STIGMA: Notes on Medicine's Mirror

CARLO CADUFF
King's College London
https://orcid.org/0000-0003-4505-3408

Stigma is like a tenacious contagious disease. It has an inherent tendency to both cling and spread to "ever new categories of persons" (Goffman 1963, 9). But even Erving Goffman (1963, 9), the eminent sociologist of the abnormal, would have been astonished to see doctors among those "disqualified from full social acceptance." How could it be that doctors—the masters of modern medicine and custodians of the normal—are now burdened with the very affliction that haunts so many of their patients?

In January 2020, I moved to India to begin my ethnographic research in Asia's largest public cancer hospital, Tata Memorial in Mumbai. Despite meticulous preparation, very little unfolded as planned, and then, in March, the Indian government declared a national lockdown. I decided to stay, and like everyone else in Mumbai, I found myself confined in a silent, empty city by the sea, once defined by the vitality of its streets: the crowds, movements, noises, transactions, and fleeting encounters of strangers traveling in trains, cars, trucks, bikes, and buses. Once the lockdown was announced on television in the spectacular form of a sovereign decree, all the intensity of Indian metropolitan life vanished overnight.[1] Nothing felt normal and little offered relief, except the arrival of the seasonal rains in June and the cooler winter months.

CULTURAL ANTHROPOLOGY, Vol. 41, Issue 4, pp. 812–838, ISSN 0886-7356, online ISSN 1548-1360. Cultural Anthropology *is the journal of the Society of Cultural Anthropology, a section of the American Anthropological Association.* Cultural Anthropology *journal content published since 2014 is freely available to download, save, reproduce, and transmit for noncommercial, scholarly, and educational purposes under the Creative Commons BY-NC 4.0 license. Reproduction and transmission of journal content for the above purposes should credit the author and original source. DOI: 10.14506/ca41.4.07*

A widely reported scandal intrigued me: doctors had become victims of harassment, stigmatization, and violence during the pandemic. In November, I returned to the hospital to work with oncology colleagues on a study investigating the social experiences of hospital employees in pandemic Mumbai. The concept of stigma became a pathway to understand what it means to be a hospital employee during a public health crisis—and to explore how the social and the cultural figure in public health writing more broadly. Drawing on medical anthropology, the history of science, and science and technology studies, this article combines an ethnographic account of social tension, irritation, and harassment with a critical epistemological analysis of stigma's role in contemporary health research and policy.

Over the past two decades, stigma has become a ubiquitous trope in media reporting. Yet in medical discourse, it is more than a popular expression: it functions as a standard. It shapes the rules of knowledge production, reduces the risk of discursive dissonance, and facilitates collaboration across communities of practice. The term's interoperability suits an international culture of science focused on impact and output, but this comes at a cost. The standardization, even reification, of stigma in public health research and policy reflects a biomedical style of reasoning about the social that contributes to its erasure. As my research in Mumbai reveals, people make sense of experiences of social tension, irritation, and harassment through a different vocabulary, a language of caste, class, and urban life. This language raises questions about identity, the meaning and value of social relationships, and the power of the state. Replacing these local articulations with a standardized conception of stigma as promoted by health researchers fundamentally obscures the political stakes of collective life in a time of rupture. The pandemic response triggered a wide array of disruptions that demand a careful social analysis—one that moves beyond convenient templates.

* * *

In July 2020, a *Lancet* journal published an article on stigma during the coronavirus pandemic that raised the alarm about a "serious threat" to health-care workers and patients who were "facing stigma and discrimination all over the world" (Bagcchi 2020, 782). Citing a public declaration by an international coalition of medical and humanitarian organizations on "the current situation of violence against healthcare," the article emphasized that many pandemic responders were now "experiencing harassment, stigmatization, and physical violence." According to the declaration, "each day brings new stories of intimidation and harm."

The *Lancet* article recounted disturbing examples of stigmatization, drawn from anecdotes in newspaper reports and interviews with health-care

professionals. Like other publications, it presented short, sharp narratives that made the problem tangible and relatable: the patient abandoned by family, refused in the shop, and harassed on social media; the doctor denied access to public transportation, insulted in the park, and evicted from the neighborhood. The supposed stigmatization of medical staff during the pandemic appeared to be a widespread phenomenon, even if its manifestations varied across locations.

Despite claiming to describe a problem common "all over the world," nearly all the article's examples came from the Global South. According to the author, patients and health-care workers in Mexico, Malawi, India, and Zimbabwe were facing substantial stigma due to the "baseless beliefs" and "improper understandings" of the "common masses" (Bagcchi 2020, 782). The situation in the North was portrayed as different. As a doctor based in Kent explained, "in the UK, we were fortunate not to have stigma." Only in certain parts of the world, the article implied, did patients and health-care workers face stigma during the pandemic. These places, the author declared, were in urgent need of "proper health education" to "scientifically destigmatize Covid-19" (Bagcchi 2020, 782).

A review of scholarly publications and gray literature suggests that the idea of the Global South as a place of irrational beliefs, and thus burdened by stigmatization, has quickly become global common sense in COVID-19 health research and policy. According to this literature, stigma is contagious, "more contagious than the virus itself" (Banerjee, Kallivayalil, and Rao 2020, 102), and yet, it sticks to specific places, especially in the Global South. India, a geographic location long associated with epidemic disease (Arnold 1993, 2022; Sivaramakrishnan 2020), is a place where stigma—the "cruel mark," in Hélène Cixous's (2005) apt phrase—is now perceived as a "perennial problem" (Menon, Padhy, and Pattnaik 2020, 400). What this intense attention to "India" and the discursive territorialization of the problem in the Global South more generally reveals is that the COVID-19 stigma literature appears to have a stigma problem of its own.[2]

Here I take a step back from the political geography of stigma research and examine how scientific discourse appropriates this expression and constructs it as an object. I argue that stigma has become a foundational term in mainstream international health research and policy, where it increasingly operates as a discursive black box.[3] As a coin with currency beyond scientific discourse, stigma has attained a level of recognizability that allows it to be applied indiscriminately and with little reflection to almost any kind of negative social experience associated with disease.

A bibliometric study of publications over the past two decades identified 17,156 articles, reports, and reviews on stigma across 682 journals, with a steady annual increase since 2008 (Chen et al. 2020). My own Web of Science search

yielded more than 50,000 results. For COVID-19 alone, a systematic review published in 2021 identified 46 articles on work-related stigmatization (Schubert et al. 2021). A year later, that number had grown to 249 (Kartono, Salahudin, and Sihidi 2022). Most of these studies appeared in psychiatry and mental health journals, where stigma is linked to stress, anxiety, shame, and depression.

The psychological consequences of stigma are important. But in mainstream biomedical health writing, the concept matters because stigmatization is seen as a "barrier to health-seeking behavior, engagement in care, and adherence to treatment" (Stangl et al. 2019, 1). Stigma researchers aim to remove such obstacles, improve access to health care, enhance treatment compliance, and make medicine more effective. Researchers argue that stigmatization undermines medical interventions and thus represents "a major driver of poor health outcomes globally" (Stangl et al. 2019, 2). In this framing, stigma refers to social and cultural processes that threaten the therapeutic mission of medicine. Indeed, it is rare to find biomedical health studies that do not begin with the assumption that the social and the cultural are obstructions that subvert the good intentions of health professionals. Embedded in this conception is the modernist assumption that the social and the cultural lie outside the domains of science and medicine.

Like other popular terms such as *trauma* or *depression*, *stigma* is often used as a label in biomedical health research, where its primary epistemological function is to capture experiences, feelings, and perceptions of people who are suffering from—or associated with—particular pathologies. While most studies examine stigma in relation to specific medical conditions—schizophrenia, HIV/AIDS, tuberculosis, leprosy, obesity, epilepsy, depression, and, more recently, COVID-19—some advocate for a generic application of the term to describe "a variety of stigmatized health conditions in very diverse cultures" (van Brakel et al. 2019, 3). The hope is that this generic use will enable scalable knowledge production in support of standardized health interventions. To this end, most stigma studies rely on validated survey instruments with fixed-item responses (Yang et al. 2007, 1531; Schubert et al. 2021).

One consequence of this methodological emphasis on generalization and standardization is that *stigma* is now used freely and broadly across a wide range of medical conditions, collapsing diverse social phenomena into a single term.[4] Today, stigma operates as a form of classification and labeling in its own right. This suggests that the *object* of research has become the *method*. As Peter Gordon (2018, 56) observes in his essay on Theodor Adorno's contribution to the study of the "authoritarian personality," this research structure "opens up the possibility of a vicious circle or self-referential paradox where the principle that

animates the study becomes trapped in its own diagnostic. If stereotypical thinking involves the reduction of differentiated persons to quasi-natural kinds, one cannot help but wonder if the social-psychological method of the study itself has deployed the very technique it marks as a pathology."

In this recursive entrapment of stigma as technique where classification becomes *a mode of explanation* lies its unique appeal to a biomedical science driven by the pursuit of simple, scalable tools with instant recognizability and universal applicability. What the term loses in terms of specificity and analytical precision, it gains in applicability, comparability, and generalizability. I suggest that the term and its citability—its capacity to circulate across disciplinary boundaries and create a sense or semblance of understanding about the social and cultural causes of ill health—reveals more about the nature of contemporary health writing (and modern biomedical culture more broadly) than about stigma itself. Of course, not all stigma research follows the same approach. There is a pattern, however, that characterizes mainstream health research, where the pursuit of generalizable findings that transcend contextual differences represents both a *methodological imperative* and a *disciplinary norm*.

As a concept, stigma is at once vague, common, and compelling. It is a scientific coin with popular currency. Any kind of engagement with stigma demands critical awareness of its exceptional value as a generative, citable, and interoperable term that has secured its prominence in contemporary knowledge production and popular discourse precisely because of its standardization.

It is important to emphasize that the structural investment in research standardization normalizes the very social conditions that stigma studies oppose. If there is a flaw in the social order itself that gives rise to stigma and that makes it stick and spread, then the promotion of standardized science inadvertently perpetuates the pathologies of a world that is typed and that can only think in rigid, standardized terms.

The key aim of this article is to decenter the concept of *stigma* and to approach it not as an answer but as a question. While medical anthropologists have long examined how specific diseases become stigmatized and what this means for patients, this article proposes a shift in perspective, showing how stigma is produced *as an aspect of medical knowledge itself*. I argue that both the object and its science form part of the same social order—and that what seems like a struggle against stigma also constitutes an unconscious affirmation of the very logic that enables its persistence. In what follows, I begin with an analysis of how stigma operates within medical discourse. I then turn to pandemic Mumbai to examine how the term contributes to the unseeing of the state and its entanglement in various forms of violence.

CONSTRUCTIONS

At the beginning of object construction lies concept definition. Most publications on stigma start by defining the concept and citing Goffman's seminal 1963 book, which made *stigma* popular as a term for both the social and the medical sciences. For Goffman (1963, 9), stigma denotes "the situation of the individual who is disqualified from full social acceptance." Stigma, in Goffman's view, involves a negative moral judgment directed at categories of persons marked as *different*. This moral judgment, Goffman (1963, 167) argues, is a "general feature of social life," and thus *inevitable* and *universal*. His primary sociological concern lies with interaction and identity, particularly in how stigmatized people navigate and respond to the "dynamics of shameful differentness" (Goffman 1963, 167).

Definitions often emphasize stigma as "a social process or related personal experience characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group identified with a particular health problem" (van Brakel et al. 2019, 3). However, health researchers have often shown more interest in the "personal experience" than in the "social process." This emphasis reflects a psychological orientation that frames stigma as itself a kind of disease (thus contributing to the psychologization of social experience more broadly). It also stems from the methodological challenge of moving beyond frameworks that focus solely on individuals or statistically defined populations. The central aim of such research is to determine whether individuals or groups feel stigmatized because of a medical condition that marks them as "different."

The difference at stake is typically biomedical and, because it is grounded in scientific evidence, presumed to be real. Consequently, it is rarely treated as a historically contingent construct shaped by material infrastructures and classificatory practices that "make up people" and that constitute categories of persons "as definite classes defined by definite properties" (Hacking 2006).[5] The medical framing of disease as deviation from the norm—and of people as carriers of disease—has become so deeply embedded in modern medical culture that questioning it would undermine the epistemological foundations of health research itself. Health research must thus find the reason for stigma *elsewhere*, outside the domain of medical science, in the social and cultural world. Stigma cannot be based on the same epistemological foundation that makes health research possible and that identifies people with "their" disease, and so this mutually shared epistemology must be obscured. Medical professionals, in taking a stance against stigmatization, frequently focus "on everyone else's attitudes but their own" (Stuart, Arboleda-Flórez, and Sartorius 2013, 63). Stigma is useful precisely because it is

attributional, something that happens *elsewhere*, "something that 'other people' do" (Stuart, Arboleda-Flórez, and Sartorius 2013, 58).

This *externalization* of stigma constitutes a defining feature of mainstream health research. It obscures the process through which stigma operates as a social and cultural marker of the modern medical understanding of the pathological. Rather than investigating how stigma is produced, these studies tend to focus on how individuals bear its burden—within families, communities, and workplaces. But what generates the conditions for stigmatization in the first place? What enables moral judgement, discrimination, and blame?

The externalizing approach to stigma embodies a medical perspective concerned with diagnosis: What is the problem? Who is affected? How prevalent is it? Stigma thus functions as a *diagnostic category*, grounded in the assumption that entities exist that can be described and identified with precision. As the historian of medicine Charles Rosenberg (2002, 239) noted, diagnosis "labels, defines, and predicts and, in doing so, helps constitute and legitimate the reality that it discerns." The diagnostic use of the concept enables the identification and classification of distinct "personal experiences" as stigma, independent of any social processes and conditions that engender these experiences.

The biomedical orientation constructs stigma as a self-evident entity: something that can be labeled, quantified, and tracked. This orientation is explicit in the language used to talk about stigma: *incidence*, *severity*, *prevalence*, and *burden*. Such epidemiological language positions stigma as a pathology in its own right: a social analog of disease. In this framing, stigma follows disease like a shadow, both *metaphorically* (as itself a kind of disease) and *metonymically* (as a social consequence of disease). For health researchers, stigma is omnipresent because it has become a metaphor and metonym of the problem of illness *itself*.

Yet stigma functions here more as a label than as an explanation. It stabilizes a referent without necessarily illuminating the experience it names. Once labeled, experiences are rarely allowed to challenge the category; instead, they are often reduced to stereotypes. In health research committed to the project of generalization, stigma has become a label that can be used freely and widely. As in normal science, to use Thomas Kuhn's (1962) apt assessment, the object of research is taken for granted, the research process works to stabilize it, and foundational questions are presumed to have been settled. The goal becomes application and replication. Methodological rigor and standardized research designs are seen as essential for improving the "quality" of future studies (Schubert et al. 2021). In this way, the pursuit of normal science becomes the defining aim of stigma research.

A key template for understanding stigma rests on the assumption that it arises because people (i.e., "other people") lack the correct scientific understanding of disease and therefore engage in negative social behavior. Yet this assumption lacks evidence and is fundamentally misleading. It presumes that science is inherently innocent and that accurate scientific knowledge will automatically lead to positive social behavior. As I have argued, stigma *shares* with medical knowledge a common epistemological foundation: a common sense embedded in a medical culture that identifies people with "their" disease and that defines disease as deviation from the norm. Stigma is based on knowledge (not the absence of knowledge). It is medicine's mirror.

The framing of stigma as a kind of disease in itself both reveals and obscures this common epistemological foundation. In this view, stigma is medicine distorted by "culture"—corrupted by rumor, fear, and false belief. It is seen as incomplete medicine, para-medicine, but it is still *medicine*, a quasi-medical view of the world and thus part of a modern medical culture of promoting medicine-images in the world. In the case of stigma, these medicine-images are seen as false beliefs in need of fixing. Like other categories of intelligibility such as *trauma* (Fassin and Rechtman 2009), stigma has become a popular notion circulating beyond the medical field. Yet unlike trauma, stigma emerges in the literature as a form of mistaken medicine—and thus as an educational opportunity to teach "other people" proper medical knowledge. This makes stigma useful—a normative project disguised as social analysis.

As a field operating under conditions of normal science with a powerful paradigm, it is unsurprising that most studies confirm the existence of stigma. However, the standardization of stigma research and the emphasis on naming and counting make both the findings and the recommendations highly predictable. This suggests that the field has reached such a level of coherence and consolidation that it now largely follows its own logic, independent of the social realities it claims to investigate. In this literature, stigma has become an archetype, a template that allows scholars to turn almost any negative social experience associated with disease into a copy of the same type for which there exists a standard explanation and a standard solution. As an archetype, entrapped in its own diagnostic, stigma freezes all futures in the past, in the always-already existing social shadow that accompanies disease, in the sedimented logic of distinction, the stereotype.

I want to be clear that my critique is not directed at stigma research as such. It is an immanent critique aimed at the methodological orthodoxy that privileges generalizability within mainstream health research. I trace both the consequences of this commitment and illuminate why it exerts such a powerful

appeal for researchers—an appeal that goes far beyond its nominal role as a sign of scientific rigor. The black-boxing of stigma calls for unlearning. We must move beyond the reductive logic that links disease to fear to ignorance. Instead, we need to bring the social and the cultural back into the picture and cultivate a different sensibility altogether.

ERASURES

In the second part of this article, I will examine scenes of social tension, irritation, and harassment that emerged during the coronavirus pandemic in Mumbai. I move away from epistemological constructions to explore the silences and absences they produce and illuminate the stakes and politics of knowledge more clearly. I have already discussed one significant erasure: how health research often obscures medicine's complicity in the production of stigma by locating its causes in "society," thereby absolving medicine as a knowledge system of responsibility. In what follows, I will extend this approach to show how COVID-19 stigma research contributes to the unseeing of the state. I present this as a situated case study without claims to universal applicability. The contribution lies in offering readers a concrete example against which to compare and contrast other contexts and conditions.

The empirical material I draw on includes a survey and interviews with staff at Tata Memorial Hospital, India's oldest and largest public cancer center, as well as participant observation conducted over two and a half years of living and working in Mumbai during the pandemic. To sustain operations and coordinate its COVID-19 response, Tata Memorial established a COVID-19 Action Group comprising clinicians, paramedics, administrators, and nurses. As an officially designated COVID-19 care center, the hospital provided diagnostic and treatment services for both patients and staff throughout the crisis. I focus on a broad spectrum of hospital employees, medical and non-medical alike: firefighters, security personnel, drivers, janitors, doctors, nurses, students, laboratory technicians, researchers, administrators, plumbers, electricians, and gardeners. This broad view challenges the narrow framing of "health-care workers" in most COVID-19 stigma studies and disrupts the notion of the hospital as a total social institution populated only by doctors, nurses, and patients, and where staff are presumably isolated from the wider society. Instead, I ask: What forms of social negativity did hospital employees encounter during a pandemic that blurred the boundaries between personal and professional life? Can these experiences be adequately captured by the concept of stigma? What becomes possible when we shift the analytical frame beyond stigma?

Mumbai offers a compelling site for anthropological studies of social disruption, given its long and often violent history of conflict over residency, belonging, employment, and mobility (Chatterji and Mehta 2007; Blom Hansen 2002). For more than a century, the city has been shaped by contestations over urban space and by state efforts to regulate the extreme proximities of slums, shantytowns, and working-class tenements. Pandemic policies, implemented under the banner of infectious disease control, were layered onto these already fraught and contested spatial and social boundaries, challenging everyday practices of relationality. Who is permitted to live, work, eat, sleep, love, walk, exercise, suffer, age, and die in proximity to whom? Who must remain at a distance? These are not novel questions in Mumbai, but the pandemic charged them with renewed urgency.

As part of a study I initiated with hospital colleagues, we surveyed 376 employees who tested positive for COVID-19. During the first, epidemiologically milder phase of the pandemic (April–November 2020), 595 of the hospital's 4,235 employees tested positive, meaning the survey captured more than half of those infected. We then conducted in-depth interviews with 60 purposively selected participants to better understand their experiences both within and beyond the hospital. The data reveal three distinct scenes of negative social experience.

Neighborhood Tensions; or, Mobility's Fundamental Ambivalence

Hospital employees frequently reported issues around mobility in residential neighborhoods. India's strict lockdown permitted only so-called essential workers to leave their homes, while others faced prolonged income loss (Caduff 2020). It also made it difficult for people to escape the crowded housing conditions characteristic of everyday life in Mumbai's slums, slum redevelopment areas, and working-class tenements (*chawls*). More than 80 percent of surveyed hospital employees lived in cramped conditions: 82 percent of all households shared one bedroom, one bedroom with kitchen, or one bedroom with hall and kitchen; 85 percent of all households shared them with three to six members of the household. Those residing in slums, chawls, or slum redevelopment buildings were significantly more likely to report negative social reactions (42%) than those in hospital quarters or private apartments (28%). Living in a lower-income setting and working as an employee with less medical "expertise" and "authority" increased the likelihood of supposed stigmatization. However, it is important to emphasize that all employees who experienced negative social reactions were subject to stigmatization *because* of their association with the hospital.

The unequal access to mobility, and thus income, during the lockdown created animosity toward people allowed to move because they were hospital employees. Such tensions remained independent of hospital type (i.e., cancer hospital, private hospital, government hospital), the person's role in the hospital, and any actual infection, and they tended to occur throughout the pandemic and the lockdown. What mattered was people's association with a hospital. As Kalpana, a nurse in Tata Memorial, phrased it: "The neighbors thought that they are at home, so we should also have to stay at home and not go to the hospital." Running alongside this sense of injustice and inequality was the fear of infection. Neighbors worried that people who went out for work in a medical setting would bring the disease back to the neighborhood. Such responses are better understood not through the individualizing lens of stigma but in a more collective register as neighborhood tensions over rights and obligations.[6] At the heart of these tensions lies the ambivalence of mobility as *both desirable and dangerous*. The state's drastic restrictions on movement, on the one hand, and the symbolic association of mobility with disease transmission, on the other hand, intensified this ambivalence. Hospitals, with their mobile staff, became hot zones where these contradictions were most acutely felt.

Distancing; or, the Moral and the Medical Inside Out

When hospital staff tested positive for COVID-19, they often found themselves distanced by neighbors and colleagues. This distancing led to feelings of abandonment and rejection in a time of crisis. Sunil, a janitor in the operating theater, recalled how his neighbors in the slum stopped speaking to him; when they saw him, they would cover their faces and retreat indoors, as if he were an outcast. "I used to feel very bad," he said. The sudden shift from ordinary medicine to extraordinary pandemic changed the status of hospital employees once they became the patients: "We used to interact with patients in the hospital, but we never behaved like this. I felt bad. Just like people say, 'We're with you' . . . but in this disease, nobody is there to support you." The reversal in medical roles turned caregivers into care-receivers, creating the possibility for inverted perspectives. One hospital employee said, "Whenever I see patients, especially cancer patients, I have always shown sensibility towards them. But when you find yourself among the patients, then the entire role changes." As patients in their own hospital, employees perceived themselves in a circular fashion ("now we are in their place") and viewed the values, social commitments, and duties of their profession through a distorted mirror. Feelings of disappointment emerged because the caregivers' care turned out to be a gift that wasn't returned when roles reversed.

Salman, an ambulance driver, described how all his friends and colleagues used to talk to him respectfully before his positive test report. But then, he recalled, "When they found out, their behavior shifted. For over a month they asked me to not come near. They told me that I still had the virus despite my full recovery, and they asked me to stay away from them even at mealtimes. It was humiliating. I broke the bond with them, and I haven't spoken to them since." Samesh, a fire department technician, was isolated in the hospital when he tested positive. His neighbors in the slum put pressure on his family. No one was willing to fetch supplies. Samesh recounted, with some bitterness, "Before the pandemic, the people in the neighborhood used to come to me for the smallest things and tell me that they have someone who is a patient and who needs urgent help. I used to help and refer them to a doctor. It was disappointing to see how they gave up on me when I was in need, while I had been offering a helping hand for a long time."

Because hospital employees were allowed to travel in the city, they could provide all kinds of support to the community. Sunil, working in the operating theater as support staff, helped people get around. He told of helping a family attend a funeral: "There was a TB patient who had died, so I had gone to the funeral with the patient's family. Nobody allowed them to travel, so I showed the officials my hospital ID card and took the family along." But when Sunil tested positive, nobody stepped forward and provided support to him. Sunil blames the pandemic for the rupture: "Because of this disease, all relations are broken, and nobody talks to us."

What Samesh and Sunil's experiences highlight is a sudden rupture in their social identities as hospital employees. Working in a government hospital provided not only stability and a secure income; it also allowed them to work informally as local brokers, providing relatives, friends, and neighbors in the slum with valuable knowledge, advice, and support, including services and connections to the distant world of doctors and officials.[7] But with the spread of the virus, the meaning and value of this role shifted. The hospital ID, once a symbol of prestige, became a mark of suspicion hanging around their necks and challenging their social status. As Lisa Björkman (2022, 13) notes, in Mumbai, "myriad everyday crises and contradictions of city life are managed, mitigated, and metabolized by a myriad of brokers." Yet during the turmoil of the pandemic, the meaning of ordinary words shifted, and gifts previously deemed generous dramatically lost value and couldn't fetch a reciprocal return anymore.[8]

Precisely because of their transactional role in the community, as channels to the external world, brokers of medical resources could simultaneously appear as vectors of another possibility. Anything, including viruses, could flow through these membranes that lubricate transactions and facilitate movement across borders.

What mattered for the emergence of stigma in a particular person was thus not just the professional role and location of the work but also the meaning and value of this work for the community, the transactional nature of social relationships, and the resignification of identities and roles of people already defined socially through their proximity to the hospital. What shifted in the community was the moral evaluation of the implications and potential consequences of this proximity.

We can thus best understand this type of negative social experience in the context of critical events as a response to the rapid transformation of the social identities and roles of hospital employees, from figures of connection, support, and care to media of risk and danger. In turn, employees expressed feelings of disappointment and betrayal, framed as a moral failure of their relatives, friends, and neighbors. For hospital workers, social distancing signaled a transformation in the moral evaluation of their identity and a break with normative expectations embedded in the give-and-take of social relationships.

Importantly, this distancing was not simply a pathological social response: it was also official government policy, designed to curb transmission of the virus. The problem, of course, is that distancing makes for a mechanism operating at the heart of both infectious disease prevention *and* stigmatization. In fact, social distance is "one of the most commonly used measures" in quantitative stigma research (Link et al. 2004, 519). Once distancing became official behavioral policy in Mumbai and elsewhere, it introduced an ominous gray zone into social relationships, where skepticism could grow about the motivations of those keeping a distance.

Hospital employees had difficulties reading the social meaning of distancing; they frequently placed it in a moral register, seeing it not as compliance with mandatory government rules but as indicating a lack of empathy, the refusal of reciprocity, and a challenge to their earlier identity as medical brokers and professional caregivers. At stake here is thus a blurring between physical and social distancing, between civic and social morality, between citizens' duties to the state and the normative expectations and ideals inscribed in the medical profession, as well as in social relations among relatives, colleagues, friends, and neighbors. In some cases, the lack of support and the refusal of reciprocity left people with broken relationships. As Nikhil from the laundry department noted, "I had tears in my eyes thinking about the people with whom we have been staying together for so long. What is the use if they behave like this? I have broken relationships with all my neighbors. I don't talk to anyone now. I just keep to myself."

Harassment; or, State Containment Zones

India's response to the coronavirus pandemic ranked among the most stringent in the world.[9] With sweeping bans on movement and a complete shutdown of public transportation for months, public space in cities like Mumbai became a site of relentless surveillance and control. As part of the state's evolving strategy, municipal authorities assumed extraordinary powers and implemented strict containment measures, sealing off entire slums and chawls with little warning. The policing proved relentless.

Regardless of the number of inhabitants, any building home to a person with a case of COVID-19 was marked a "containment area" for a minimum of two weeks. Only officials and medical professionals were permitted to enter or exit. Authorities posted large warning banners at entrances to such buildings, marking them out visually and symbolically. In dramatic displays of state power, the police sealed buildings without prior notice, often leaving residents scrambling for necessities. Over the course of the pandemic, thousands of buildings across Mumbai were sealed, some repeatedly, as the virus continued to circulate. These containment zones localized a highly mobile virus, transforming abstract risk into concrete danger, identifying particular people and places with the disease. Residents could now see the virus next door—thanks to the state's public performance of pandemic governmentality.

The sealing of buildings sparked anger and resentment, particularly toward hospital staff who tested positive and were blamed for triggering the dramatic government intervention in the neighborhood. Geetika was among the first hospital employees who tested positive. She used to work as a nurse in the COVID-19 ward, where she was looking after cancer patients infected with the virus. Early in the pandemic, she, her husband, and her son tested positive, while her daughter remained negative. Because she lived with her family in a small one-bedroom *chawl* flat, a working-class tenement where residents on each floor share the toilet and the bathroom, she was isolated with her husband and son in the very ward where she used to work. When they left their home late at night for hospitalization in Tata Memorial, neighbors in the building began speculating, wondering where they had suddenly gone. Some called her on the phone and told her: "Because you are working in a hospital, that's why it happened, and we will also have a problem here now."

Once authorities were notified of the positive test results, the entire building—home to eighty families—was sealed. Tensions escalated in the *chawl*. Isolated in the hospital, Geetika received harassing calls from neighbors who insisted she not return, even after testing negative. They refused to help her family



Figure 1. Poster at the entrance to a sealed residence in Mumbai. Photo by Arun Sambhu Mishra/Shutterstock.

with food and supplies. Despite obtaining an official letter from the hospital confirming her son's negative status, neighbors blocked his return. Geetika made a complaint at the local police station. A police officer escorted her son to the building and explained to the residents that the son was now negative, and they should let him return to the house. Even then, the harassment continued. Neighbors sprayed toxic disinfectants on her door and demanded that all windows remain shut: "If you open the windows, the virus will come out and we will all get corona," they warned. When others in the *chawl* developed symptoms, they refused testing. Four people died, but the neighbors insisted they had succumbed to "stress," not COVID-19.

Placed under indefinite quarantine and sealed off from the outside, solidarities within communities fractured. Hospital staff—regardless of their role—were blamed for the measures and the disruption of everyday life. "I had to face so much difficulty," said Neelam, "because my building was sealed, so all my neighbors were accusing me. There were two or three people who were planning to go to their village outside Mumbai, but they were not allowed to go because the whole building was sealed." Neelam's neighbors refused to talk to her for months. Similarly, a few months later, Geetika's neighbors admitted their anger: "Since we also had to suffer all this, that's why we were angry with you. Had no one treated us like this, we wouldn't have been upset. We felt that it's because of you, because you were positive, that we also had to suffer a lot. That's why we were angry with you."



Figure 2. The cruel mark: A home quarantine stamp in Mumbai. Photo by Ayush Das/Shutterstock.

Hospital workers became increasingly seen not as caregivers but as carriers of disease and catalysts of state intervention. "It's because of your mother that we're locked up in the building," a neighbor complained to the fourteen-year-old daughter of Poonam, another hospital employee. As Poonam related: "The municipal authorities just informed everyone that they will seal the building, and they didn't give anyone an opportunity to get some groceries. They just went there and simply sealed the building. That was the main reason that everyone got very annoyed and angry, because they went there without prior notice." Neighbors blamed Poonam, abused her, and then ignored and avoided her.

Speaking as individuals, but in a voice articulating an anonymous discourse, Poonam's neighbors felt upset that she had "gone to the hospital to rest and recover from the disease, but because of her we are facing the brunt of the burden and our building has been sealed." They insisted that "all these people working in the hospital should not be allowed to stay in the building, because they return from the hospital after testing positive and then create problems for others." The harassment and retribution that hospital staff faced in local communities articulated a broader suspicion that "all the people working in the hospital bring disease along with them." Of course, "disease" here refers to more than just the virus; it also refers to that which comes along with the virus, namely, the police.

To prevent the appearance of the police in the community, people with symptoms systematically abstained from testing and avoided doctors.

Stories of social tension and fractured relationships proliferated during the pandemic. Aisha, a trainee in Tata Memorial, lived with her parents and her four sisters in a *chawl* in a modest two-bedroom apartment. Her neighbors taunted the family for allowing Aisha to continue her hospital training, despite the risk. The stipend she earned was essential to the household, but neighbors saw it differently. One remarked bitterly to her parents: "You have a problem; you are so greedy for money that you have sent your daughter to the hospital and didn't think of us!" When Aisha tested positive, authorities insisted that she be quarantined in an isolation facility. In Lakshmi's case, policemen locked her family in their home, nailing bamboo sticks across their door, sealing them inside. She recalled, "They said they will come after fourteen days and carry out tests, and only then will we be allowed to come out. They didn't provide any food and told us to eat whatever was there in the house. They nailed the sticks and went away."

Hospital employees who experienced exclusion and social distancing drew on the language of caste, associating disease status with caste status, and comparing their treatment with the fate of "untouchables." Sneha, a hospital clerk, reflected: "We became like untouchables. The neighbors behaved like that with us. It was as if we had some kind of disease of untouchability [*achhut ki bimari*] that will spread and catch everyone."

The historian and novelist Mukul Kesavan (2020) echoed the sentiment in a newspaper article, where he drew on this locally meaningful analytic of caste. He wondered whether social distancing comes "naturally to someone raised within a broadly Brahminical society," with its extensive routines of purity and pollution and its elaborate techniques of avoiding "untouchables."[10] As Kesavan notes, caste society's "gift for social distancing and exclusion" serves Indians well in this season of infection. He continues, "In India, the coronavirus is a polluting disease kept at bay by ritualized alertness. It is contained by avoiding proximity and through constant purification. It is a challenge that caste society was built to meet."

Because caste and contagious disease are often articulated socially, practically, and ideologically as problematic of touch (and therefore as matter of proximity and distance), concerns with caste and concerns with contagious disease can blur into each other, reinforce each other, and become indistinguishable. In Kesavan's article, the logics of caste appeared as a flexible analytic to both contextualize and render culturally and historically meaningful experiences of social distancing, as well as to challenge, contest, and oppose these very practices



Figure 3. Pandemic policing.
Photo by stockpexel/Shutterstock.

of keeping people apart. Yet, problematically, his account transforms caste into a "naturalized representation" by positing upper-caste ideology as "descriptor of social reality" (Rao 2009, 8). This proves particularly relevant in the context of elite institutions like Tata Memorial. Here, references to "untouchability" typically reflected an upper-caste concern with caste stigma: upper-caste employees, who perceived themselves as "casteless moderns" (Subramanian 2019), emphasized that they were treated *as if* they were untouchables.[11] Similarly, the doctors of Tata Memorial, a medical institution committed to the idea of "castelessness," were surprised to see their special social status suddenly challenged in the community. This came as a shock. Here, invocations of "untouchability" have thus little to do with the complexities of how caste works in practice. What it reflects instead are anxieties about a collapsing social order, the duplicity of the upper-caste ideology of castelessness, and the shock that comes along when people at the top of the social hierarchy are suddenly treated *as if* they were at the bottom.

Accounts of the pandemic were overdetermined by the presence of the state and the threat of forced separation and institutional quarantine. In Sneha's building, residents avoided RT-PCR testing for COVID-19 and resorted instead to lung X-rays because laboratories were not mandated to submit lung reports to government authorities. Everyone knew what a positive PCR test would trigger: "Municipal authorities would come and take people away and put them somewhere in an isolation center." As Sneha emphasized, there was no fear of

contagion, disease, or death; rather, the fear was of "being admitted, or put under quarantine; there was no fear of anything else." Indeed, a nurse recounted how she begged government officials to not show up at her building when she tested positive and was isolated at the hospital.

What emerges here is not a simple binary between state and community, but a more complex negotiation (Das 2004). Communities sought to manage and contain unsettling forms of pandemic governmentality that were themselves emerging and evolving in unpredictable ways. From their perspective, it was not the virus but the specter of the state that required distancing. To contain interventions of law and order unmoored from ordinary restrictions by the extraordinary event of the pandemic, residents suppressed symptoms, avoided tests, and distanced themselves from those who might attract official attention.

* * *

To label these experiences as "stigma" and align them with other forms of stigmatization across different contexts and afflictions creates false equivalences. The lack of analytic discrimination obscures the stakes and politics of each setting. In the case of hospital staff in Mumbai, the master signifier draws attention to people associated with a disease because they work in a medical institution, but this approach fails to take into account the social identities of hospital staff and the roles of the state and the local community in distancing practices that are themselves not entirely novel, nor singular, nor coherent. As Veena Das (2007, 1) emphasizes in her anthropological reflections on violence, what needs to be shown is how a critical event "attaches itself with its tentacles into everyday life." In pandemic Mumbai, distancing was not merely a reaction to viral transmission. It was also a response to the state's appearance in the everyday life of the community and its impact on social relations. Across the city, the effects of pandemic governmentality proved uneven. Driven by imaginations of dirt and density as pathology, what Colin McFarlane (2023) terms the "density pathology imaginary," state policy affected especially low-income neighborhoods, where people living in crowded slums and *chawls* already found themselves subject to intense policing and the difficult living and housing conditions that make existence a daily struggle.[12]

By placing hospital staff who tested positive under a locally enforced containment regime, neighbors in slums and *chawls* seemed to act like the state, turning into an extension of state power.[13] Facing borders and boundaries imposed on them by government officials in lockdown Mumbai, neighbors simultaneously opposed, circumvented, reproduced, and reinforced them locally. This

response is not based on a false perception of disease, something that can be addressed with proper medical information. What we have here is something else: At stake is, first, a social history of existing normative practices of interaction and cohabitation, carefully negotiated along linguistic, regional, religious, caste, class, age, and gender divisions that mark everyday life in the local worlds of the slums and the *chawls*. At the core of these practices of interaction and cohabitation is adjustment as an achievement, a daily drama of "physical proximity between citizens whose ethos is geared toward avoidance and social distance between castes, communities and classes" (Rao 2007, 231). The state of exception brought about by the pandemic, the lockdowns and the restrictions of mobility, created a new context and challenge for this drama of "adjusted social differences," marking the social complexity of urban life in Mumbai (Rao 2007, 232).

Also at stake is how specific forms of pandemic governmentality appear in local milieus, are navigated and circumvented, and become intensified locally as retribution against those blamed for the state's drastic intervention. Social tension, irritation, and harassment of hospital employees occur in communities of dense habitation that are marked by multiple socioeconomic pressures and precarious living. This, then, creates a third mirror, where local communities become mirrors of the state, navigating, circumventing, implementing, and magnifying measures that are imposed on them in the name of life, health, security, and order.

The sealing of entire residential blocks symbolically marked not just individuals but entire communities. Slums and *chawls* bore the brunt of these interventions, driven by middle- and upper-class anxieties about dirt and density, fantasies about the lives of working-class people who share a toilet and a bathroom at the end of the corridor. Placed in an extreme condition of risk, security, and control by government authorities, communities in sealed tenements singled out hospital employees through rumor and gossip and confined them and their families to a limited sociality in an already limited form of local life. In some cases, boundaries were drawn even within the family, singling out the person working in the hospital as the culprit for the limited sociality of the entire family imposed by the state and the local community. In such cases, the "guilty" person was socially distanced and excluded from all forms of collective life, including the city, the neighborhood, the house, the household, and the family (see Das 2001).

Calls for the state to prevent stigmatization and educate the public are common in global health discourse. But such appeals prove naive in a context in which social tensions, irritation, and harassment occur *because* of the state's presence, both real and spectral, because of its own stigmatizing practices of

public marking, labeling, and distancing. Forms of retribution and exclusion are not motivated by false perceptions of disease, nor are they simply locatable in individuals who lack proper medical education. Instead, they are, first, part of a broader system of knowledge and power, one with modern statecraft firmly at its center, and second, driven by principles and dynamics of social stratification and distancing that already inform everyday life and its underlying "violence of adjustment" (Rao 2007, 231). Stigmatization is a way of creating and maintaining borders and must thus be seen as a continuation of the state's own deployment of borders and boundaries as "techniques of governing" infectious disease (Aradau and Tazzioli 2021). By creating borders and boundaries to regulate and restrict the movement of people, the state controls mobility. What is termed "stigma" is not a response to differentness exaggerated by fear of the abnormal or unknown. This simplistic social psychology found in stigma studies is misleading. Instead, "stigma" in pandemic Mumbai is a site of struggle around access to mobility in a context of rigorous regulation, stratification, and confinement. It forms part of a much broader effort of communities to contain the threat of pandemic governmentality that unsettles local arrangements of adjusted differences. As long as we continue to deploy *stigma* as a shortcut master signifier that can capture almost any kind of negative social experience, one that creates false equivalences across settings and that naturalizes and de-historicizes what it describes, we are at risk of unseeing how the forces of science, medicine, and the state are complicit in the very violence they ostensibly oppose.

* * *

On April 22, 2020, India's Health Ministry issued an ordinance amending the Epidemic Diseases Act of 1897—a colonial law originally enacted by the British to control plague outbreaks in the nineteenth century. More than a century later, this law has remained central to India's response to the spread of the coronavirus, providing the legal framework for containment, surveillance, and restrictions on mobility. The 2020 amendment was introduced under the pretext of protecting "the safety and security of healthcare workers at their living and working premises." Officials cited rising reports of "stigmatization" and "physical violence against doctors." The government called for "strict implementation of the Epidemic Diseases Act" while simultaneously protecting health-care workers from "stigmatization."

As Dwaipayan Banerjee (2020) argues, the Epidemic Diseases Act has "nothing to do with the management of disease. Drafted by the British to discipline

a restless native population, its provisions only seek to extend the state's ability to criminalize and suspend civil liberties." Indeed, emphasizing inspection, enforced segregation, and mandatory hospitalization, the act has as its key function to authorize and extend the powers of policing. The historian David Arnold (1993, 204) underscores this point, noting that the Epidemic Diseases Act "gave the government powers to inspect any ship or intending passenger; to detain and segregate plague suspects; to destroy infected property; search, disinfect, evacuate, and open up for ventilation, or simply demolish any dwelling thought to harbor plague; to prohibit fairs and pilgrimages; to examine and detain road and rail travelers—in short, to do whatever medical and official opinion held to be necessary for the suppression of plague." As a prominent port city with connections to the world, Bombay emerged in the colonial health nexus as a key site where "Indian" diseases became "global pandemics." As an island city, it was seen as both a gateway for global contagion and a space uniquely suited for quarantine. In 1897, nearly half of Bombay's population deserted the city, a mass migration that was "precipitated more by the threat of plague operations than by the advent of the epidemic itself" (Arnold 1993, 207). The extreme measures to control the spread of the plague in India unleashed urban riots, including violence against hospitals, health-care workers, and government officials. Arnold (1993, 202) describes this as "the greatest upsurge of public resistance to Western medicine and sanitation that nineteenth century India had witnessed." By 1947, the plague had been contained and India gained independence. Yet the colonial law remained unchanged and unchallenged.

It is the state that determines risk and danger, that spatializes and localizes disease in people and places, that creates borders and boundaries to restrict movement and that segregates populations singled out for treatment and observation. Although comprehensive alternatives to the colonial law have been drafted, none have been enacted. Instead, the recent amendment turned the fight against "stigma" into yet another opportunity for the state to police the population and consolidate power. Under the revised law, anyone who commits violence against health-care workers or damages medical infrastructures faces fines and imprisonment of up to five years.

With this amendment we have come full circle. *Stigma* is a popular term mobilized and authorized by experts across disciplines. But it is also, simultaneously, a technique of governmentality, a cruel mark, revealing the state's complicity in the violence it claims to contain.

ABSTRACT

This article offers a critical examination of the concept of stigma. *I argue that it has become a foundational term in contemporary health research and policy, where it increasingly operates as a discursive black box. Far from being merely an object of analysis, stigma now functions as a discursive standard: it shapes the rules of knowledge production, reduces the risk of discursive dissonance, and facilitates collaboration across diverse communities of practice. While its interoperability offers many advantages, it also obscures the political stakes of social disruption, reframes stigmatization as a problem of information, and contributes to the silencing of the social. Drawing on original ethnographic fieldwork in India during the coronavirus pandemic, the article explores scenes of social tension, irritation, and harassment to illuminate what is erased when* stigma *is deployed as a technical term. Situated in pandemic Mumbai, the essay follows health-care workers as they move in and out of the hospital in an unprecedented time of death, disease, and an almost total disruption of everyday life.* [stigma; power; sociality; state; medicine; India]

NOTES

Acknowledgments I greatly appreciate the comments and suggestions I received from Shagufta Bhangu, Maria José de Abreu, Angie Heo, Sarah Hodges, Dörte Bemme, Sean Brotherton, Philip Jagessar, Erin Martineau, Sarah Pinto, Fabien Provost, Anthony Stavrianakis, as well as from the members of the Culture, Medicine & Power research group and my colleagues in the Department of Global Health and Social Medicine at King's College London. At Tata Memorial Hospital, I thank Dr. Priya Ranganathan and Dr. Sandeep Tandon, as well as Dr. C. S. Pramesh—this work would not have been possible without their generous support. I am indebted to my research assistants, Dr. Pooja Sharma, Sufiyan Khan, and Sanjeev Sharma, as well as to all the hospital staff who participated in the survey and the interviews during a distressing time. My thanks to Debjani Ganguli for hosting me as the Spring 2022 Distinguished Visitor at the Institute of the Humanities and Global Cultures at the University of Virginia, where I presented the first version of this article. Audiences at the University of Salerno in Italy and the Center for the Study of Developing Societies in New Delhi offered generous comments. My thanks to Timothy Campbell, Davide Tarizzo, and Ravi Sundaram for hosting me. At SOAS, I am grateful to Bhrigupati Singh, Neil Armstrong, Nikita Simpson, and David Mosse for the opportunity to discuss stigma at the Centre for Anthropology and Mental Health Research in Action. At Columbia University, I thank Naor Ben-Yehoyada, Nadia Abu El-Haj, and Elizabeth Povinelli for their kind invitation to present this essay as a Boas Lecture. This research was generously supported by funding from the Wellcome Trust (Grant No. 214920/Z/18/Z).

1. In India, the surprise lockdown declaration resonated ominously with the prime minister's disastrous 2016 television announcement of "demonetization," which led to prolonged cash shortages in the country.
2. The majority of COVID-19 stigma studies focus on regions outside of Europe and North America. See Banerjee, Kallivayalil, and Rao 2020; Tee et al. 2020; Roelen et al. 2020; Moideen et al. 2021; Cassiani-Miranda et al. 2021; Elhadi et al. 2020; Kartikey, Laskar, and Rasania 2020; Caldera-Villalobos et al. 2020; Bhanot et al. 2021; Badi et al. 2021; Aquel et al. 2020; Abuhammad, Alzoubi, and Khabour 2021; Abdelhafiz and Alorabi 2020; Abdel Wahed et al. 2020.
3. Bruno Latour (1999, 304) observes that black boxing is "the way scientific and technical work is made invisible by its own success. When a machine runs efficiently, when

a matter of fact is settled, one need focus only on its inputs and outputs and not on its internal complexity. Thus, paradoxically, the more science and technology succeed, the more opaque and obscure they become."

4. As Lawrence Hsin Yang and colleagues (2007, 1528) note, "We must be careful not to collapse all forms of discrimination into a formulaic idea of stigma." In scholarly discourse, *stigma* often operates as another name for *discrimination*, one that provides an explanation for it: people are stigmatized because of stigma. Herein lies the (false) promise of the concept.
5. See, for example, the work of the anthropologist Roy Richard Grinker (2020, S55), who argues that "stigma . . . is deeply embedded in historically contingent structural conditions of modern capitalism and ideologies of individualism."
6. I examine these rights and obligations in more detail below.
7. For an urban ethnography of brokers in Mumbai, see the excellent collection edited by Lisa Björkman (2022).
8. On resignification, see the work of Veena Das (2004) on violence, and of Jacques Derrida (1988) on the signature.
9. For accounts of the pandemic response in India, see Mander 2023 and Arnold 2022.
10. Caste has been theorized in multiple ways, and not all accounts of caste highlight the distinction between the pure and the impure. Here I simply note the local reference to a particular understanding of caste. For critical engagements with Louis Dumont's structural approach and his emphasis on the purity/impurity divide, see, among other publications, Khare 2006.
11. As Ajantha Subramanian (2019) shows in her critical examination of an elite Indian educational institution, upper-caste self-definition is strategic and always shifts according to circumstances.
12. For an anthropological account of urban density in Mumbai, see Rao 2007.
13. See as well Emma Tarlo's (2003) account of the sterilization and "family planning" campaigns during the national Emergency in India.

REFERENCES

Abdel Wahed, Wafaa Yousif, Enas Mamdouh Hefzy, Mona Ibrahim Ahmed, and Nashwa Sayed Hamed
2020 "Assessment of Knowledge, Attitudes, and Perception of Health Care Workers Regarding COVID-19: A Cross-Sectional Study from Egypt." *Journal of Community Health* 45, no. 6: 1242–51. https://doi.org/10.1007/s10900-020-00882-0

Abdelhafiz, Ahmed Samir, and Mohamed Alorabi
2020 "Social Stigma: The Hidden Threat of COVID-19." *Frontiers in Public Health* 8: 429. https://doi.org/10.3389/fpubh.2020.00429

Abuhammad, Sawsan, Karem H. Alzoubi, and Omar Khabour
2021 "Fear of COVID-19 and Stigmatization towards Infected People among Jordanian People." *International Journal of Clinical Practice* 75, no. 4: e13899. https://doi.org/10.1111/ijcp.13899

Aquel, Ubada, Mohammad Daud Ali, Zeenat Iqbal, and Mohammad Aamir Mirza
2020 "Knowledge, Attitudes, and Practices toward Coronavirus Disease-19 Infection among Residents of Delhi NCR, India: A Cross-Sectional Survey Based Study." *Asian Journal of Pharmaceutical and Clinical Research* 13, no. 10: 110–16. https://doi.org/10.22159/ajpcr.2020.v13i10.38943

Aradau, Claudia, and Martina Tazzioli
2021 "Covid-19 and Rebordering the World." *Radical Philosophy* 2, no. 10: 3–10.

Arnold, David
1993 *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. Berkeley: University of California Press.
2022 *Pandemic India: From Cholera to Covid-19*. London: Hurst & Company.

Badi, Safaa, Muhammad Abdou Abdulraheem, Anas Albagir Mustafa, Mazin Matar, and Bashir Alsiddig Yousef
2021 "Knowledge, Attitude, and Practice of University Students toward COVID-19 in Sudan: An Online-Based Cross-Sectional Study." *Current Medical Issues* 19, no. 2: 70–77. https://doi.org/10.4103/cmi.cmi_155_20

Bagcchi, Sanjeet
2020 "Stigma during the COVID-19 Pandemic." *The Lancet Infectious Diseases* 20, no. 7: 782. https://doi.org/10.1016/s1473-3099(20)30498-9

Banerjee, Debanjan, Roy Abraham Kallivayalil, and T. S. Sathyanarayana Rao
2020 "The 'Othering' in Pandemics: Prejudice and Orientalism in COVID-19." *Indian Journal of Social Psychiatry* 36, Suppl 1: S102–S106. https://doi.org/10.4103/ijsp.ijsp_261_20

Banerjee, Dwaipayan
2020 "Fantasies of Control: The Colonial Character of the Modi Government's Actions during the Pandemic." *The Caravan*, July 30.

Bhanot, Divya, Tushar Singh, Sunil K. Verma, and Shivantika Sharad
2021 "Stigma and Discrimination during COVID-19 Pandemic." *Frontiers in Public Health* 8: 577018. https://doi.org/10.3389/fpubh.2020.577018

Björkman, Lisa, ed.
2022 *Bombay Brokers.* Durham, N.C.: Duke University Press.

Blom Hansen, Thomas
2002 *Wages of Violence: Naming and Identity in Postcolonial Bombay*. Princeton: Princeton University Press.

Caduff, Carlo
2020 "What Went Wrong: Corona and the World after the Full Stop." *Medical Anthropology Quarterly* 34, no. 4: 467–87. https://doi.org/10.1111/maq.12599

Caldera-Villalobos, Claudia, Idalia Garza-Veloz, Nadia Martínez-Avila, Iván Delgado-Enciso, Yolanda Ortiz-Castro, Griselda A. Cabral-Pacheco, and Margarita L. Martinez-Fierro
2020 "The Coronavirus Disease (COVID-19) Challenge in Mexico: A Critical and Forced Reflection as Individuals and Society." *Frontiers in Public Health* 8: 337. https://doi.org/10.3389/fpubh.2020.00337

Cassiani-Miranda, Carlos Arturo, Adalberto Campo-Arias, Andrés Felipe Tirado-Otálvaro, et al.
2021 "Stigmatisation Associated with COVID-19 in the General Colombian Population." *International Journal of Social Psychiatry* 67, no. 6: 728–36. https://doi.org/10.1177/00207640209724445

Chatterji, Roma, and Deepak Mehta
2007 *Living with Violence: An Anthropology of Events and Everyday Life*. London: Routledge.

Chen, Shixiang, Qi Lu, Jinbing Bai, Cuiyu Deng, Yaogang Wang, and Yue Zhao
2020 "Global Publications on Stigma between 1998–2018: A Bibliometric Analysis." *Journal of Affective Disorders* 274: 363–71. https://doi.org/10.1016/j.jad.2020.05.006

Cixous, Hélène
2005 *Stigmata: Escaping Texts.* Second edition. London: Routledge.

Das, Veena
2001 "Stigma, Contagion, Defect: Issues in the Anthropology of Public Health." Unpublished paper.
2004 "The Signature of the State: The Paradox of Illegibility." In *Anthropology in the Margins of the State*, edited by Veena Das and Deborah Poole, 225–52. Santa Fe, N.M.: School of American Research Press.
2007 *Life and Words: Violence and the Descent into the Ordinary*. Berkeley: University of California Press.

Derrida, Jacques
1988 "Signature Event Context." In *Limited Inc.*, 1–23. Evanston, Ill.: Northwestern University Press.

Elhadi, Muhammed, Ahmed Msherghi, Moutaz Elgzairi, et al.
2020 "Psychological Status of Healthcare Workers during the Civil War and COVID-19 Pandemic: A Cross-Sectional Study." *Journal of Psychosomatic Research* 137: 110221. https://doi.org/10.1016/j.jpsychores.2020.110221

Fassin, Didier, and Richard Rechtman
2009 *The Empire of Trauma: An Inquiry into the Condition of Victimhood*. Translated by Rachel Gomme. Princeton, N.J.: Princeton University Press.

Goffman, Erving
1963 *Stigma: Notes on the Management of Spoiled Identity*. London: Penguin Books.

Gordon, Peter
2018 "The Authoritarian Personality Revisited: Reading Adorno in the Age of Trump." In *Authoritarianism: Three Inquiries in Critical Theory*, edited by Wendy Brown, Peter Gordon, and Max Pensky, 45–84. Chicago: University of Chicago Press.

Grinker, Roy Richard
2020 "Autism, 'Stigma,' Disability: A Shifting Historical Terrain." *Current Anthropology* 61, no. S21: S55-67. https://doi.org/10.1086/705748

Hacking, Ian
2006 "Making Up People: Clinical Classifications." *London Review of Books* 28, no. 16.

Kartikey, Yadav, Ananya Laskar, and S. K. Rasania
2020 "A Study on Stigma and Apprehensions Related to COVID-19 among Healthcare Professionals in Delhi." *International Journal of Community Medicine and Public Health* 7, no. 11: 4547–53. https://doi.org/10.18203/2394-6040.ijcmph20204760

Kartono, Rinikso, Salahudin, and Iradhad Taqwa Sihidi
2022 "Covid-19 Stigmatization: A Systematic Literature Review." *Journal of Public Health Research* 11, no. 3: 1–9. https://doi.org/10.1177/22799036221115780

Kesavan, Mukul
2020 "Caste and Contagion." *The Telegraph*, March 25.

Khare, R. S., ed.
2006 *Dumont Revisited: Caste, Hierarchy and Individualism: Indian Critiques of Louis Dumont's Contributions*. New Delhi: Oxford University Press.

Kuhn, Thomas
1962 *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Latour, Bruno
1999 *Pandora's Hope: Essays on the Reality of Science Studies*. Cambridge, Mass.: Harvard University Press.

Link, Bruce G., Lawrence H. Yang, Jo C. Phelan, and Pamela Y. Collins
2004 "Measuring Mental Illness Stigma." *Schizophrenia Bulletin* 30, no. 3: 511–41. https://doi.org/10.1093/oxfordjournals.schbul.a007098

Mander, Harsh
2023 *Burning Pyres, Mass Graves, and a State That Failed Its People: India's COVID Tragedy*. New Delhi: Speaking Tiger Books.

McFarlane, Colin
2023 "Repopulating Density: COVID-19 and the Politics of Urban Value." *Urban Studies* 60, no. 9: 1–22. https://doi.org/10.1177/00420980211014810

Menon, Vikas, Susanta Kumar Padhy, and Jigyansa Ipsita Pattnaik
2020 "Stigma and Aggression against Health Care Workers in India amidst COVID-19 Times: Possible Drivers and Mitigation Strategies." *Indian Journal of Psychological Medicine* 42, no. 4: 400–401. https://doi.org/10.1177/0253717620929241

Moideen, Shamsudeen, N. A. Uvais, Sooraj Rajagopal, V. Maheshwari, Tasneem Abdul Gafoor, and S. Haja Sherief
2021 "COVID-19-Related Stigma among Inpatients with COVID-19 Infection: A Cross-Sectional Study from India." *Primary Care Companion to the Journal of Clinical Psychiatry* 23, no. 1: 20br02853. https://doi.org/10.4088/pcc.20br02853

Rao, Anupama
2009 *The Caste Question: Dalits and the Politics of Modern India*. Berkeley: University of California Press.
Rao, Vyiayanthi
2007 "Proximate Distances: The Phenomenology of Density in Mumbai." *Built Environment* 33, no. 2: 227–48. https://dx.doi.org/10.2148/benv.33.2.227
Roelen, Keetie, Caroline Ackley, Paul Boyce, Nicolas Farina, and Santiago Ripoll
2020 "COVID-19 in LMICs: The Need to Place Stigma Front and Centre to Its Response." *European Journal of Development Research* 32, no. 5: 1592–612. https://doi.org/10.1057/s41287-020-00316-6
Rosenberg, Charles
2002 "The Tyranny of Diagnosis: Specific Entities and Individual Experience." *Milbank Quarterly* 80, no. 2: 237–60. https://doi.org/10.1111/1468-0009.t01-1-00003
Schubert, Melanie, Julia Ludwig, Alice Freiberg, et al.
2021 "Stigmatization from Work-Related COVID-19 Exposure: A Systematic Review with Meta-Analysis." *International Journal of Environmental Research and Public Health* 18, no. 12: 61–83. https://doi.org/10.3390/ijerph18126183
Sivaramakrishnan, Kavita
2020 "Looking Sideways: Locating Epidemics and Erasures in South Asia." *Bulletin of the History of Medicine* 94, no. 4: 637–57. https://doi.org/10.1353/bhm.2020.0087
Stangl, Anne L., Valerie A. Earnshaw, Carmen H. Logie, Wim van Brakel, Leickness C. Simbayi, Iman Barré, and John F. Dovidio
2019 "The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas." *BMC Medicine* 17: 31. https://doi.org/10.1186/s12916-019-1271-3
Stuart, Heather, Julio Arboleda-Flórez, and Norman Sartorius
2013 *Paradigms Lost: Fighting Stigma and the Lessons Learned*. Oxford: Oxford University Press.
Subramanian, Ajantha
2019 *The Caste of Merit: Engineering Education in India*. Cambridge, Mass.: Harvard University Press.
Tarlo, Emma
2003 *Unsettling Memories: Narratives of the Emergency in Delhi*. Berkeley: University of California Press.
Tee, Michael L., Cherica A. Tee, Joseph P. Anlacan, Katrina Joy G. Aligam, Patrick Wincy C. Reyes Vipat Kuruchittham, and Roger C. Ho
2020 "Psychological Impact of COVID-19 Pandemic in the Philippines." *Journal of Affective Disorders* 277: 379–91. https://doi.org/10.1016/j.jad.2020.08.043
van Brakel, Wim H., Janine Cataldo, Sandeep Grover, et al.
2019 "Out of the Silos: Identifying Cross-Cutting Features of Health-Related Stigma to Advance Measurement and Intervention." *BMC Medicine* 17, no. 1: 13.
Yang, Lawrence Hsin, Arthur Kleinman, Bruce G. Link, Jo C. Phelan, Sing Lee, and Byron Good
2007 "Culture and Stigma: Adding Moral Experience to Stigma Theory." *Social Science & Medicine* 64, no. 7: 1524–35. https://doi.org/10.1016/j.socscimed.2006.11.013