went to hospital after two days of feeling symptoms

get sick. Even when I was still in Hope, they would message me day and night, blaming me for spreading the disease in the community."

Two participants said that the biggest impact of COVID-19 for them is the discrimination from other people. One of these two participants said that the treatment of other people affected her so much that she could not sleep, and she found herself crying all the time.

Experiences with Discrimination From State Actors

Two participants said they experienced stigmatization from public health workers and local government officials. During the open-ended interview, one of them recounted the inhumane treatment of the village public health officer (known colloquially as BHERT or Barangay Health Emergency Response Team) who came to pick him up to be brought to the quarantine facility and spoke of how this influenced the way his neighbors started to perceive and treat him:

> I was picked up around noon by the BHERT, along with policemen who had guns. I did not want to come because I was not even given any results yet. I was forced to ride the mobile and was treated like a criminal. The barangay people who were not restraining me were shouting to my neighbors, 'get inside your house, you might be infected!'. The mobile had loud alarms *(wang-wang)*. It was like a movie. All the neighbors saw this, so that must be why they treat me badly. That is why they avoid me.

This experience with public health officials was echoed by another participant. "It is like Tokhang," she said, referring to police operations in the war on drugs where police officers would brusquely knock on the doors of drug suspects in urban poor communities. In many of these encounters, the drug suspects would end up sprawled lifeless in a pool of their own blood.

Some participants also said that some of the frontliners at the quarantine facility act as if "they are repulsed by the COVID-positive patients." One said that some of the frontliners spray disinfectant right in front of their faces "like we are the virus."

Emotional Reactions to Stigma and Discrimination

Almost all participants experienced adverse emotions or feelings because of these experiences. The only persons who experienced discrimination but said they did not experience adverse emotions were Female 4, who is grieving the loss of her father and has "no other emotion," and Female 12, who said she does not care about her neighbors and is just worried about her family and getting ill again.

The dominant emotions that surfaced when prodded were sadness and anger. More than half of the respondents used the Tagalog word for sad (*malungkot*) to describe how they felt after their experiences with stigmatization and discrimination. One participant felt rejection, as a girl that he had been dating for some time decided to leave him because she was afraid he would bring COVID-19 to her family. Three used the word "depressed," signifying a deeper and more lasting state of sadness. Sadness was described as feelings of loneliness and isolation, missing their neighbors and social networks, and being hurt for loved ones who were also experiencing discrimination. One of the participants became emotional while recounting how his 11-year-old daughter was deeply hurt when she overheard her playmates being told by one of the adult neighbors that they should stop playing with her. "That was what really hurt me," the participant recounted. "My child is also being attacked."

Anger was also a consistent word used—with some angry at specific acts like vandalism and closing doors and windows, and some angry that they were being made to feel isolated while grieving for the loss of their loved ones from COVID. A participant who is already at home said that even after she received her negative result, her neighbors would still avoid her and would even yell to her face.

Another emotion was worry—worried in general, worried for loved ones, and worried about the economic impacts of the stigmatization. For example, one participant said that she was forced to close her small store because people stopped buying. Another participant mentioned shame. When prodded to explain the emotion of shame, the participant who was hauled into a vehicle with police officers in sight said that it felt shameful to be seen that way by his neighbors because they might think he had committed a crime. Another respondent said that she was ashamed because they might think that she did not take the precautions needed to fight the virus, such as wearing masks or

avoiding gatherings. "They might think I am *pasaway*," she said, self-internalizing the pejorative word used to mean stubbornness and foolhardiness.

Although a number of participants also indicated that they understood their neighbors who discriminated against them, there were also some who expressed a more severe form of anger—one said that he "hates" their neighbors, whereas another said that he sometimes thinks of hurting them, even though he knows that that is wrong.

Perceptions of the Differences in Treatment Received by the Rich and Poor

The participants were asked whether or not they believe rich people with COVID and poor people with COVID experience stigmatization differently. The question was intended to trigger reflections on whether or not and how their experiences as COVID-positive individuals are linked to issues of class and differentiation. The answers were divided and insightful.

Eight participants said that there was no distinction between rich and poor where experiences with COVID-19 stigmatization are concerned. A number of those who said there was no distinction relied on perceived features of the disease to justify their answer—COVID is unknown, it is a big issue; therefore, anyone who has it would probably be the subject of discussion. Another said that the fear of the virus makes stigmatization the same regardless of class – "everybody is scared of the virus, and scared of people with the virus." It is interesting to note that two of the interviewees out of the six said that while there is no difference between the experiences of the rich and the poor, the impacts of stigmatization are different. One of these two raised the issue of a sitting Senator who received brickbats on social media after it was discovered that he went to a hospital nursery and a supermarket while COVID-positive. In the perception of the participant, the senator—by suggestion, a wealthy and powerful individual—did not suffer any long-term repercussions, while poor people have to live with longer-term consequences. Another participant put it more succinctly: "it is the same, but they will not lose their jobs if they have COVID."

Two interviewees said that because of lack of education, the poor are more afraid of COVID—with one saying that the idea of a COVID-positive patient bringing misfortune into a community is the product of a lack of education ("Only the poor have that thinking because we are not educated.") There were also some that drew from perceived characteristics of rich people vis-a-vis poor people: "rich people are not gossipmongers like poor people," "rich people are too busy," and "rich people are educated."

The answers of those who said that the rich and the poor experience COVID-related stigma differently are likewise fascinating. A number of interviewees chose to answer in ways that appear to explain, and in some ways even justify, the stigmatization. According to one, the poor are likely to experience stigmatization from their (similarly poor) community because poor people are more afraid of getting sick, and therefore they are more likely to behave in stigmatizing ways against the subject. One also said that their houses are very close to each other, increasing the propensity for gossip. Many focused their answers on their perceptions of the rich: "rich people have privacy," "rich people live alone in their houses and do not talk to their neighbors," "no one will throw garbage and objects at the rich," and "the rich will never have policemen picking them up in their homes."

Perceptions of the Duty to Disclose

However, what is striking is that when each of the participants was asked whether or not they think that COVID-19 patients have the duty to voluntarily disclose their status to their community, all but three agreed with the statement.

It is of interest to note the profiles of the participants who said there is no duty to disclose or that they have opted not to disclose. Female 3 is married to an overseas Filipino, Female 4 owns a row of apartments for rent, Female 6 is a health worker, and Female 10 is a housewife married to a businessman in the used car business—all four with greater economic privileges than the other participants.

Discussion

Taken together, the data shows that the participants experienced discrimination from their community and from state actors and that these experiences impacted their emotional well-being. Sadness, anger, worry, and shame were the common emotional responses from the participants.

Table 3

Perceptions of the Duty to Disclose vis-a-vis Experiences of Discrimination

Participant	Experiences of discrimination	Description
Male 1	Avoidance	Yes. I will tell them for their sake and for their family's sake. If it is kept a secret, COVID will only spread in the community. The community needs to help each other and support each other so it also makes the COVID-19 patients feel better.
Male 2	Avoidance (secondary)	Yes, I will tell them because if a person has a low immune system, then he can get the disease from me. I will also tell them that the disease is something a person can kick.
Male 3	Avoidance, Hostility	Yes, I can tell them because I do not want anyone to get sick. COVID has no cure yet, but if I show them my case, someone who drinks and smokes a lot with a lot of health problems but who recovered from COVID, maybe they will know it is not the end.
Male 4	Avoidance, Gossiping	Yes, it is still important. In my case, I told them right away, so they are aware. When it was my mother who first became positive, I told the next-door neighbors right away. Our homes are so close to each other.
Male 5	Avoidance, Gossiping	Yes, of course, Ma'am. Everyone needs to be aware. First, the virus should not spread. That's the most important. Also, they should know that COVID is not something to be reviled. Actually, I also think it is important that we tell them because now we know who cares for our family. Our neighbors here in the inner alley even gave us food and our basic needs.
Male 6	Avoidance	Yes, at least inform the *purok* (village) leader and the neighbors close to you. Well, in my case, the neighbors are my good friends, and we are used to going into each other's houses straight into the kitchens. So they need to be told the situation.
Male 7	Avoidance, Hostility	Yes, I will tell them my suffering because what they are doing to me and my family is temporary; but if they die because I give them COVID, that is permanent.
Male 8	Avoidance, Gossiping	Yes, we should tell them. Because what if we transfer the illness to senior citizens and children?
Female 1	Avoidance, Gossiping	I am willing to tell. I actually told my next-door neighbor immediately because I wanted her to take care.
Female 2	N/A	Yes, a person who has COVID must disclose it. We have to tell people so they can protect themselves. As in my case, when I go back home to Capiz, I know Capiz is still COVID-free. I do not want to be the one to bring danger to my hometown.
Female 3	N/A	To be honest, I know we need to disclose, that is why my mind is struggling. But for me, the safety and peace of mind of my family are important too. My husband is not here to defend me; he is working abroad.
Female 4	Avoidance. Gossiping	No, if there is a choice, I will not share it. I do not want there to be any issue. I do not want the world to know about my COVID-19 status. I will just be careful so that I do not infect anyone. And I have been careful.
Female 5	Avoidance, Gossiping	Yes, we should voluntarily disclose. What if they catch the virus from us, and then they find out we knew but did not tell them? Then we will be blamed. Communities should protect each other, not hide secrets.
Female 6	Avoidance	I will not disclose, and I will even say I have no illness. Why? Because I can see that my body is still strong and I feel nothing, no symptoms. So perhaps I am not even contagious. I heard that if you have no symptoms, you are not contagious.
Female 7	N/A	Yes, because I do not want to infect anybody.
Female 8	Avoidance, Gossiping	Yes, of course. We should not be ashamed. It is better to disclose so more people can be aware of COVID. People in my neighborhood only care about *ayuda* (social amelioration package or cash transfer), but they do not care about the disease. I want to help increase awareness.
Female 9	Avoidance	Yes, even after everything. I will do it for the sake of the people here. We are all poor.
Female 10	N/A	No, sorry, I have to protect my family.
Female 11	Avoidance. Gossiping, Hostility	Yes, it is still needed so we can avoid infection. We really need to isolate the senior citizens and the young children. Me, I am strong, but how about others? Actually, COVID really did not get me. A toothache is worse than COVID for me. But COVID hits people in different ways.
Female 12	Gossiping	Yes, I am willing to disclose. In fact, I already shared it on Facebook to ask for prayers.
Female 13	Avoidance, Gossiping, Hostility	Yes, I still want to tell people even after everything I went through. It is because people should be taking better care of themselves. If they feel anything bad, they should seek medical help.

When prodded to reflect on whether or not, and why, rich people experience COVID-related discrimination differently from the poor, a number spoke of perceived specific features or conditions of poverty that appear to make experiences of stigmatization either more logistically possible or more acutely felt for the poor than for the rich. These features can be further broken down into physical features (e.g., structures of houses and living conditions) and perceived non-physical features (e.g., lack of education, propensity for gossip because of idle time, fear caused by ignorance). Examples of the first category can be found in the answers "our houses are so close together," "rich people have privacy," and "rich people live alone in their houses and do not talk to their neighbors." The second category can perhaps be illustrated by the statement, "only the poor have that thinking because we are not educated."

Of interest are two particular responses—"no one will throw garbage and objects at the rich" and "the rich will never have policemen picking them up in their homes"—that reveal an awareness, if not acceptance, of the ways by which class mediates how diseases and public health emergencies are experienced. The second response is particularly striking in that it was expressed by the same participant who compared how he was taken to the quarantine facility as similar to the brusque police incursions in the war on drugs campaign. Critics have described the war on drugs as a war on the poor, and the comparison between the government's pandemic approach and its anti-illegal drug incursions, especially with respect to their disproportionate impacts on the poor, enriches the proposition that both strategies draw from the same populist well.

However, despite these experiences with discrimination and stigma, and despite a majority consensus that these experiences impact the poor more severely than the rich, a very clear majority of participants still felt that they had a duty to disclose their COVID-positive status even without coercion from the State. Most of the reasons given involve protecting the community: "communities should protect each other, not hide secrets," "the community needs to help each other and support each other," "people should be taking better care of themselves," and "I do not want to be the one to bring danger to my hometown."

A number of participants zeroed in on even more vulnerable populations within the population set: "we really need to isolate the senior citizens and young children," "yes, we should tell them because what if we transfer the illness to senior citizens or children," and "if a person has a low immune system, he can get the disease from me." At least two cited social relationships or friendships as the motivation for voluntary disclosure: "I actually told my next-door neighbor immediately, so she can take care," and "the neighbors are my good friends, and we are used to going into each other's houses straight into the kitchens." One participant explicitly mentioned the need for solidarity among the poor when asked whether or not he would disclose his COVID-positive status: "I will do it for the sake of the people here. We are all poor." Another described how it was their neighbors in the inner alley—the impoverished pocket of space existing parallel but almost invisible to the outer asphalted streets—who actually helped them and provided food and basic necessities for them and those in the outer streets who gossiped about his family.

It is perhaps too simplistic to say that the solidarity networks and the bonds of the poor community remain unaltered amidst a public health crisis or that the poor are always compassionate to each other and draw from organic support systems to protect against the State and its multiple aggressions. After all, members of the community themselves committed acts of discrimination and hostility against fellow community members when the latter received a positive diagnosis. But the data seeks to contest the assumptions on how people behave, relate, and interact with each other—assumptions that are embedded in and used to justify the government's authoritarian pandemic responses and its "virtuous" vs. *pasaway* dichotomies.

Conclusions

By and large, the data at hand demonstrates that stigma and discrimination are woven into the lived experiences of the participants who were COVID-19 patients in the urban poor areas in the Philippines, but this stigma and discrimination do not appear to impair participants' appreciation of the duty

to disclose their COVID-19 status, particularly participants who are classified as poor. What kind of reflections surface from these findings? This paper offers a few.

The research suggests that this punitive regulation of the poor might be misplaced. The value given to the community by the poor—"I have a duty to disclose my infection because I need to protect my community"—is already corroborated by a large body of literature devoted to social solidarity and moral economy. The research also adds to the work of Kusaka (2020), who investigated solidarity strategies in the midst of the pandemic and its accompanying lockdowns. The question now should be how to leverage these values in COVID-19 responses. Militaristic approaches have been unable to prevent the spread of the virus while deepening social cleavages. An alternative paradigm should be considered.

Secondly, the data demonstrating the social solidarity of the poor in a public health crisis must be examined vis-a-vis rich and persuasive data on the risky health behavior of the poor. The data at hand begs the question: if the poor can be called upon to consider the community in a pandemic situation and obviously have an understanding of the importance of health, even after experiencing stigma and discrimination, why are they not engaging in more health-seeking behavior for themselves? Could it be that what has been widely understood as risky "live for the day" health behavior patterns are, in actuality, by-products of privatized health care systems that exclude the poor and privilege the rich? There is room for further research in this direction.

Lastly, what appears to be the urgent imperative is to surface the voices of the underheard and the under-resourced when policies are being crafted, voices that are drowned out every day but more so in the midst of a public health crisis. A compassionate, people-centered set of strategies, one that renders visible those at the margins and takes into account the fluid and ever-changing dynamics of community and solidarity from below, may yet be the more effective one.

Declaration of Ownership

This report is my original work.

Conflict of Interest

None.

Ethical Clearance

This study was approved by the institution.

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