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Original Research

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The Lived Social Experience of COVID-19 Survivors in Southwestern Nigeria

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Abstract

The traditional perceptions of disease causation often reinforce the feelings of stigmatization and discrimination towards individuals who have recovered from an illness. This study investigated the existing social practices with regard to stigmatization and discrimination against COVID-19 survivors in Southwest Nigeria. Using the Psychoanalytic Theory, this phenomenological qualitative study utilized the snowball sampling method and an in-depth interview to sample 25 COVID-19 survivors in Southwest Nigeria. Collected data for this study were analyzed thematically, using content analysis with the aid of the ATLAS.ti software. Findings from the study indicated that COVID-19 survivors generally experience sympathy, hostility, mockery, and social exclusion. Basically, the nature and type of stigmatization experienced by the survivors were psychological in nature. Reactions towards stigmatization manifested in negative emotions, such as suicidal thoughts and emotional outbursts. The study recommended the use of effective mediums to enlighten the public about the dangers inherent in discrimination against survivors.

Keywords: COVID-19, stigmatization, survivors, social exclusion, psychoanalytic theory

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Introduction

Erving Goffman, in his work entitled *Deviance and Liberty, Social Problems and Public Policy,* theorized that social stigma discredits an individual by classifying them as an *undesirable other* by the society (1974). The

Note: The authors wish to appreciate the participants who took time out of their busy schedule to respond to the interviews.

phenomenon of socially stigmatizing the sick (especially those with communicable diseases) is not new. For instance, the "Law of Purity" of old Israel specifies rules concerning managing those plagued with communicable diseases, such as leprosy. Then, lepers were expected to be excluded from society throughout their disease duration. Once the disease was confirmed, the individual was relegated to living outside the community and living with people with similar conditions (Grzybowski & Nita, 2016). The process of classifying some as an *undesirable other* is known as *othering* as used by Husserl (cited in Miller, 2008) to portray the reductive activity of labeling and characterizing an individual as belonging to a lower category through social stigma segregates, stereotypes, and prejudice against the sick mainly by those perceived to be healthy (Canales, 2000). During the time of social crisis (especially the outbreak of pandemics and infirmities), *othering* can lead to full-scale discrimination and blame. While it might be easy to advocate for the cessation of social stigma against the ill, the process of achieving it is more Herculean than can be perceived, as the unknown correlates to pandemics, thereby increasing social disgrace against perceived groups or individuals (Bhattacharya et al., 2020). These fears, myths, and rumors, as shown by research, have bred a feeling of uncertainty, which has affected human behavior significantly on how to react and deal with people perceived to be infected. Hence, sometimes, aggression, blame, and stigmatization seem to be the unhealthy manifestation of these fears (Manfredi & D'Onofrio, 2013).

Literature Review

The Normalization of Social Isolation

Currently, socially isolating people infected with COVID-19 disease is thought to be normal behavior around the world, since it is socially acceptable to ostracize the sick in the midst of the unknown confusion. The institutional isolation of those infected with COVID-19 disease further reinforces the stigma (Bharat, 2011; Trani et al., 2015). Even COVID-19 prevention requires isolation. Terms such as quarantine, isolation, and social and physical distancing have become household words in this pandemic period. In particular, quarantine areas have been set up with separate laboratories allocated to hospitals for the medical care of COVID-19 patients, creating containment areas. Additionally, most countries have been divided into color-coded areas, according to the incidence rate of COVID-19. These are just steps adopted to flatten the constant graph. But since it is over a pandemic biomedical peculiarity, the series of steps additionally have their social effects (Krishnatray, 2020).

Impact of Social Stigma on the Management and Prevention of COVID-19

During a pandemic such as COVID-19, the social stigmatization of different stakeholders can assume a significant part in undermining social cohesion, as well as strengthening social isolation. For instance, the International Federation of the Red Cross (IFRC), World Health Organization (WHO), and the United Nations International Children's Emergency Fund (UNICEF), in issuing guidelines to forestall and resolve the social shame surrounding COVID-19, noted that there is a possibility of social stigma to impact the treatment and counteraction of the infection (UNICEF, 2020). Hence, in several countries, reports have shown that many persons, for fear of facing social stigmatization and discrimination, have refused to report their travel history or COVID-19 symptoms, resulting in low testing rates and high mortality (Bhattacharya et al., 2020). As per public health specialists, the social shame related to the diagnosis is causing dread in the population and hampering the viable management of the infection, especially in metropolitan settings (Bhattacharya et al., 2020).

Impact of Social Stigma on the Mental and Social Health of COVID-19 Survivors

One common problem facing the survivors of pandemics is social rejection. Discrimination and stigmatization from friends, family members, neighbors, co-workers, and even members of the same

religious organizations, of course, have often been prevalent over time. Before recovering from their ailment, those infected with a dreaded disease are treated with disdain as they are excluded from social groups.

For individuals recuperating from COVID-19, the effect on their social life and mental health could be enormous (Tshangela et al., 2020; Semo & Frissa, 2020). This scenario played out during the incident with Ebola. Studies revealed that, due to stigmatization and discrimination, most Ebola survivors went through traumatic psychosocial experiences from members of their immediate environment. This caused survivors to develop mental illnesses, such as despair, anxiety, and grief (Ameyaw et al., 2020; Lötsch et al., 2017). This assertion was also backed up by Kaufman et al. (2020), who noted an increase in reports about resentment towards COVID-19 patients in places where the infection rate was high. Thus, visitors and tourists from hotspot countries were barred from traveling to other countries. When they successfully travel, they are subjected to strict screening and are quarantined. Hence, most pandemics, such as the Middle East respiratory syndrome, bubonic plague, African Ebola, Asiatic flu, and cholera, have all been related to stigmatization, bigotry, polarization, and faultfinding against specific ethnic groups (Bhattacharya et al., 2020; Davtyan et al., 2014). Naming of a pandemic by place or country of its origin is called "pandemic orientalism." This has been described by some social scientists as a form of stigma and labeling (Bhattacharya et al., 2020). This labeling might, thus, have several implications for the social life of those who are recovering from the pandemic, especially from the labeled countries as illustrated earlier.

Given the high rate of recovery from COVID-19 in Africa, it means we will have more survivors of the dreaded pandemic in our community. Hence, there is a need to study the various ways that survivors are discriminated against to formulate adequate policies that will ensure the social integration of all recovered persons into the community to fully live their lives. Having an all-around and extensive policy on reintegrating recuperated COVID-19 patients to society becomes extremely important for the functionality of the African society. Policies to reintegrate recovered patients are important because, within the context of African society, it might take a longer period for people to be reintegrated as, more often, diseases of this nature are attributed to supernatural forces, such as God's punishment for the sinners (Ozioma & Chinwe, 2019; Whittle et al., 2017). These traditional and religious perceptions of disease causation reinforce feelings of stigmatization and discrimination towards persons who have recovered from an illness.

Theoretical Framework: Psychoanalytic Theory

According to the assumption of psychoanalytic theory, individuals tend to be aggressive toward a contingent group due to social crises and personal frustrations. This behavior can be considered an "aggressive displacement." It is contended that there are motivations and adaptive dimensions that support prejudice; that individuals develop their self-confidence through prejudiced behavior; and that biased behavior has versatile self-defense functions (Demirtas-Madran, 2020; Whitley & Kite, 2009). In addition, as indicated by psychodynamic methods, as nervousness increases, other people start to be labeled as "awful guys."

Splitting remains a deep-rooted psychological process that is used as a method of adapting to this tension. It is a subliminal defense technique that appears before adolescence, which connects good experiences with oneself while, at the same time, projects bad things on others so that "bad" is far away from "good." When confronted with tension-inducing circumstances (like a pandemic), this defense mechanism will surface. The framework of Joffe (2003) as a psychodynamic expansion of social representation theory assumes that the individual is in an anxious state when facing potential danger, which prompts them to represent the danger in a specific way. The threat is linked to the "other," which is principally founded on an oblivious reaction to nervousness. Therefore, from the psychoanalytic theory's perspective, frustration derived from social and personal anxiety may be the reason for the aggressive attitude manifested in the form of stigmatization and discrimination towards minority groups (Whitley & Kite, 2009)—in this case, COVID-19 survivors.

Methods

Design and Setting

This phenomenological qualitative study is designed to investigate the lived social experiences of COVID-19 survivors in Southwest Nigeria. The design is phenomenological in nature because it explores the experiences of a social group of people. The study was conducted in four Southwestern states, namely Lagos State, Ekiti State, Ondo State, and Osun State. The choice of selecting this region was based on the premise that it had the highest number of recorded COVID-19 cases and, correspondingly, the highest number of recoveries.

Sampling and Data Collection Procedures

A total of 25 respondents, who had recovered from COVID-19 in the Southwest of Nigeria, were recruited and interviewed individually for the study. Each of the respondents met the inclusion criteria, which were people who were aware of their COVID-19 status; people who had recovered from COVID-19; people who had recovered from the disease for at least 3 months; and people who either live or work in any of the Southwest states. Also, only those who consented to take part in the study were recruited.

Given the nature of the study, we adopted a snowball sampling technique to reach the participants of the study—COVID-19 patients who had recovered. Hence, each COVID-19 survivor interviewed helped to refer the researchers to another survivor of the disease, since they were once in the same isolation center. A brief call was usually made to introduce the next survivor to the nature and aim of the study. The participants were asked to choose an interview setting they found most comfortable. In response, some participants preferred to be interviewed in their homes, while others chose neutral settings, such as relaxation centers. Notably, some health workers chose to be interviewed in the health facilities in which they work.

Before each interview, the objectives and eligibility criteria for being a participant in the study were explained to the participants. The individuals who consented to take part in the study had been given consent forms to sign before the interview started. The interviews were conducted in English and Yoruba language, contingent upon the preferred language of the participants. While English is the official language of communication in Nigeria, Yoruba is the informal language used in Southwestern Nigeria. Thus, the researchers gave the participants the opportunity to choose the language they could best express themselves in.

Instrumentation

The instrument for data collection was an unstructured in-depth interview (IDI) guide to elicit responses based on the objectives of the study from participants. The inquiries were intended to permit an in-depth probing of emerging themes. Some of the questions asked include: How was the general reaction of people around you after you recovered from COVID-19? After your recovery, were you excluded by any group from any social or economic activities? Describe any form of stigmatization or discrimination you think you experienced from any group. What were your reactions towards any form of stigmatization or discrimination you received? Each question asked was followed with a probe by the researchers for specific responses by the respondents. In every question asked, participants were given the free hand to express themselves. Where necessary, a follow-up question was asked for participants to expatiate on their points. Throughout the interview process, the researchers ensured that leading questions were avoided. This was to ensure that the participant experience was explored to the fullest. Each interview session lasted between 20 and 30 minutes. While an initial 30 respondents were scheduled to be interviewed in the study, as suggested by Adler and Adler (2012), data saturation was reached at the 25th participant. Thus, at this point, there was no new information emanating from participants. Each IDI session was audiotaped and transcribed verbatim into

English after grammatical errors were corrected. Transcripts from the Yoruba language were discussed with experts who helped to translate participant responses to ensure that the views of the respondents were adequately captured as expressed in both Yoruba and English languages.

Validity and Reliability of Data

The research instrument was tested with two recovered COVID-19 patients who were not part of the selected participants for the study. It is worth mentioning that necessary adjustments were made by the researchers before the test was administered to the recruited respondents. Also, some senior colleagues in Niger Delta University, Afe Babalola University, and Obafemi Awolowo University assessed the instrument for data collection. Based on their feedback, the instrument was revised to ensure that it validly and consistently reflects the purpose of the study. To also ensure consistency, the same IDI guide was used to interview all participants.

Ethical Considerations

The moral norms of the national code of research in Nigeria were strictly adhered to throughout this research. This procedure is also in line with the Helsinki assertion (1964) and its later revisions and similar moral guidelines. Ethical approval for this study was obtained from the College of Health of Afe Babalola University, Ado-Ekiti, Ekiti state with the approval number: AB/EC/020/09/370.

Data Analysis

Data analysis for this study was done using the six steps and processes (acquaintance, coding, creating subjects, inspecting topics, characterizing and naming topics, and reviewing) of doing thematic content analysis as outlined by Braun and Clarke (2006). The Atlas.ti software was used to manage the collected data for the thematic content analysis. The choice of the use of thematic content analysis was to enable the researchers to intently look at the collected data to recognize normal subjects, that is, themes, thoughts, and patterns of meaning that came up repeatedly from the interview.

Transcripts from the interview were studied repeatedly by the researchers to generate comprehensive meanings of participant narrations. Transcripts from individuals were given codes (e.g., M1, M2 … M25). Codes were grouped to form sub-themes while sub-themes were regrouped to form major themes. Each sub-theme and major theme generated for the study was thoroughly discussed by the research team before its analysis and presentation.

Results

Socio-Demographic Characteristics of the Respondents

The study recruited a total of 25 participants who had earlier tested positive for COVID-19 and were later certified to be fully recovered from the virus. The study had more male participants than female participants (61.9% and 38.1% respectively). The age range of participants was between 34 and 67 years and their average income was N16,285.71 per month ($38.85). The majority of the respondents had tertiary education and were mostly government workers. All participants were married, and a good number of them were Muslims. Also, the highest number of participants were affiliated with the Yoruba ethnic group (76.2%), which is indisputably the major ethnic group in the Southwest of Nigeria.

General Reactions of People Towards COVID-19 Survivors

The opinions expressed by the respondents on the reaction of the people towards COVID-19 survivors differ

greatly. While some respondents expressly stated that members of their community were hostile towards them, other respondents revealed that people were sympathetic to them when they tested positive for COVID-19. Still, some believed that the whole thing was a scam even after they knew their status. Thus, in this section, we are grouping the various reactions into the following sub-headings:

(i) The Shocked, Sympathetic, and Sorrowful

Just like any other viral infections and diseases that have ravaged throughout human history, such as Ebola and HIV/AIDS, most patients were shocked after testing positive for COVID-19, and many became sorrowful, even going into depression. Although the majority of the survivors experienced sympathy from their family members, friends, and associates, others were neglected and stigmatized. According to the respondents, on finding out about their status, some persons reacted with shock and sympathy. In their words:

> **M1:** One of my friends was so shocked as she exclaimed, "Oh, my God! This deadly disease has visited my good friend! Could it be that you have offended some gods or got involved in abominable acts or corrupt practices or were responsible for the death of somebody because this disease kills like Alusiyi (a vengeful god in Igbo land that can wipe out a whole family for the sin of a family member). It is bloody politicians that are dying lately because of their blood-stained hands."
>
> **M5:** When my friend found out about my condition, she became very sad and sympathetic and said, "Oh, really, this is sad! My friend, it is disheartening to hear this, that, you are positive. Please, take heart, the lord is your strength. It is well with your soul."
>
> **M7:** A family member of mine, having known about my status, said, "Why my family? This disease is for the rich because, going by its spread, only the rich are the ones being killed by the disease. Why now my poor sister?"
>
> **M20:** Most people felt that testing to COVID-19 means that you are no longer normal because even when I came back from the isolation center, people who visited me in my house behaved as if in few weeks or months I would die instead of rejoicing with me. They were always sorrowful even though I had been discharged.

(ii) The Hostile, Unconcerned, and Mockers

The hostility, discrimination, rejection, and outright stigmatization associated with certain ailments are better unimagined. Some of such diseases and infections include leprosy, tuberculosis, HIV/AIDS, and coronavirus. Such hostility can drive victims or patients who are infected with any of the above ailments to attempt suicide as some are, in most cases, excommunicated from the community. Because of this, some of the respondents who once tested positive to COVID-19 had this to say:

> **M8:** On finding out about my condition, a friend kind of mocked me by saying: "How long are you going to live with this disease that is ravaging the whole world? I hope you will get over it."
>
> **M9:** I was shocked when a friend mocked me by asking a very annoying question like, "So, finally you have joined the league of those that are infected with the disease from Wuhan China? I wish you well; it is well with your soul."
>
> **M17:** A colleague of mine mocked me and remarked thus: "Daddy Ade, you have finally become a member of those infected with COVID-19. So, if they are to be given 'incentive,' it means you will benefit from the Western people 'incentives.'"
>
> **M18:** A close friend of mine showed less concern about my condition after she found out and just

told me that "it is well with you, my friend, but you know because of the COVID-19 lockdown, I can't even pay you a visit but know that our prayers are with you."

(iii) The Unbelievers

Ironically, according to some respondents, a number of people did not believe in the existence of COVID-19, feeling that it was a ploy by those in authority to amass wealth. Hence, these skeptics never took those infected with the disease seriously. It was also believed that testing positive to COVID-19 was an avenue for individuals to become rich by getting palliatives. Many people also argued that such a disease is just a punishment from God who is sick and tired of the ills, inhuman treatment, and bloodshed that have continued to ravage all the continents of the world. Similarly, some believed that diseases are from God to checkmate man's excesses; thus, offenders are struck with deadly diseases, such as COVID-19. The instance of the Egyptians who were punished by God with different plagues for inflicting pain on the Israelites was a point of reference for some. In this regard, some respondents expressed their feelings thus:

> **M19:** Most people felt that testing positive [for] Covid-19 is an avenue to become rich because you are closer to getting the COVID-19 incentive. So, they do not even take you seriously when they find out that you are COVID-19 positive.
>
> **M21:** There is a group of people who believed that COVID-19 was just a government's trick to swindle international communities out of money. This set of persons did not take my condition seriously; so, they related with me as if nothing had happened.
>
> **M22:** Most people felt COVID-19 was not a real disease; hence, they began to ask questions like: "Were you sick or it was just an avenue to get government's attention"? They also asked if I would have left the isolation center if I had gotten incentive.
>
> **M25:** Some of the respondents affirmed being termed or referred to as witches and wizards upon testing positive to Covid-19, as people believed that it was just a means through which the gods exposed the evil deeds of the victims.

(iv) Social Exclusion

Some participants in the study lamented that they were excluded from their social circles as soon as people got to know that they tested positive for COVID-19. In survivors' words:

> **M2:** It was heartbreaking for me. I wasn't allowed to be consoled by my neighbors and friends, as my family members insisted that I should be left alone because of my critical condition even though I had been discharged from the hospital.
>
> **M3:** In my case, I saw hell at my workplace. When I returned to work, no one wanted to interact with me. Some even told me to my face that they would not be coming close to me until they were sure of my negative status. Because I was being socially excluded, I had to stop going to work for a while.
>
> **M4:** My case was pathetic because when I got to the church, I realised that people that would exchange pleasantries with me before neither wanted to sit by me or relate with me. They told me point-blank that they would never interact with me until my COVID-19 result showed that I was negative.
>
> **M6:** When I attended my village meeting after a few months of my return from the hospital, the people were hostile to me and didn't want to relate with me. They told me to my face that my

presence was disturbing them and that I needed to show them my medical report to prove that I had been free from the virus. This was how I lost my membership.

M23: People refused to shake hands or exchange pleasantries with me when I resumed attending church services after many months of staying at home. So, I decided to stop attending various committee meetings in the church to avoid embarrassment.

M24: I was very active in family functions before. Three months after my return (from the isolation center), whenever I wanted to participate in some family functions, my children would disallow me to attend.

M25: I stopped attending my village meetings in the Lagos branch because two consecutive times I attended after my return from the isolation center, they never gave me attention even though they contributed financially to support me while I was in the hospital. However, delegates were later sent to me to tell me that I should resume attending meetings formally after my negative status had been confirmed.

The Nature and Types of Stigmatizations Against COVID-19 Survivors

The nature of discrimination experienced by the participants in this study was mainly psychological. As revealed by the respondents, they were insulted verbally and maltreated repeatedly, especially during the time of recovery. Nevertheless, a participant stated that some persons, especially health professionals, were nice to them. The responses of the participants captured below give a vivid description of the nature of stigmatization they experienced:

M18: My routine drugs, before I finally left the isolation center, were thrown at me as if I were a dog just because healthcare workers did not want to get close to me.

M19: In my case, I received both direct and indirect verbal insults from some of my neighbours. To worsen the situation, I was terribly insulted by health workers.

M17: Some neighbors hurled abuse on me in my absence, adding that I might have done something wrong to be plagued with this ailment. Some even attempted calling me an evil man.

M20: The hostility and verbal abuse from the healthcare practitioners were unbearable. Some considered me as a plague to be avoided and told me to my face that they couldn't come close to me.

M13: Unlike other health workers, I received comforting words from a nurse who came to check on me in my house. She consoled and told me not to mind those who treated us (COVID-19 patients) badly in the isolation center. She revealed that they (healthcare practitioners) were scared of being infected because of lack of protective equipment.

The Reactions of COVID-19 Survivors to Stigmatization

In reacting to the way they were treated by the general public after surviving the pandemic, some of the respondents stated that they became sick because of the stigma people attached to them. Some of these survivors confessed that they too reacted by being hostile to those who stigmatized and discriminated against them. A respondent claimed that they developed high blood pressure because of the unfriendly attitudes of people towards them, while another respondent said that they became depressed and started contemplating suicide. Some reactions of the respondents against stigmatization include ignoring those stigmatizing them and making negative comments about their condition, being jovial about their situation, and avoiding social

gatherings. However, as stated by a participant, they faced no form of discrimination since their COVID-19 status remained secret. Below are statements made by some participants:

> **M1:** Mentally, I became sick because those around were so hostile to me although I have gotten over everything.
>
> **M2:** I quarreled with people daily because they were so disrespectful to me having found out that I was a COVID-19 survivor. However, I have noticed that this discrimination has stopped.
>
> **M13:** At a time, I felt like committing suicide because, aside from the harsh treatment given to me by the general public, even members of my family were scared of seeing me. It was saddening that whenever your relatives came around to deliver anything to you, they would just drop it at a far distance and quickly left you.
>
> **M15:** I cried most times, realizing that I was stigmatized and discriminated against. But I am over it now.
>
> **M11:** I developed high blood pressure because of too much thinking due to the way people were treating and avoiding me but the ill treatment has reduced now.
>
> **M12:** I was also hostile to those who were hostile to me because of my previous condition. I think I'm free now from discrimination.
>
> **M14:** I kept to myself often because people around me were so annoying and made me have headaches because of my positive COVID-19 status. Well, I have moved on with my life with or without discrimination.
>
> **M4:** Instead of being angry, I became jovial while relating with people who made jest of me. I was friendly with them all because I knew doing this would help me get back on my feet quickly instead of developing high blood pressure because of what people were saying about me.
>
> **M3:** I steered clear of people, while in church, since I knew they were avoiding me. I tried to avoid them too. So, as soon as I saw people coming towards my direction, I stayed clear of them. But I can't stop going to church because of a disease that God has healed me from.
>
> **M6:** I was always in my room and not willing to talk to anybody even when the need arose. It was obvious that my immediate family, in a bid to protect their interest, were already discriminating against me because of my COVID-19 status even though I had been tested negative and discharged from the hospital. Imagine, as a polygamist, even my wives were finding it difficult to perform their conjugal roles. They all claimed that they were busy with activities that were not relevant just to stay away from me. I tried to avoid all of them too knowing full well that they would all come back to ask me for money. Stigmatization is normal in all situations of life. At one point or the other, people will always have something to say, but what is more important is that I have moved on with my life.
>
> **M8**: In my neighborhood, I was not at peace for some time because of the side comments made about me before my children upon my return from the hospital. I heard a lot of negative comments like, "Your papa no die"? (Didn't your father die?), "He go soon die" (He will soon die), and the like. So, I couldn't do anything but to console my children and hope that things would get back to normal, and, eventually, it did. Currently, nobody talks about me to my children any longer, so I believe the stigmatization has ended.
>
> **M9:** It was my children that suffered the brunt of stigmatization because I made up my mind not to

go out for about 3 months after my return from the hospital. Whenever my children went out, they would come back with one complaint or the other about what people said about their father who had been tested positive to COVID-19. During this trying time, we resolved to be silent even though it was painful taking insults from different people because of my health situation. In the long run, keeping silence has paid off, as nobody talks about my health any longer to my children.

M17: I lost most of my friends because I tested positive to COVID-19. Upon my return, some did not check on me, and even when I attempted to check on them, they were cold to me, indicating that they were no longer interested in my friendship. So, I have moved on with my life; I don't care about friends any longer after all they are not the ones that have sustained my life till today.

M16: In fact, when I was tested positive, most of my family members stopped relating with me until I became alright by testing negative. I too made sure that I avoided them. I can't be relating to people who do not wish me well.

M7: I tried not to disclose my status to anyone, so I was not discriminated against or stigmatized by anyone.

Discussion

Findings from this study indicate that reactions of people towards COVID-19 survivors ranged from sympathy, hostility, dismissing the sickness as a scam, socially excluding, and mocking the survivors. These findings mirror those of some other studies conducted in India and Malawi, which revealed the physical and emotional violence of different sorts faced by those perceived to have the COVID-19 virus (Abuhammad et al., 2020; Chibwana et al., 2020). Another qualitative inquiry by Brooks et al. (2020) similarly affirmed the notion that COVID-19 survivors were socially excluded from communal activities. These assertions echo earlier research by James et al. (2019), who noted that various forms of stigmatization exist among infectious disease survivors.

Previous studies also reinforce the findings of this current study concerning conspiracy theories about the virus. For instance, the study found that there were doubters and those who believed that the virus was a figment of some people's imagination. Although the report of BBC News.com (2020) did not exactly state this, it noted that some people believed that the 5G network installation could be liable for the virus. It was further revealed that some of the misinformation and lackadaisical attitudes of people about the pandemic could make survivors of the virus more prone to social rejection. A study also indicated that as a sign of mocking a COVID-19 survivor in Zimbabwe, the road to her house was named "Corona Street" (Awusu et al., 2021).

Generally, the nature and types of stigmatizations experienced by survivors, as noted in this study, ranged from a mild form of physical and verbal abuse to emotional abuse. However, as revealed by the survivors, much of the abuse experienced was from health workers. Previous studies have noted that social stigma and discrimination experienced by COVID-19 survivors can translate to various forms of physical and psychological abuse. However, these studies indicated that passionate or mental maltreatment was the most common among COVID-19 survivors (Hosey & Needham, 2020; Kaseda & Levine, 2020; Owusu et al., 2021). A study further buttresses this point by noting that an extreme type of violence, as experienced by COVID-19 survivors, was the display of their images on various social media platforms as a warning for non-infected people to stay away from them (Owusu et al., 2021). Cai et al. (2020) also reported some form of physical abuse perpetrated by family members against COVID-19 survivors in Ghana. Cai et al., in their study,

additionally opined that most survivors of the coronavirus might have also experienced some form of psychological stigma and discrimination especially during their treatment and post-recovery period.

As the findings in this study revealed, the reactions that emanated from the stigmatization and discrimination by members of the society to COVID-19 survivors were mainly emotional. That means some patients became mentally sick; some had suicidal thoughts; others had various forms of emotional outbursts (e.g., crying, quarreling, etc.); and some developed further illness (e.g., high blood pressure). Previous studies have also corroborated the findings of this study. For instance, Turan et al. (2017) had earlier stated that stigmatization of the sick might lead to a reduction of the quality of life of the patients and also create some form of psychological distress. This point had also been noted by two studies that indicated stigmatization may lead to some form of dehumanizing social consequences and reactions by the survivors, which might reduce their life span (Cudjoe & Abdullah, 2020; Peprah & Gyasi, 2021). Two earlier studies also reinforced the position of this study, as they discovered that social rejection—even at its mildest form—has a painful psychological impact on those it is meted out on (Buckley et al., 2004; Eisenberger & Lieberman, 2004). On this note, two studies revealed that an extended period of social isolation, from COVID-19 patients and survivors, could lead to serious depressive symptoms (Centers for Disease Control and Prevention, 2020; National Academies of Sciences, Engineering, and Medicine, 2020).

The implication of the findings of this study is that the Yoruba society has a long way to go before it can fully integrate and accept the survivors of the deadly pandemic. While the survivors have fully recovered from the virus, they still have a second virus to overcome. This virus in question is socially constructed by members of the survivors' environment. In other words, they have "a second pandemic" to recover from, since discrimination and stigmatization against survivors are still ingrained in most people.

Another implication is that there is a possibility of survivors developing a self-stigma, especially when the perceived stigma and discrimination of members of their immediate environment are internalized (Corrigan, 2012). The manifestations of this self-stigma might include social isolations, inability to resume normal lives, and self-doubt. Finally, stigmatization of COVID-19 survivors could lead them to adopt unsafe health practices, such as not putting on nose masks or not going for post-recovery medication or tests (Turner-Musa et al., 2020).

Recommendations

Based on the discussions of the findings, some recommendations are made. First, there is a need for the general public to be educated that COVID-19 survivors pose no threat to the wellness of social communities. This can be done by using the same platforms that various governmental and non-governmental organizations have utilized over time to enlighten the public about safety measures to curtail the spread of the virus. This is expedient, as studies have previously indicated that education is a key approach to reducing people's negative perceptions and discriminatory practices against the sick and vulnerable. Some of the effective media that can be utilized to educate the public include social media, mass media, streaming media, playlets, door-to-door campaigns, and podcasts.

Secondly, stigmatized survivors need to seek counseling on how to deal with discrimination. This is based on the fact that no matter how much the public is enlightened, there will still be those who will continue to perpetrate discrimination and stigmatization against the sick. Furthermore, survivors should also not allow the act of stigmatization to get to them. This they can do by participating more in social interactions with people who accept them. Studies have indicated that social interaction is likely to reduce the level of stigmatization and discrimination.

Finally, there is the need for greater collaboration between the health and social professionals, such as social workers, psychologists, doctors, and nurses, to reduce the rate of stigmatization and abuse of COVID-19

survivors. These professionals can also work together to provide them social support such as advice, companionship, financial assistance, and other helpful forms of aid. Social support will go a long way in mitigating the impact of public stigmatization and discrimination against COVID-19 survivors. In extreme cases, when survivors of the disease or their family members are subjected to physical abuse in their immediate environment, these professionals could also help take legal action against the abusers. This, to a large extent, will act as a deterrent to those who abuse and ill-treat them and their relations.

Conclusion

Stigmatization, as it has been noted by experts, is a major factor that can kill faster than a disease itself. It threatens the social structure and patterns of society. Based on the findings of this study, it is evident that the emotional reactions of people towards COVID-19 survivors are sympathy, hostility, mockery, and social exclusion. Additionally, some people even dismissed the sickness as a scam and became suspicious of patients who survived the disease. Unarguably, the nature and type of stigmatization, as experienced by survivors, were mainly psychological. It is noteworthy that the emotional responses of the survivors towards stigmatization are manifold. Suicidal thoughts, emotional outbursts, inferiority complex, development of further illness, and the like are some of the ways the survivors reacted to stigmatization and discrimination.

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