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FACT SHEET

UNDERSTANDING AND ADDRESSING STIGMA DURING THE PANDEMIC

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INTRODUCTION

This Fact Sheet explores ways of understanding and addressing stigma during the COVID-19 pandemic. It is important to focus on stigma because the pandemic has made pre-existing social fractures and fault lines more pronounced and has seen the opening up of new fault lines and forms of discrimination. Many have experienced stereotyping, marginalisation, and discrimination – directly and indirectly – during and in relation to the pandemic. It is incumbent on the HR practitioner to understand this and address it systematically, comprehensively, and holistically.

The Fact Sheet first explores the definition of stigma and the need to consider different levels of analysis. It explores a framework to help understand the relations and dynamics between the different levels. Thereafter, the Fact Sheet explores the different types and levels of stigmatisation and how it can manifest in the workplace during the pandemic.

DEFINING STIGMA

STIGMA FRAMEWORKS

STIGMA DURING THE COVID PANDEMIC

ADDRESSING STIGMA IN THE WORKPLACE

CONCLUSION

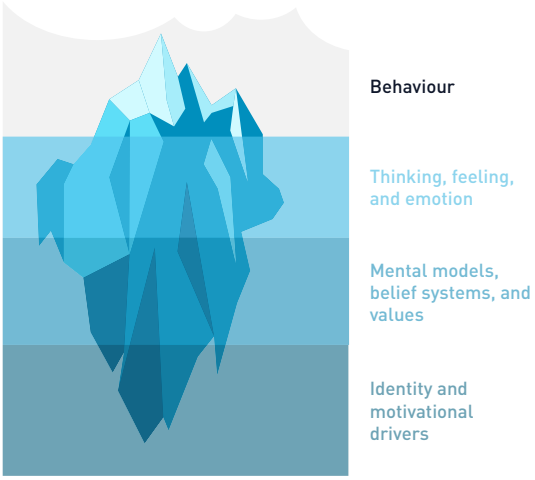
**Navigate the menu by clicking on desired heading.

DEFINING STIGMA

Stigma is a long-standing social problem. During the present COVID pandemic, stigmatisation may have been exacerbated and could have negatively impacted willingness to go for testing, help-seeking behaviour, and vaccination. It, thus, requires sustained attention and sound interventions. At first glance we may consider stigma as a phenomenon that can be readily defined, identified, and addressed. We may see it as a negative attitude to and devaluation of another and address it as such. Thus, we may tend to focus our attention and interventions on the 'stigmatised' and 'stigmatiser': (1) the individual experiencing stigma and the emotional impact on him/her and (2) the thinking and verbal and non-verbal behaviour of the person stigmatising the individual.

However, as HR practitioners, we need to be aware that stigma is multi-faceted. We need to understand it in relation to stereotyping, prejudice, and social exclusion and discrimination. Thus, we first need to be clear how we define and use these different terms. Second, we need to critically engage with stigma at different levels of analysis to understand and address it systematically, comprehensively, and holistically (Baldassarre, Giorgi, Alessio, Lulli, Arcangeli, & Mucci, 2020; Pescosolido, Martin, Lang, & Olafsdottir, 2008; Stuber, Meyer, & Link, 2008; Tyler and Slater, 2018). The figures below provide examples of how we can differentiate the levels of analysis, from the micro to the meso and macro levels.

Different levels of analysis help to understand the drivers of stigmatisation and the ways it can manifest and the impact it can have



There are sublevels within a level: For example, sublevels within the individual level

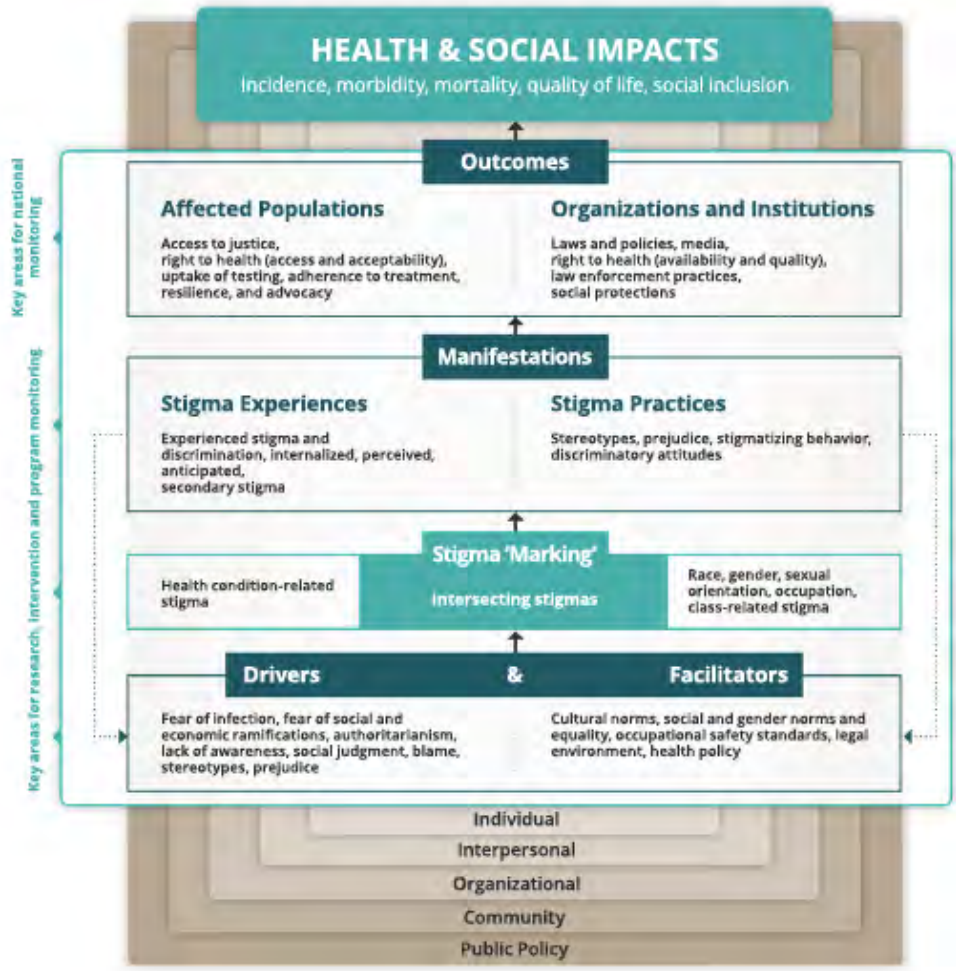
We can begin with a working definition. For example, the American Psychological Association (APA, 2020, italics added) defines stigma as:

> "the *negative social attitude* attached to a *characteristic* of an *individual* that may be regarded as a mental, physical, or social *deficiency*. [It] implies *social disapproval* and can lead *unfairly* to *discrimination* against and *exclusion* of the individual."

The definition implies that stigma is multi-faceted and cannot be reduced solely to the individual level; that is, reduced to the individual's perceptions, cognitions, and emotional reactions (the intra-individual level). This means appreciating the different levels of analysis. Thus, we cannot solely focus on the individual and dyad (or interpersonal) level in our understanding of, and interventions against, stigma. We need to attend to the group, institutional, and other macro levels. For example, we need to engage with critiques that suggest that we need to understand together the various bases and mechanisms of stigma (which include the psychological, social, cultural, political, and material); the marginalisation and power dynamics therein; its impact on individual identities and the interpersonal and group dynamics (including identifications and psychological projections); and the consequences and implications for various minorities, disadvantaged and marginalised communities, and social strata. Stigma is, therefore, an important concept in relation to current efforts to achieve diversity and inclusion in the workplace.

STIGMA FRAMEWORKS

There are a number of frameworks available to understand the stigmatisation process as well as the bases and mechanisms thereof (Stangl, Earnshaw, Logie, van Brakel, Simbayi, Barré, & Dovidio, 2019). Many of these frameworks are directed at the individual level. These attend to the "psychological pathways at the individual level, focusing either on the individuals experiencing stigma [or] those perpetuating stigma" (p2). Stangle et al propose a broader 'social ecological framework' that attends to the different levels of analysis mentioned above. The authors' illustration of the framework is provided below. It illustrates the different levels of analysis as well as drivers, facilitators, manifestations, outcomes, and health and social impacts of stigma. The authors intend to capture "how stigma related to race, gender, sexual orientation, class, and occupation intersects with health-related stigmas" (ibid) in their framework. It provides a guide for the HR practitioner to plan interventions to address stigma. And it can help the HR practitioner to think through how stigmatisation has evolved and manifests during the COVID pandemic and ways to address it.



Source: Stangl et al, 2019

As stated above, the framework attends to the health and social impacts of stigma. Prior to the COVID pandemic, many organisations addressed employee physical and mental health and the stigma related to these through their employee assistance programmes (EAP). During the pandemic it will be even more important to attend to physical and mental health as well as stigmatisation. At present many organisations are highlighting mental health, given the increasing calls for organisations to prioritise both productivity and wellbeing (Jivan, 2020). This is particularly the case with the experience of digital fatigue and rising reports of extended working hours and burn out with remote working.

The below textbox explores stigma and discrimination related to mental health. It can help the HR practitioner understand the issues that need to be considered and what needs to be addressed.

Understanding stigma and discrimination with mental health

by Professor Christoffel Grobler

We may not realise that mental health problems are common. They affect thousands of people in South Africa and other countries. This includes our friends, families, and work colleagues. We do not always realise how common some mental health disorders, such as depression and anxiety, really are. And we do not appreciate how many go through a big part of their lives with a poor quality of life, which could have been so much better had they known that the symptoms they are experiencing are related to common mental health disorders.

The two most common reasons for this situation are, firstly, stigma and, secondly, lack of mental health literacy. We frequently think that only severe mental illness like schizophrenia constitutes mental illness. We do not realise that the most common disorders, such as depression and anxiety, are also deemed mental health disorders.

Consider that in South Africa approximately 30% of our population will experience a mental health disorder in their lifetime, and that globally 1 in 5 had a common mental disorder in the previous 12 months. Even more concerning is that 38,5% of first year students at two big universities in South Africa were found to already have had a common mental health disorder, such as depression or anxiety, by the time the time they enter university. It is furthermore ***estimated*** that 1 in 6 employed people will experience a common mental health problem in any given year.

People with mental health problems experience personal and social stigma attached to mental ill health. The discrimination they experience not only makes their difficulties worse, it also makes it harder to recover. It has been found that 9 out of 10 people with mental health problems experience stigma and discrimination, with one in 10 reporting discrimination on a daily basis.

The reasons given for not disclosing a mental health problem have been ***found*** to be:

- 46% for fear of being discriminated against,
- 41% felt ashamed,
- 27% because previous experiences of disclosure made them nervous about doing so, and
- 25% because they felt there wasn't any support or guidance for doing so.

Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.

In an American study the following reasons were given by employees for not disclosing a mental illness:

- fear that the boss would interpret it as unwillingness to work (34%) or
- being labelled "weak" (31%).

Many people's problems are made worse by the stigma and discrimination they experience - from society, but also from families, friends, and employers. Employers can do a lot to challenge and break down the stigma associated with mental health disorders by providing leaders training in mental health awareness, providing inhouse mental health education through workplace mental health programs, and appointing mental health champions at work.

Society unfortunately has stereotyped views about mental illness and how it affects people. Psychoeducation at work can go a long way in breaking down the myths related to mental health disorders. Most people who experience mental health problems recover fully, or can live with and manage them, especially if they get help early on. But even though so many people are affected, there is a strong social stigma attached to mental ill health, and people with mental health problems can experience discrimination in all aspects of their lives.

Research shows that the best way to challenge these stereotypes is through first-hand contact with people with experience of mental health problems. Employees who are brave enough to share their lived experience with mental illness have been found to be a very powerful tool in breaking down stigma and making it easier for other employees to come forward with their challenges related to mental illness.

There are different types of stigma in relation to mental health. The American Psychiatric Association provides the below table as examples of *self, public, and institutional stigmatisation* related to mental health.

Types of Stigma

	Public	Self	Institutional
Stereotypes & Prejudices	People with mental illness are dangerous, incompetent, to blame for their disorder, unpredictable	I am dangerous, incompetent	Stereotypes are embodied in laws and other institutions
Discrimination	Therefore, employers may not hire them, landlords may not rent to them, the health care system may offer a lower standard of care	These thoughts lead to lowered self-esteem and self-efficacy: "Why try? Someone like me is not worthy of good health"	Intended and unintended loss opportunity

Source: American Psychiatric Association (2020, adapted from Corrigan, Druss, & Perlick (2014)

STIGMA DURING THE COVID PANDEMIC

We could easily adapt the above table of the types of possible stigma to the COVID pandemic by substituting 'mental illness' with 'COVID'. These types of stigma can negatively impact testing, help-seeking behaviour, and vaccination. The below textbox explores these types of stigma and related stereotyping, marginalisation, and discrimination at the global, local, and organisational levels.

Stigma, marginalisation, and discrimination in the wake of the COVID-19 pandemic

by Dr Anersha Pillay

We can understand the impact of the pandemic at different levels. For brevity and the purposes of this factsheet, we can explore the impact at the global, local, and organisational levels.

GLOBAL LEVEL

January 2020 saw the world come to the realisation that the COVID-19 pandemic will be a global agenda. It will not be confined to just a few isolated and unfortunate countries. Yet, instead of focusing on a common goal of collaboration and assistance to prevent the mass spread of the SARS-CoV-2 virus, we encountered blame, accusations, discrimination, and stigma. Phenomena that continue to persist more than a year later into the pandemic.

Stigma, marginalisation, and discrimination have been well documented in the literature relating to other disease outbreaks such as MERS, Ebola, and SARS, where the affected individuals and communities were left with deep psychological scars long after the outbreaks had resolved.

The COVID-19 pandemic seems to be no different in igniting these negative individual and societal responses. Only this time, the scale is large and far-reaching. Perhaps, the very first indication that this pandemic would be accompanied by stigma and discrimination, was the very prominent emergence of misinformation, disinformation, conspiracy theories, and false claims that even political leaders espoused regarding the origins, spread, and management of the coronavirus pandemic (Mukhtar, 2020; Schmidt, Cloete, Davids, Makola, Zondi, & Jantjies, 2020).

Since then, a growing body of literature has highlighted the many facets of stigma and discrimination associated with COVID-19 globally. These include reported hate speech, threats, and attacks towards Asians and Asian Americans, fueling racism and xenophobia; racial profiling and harassment by law enforcement of African American men wearing face-coverings such as bandanas; stigma towards healthcare workers caring for COVID-19 patients presumably for fear that they may be infective; and discrimination against people who have acquired and recovered from COVID-19 (Chopra and Arora, 2020; Turner-Musa, Ajayi, & Kemp, 2020).

LOCAL LEVEL

In the wake of the COVID-19 pandemic, South Africa was not immune to the impact of stigma, marginalisation, and discrimination. The stark reality of our socioeconomic inequality could not be more present than during the pandemic, with the advent of severe food shortages, worsening poverty, massive job losses, lack of equal access to COVID testing and healthcare, lack of PPE for healthcare workers in certain areas, the emergence of a secondary epidemic of gender-based violence; and currently the slow and fractured rollout of mass vaccination against COVID-19 (Mbunge, 2020).

In addition to the community impact of stigma associated with COVID-19, the working environment of many has also been beset with challenges related to stigma, marginalization, and discrimination on an unprecedented scale.

ORGANISATIONAL LEVEL

The working environment has undergone significant changes because of the pandemic, the related interventions such as the need for social distancing and isolation and the wearing of masks, and consequences that include economic strife. Since the onset of the pandemic, clinicians in hospitals and clinical practices have observed and noted the different ways that stigma, marginalisation, and discrimination present themselves within the workplace. These are detailed below:

1. REMOTE WORKING:

a. *Coping challenges*

Whilst the concept of working from home may appear to be universally appealing, this was not the case for all employees. Indeed, some found this preferential as it saved from navigating peak hour traffic and contending with the ever- changing petrol costs and car maintenance. Others had a completely different experience. The lack of separation of the work and home environment; contending with managing work together with supervising children's on-line schooling, avoiding household distractions and noise whilst on team meetings, and sometimes having to use the bedroom as an office space as well; and social isolation resulted in significant psychological distress and even mental health problems in some individuals.

Sadly, these individuals came across as not able or willing to embrace this new way of working, and they were unable to express their discontent and difficulties for fear of being stigmatised or seen as "poor copers" by colleagues and managers. The resultant and persistent distress often led to depression, anxiety and other mental health difficulties further entrenching the experience of stigma and marginalization.

b. *Extended working hours*

Another often identified problem emanated from the pressure of working well beyond the official or structured working hours. Reports of 12 – 14 hours of on-line work, including calls from managers at unreasonable hours, were a not uncommon complaint. The lack of boundaries and fixed reasonable working hours were once again a cause of distress. Attempts to address these difficulties with employers and managers were more often than not met with disregard or conflict, resulting in employees labelled and stigmatised as problematic or 'not team players' and feeling marginalised and discriminated.

c. *Work/life balance*

Whilst some individuals were and are still able to navigate and create a healthy balance between their work, family, and leisure life, others continue to find this extremely difficult through the pandemic. The restrictions imposed by social distancing, fear of contracting the virus and ever-present threat of yet another wave of infection, have resulted in less engagement in leisure activities including exercise. Employees caught up in the difficulty of establishing this balance, are likely to feel inadequate and marginalised, with "why can't I get it right" being a reported experience by them.

d. *Logistical barriers*

Socioeconomic disparities and the digital divide in the South African context mean that not all employees have equal access to stable networks and ICT support, which is particularly important for remote working. As such, deliverables may not always be met resulting in the employee being judged as a non-performer. Living in cramped or informal housing is likely to present further challenges to optimal performance. It is thus imperative that employers/managers explore these aspects to prevent the unnecessary stigma toward those in disadvantaged situations who are forced to work remotely as a result of the pandemic.

2. ON-SITE WORKING:

a. *Social distancing*

The maintenance of social distancing in the workplace can be difficult to institute, police, and maintain; particularly if colleagues have returned to the workplace after a prolonged period of lockdown. Those fully embracing the concept of social distancing, being fearful of contracting COVID–19 or suffering from co-morbidities that may render them vulnerable, are at risk of being stigmatised and discriminated against in office environments where social distancing is not actively practiced.

b. *Wearing of masks*

More than a year into the pandemic has seen the emergence of mask fatigue and in some cases continued disbelief in the need for wearing masks or the feeling that the wearing of a mask is an imposition on the right to choose. From these scenarios, stigmatisation can emerge for those who embrace the science behind mask-wearing and continue to do so in the workplace. Reports from clinical practices speak of individuals being ridiculed as being "paranoid" or "alarmist" simply by following legislated preventative measures.

c. *Fears*

Understandably, returning to the workplace following a prolonged period of lockdown can be accompanied by rational fears of greater exposure to COVID-19. Reports of keeping these understandable fears hidden for fear of being stigmatised and ridiculed were commonly reported and resulted in significant psychological distress. Employers/managers, however, were not always understanding of these fears.

3. COVID-19 INFECTION (OR NOT):

a. *Presenting with COVID like symptoms*

With the flu season approaching, many employees may feel self-conscious if experiencing flu-like symptoms for fear that they may be viewed as having COVID. There may be additional pressure to seek *COVID* testing primarily to appease fellow colleagues. Whilst seeking medical attention to prevent the non-detection of a COVID-19 infection is prudent, caution should be exercised in ensuring that employees who are unwell with flu-like symptoms are not unfairly stigmatised.

b. *Non-disclosure of COVID status*

Whilst the protection of personal medical information is sacrosanct, an individual continuing to attend work despite testing positive for COVID-19 or withholding information regarding coronavirus infection in the event that others may have been exposed, can be seen as unethical. Fear of being stigmatised for having acquired the infection, being judged as not being careful enough, fear of losing employment due to absenteeism, and denial of having the infection may be some of the factors leading to non-disclosure. The consequences of this though can be dire.

c. *Acquiring COVID*

Once again, the acquisition of *COVID* can be met with stigma, primarily from the perception of one having not being careful enough. Yet, in a pandemic with the pervasive amount of circulating virus, particularly at the height of a wave, it may be difficult for an individual to try to dissect when, where and how he or she contracted COVID-19. Despite this, many patients report feeling immensely guilty for contracting *COVID* and further report being marginalised by their colleagues.

3. COVID-19 INFECTION (OR NOT) – CONTINUED

d. *Return to work post-infection*

With the knowledge base on COVID-19 increasing exponentially as the pandemic persists, literature has emerged that a subset of COVID-19 sufferers, irrespective of their pre-morbid health status, will struggle to return fully functional to work. Residual symptoms of fatigue, reduced effort tolerance, headaches, cognitive difficulties, and body pains may impede the employee's ability to function optimally. Reports indicate that up to 57.4 % of infected individuals may experience these on-going symptoms.

Of even greater concern is the complication of Post-*COVID* syndrome, also known as "long- haulers" and Neuropsychiatric COVID. Up to 35% of patients experience these complications of *COVID* beyond 3–12 weeks post the acute infection. These neuropsychiatric symptoms may include debilitating headaches, seizures, sleep disorders, brain infections (encephalitis and meningitis), stroke, depression, anxiety, trauma, and medication side effects. All of which may have significant negative impact on the employee's neurocognitive abilities.

This scenario can lend itself to stigmatisation and discrimination by colleagues and managers who have little knowledge that such complications may exist.

4. HR AND MANAGEMENT RESPONSIVENESS:

This experience of a global pandemic – which leaves illness, disability and possible death in its wake – affects every individual, irrespective of their level of resilience. Individual responses may range from denial to disregard or bravado and at the extreme immense panic and severe psychological distress. Stigmatisation, marginalisation, and discrimination of these individual responses to the pandemic, as well as those who survived and those who are deemed to be at risk for infection, serve only to impede the opportunity to prevent the spread of infection. It also impedes the prevention of the dissemination of misinformation and disinformation. These can exacerbate employee distress and facilitate the creation of an unsupportive and psychologically unhealthy workplace.

It is thus imperative that employers, managers, and HR practitioners actively address stigma, marginalisation, and discrimination during the COVID-19 pandemic. This is to ensure that they and their employees are well educated on these concepts, are vigilant against promoting these negative mindsets, and seek advice on ways of mitigating against the emergence of a secondary epidemic of neuropsychiatric and psychological distress long after the COVID-19 pandemic has resolved. As such, the maintenance of a psychologically as well as physically healthy work force remains imperative in the wake of this devastating pandemic.

ADDRESSING STIGMA IN THE WORKPLACE

As can be seen from the discussion in the above textbox, the workplace does not exist in a vacuum. It is very much part of the social context it is embedded in. The below textbox elaborates on this and provides a perspective from industry. It emphasises that employers need to plan and lead efforts to address stigma. This includes the in-depth work of examining the organisation's belief system.

Stigma in the workplace

by Steven Teasdale

As previously noted, stigma is a pervasive challenge for society, and its emergence in the workplace is not spared. We are probably more exposed to it in the workplace, given the amount of time we spend working. Add to this the social desirability that is at play in relation to the organisational systems we operate in. The dictionary definition of stigma, referring to the 'shame or disgrace attached to something regarded as socially unacceptable', is equally revealing of our lack of acceptance of certain issues.

At the heart of this dilemma is the perceived consequences of revealing the distinguishing characteristics that lead to the negative attitudes or discrimination to those we work with, learn from, or even more so those who have an influence on our career opportunities. In many ways we will struggle to expose these distinguishing characteristics until our belief system allows us to believe the consequences will not be negative, or we believe that they may be negative but proceed anyway. Until we address our belief systems we will struggle to support our colleagues/teams, both sustainably and effectively.

What could give us hope is the changing attitudes of leaders and organisations around two fundamental stigmas that were pervasive at a point in time, but they have become more inclusive in relation to work and career than ever before. The first is the stigma emerging out of being a female employee (or candidate) who is of childbearing age: the stigma emerging around the disruption it will cause to the organisation behind the flawed assumption of levels of commitment vs the family or time off work. The second is HIV. The stigma and related assumptions at a point in time for the illness was offensive. As education and leadership emerged in these areas we have moved forward. While females and individuals with HIV still suffer stigma, both have moved significantly in the right direction.

The stigma in the workplace that remains more pervasive concerns mental health. The irony is that the meaning and focus of having work can often support the recovery from mental health conditions, and the leadership opportunity to support colleagues through the challenges will result in immense impact for both individuals and the organisation. The espoused acceptance of mental health by leaders unfortunately is not consistently followed up in action. As leaders we struggle to be vulnerable with our own mental health, once again reinforcing the assumption that only those free of the illness can succeed.

In progressive news, mental health in the workplace has never been more acknowledged and never have we seen so many tools, resources, and avenues for employees to turn to their workplace, confidentially. Equally, we are seeing more procedures and policies emerging in the workplace, and organisations are making significant investments to support mental health. However, this is not enough. We need more from organisations to break this at a belief system level.

A key opportunity lies in a human-centric examination of the employee experience. This means, for example, exploring different scenarios and developing representations of individuals and groups to examine their experiences in these scenarios. These representations or personas can help to understand the experiences of those with differing levels of mental health and wellbeing challenges. These then can be linked to the organisational challenges and create opportunities for Human Resources to respond to these challenges. Hopefully, in this way we can bring reform and enable those with challenges to recover. A significant component of the success of such initiatives and programmes needs to rest on, and be internalised by, leadership who can act as a key lever to unlocking the barriers to the reduction of stigma in the workplace. The question remains as to what the best mechanisms are to get leaders to examine and challenge their own belief systems; to recognise their blind spots to certain assumptions; and fragility within their actions and behaviour around the stigma of mental health in general including the workplace.

While putting pressure on leadership, we also know that organisations need to educate more and ensure we are enabling certain fundamental organisational capabilities to bring about change in this area. Ultimately, the responsibility sits with every single individual to listen, be more open, inclusive of ideas and beliefs that differ from ours.

Leadership, culture (especially the organisation's belief systems), employee experience and empowerment, and formal and informal behavioural rewards in an organisation are critical areas to be addressed. These can also serve as levers to address stigma. Thus, the HR practitioner needs to contextualise the interventions to address stigma. Drawing on the American Psychiatric Association (2020) suggestions, the following can help the HR practitioner:

- Tailor approaches and programmes to your company culture and existing strengths. Challenge the culture and organisational belief systems where necessary and ensure systematic OD and change management interventions.
- Provide information and education resources and programmes for managers and employees. Provide reliable and sound information resources on vaccination to address fears, concerns, and individual understanding of vaccines.
- Secure executive and management support and help them to challenge their limiting assumptions and belief systems on wellbeing in the workplace. Managers need to show their commitment to wellbeing and a psychological safe workplace. Managers need to ensure that wellbeing and safety are part of the company's commitment to its overall culture of health, to its attraction and retention of talent, and of how they value their employees.
- Train managers to (1) proactively identify and address emotional distress, stigma, marginalisation, and discrimination and (2) understand the course, impact, and long-term effects of infection. Ensure managers know how to make referrals to and use employee assistance programmes. And put in place training and mechanisms for them to respond promptly and constructively to behavioural performance issues.
- Be welcoming of the need for accommodations. Train managers to respond appropriately.
- Identify the causes and the incentives/rewarding of non-constructive or unethical behaviour and address these promptly as an organisation.
- Avoid addressing wellbeing, productivity, and employee engagement in silos. These interventions need to be integrated and systematic.

The above suggestions can form part of the solutions that HR practitioners need to help put in place to address stigma and stigmatisation systematically, comprehensively, and holistically. The HR practitioner can also utilise the eight wellness dimensions, as defined in the SABPP National HR Standards, to help identify and address the possible types and levels of stigma. The below table lists the wellness dimensions and related wellbeing interventions that the HR practitioner can use, together with the stigma framework presented earlier, as a basis to proactively identify possible stigmatisation in the workplace and the ways to address it. More importantly, the pandemic has highlighted how important it is to address these dimensions in the employee/employment value proposition.

WELLNESS DIMENSIONS

Consult with stakeholders to examine the above dimensions and the impact of the COVID-19 pandemic (and the organisation's responses to it and the related changes in work and workplace) will have on these dimensions:

PHYSICAL:

The practice of healthy behaviours and habits in relation to physical activity, nutrition, sleep, and relaxation; the use of preventive screening; and actively monitoring and managing chronic conditions

- Screening at entry, exit and for high risk groups
- Institute mandatory hygiene protocols
- Provision for testing for suspected infection in collaboration with service providers or medical aid
- Providing information and guidelines for staff to self-monitor and report symptoms as well as on how to engage team members who may have had possible exposure or are infected
- Institute formal reporting channels, resources or mechanisms that does not lend itself to stigmatisation
- Link to existing healthy living campaigns and behavioural change programmes

High risk groups

- Identify and manage high risks groups with comorbidities, immune suppression and other relevant factors

MENTAL AND EMOTIONAL:

Developing the capacity to self-regulate, thrive and fully experience the diverse range of human emotions

- Provide psychological support, counselling and referral systems
- Provide programmes to develop resilience and to adapt to flexible and remote work where necessary
- Provide guidelines on how to structure working from home and balance work and life demands and time conflicts
- Provide interventions and resources to identify, manage and seek help with stress, anxiety, depression, burnout, substance abuse, and risk-taking behaviours
- Provide specific programmes for managers to identify their own difficulties with coping with and managing the uncertainty and challenging economic environment
- Provide programmes to help managers identify their team members who are experiencing difficulties with coping with and managing uncertainty and challenging economic environment as well as those who are stigmatised

High risk groups

- Identify and manage high risks individuals or groups for stress, anxiety, depression, burnout, substance abuse and risk-taking behaviours

ENVIRONMENTAL:

Contributing to safe, healthy and sustainable environments to work and live in

- Occupational Health and Safety Act
- COVID regulations, including those for the workplace, provision of protective and other equipment, number of workforce present, and hours of work
- Company occupational health and safety policies, and COVID-specific policy or updates
- Entry and exit controls, sanitisation, and exposure and infection risk management
- Internal movement controls and physical distancing management
- Internal configuration of offices, social areas, canteen, production and plant for physical distancing and exposure and infection risk management
- Quarantine area for managing potential infections or staff members showing signs of COVID-19 and address potential stigmatisation and marginalisation
- Business continuity and contingency plans for quarantining sections of offices, social areas, production and plant where exposure/infection risk present or suspected
- Provision of information, signs, guides, sanitizers, personal protective equipment, and other necessary resources

High risk groups

- Identify and manage high risk groups for exposure and infection risk during work and at the workplace without causing stigmatisation or marginalisation
- Identify and manage high risks groups with comorbidities, immune suppression and other relevant factors without causing stigmatisation or marginalisation

FINANCIAL:

Developing awareness, knowledge and skills for financial planning and decisions

- Ensure communication on organisation's decisions regarding salaries (including reduced time or retrenchments), benefits, and sick leave for self-isolation and quarantine
- Provide guidelines, support and resources for financial planning

OCCUPATIONAL:

Developing personal satisfaction and enrichment from work and the workplace

- Monitor and manage online and offline time periods
- Monitor and manage absenteeism due to ill health or infection and sick leave usage patterns within business functions and units, educating managers and employees on COVID and its potential short and long-term effects
- Monitor use of flexible and remote work through surveys, provision of support services, employee engagement assessments, and manager evaluations
- Monitor and manage the impact on staff that are unable to continue to work from home or remotely

SOCIAL:

Developing a sense of belonging, having a well-developed support system, and connecting to and contributing towards more diverse and inclusive communities

- Develop awareness campaigns and interventions on inclusion in virtual meetings
- Develop campaigns for social engagement and bonding using virtual, chat or other available platforms
- Develop and facilitate support systems in teams
- Actively address stigmatisation and marginalisation

INTELLECTUAL:

Enabling the pursuit of knowledge, skill development, and curiosity and innovation

- Develop or enhance existing programmes for mindfulness and structured times for reflection
- Develop structured times and facilitation for disengaging from crisis mode and regain perspective on the short, medium and long-term planning for the organisation

SPIRITUAL:

Developing and enhancing a sense of purpose and meaning in life

- Develop programmes of appreciation and facilitate sense and meaning-making during challenging times
- Provide programmes for grieving the loss of family, friends and peers
- Provide programmes for grieving the loss of the familiar, routine and structure in work, family and personal lives

CONCLUSION

The HR practitioner needs to understand the different types and levels of stigma so that these can be addressed systematically, comprehensively, and holistically. The pandemic has highlighted that the care of employees' wellbeing is an important component of the employee value proposition. The HR function needs to address wellbeing, productivity, and employee experience in an integrated and systematic manner. In this way it can proactively intervene on existing and possible stigmatisation, marginalisation, and discrimination, and help build a culture of inclusivity, resilience, and engagement.

EARN 1 CPD POINT

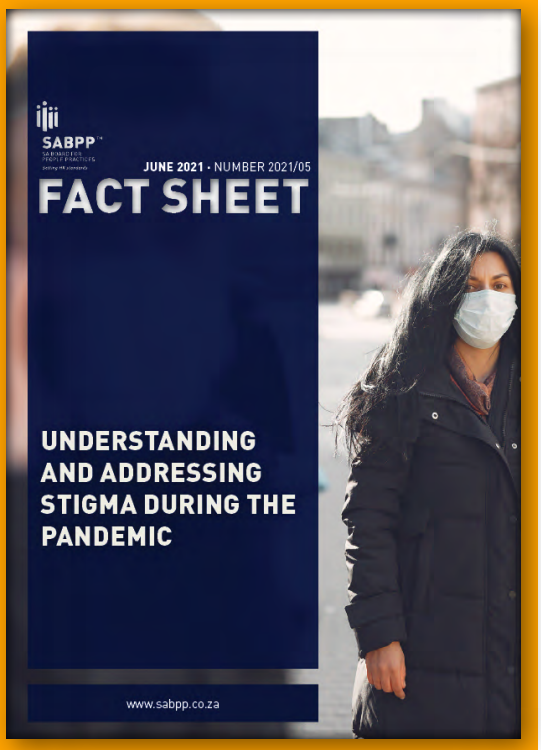
This fact sheet was written by:

Dr Ajay Jivan:
SABPP Head of Research and Assurance, Director at Vantage Lab, and Clinical Psychologist;

Professor Christoffel Grobler:
Extraordinary Professor (Faculty of Health Sciences, University of Pretoria), Associate Professor (Faculty of Health Sciences, Walter Sisulu University) and Head of Clinical Unit at Elizabeth Donkin Hospital, Port Elizabeth;

Dr Anersha Pillay:
Specialist Neuropsychiatrist at Life Riverfield Lodge and Wits Donald Gordon Medical Centre, Honorary Lecturer at the Department of Psychiatry, University of the Witwatersrand, and Board Director at Psychiatry Management Group (PsychMG);

Mr Steven Teasdale:
Group Head of Organisational Development, Change and Transformation at Discovery Group.



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