

Perspectives on xenophobia during epidemics and implications for emergency management

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ABSTRACT

Coronavirus disease 2019 (COVID-19) is an infectious disease that traces its earliest known cases to the Hubei region of China in late 2019. As the COVID-19 pandemic has spread across the globe wreaking unprecedented disruption, increasing levels of xenophobia and racial discrimination have been documented against those of Asian descent. We investigate the historical connections between disease and rise of xenophobia as described in the peer-reviewed literature addressing prior epidemics, such as Ebola and the Hong Kong Flu, in conjunction with concurrent cases of prejudice toward certain groups of people. Attempts to better understand why such attitudes emerge are examined in the context of xenophobic actions during pandemics. Prevailing views suggest that xenophobia ultimately leads to increased stigmatization of those afflicted by disease, which in turn leads to decreased trust in the medical system, resulting in a negative feedback loop. Accurate disseminated information and improved public education on sources and modes of transmission of infectious diseases are essential to check xenophobic tendencies, reduce negative effects and foster greater cooperation.

Key words: pandemic, epidemic, xenophobia, racism

INTRODUCTION

Coronavirus disease 2019 (abbreviated COVID-19) is a contagious respiratory disease caused by person-to-person transmission of respiratory droplets containing the SARS-CoV-2 virus.^{1,2} With earliest

known cases believed to have originated from the city of Wuhan in the Hubei Province of China in late 2019, this novel disease outbreak has spread throughout the world.³ As of June 26, 2020, there are a total of over 9.5 million confirmed cases and nearly 500,000 deaths in 188 different countries.⁴ Xenophobia, may be defined as fear and hatred of strangers or foreigners or of anything that is strange or foreign.⁵ Amid reports of rising cases and deaths, COVID-19 has triggered numerous accounts of xenophobic responses toward Asian immigrants and those of Asian descent in the United States attributable presumably to perceived connections with the origin of the virus or its spread.^{6,7} Conspiracy theories regarding the origin of the virus have also surfaced, with many subscribing to the belief that SARS-CoV-2 originated from a Chinese laboratory rather than from wildlife or meat markets as originally postulated.⁸ In the United States, the strong xenophobic reaction in response to COVID-19 can be viewed through the lens of prior disease epidemics. We conducted a comprehensive review of the peer-reviewed literature to characterize xenophobia, racism, or racial discrimination with respect to epidemics.

METHODS

Search strategy

A search strategy was developed by the team in consultation with a university informationist targeting the PubMed database (National Center for Biotechnology Information; Bethesda, Maryland) for English peer-reviewed journal articles published on

xenophobia and epidemics. Keyword search terms included the following: Xenophobia[MeSH], xenophobia, xenophobic, racism, racial discrimination; Communicable Diseases[MeSH], Communicable Diseases Emerging[MeSH], Disease Outbreaks[MeSH], Communicable Diseases Imported[MeSH], infectious disease, infectious diseases, communicable disease, communicable diseases, pandemic, pandemics, epidemic, epidemics, coronavirus, Ebola.

Inclusion and exclusion criteria

Inclusion and exclusion criteria were determined by the study team prior to initiation of the search. Articles that met inclusion criteria encompassed any study types covering both the topic of xenophobia and communicable diseases, communicable diseases emerging, disease outbreaks or communicable disease imported. All dates before March 22, 2020 were included for the purposes of the review. Articles that were excluded were those to which one of the following criteria applied: languages other than English, full text unavailable, not related to xenophobia or not related to communicable disease or disease epidemics.

Article selection

The study team selected articles for review in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.⁹ Articles identified through the literature search process were downloaded from the database, recorded in Excel where duplicates were discarded. Next, a member of the team conducted sequential title screening followed by abstract review during which any reports which met exclusion criteria were removed (CC). Full texts of the remaining articles were reviewed and relevant information regarding type of epidemic, xenophobic activity, response to this type of activity and public health guidance pertaining to handling xenophobic concerns during epidemics were extracted by one of the co-authors (CC) and reviewed by another co-author (EBH). Figure 1 below details the search stages and selection process that yielded the final included articles.

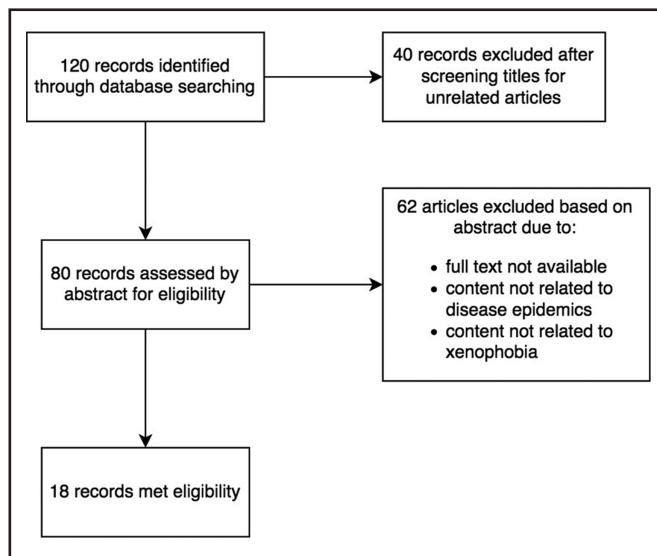


Figure 1. Search stages and selection.

RESULTS

The literature search in PubMed using the outlined methodology resulted in 120 unique preliminary citations. After title screening, 80 records remained. Following abstract review and application of exclusion criteria, 18 peer-reviewed publications remained, met eligibility, and were included in this review.

Articles pertaining to xenophobia and epidemics spanned a wide range of time with the oldest eligible article published in 1987, while the most recent article included was published in 2020. The most frequently mentioned disease epidemics were Ebola (n = 6) and human immunodeficiency virus (HIV) (n = 6). Two publications detailed the current COVID-19 pandemic. Some articles did not address a specific outbreak but rather only generally referenced xenophobia and infectious diseases. Table 1 below details all communicable diseases referenced across the 18 analyzed records.

The 18 articles that met eligibility were fully reviewed for any mentioned instances of xenophobic behavior in reaction to a disease pandemic, as well as information regarding how to respond to such behavior and what implications it has on our ability to counter pandemics.

Xenophobia in response to disease outbreaks often originates in the naming of epidemics. The tendency

Table 1. Referenced infectious diseases in the discussion of xenophobia. Articles mentioning more than one are counted multiple times	
Epidemic	Number of articles
Ebola	6
HIV/AIDS	6
No specific epidemic	3
COVID-19	2
Smallpox	1
Syphilis	1
Spanish flu	1
Zika virus	1
Swine flu	1
Hong Kong flu	1
Asian flu	1

to name epidemics after certain regions or people has been frequently repeated in the past, with four major epidemics in the twentieth century being referred to by names mentioning a specific group, eg, Hong Kong flu, Asian flu, Spanish flu,¹⁰ and gay-related immune deficiency (GRID) now recognized as AIDS.¹¹ Some even go as far as to say that the fact that there is no “American flu” is suggestive of global inequalities and that the colloquial naming of infectious diseases allows more powerful countries to assign blame on foreigners.¹⁰ The World Health Organization (WHO) now actively discourages the naming of pandemics, by both scientists and public figures, with specifiers indicative of a group of people, place, animal, or occupation.¹⁰ Despite this admonishment, many, including prominent US leaders are referring to the current COVID-19 outbreak as the “Chinese virus.”¹²

With regard to COVID-19, evidence of xenophobia toward those of mainland Chinese descent was documented in Hong Kong¹³ and Japan.¹⁴ In Hong Kong, one may argue that these attitudes are due to the current climate (eg, protests¹⁵) and reflective of inherent xenophobia that has been exacerbated

by the epidemic. For example, the restaurant chain, Kwong Wing Catering, publicly announced on the social media platform Facebook that it would no longer be serving customers who speak Mandarin and only those who speak English or Cantonese.¹³ This was labeled as a “public health measure.” However, measures such as these are not recommended as they often result in stigma, preventing those who truly carry the disease from seeking treatment in a timely manner due to shame.¹³ In Japan, after some false news, similar sentiments arose in early 2020. The Chinese became viewed as “dirty, insensitive, and even bioterrorists,”¹⁴ which led to the hashtag *#ChineseDon’tComeToJapan* gaining large popularity in January 2020. Due to this incident, authors concluded that the media should be held to higher standards of responsibility for the validity of the content they provide to the public,¹⁴ especially in this current era with widespread usage of social media.¹⁰ By working with healthcare professionals, journalists should also promote understanding of accurate information related to pandemic outbreaks.¹⁴

Xenophobia was demonstrated during the Ebola epidemic to foster medical mistrust. This ultimately reduces the likelihood of those falling ill to seek treatment and reduces support of quarantine measures.¹⁶ The sentiment that xenophobic actions are purely negative, however, is not held by all individuals. Discriminatory actions are claimed to be “a containment imperative” rather than “irrational prejudice” amidst a pandemic.¹⁷ During the Ebola crisis, such statements were used in Dallas to justify the discrimination against Africans, specifically Liberians, based on their skin color and accent.¹⁷ A 2017 study termed this process by which certain regions acquire excessive blame for the cause of an epidemic due to logical, historical, or cultural connections as “placism.”¹⁷ Some correlated these xenophobic feelings after a pandemic with certain traits, such as high individualism and low collectivism.¹⁸

In China, xenophobic sentiments against Africans in response to Ebola also prevailed. One example showed 90 people from the African countries of Sierra Leone, Guinea, Liberia, and the Democratic Republic of Congo being forced to disembark from an airplane

before other passengers and subjected to mandatory health screenings.¹⁹ In Guangzhou, an unofficial quarantine of all African visitors from countries affected by Ebola was also imposed.¹⁹ Although preventive measures to control the spread of a disease across political borders are considered reasonable, actions that were taken in these situations were not applied uniformly to all people at risk for carrying Ebola, but rather preferentially applied to those of African descent.

Similar events occurred in relation to the HIV pandemic. By placing blame for the start and/or spread of a disease on a separate racial or cultural group, individuals gain a perceived sense of security, or a notional form of protection against it.^{10,20} This led to pervasive discrimination against homosexuals, Haitians, and west or central Africans after the start of the HIV pandemic in 1981.²⁰ Different countries had different xenophobic beliefs with assertion of blame on groups apart from their own. In the western countries, people of African descent were required to have mandatory health screenings, and propaganda fraudulently inflated the rates of HIV in African countries. In Asian and African countries, people believed that the infection was spread by American homosexuals. The Japanese Prime Minister at the time, Noboru Takeshita, proposed a joke at one of his political fundraisers, stating that American servicemen will be staying on base now, giving each other AIDS, instead of finding Japanese hospitality women due to the increase in the value of the Japanese yen.²⁰ In Manitoba, Canada, significant stigma was placed on indigenous people due to their higher rates of HIV infection.²¹ Once again, this stigma often leads to mistrust of medical professionals, decreased rates of obtaining effective treatment,²² as well as lower levels of disease education²¹ and a lack of a uniform response.²³ This is a particularly salient problem in the US due to its heterogeneity and history of racism.²³

A shocking parallel exists to the current xenophobia seen in the US. In the mid- to late-1800s, during the outbreaks of smallpox, there were highly prevalent xenophobic attitudes toward those of Chinese descent, especially those living in Chinatown neighborhoods

within San Francisco. The Health Officer at the time addressed Chinese individuals as “moral lepers” who had “habits and manner of life of such a character as to breed and engender disease wherever they reside.”²⁴ When smallpox returned to the city for the second time in 1876, the Chinese were again blamed despite the high likelihood that the resurgence was caused by European and American travelers immigrating from the West and Midwest where there was a resurgence of outbreak years earlier. With only a small percentage of the cases in San Francisco occurring within the Chinese population, the Health Officer at the time argued without substantive evidence that many more cases were most likely being hidden within Chinatown.²⁴ Generally, as seen in this case, xenophobic attitudes tend to persist despite contrary evidence.¹⁰ Similar xenophobic propaganda was used in the nineteenth century following a large number of cases of venereal diseases such as syphilis.²⁵

In general reference to epidemics, development of xenophobia as a response has been explained in many ways. Often there are perceived benefits to reacting in such a way as these attitudes decrease the chances of exposure.²⁶ From a psychological basis, people have evolved appraisal mechanisms that reduce the likelihood of erring with false-negative judgements that have very negative outcomes. Consequently, this leads to higher rates of false-positive conclusions. In other words, when confronted with the risk of infectious disease, people have the tendency to adopt avoidance of all individuals that share simple, even superficial commonalities to individuals that carry the disease. One of the simplest ways to identify relations between individuals is through formation of group stereotypes, leading to overt or implicit biases. Regrettably, xenophobic beliefs facilitate the rush to simple and often incorrect judgements precluding the level of inquiry that might reveal deeper, nuanced, or more accurate explanations that could lead to effective solutions.²⁷ Additionally, xenophobia erodes the support for humanitarian aid to foreign countries,²⁸ as well as fortifies mistrust of foreign aid that could be instrumental in helping to deter the continuation and spread of a disease.²⁷ This was witnessed in the US’s response to the Zika virus pandemic in Africa with

some officials expressing the view that “Zika is an immigrants’ disease; just keep the foreigners out.”²⁹

Another perceived benefit that motivates the emergence of xenophobia during an epidemic is enhancement of group loyalty. By establishing closer ties and relationships with members of one’s own group, the group will increase one’s chances for survival.²⁶ On a macroscopic level, creating and linking real or imagined associations between foreigners and pandemics may either foster fear or a sense of security within citizens, as mentioned previously. During the first outbreak of a different form of coronavirus, SARS-CoV, British authorities attempted to calm the masses by suggesting that the British people’s difference from the Chinese would protect them from being infected.¹⁰

To mitigate xenophobic actions, it is imperative to educate the public regarding diseases that are the source of pandemics. Specifically, awareness about how the disease spreads is recommended¹⁹ as xenophobic attitudes appear to be inversely related to one’s level of knowledge about an infectious disease, even when controlling for sociodemographic factors such as political affiliation.³⁰ Further, people are more likely to espouse prejudice toward a group of people, if they perceive a higher risk of infection or a lower level of institutional preparedness.³⁰

DISCUSSION

Through a review of literature related to xenophobia and disease epidemics, it is evident that xenophobia is a commonly documented consequence of an infectious disease outbreak across time with references in literature published as early as 1987, detailing pandemics as early as 1868.²⁴ Not only is this type of response during a pandemic recurrent throughout history, but also across space with testament of its occurrence in many different countries including Britain, Canada, US, China, Japan, and some in Africa.

Given the current situation regarding COVID-19, as well as reports of prejudice against those of Chinese descent, the relationship between xenophobia and disease epidemics is very pertinent.

On March 19, 2020, the Asian Pacific Policy and Planning Council (A3PCON), along with Chinese for Affirmative Action (CAA) and San Francisco State

University’s Asian American Studies Department, began an initiative called Stop AAPI Hate.³¹ This project aims to gather information about incidents of hate speech, harassment, and violence against Asian Americans and Pacific Islanders due to COVID-19 in order to inform responses to future occurrences.³¹ Within 6 weeks of its inception, 1,710 incident reports were submitted from 45 different states and Washington, DC.³¹ According to a survey conducted by Ipsos, 30 percent of Americans and 60 percent of Asian Americans also state they have witnessed individuals placing blame for COVID-19 on people of Asian descent.³² Principally, unlike prior epidemics, COVID-19 has contributed to not only a rise in racial tensions within the US, but also in geopolitical tensions, particularly between China and the US.³³ As a result, COVID-19 occupies a unique position in history.

The relationship between xenophobia and epidemics is also important to address due to its impact on emergency management. Throughout numerous past pandemics, xenophobic sentiments have been shown to cause lower rates of obtaining effective treatment and higher rates of medical mistrust.^{13,16,22} These eventually lead to lower levels of support for quarantine measures¹⁶ and a lack of uniform institutional response,²³ both of which contribute to a decreased level of containment of a disease. On a global scale, racial prejudice can cause decreased support for accepting²⁷ and distributing foreign humanitarian aid²⁸ that would crucially help in efforts to control the spread.

This information identified regarding the consequences of xenophobia on healthcare structures can inform the responses of emergency management officials to improve current and future operations related to public health emergency preparedness. More research in the future should be conducted, perhaps in the form of a review of news articles, to fully document the extent of xenophobic sentiments during past pandemics, as well as to investigate the effects such attitudes and behaviors have on our global health system designed to mitigate infectious diseases. Furthermore, with xenophobic attitudes directly related to lower rates of education, future

work should continue to look for optimal methods to disseminate accurate information regarding pandemics to mitigate xenophobic actions. Through our review, most xenophobia was perpetuated due to misinformation. By providing an avenue to acquire accurate information, we can ideally minimize the amount of xenophobia that occurs and increase the faith in the healthcare system. By encouraging individuals to investigate situations more deeply, past preliminary racial conclusions, more accurate and effective solutions are likely to be implemented as well, strengthening the overall response against pandemics.

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