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Blaming Others: Stigmas Related to COVID-19 Pandemic in Indonesia and Malaysia

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ABSTRACT

High stigma toward COVID-19 sufferers was observed in Indonesia's and Malaysia's social media spheres, especially at the beginning of the pandemic in 2020. This study compared individual and interpersonal stigmas through analysis of online conversations and established government protocols in handling COVID-19 in Malaysia and Indonesia. The critical narrative found was 'blaming others,' pointing fingers toward other actors, such as certain ethnic and religious groups, for the continuous spread of the virus. We found that stigmatisation of COVID-19 in Indonesia and Malaysia pointed out jarring concerns, 1) lack of knowledge on COVID-19, 2) the need for effective and efficient dissemination of information to avoid victim blaming, and 3) politicisation of COVID-19 for one's benefit. In times of public health crises such as COVID-19, governments should not only be responsive in formulating just policies that could help to control the spread of the virus but also mitigate stigmatization towards certain members of society. For Indonesian and Malaysian governments, while there were attempts to address COVID-19 stigma through various online and offline campaigns, observers expressed concern over the lack of recognition of the effects of stigma in COVID-19 official protocols. We discovered that COVID-19 protocols did not provide sufficient information on how to develop a safe environment for COVID-19 sufferers, thus preventing people from getting health treatment and other public services during the pandemic. Also, the protocols were found to have strengthened existing negative stereotypes toward marginalised groups.

Keywords: *Stigma, COVID-19, pandemic, Indonesia, Malaysia, Twitter.*

INTRODUCTION

In December 2019, the world recorded its first COVID-19 case in Wuhan, China. The outbreak quickly expanded to other parts of the world, affecting thousands of people, and has claimed many lives. Like during other pandemic and high-risk diseases, stigmatization also rose across the globe amid the COVID-19 outbreak. This could be seen through many examples, including in the press statement made by the US President Trump calling COVID-19 as the "Chinese virus" (Sandler, 2020) to neighborhood rejections of COVID-19 victims burials in Indonesia (Suherdjoko & Hajramurni, 2020). Stigma and stereotyping often occur around people with illnesses (Lau et al., 2006; Guidry et al., 2017), primarily when the disease is novel and not widely known (Herek & Capitanio, 1999). In the Southeast Asia region, Malaysia and Indonesia recorded the highest confirmed cases as in April 2020 (Worldmeter, 2020), and increased

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stigmatization is observed as the pandemic worsens in the two nations. Negative stigmas toward the pathogen, patients and their families, and even towards medical workers were found in both countries (Idris & Jalli, 2020). Such stigmas are causing community rejections and isolation from friends, which also often leads to reluctance for potentially infected individuals to get medical care.

Since its first case in January, conversations on COVID-19 flooded social media (Garza, 2020), including in Indonesian and Malaysian Internet spheres. With active social media users in both countries, analysing social media conversations would help in understanding public opinion on COVID-19. Indonesia, for example, has the highest social media users in Southeast Asia (Kemp, 2020), while Malaysia has a high internet penetration of 80% which is third highest in the region (Jalli, 2020). Thus, analysing conversations on social media domains would serve as one of the best approaches to gain valuable insights into our study.

Many scholars in media studies believe that social media is the new public sphere (Dahlgren, 2001) and its role as the new public domain is increasingly crucial during the self-quarantine period as many people use social media platforms to discuss this issue. The purpose of this study is to investigate and compare stigmas toward COVID-19 and pandemic in Indonesia and Malaysia. By understanding stigmas related to COVID-19 on social media, it is hoped that our findings will provide some insight on how to establish effective communication strategies for governments and relevant agencies. We hope that the results will also offer perspicacity on the ramifications of stigmatisation related to COVID-19.

Belief in a Just World Perspective: Dealing with Stigma

Belief in a just world—a place where justice serves people who do good things – has existed for a long time (Lerner & Miller, 1978). One of its functions is to provide an excuse and comfort for unpleasant situations that happen in tough environments (Lerner & Miller, 1978), such as disease outbreak, poverty, or disaster. However, this belief could derive stereotyping, unsympathetic, or stigmatization of the victims because it accommodates the assumption that some groups deserve what they get (Rubin & Peplau, 1975).

Hafer and Sutton (2016) opined that belief in a just world is linked to harsh attitudes to victims, "which can be expected to lead to adverse social outcomes such as heightened disadvantage and inequality" (p. 152). According to Mariss, Reinhardt and Schindler (2022), belief in a just world helps to explain people's compliance with social distancing during the pandemic. However, little has been found about the relationship between belief in a just world and stigma.

Stigma and Diseases

Research on stigma and diseases is not a new study dimension and for many years has been one of the essential aspects of research on public health. Through studies done on patients of certain diseases such as HIV/AIDS, tuberculosis, and Ebola (see Alonzo & Reynolds, 1995; Macq et al., 2006; Davytan et al., 2014; Karamouzian & Hategekimana, 2015; Kimera et al., 2020; Armoon et al., 2021), sufferers of these diseases experienced stigma which led to insecurity and reluctance to seek treatment from health professionals. Due to the limited understanding of these diseases, the public, driven by fear and misinformation, created a safety bubble by taking precautions through distancing themselves from the patients (Krishna & Thompson, 2019; Kartono & Shidi, 2022). According to Aikins (2006) and Kartono and Shidi

(2022), stigma can be understood through two different lenses: 1) through a micro-social or socio-psychological perspective where researchers explore how stigma works at the individual and intra-individual levels, or 2) through a macro-social perspective, symbolised by sociological work, exploring how stigma operates at group levels, socially, culturally, or structurally.

Stigma is often rooted in fear of the unknown (Shoib et. al, 2021). With no vaccine available for COVID-19 and many aspects of the pathogen remains unknown, the feeling of not knowing breeds a sense of dread to many (Roberto, Johnson & Rauhaus, 2020). Stigma can be viewed as the byproduct of that fear, and isolating potential carriers from the community through misguided perception would create a false sense of security among the public (WHO, 2020; Shoib et. al, 2021; Sahoo & Patel, 2021). Stigma also made worse with the abundance of misinformation on COVID-19 on social media, which at times were found to demonise certain members of the society by labelling them as carriers of the virus (Chew et al., 2021). Several studies done on diseases and stigma found that misinformation not only amplified stigma but also contributed to the worsening of psychological experience among the stigmatised individuals (Monnapula-Mazabane et al., 2022; Parker & Aggleton, 2003; Henderson & Thornicroft, 2009; Herek et al., 2002).

Conclusively, stigma could pose significant threats, especially during the COVID-19 global pandemic, as it would encourage people to hide their health status and contribute to the continuous increase of new positive COVID-19 cases.

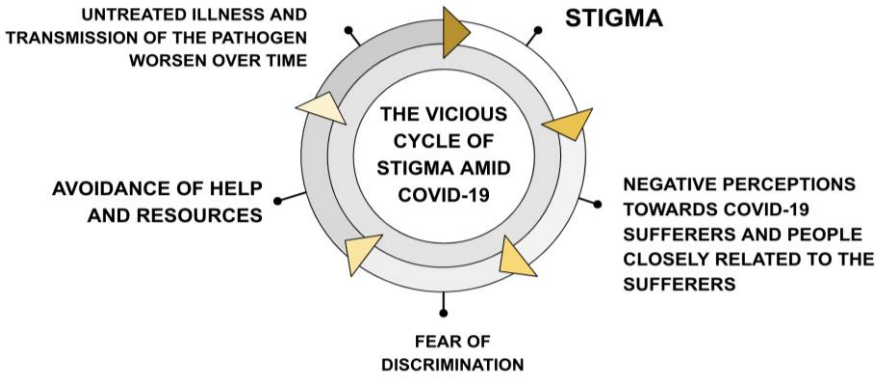

Figure 1: The vicious cycle of stigma amid COVID-19 pandemic

Stigma and COVID-19 in Indonesia and Malaysia

Public health officials worldwide have acknowledged that testing and contact tracing are vital to containing the coronavirus pandemic. But for many people, getting tested and exposing personal information is more terrifying than contracting COVID-19 (Lin, 2020). With increasing cases over time and various unknown factors surrounding COVID-19, fears among the public led to speculations on the causes of the outbreak. Like in many parts of the world (Lin , 2020), the stigma surrounding COVID-19 in Malaysia and Indonesia at the beginning of the epidemic was focused on the Chinese (Budhwani & Sun, 2020) from mainland China (Idris & Jalli, 2020). There were calls by the public pushing for Malaysian and Indonesian governments to stop allowing Chinese visitors and migrant workers to enter the country, fearing that the uncontrolled movement of Chinese mainlanders would further spread the disease. Among

the Chinese community in Malaysia and Indonesia, there was apparent dissociation between Malaysian and Indonesian Chinese towards the Chinese mainlanders.

As time passed, stigma towards a larger group of people began to emerge, especially towards COVID-19 sufferers (Atika, 2020), and medical workers. In Indonesia and Malaysia, stigma towards COVID-19 sufferers has caused people to be reluctant to come forward for medical testing. With vulnerable people afraid to come forward, the probability for the virus to become widely spread increased significantly. Aware that stigma posed a risk to national wellbeing amid COVID-19, government agencies in Indonesia and Malaysia actively campaign against stigmatising COVID-19 sufferers and potential victims and encourage them to come forward for testing.

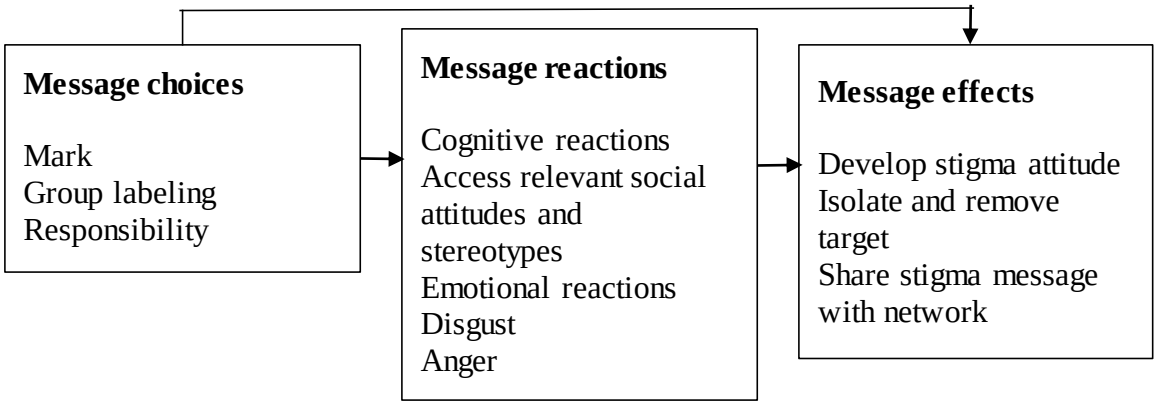

Figure 2: Model of stigma communication by Smith (2007). According to Smith (2007), stigma communication is messages spread through the community to recognize the 'disgraced,' (and in this case COVID-19 sufferers, and alleged spreaders) allowing the community to react appropriately.

In Malaysia, for example, the Ministry of Health Malaysia, through a daily press conference and social media posts, called for the public to stop stigmatising the virus, and urging people exposed to COVID-19 positive patients to come forward for testing (Ministry of Health Malaysia, 2020). The fear of isolation and society's perception caused many COVID-19 sufferers, and vulnerable individuals afraid to come forward (Bernama, 2020). For example, the largest COVID-19 cluster in Malaysia, the 'Tabligh cluster' which was first reported on March 11, 2020 after finding out one positive case in Brunei originated from a 16,000 strong religious gathering (Idris & Jalli, 2020) in Seri Petaling Malaysia (Shah et al., 2020). The massive Muslim religious assemblage or 'Tabligh Akbar' was attended by many nationals, with more than half of the attendees were Malaysians (Shah et al., 2020). Since the discovery of the 'Tabligh cluster,' social media has been filled with negative stigma towards the tabligh community (Hariz, 2020), calling them various names, pushing many attendees into hiding, and refusing to surrender for medical testing.

Recovered patients in Malaysia also described that they experienced psychological trauma after confirmed positive of COVID-19, due to insults and verbal abuse by social media users. After returning from Hong Kong, one patient who contracted the disease said that he was traumatized by the horrifying experience, especially when he saw his personal information, including home address, was widely shared online (Soon, 2020). However, his experience is not isolated as there are other COVID-19 patients who were doxxed (Anderson & Wood, 2022) and had their personal information leaked on social media (Yusof et al., 2020), especially of those who were deemed 'guilty' by the public for spreading the pathogen. For

example, patient number #136, the alleged superspreader for 'Tabligh cluster' was doxxed and had his photos and home address shared on social media. Social media users claimed that he failed to adhere to home quarantine order after returning from South Korea five days before Tabligh Akbar gathering, which prompted the sudden spike of COVID-19 cases in Malaysia (CodeBlue, 2020).

In Malaysia, refugees and illegal workers are stigmatised by locals as potential COVID-19 spreaders in the country (Ambrose, 2020). Stigma leads to many refusing to be tested, as they fear losing their jobs, and risking being deported for being in the country illegally or having expired visas. Aware that COVID-19 also affected a significant number of migrant workers, the National Security Council of Malaysia (NSC), on March 22, 2020, also promised "conditional" amnesty to illegal workers to come forward for testing (Carvalho, 2020). However, critics disputed that the Malaysian government did not keep its promise (Ambrose, 2020) as a large number of illegal immigrant workers were immediately scheduled for deportation even though they tested negative of COVID-19 (Babulal, 2020). The then Malaysian Minister of Defence, Ismail Sabri Yaakob, however, justified the decision to deport illegal workers as prudent after none turned up for COVID-19 testing before the amnesty offer ended on May 31, 2020 (Carvalho, 2020).

In Indonesia, stigma is not only against Chinese mainlanders and sufferers of COVID-19 but also towards family members of the sufferers and medical workers. Similarly, like in Malaysia, COVID-19 patients and their family members experienced public scrutiny, pushing them to remain silent about their health status (Abdillah, 2020). Fear of ostracism and isolation were often reported as the reason for refusing testing and treatment after witnessing increased stigma towards affected individuals on social media including community rejection, physical assault, and termination of employment (Atika, 2020).

Medical workers also reported experiencing extreme stigma amid COVID-19. For example, in East Jakarta, medical workers, including nurses and doctors who treat COVID-19, were kicked out of their bordering houses near the hospital due to fear that medical workers would spread COVID-19 to neighbours (Idris & Jalli, 2020). In several areas in Indonesia, the dead bodies of medical officers were also rejected from being buried in local cemeteries as the corpses were stigmatised as a primary source of COVID-19's infection (Azanella, 2020). The community also shunned family members of medical officers who treat COVID-19 patients as family members were in close contact with medical workers, thus, highly likely to spread COVID-19. Children of medical workers were reportedly even prohibited from playing with their friends (Astuti & Syaefullah, 2020). Due to the limited understanding of COVID-19, with exposure to misinformation on social media, Indonesians built psychological and social barriers as defensive mechanisms to protect them and their families.

Interventions to Reduce Stigma

Stigmatisation is a process that occurs from the individual level, interpersonal, organizational and community, to the public policy (Qin & Song, 2021). At the public policy level, stigmas could be caused by racist and xenophobic views implemented in government policies and programs. For example, former President Trump of the United States was infamously criticized worldwide for releasing an executive order to ban Muslim travelers from seven countries—Iraq, Syria, Iran, Libya, Yemen, Sudan, and Somalia – justifying it was the right

move to control terrorism in the United States (Aguallo, 2022; Alsultany, 2022. Such policy opened a big room for the stigmatisation of Muslims and terrorists and potential terrorists (Belew, 2022).

The danger of politicising public policies during health crises has been studied over the years (Goldberg, 2012; Adida et al., 2018; Rothgerber et al., 2020). According to Devakumar et al. (2020), at the height of the COVID-19 pandemic, many political leaders misappropriated the pandemic to reinforce racial discrimination, doubling down on policies such as increased border controls and conflating public health restrictions with anti-migrant rhetorics (pp. 1194). Implementing politicised policies through racial and discriminatory responses was almost standard, found in various government policies worldwide (Devakumar et al., 2020; Economou, 2021). These consequently led to social problems such as increased violence towards groups such as the Asian community, health workers, and COVID-19 sufferers, among others. The spike in hate crime involving these groups was reported in the media, and the impact of such policies continue to persist (Tessler et al., 2020; Cordero, 2021; Xu et al., 2021). The best approach to implementing sound COVID-19 policies is not only through the development of holistic and inclusive interventions but also through solid regulation of policy implementation. Otherwise, micro-level efforts by individuals and communities to mitigate COVID-19 problems (spread and stigma) would not be elevated to a larger scale as they are systematically fenced by poor policy implementation. Therefore, understanding this, it is essential to investigate approaches applied by governments in addressing and controlling stigma during COVID-19 – and critically evaluate whether policies implemented are ethical and based on humanitarian principles.

Theoretical Framework

During pandemic or health crises, stigmatisation often occurs because of the lack of information, and people need a simple explanation of complicated situations. According to Goffman (1963), stigma is a discrediting attribute that resulted from social construction (Manchha et al., 2022). This research is guided by Bresnahan and Zhuang's (2010) dimension of stigma based on these constructs: labeling, negative attribution, separation, status loss, and controllability.

The dimension of labelling is related to "the act of assigning an unfavorable descriptor to a problematic condition" (Zhuang & Bresnahan, 2012). During the COVID-19 pandemic in Indonesia and Malaysia, this kind of stigma includes using the words "China" or "Chinese" to describe the virus. The dimension of negative attribution incorporates negative terms to call the person who has the virus or even the family member of confirmed cases.

The third dimension of separation can be understood from the view that the person with an unfavorable condition cannot have contact with other people. The dimension of status loss shows situations where a patient or his family loses their privilege or social recognition, including housing, education, employment, and health care. The last dimension, controllability, is related to one's capacity to control the situation to avoid unfavorable conditions, including the responsibility for preventing such situations. Besides dimensions, we also investigated the object of the stigma, whether there is increased stigma associated with certain physical conditions such as defective body, characteristics of the person, or one's background (Wu et al., 2022). For the object of stigma, one's background includes race, nationality, gender, or social groups.

Research Questions

Amid the COVID-19 pandemic with many countries employing drastic measures including national lockdowns, and enforced compulsory self-quarantines for potentially infected individuals (Secon, Frias, & McFall-Johnsen, 2020), we projected increased use of social media to obtain and share information related to the pandemic. The global media also reported increased cases of stigmatisation towards certain groups of people, particularly towards the Chinese and Asian people, and COVID-19 sufferers (Lau, 2020). Thus, we believe that it is apt to investigate stigmatisation related to COVID-19 with a specific focus on social media conversations. Due to the overwhelming data on social media, we narrowed down our scope of research to conversations on Twitter, focusing on the Indonesian and Malaysian public.

Specifically, our research questions are as follow:
RQ1: How do Twitter users stigmatise COVID-19?
RQ2: What is the content of tweets related to the stigma of COVID-19 in the Indonesian and Malaysian Twitter-spheres?
RQ3: How do the governments in Indonesia and Malaysia apply communication management and preventive measures in their COVID-19 protocols?

METHODS

Sampling

For the purpose of this research, samples were collected from the Twitter platform. This is because, according to We are social & Hootsuite data provided in January 2021, Indonesia's number of Twitter users hit 170 million, or 61.8 percent of the overall population. Meanwhile, 49% of social media users in Malaysia aged 16-64 use Twitter (We are Social & Hootsuite, 2021).

Altogether, 1,106,620 Twitter conversations related to the COVID-19 were posted when it was first recognised as a global pandemic – from March 1 to May 30, 2020. These samples were collected based on a keyword search of “Corona” OR “Covid” because in both countries the terms were used interchangeably. The second step was cleaning the data to ensure that there were no duplications or retweets as its function was merely to amplify messages. The third step was to randomly select samples from both countries. We had 24,293 samples with the error margin of ± 1 % at the 95% confidence level. We collected more tweets from Indonesia, compared to Malaysia, and we selected the sample based on the proportional number of tweets that we collected. The sample consisted of 16,483 samples from Indonesia and 7,810 samples from Malaysia and we analyzed them using quantitative content analysis based on the codebook created.

To answer RQ3, we also collected government policy documents from both countries to investigate governments protocols and approaches in addressing and controlling stigma during the pandemic. We browsed the government websites to collect policy documents from the presidential and prime ministerial levels. From both countries we found 32 government policy documents on COVID-19 that were issued by the government at the national level. We then study the whole document and look for intervention on stigmatisation.

Quantitative Content Analysis

The foundational definition of *content analysis* is the evaluation of written, verbal, or visual communication messages. To identify the types of stigmas contained in a tweet, we conducted a quantitative content analysis. According to Krippendorff (2004, p. 25), "Content analysis is a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use." It's a research technique for the objective, systematic, and quantitative description of the manifest content of the communication. There are five units in content analysis: physical, syntactical, categorical, propositional, and thematic (Krippendorff, 2004). This research uses the thematic unit, which rely on textual features that are distributed throughout a text or thematic narratives that are generated from the whole text. Data analysis using this method employs inductive reasoning, by which themes categories emerge from the data through the careful examination and constant comparison of research data (Elo & Kyngäs, 2008). The same method was also used to examine government policy documents obtained for this study.

Units of Analysis

The stigma specification used in developing a codebook for this study is loosely based on research done by Zhuang and Bresnahan (2012), which studied stigma and HIV/AIDS. The five themes are: labelling, negative attributions, separating, status loss and responsibility. As the first author read through all tweets, themes that appeared in each tweet, including both the text and context of the message, as suggested by Krippendorff (2004), were analysed. Two coders were involved in this study, in which all of them understand Bahasa Indonesia and Bahasa Malaysia. The intercoder reliability results for all five categorizations with Cohen's Kappa ranged from 0.89 to 96.00.

Table 1: Stigma themes

Themes	**Description**
Labelling	Act of assigning an unfavorable descriptor to a problematic condition.
Negative attribution	Negative terms to call the person who has the disease or even the family member of confirmed cases
Separating	View that the person with an unfavorable condition cannot have contact with other people.
Status loss	Situation where stigmatized individuals lose their privilege or social recognition.
Responsibility	View that individuals have power to control the situation to avoid unfavorable conditions, including the responsibility for preventing such situations.

Source: Bresnahan & Zhuang (2010).

For the government policy document, we used themes as the unit of analysis, specifically related to the government protocols and messages addressing stigma. We read over the 32 papers to look for communication guidelines, directives, or regulations on COVID-19 and stigmas/stigmatisation.

FINDINGS

The Stigmatisation of COVID-19

Our analysis found that most of the tweets were not related to stigma, and only 712 (2.9%) out of 24,293 tweets contained stigma. From all tweets that contained stigmas, 204 tweets were from Indonesia and 508 from Malaysia. For the non-stigma tweets in Indonesia, most of the tweets contained criticism and negative sentiment toward the Indonesian government and their policies in handling the COVID-19 pandemic. Meanwhile, in Malaysia, most tweets were related to the government's appeal to stay home.

We found that the main stigma in Indonesia was 'labelling' (60.8%), followed by 'controllability/responsibility' (18.6%), 'separation' (8.8%), 'negative attribution' (7.4%), and 'status loss' (4.4%). While in Malaysia, it was 'responsibility' (76.8%) of the religious group amid the pandemic that came out as the main stigma, followed by 'labelling' (13.4%), 'negative attribution' (7.7%), and 'separation' (2.2%). We found no stigma of 'separation' in Malaysia.

Table 2: Cross tabulation of countries and categories of stigma's narrative

	Percentage of category		
Countries	**Physical condition**	**Characteristic**	**Background**
Indonesia	6.9%	17.6%	75.5%
Malaysia	0.2%	40.6%	59.3%

Although differing primary stigmas, Twitter conversations in both countries were inclined to place blame toward other actors as the cause of the COVID-19 pandemic. For the narrative of the stigma, tweets from both countries showed that one's background came out as the main focus. In Malaysia, stigma toward one's background was 59.3%, followed by characteristic (40.6%) and 0.2% stigma toward physical condition. In Indonesia, we found 75.5% stigma toward one's background, followed by characteristic (217.6%) and physical condition (6.9%).

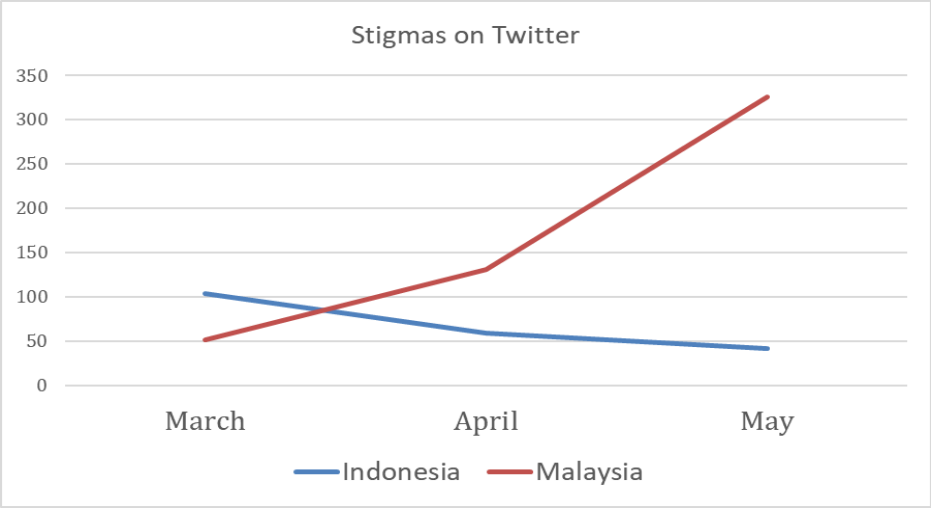

Figure 3: The trend of tweets contained stigma in Indonesia and Malaysia

In order to present the dynamic of stigma in Indonesia and Malaysia, we also examined the trend of tweets containing stigma. Figure 3 shows that during the first month of the pandemic, Twitter conversation in Indonesia had more tweets containing stigmas compared to Malaysia. However, during the second month of the pandemic, the Malaysia Twittersphere in our study had more stigma than the Indonesia Twittersphere. In May, tweets with stigma from Malaysia Twittersphere (326) were about eight times more than Indonesia (41).

Content of Tweets Related to Stigma

To answer the second research question, we conducted a text analysis to see what words were frequently used when people posted tweets related to stigma. In Indonesia, the most frequent terms used were "corona" (170), "Indonesia" (158), "China" (128), "Virus" (80). "people" (27), "negara" (18). "wuhan" (18), "covid" (16) and "positif" (18). Most of the tweets in Indonesia labelled (associating) the virus with China -- the place where COVID-19 was first reported. In Malaysia, the most frequent words were "Malaysia" (541), "Corona" (503), "India" (248), "from" (159), "Tablighi" (143), "Jamaat" (135), "virus" (132), "Pakistan" (128), "they" (115) and "Indonesia" (107). For Malaysia, the use of frequent words suggest 'responsibility' as the key theme at least during the data collection period.

Application of Communication Management and Preventive Measures in Indonesia and Malaysia's COVID-19 Protocols

To answer the third question, we found that only two out of nineteen documents from the Indonesian government contain information about stigma albeit very limited. The concept and intervention of stigmatisation were seen as trivial in which we found sentences only in the COVID-19 protocols shared near national borders (immigration entry points), such as "the need to omit stigma" or "the need to prevent the risk of stigma". However, we found no further elaboration of the policy, and not just a trivial instruction such as "The protocol for the country borders: do not stigmatise/discriminate people with COVID".

Meanwhile in Malaysia, we found only four out of thirteen government policies and documents that tried to regulate COVID-19, contain information about stigma. The mention of stigma can be found in the government guidebook on mental health for front liner officers and policy directives related to quarantine procedures. In Malaysian policy documents, there was a comprehensive message to address the stigmatisation of labelling, such as emphasising to call infected individuals as "people who have COVID-19", "people who are being treated for COVID-19", or "people who are recovering from COVID-19". The policy papers from the Malaysian government also address the stigmatisation of separation by dedicating a section on how to handle avoidance by family or community due to COVID-19 stigma or public fear. In the guidebook, the Malaysian government also showed concerns for COVID-19 sufferers to overthink social stigma and discussed the necessary coping skills to handle emotional stress. In addition, there was a section about the potential dangers of stigma, particularly for those who might require mental health support services amid the COVID-19 pandemic but would refuse to seek medical support due to the social stigma associated with the virus.

DISCUSSION AND CONCLUSION

Based on Twitter conversations related to COVID-19 in Indonesia and Malaysia, we found that there was a strong sentiment from both countries to blame other actors. In Indonesia, the central stigma revolves around labelling the pandemic on China and the Chinese. Such sentiment was prevalent due to the Indonesian government's policies allowing Chinese tourists and foreign workers to enter the country despite the increased cases of COVID-19 recorded in countries all over the world. We also found that the conversation in the Indonesian Twitter-sphere is dominated by criticism towards the government's poor performance in handling the COVID-19 crisis. The discussion on COVID-19 in Indonesia transcended beyond the medical aspect and often debated with a political slant.

Meanwhile, in Malaysia's Twitter-sphere, most tweets were found to blame other actors as causing factors of COVID-19 in the country. This is particularly evident after news reports of 16,000-strong religious gatherings (Tabligh Akbar) reported in Sri Petaling Malaysia, which caused a sudden spike of positive COVID-19 cases in Malaysia. The 'Tabligh Cluster,' which was a term used widely on the local media and government agencies, has indirectly influenced public sentiment towards Tabligh religious groups in Malaysia as proven by the number of tweets stigmatising this group.

In Indonesia, this study showed that the blaming was toward only one race – the Chinese. In Malaysia, at least during this research was conducted, the blame was directed at Indians, Pakistanis, and Indonesians. The reason for these differences was that the attendees of Tabligh Akbar were also from India, Pakistan, and Indonesia. As asserted by Jones (2020), the discourse of blame exploits existing social divisions of religion, race, ethnicity, class, or gender identity and in the case of Malaysia, the 'otherness' of non-Malaysians Tabligh Akbar attendees amplified stigma in Malaysian public discourse.

We also found stigma interventions in both countries were also quite different. In Malaysia, the Ministry of Health, through a daily press conference (on TV and social media live) and social media posts, called for the public to stop stigmatising the virus and urged people exposed to COVID-19 patients to come forward for testing. In Indonesia, the Ministry of Health addressed the stigma mainly through communication campaigns, webinars, and infographics. It is pivotal for government protocols to address stigma problems strategically and provide enough information to establish a safe environment for COVID-19 sufferers. In Indonesia, for example, the government formed a COVID-19 task force starting at the neighbourhood level, school communities, office communities, up to the national level. The task force aimed to assist COVID-19 sufferers to follow protocol and get treatment, However, members of the task force did not have enough information about the potential of stigmatisation and its harmful effects. In all government guidelines that we collected in this study, none of them provided useful information. At the same time, addressing the stigmatisation only from the communication intervention would not be enough.

Besides the lack of COVID-19 protocol to avoid stigma, the Indonesian government also played a part in perpetuating the stigma toward COVID-19 sufferers. In one public announcement, the spokesperson of the Indonesian government committee made highly criticised comments by saying "in this emergency situation, the rich should take care of the poor so they can live without hardship, whereas the poor can look out for the rich by not infecting them with the virus" (CNN Indonesia, 2020). This statement explicitly blamed the

poor as the carrier of COVID-19. The loaded statement also suggested that the rich were not the culprits of the increased cases in Indonesia and indicated that the affluent groups would know better to handle COVID-19 than the poor community.

In this study, although Indonesian people were more active in tweeting about COVID-19 than Malaysians, we found that tweets from Malaysia contained more stigmas than those from Indonesia. However, unlike Indonesia, the Malaysian government responded quickly to the concerning trend (albeit only through four out of the thirteen official policies) by including stigma and its potential risks in policy documents, directives, and quarantine protocols. Meanwhile, the Indonesian government focused on addressing stigma mainly via communication campaigns and public awareness – but did not officially publish official orders and policies to handle COVID-19 stigmas. While efforts were placed by both governments, we found that more attention could have been established to highlight and explicitly regulate COVID-19 stigmas. In conclusion, based on this research, we found stigmatisation of COVID-19 in Indonesia and Malaysia pointed out jarring concerns:

- Lack of knowledge on COVID-19.
- The need for effective and efficient dissemination of information to avoid victim blaming.
- Politicisation of COVID-19 for one's benefit.

It is crucial to address the stigma surrounding COVID-19 in Indonesia and Malaysia due to its negative impacts on society. It is important to remember that stigma can prevent individuals from seeking necessary medical attention, such as testing and treatment, due to fear of discrimination. This can contribute to the spread of the virus and hinder efforts to control its transmission. Therefore, it is important for public health officials and community leaders to work towards eliminating stigma and promoting understanding and inclusivity during this crisis in order to protect the health and well-being of all members of the community.

BIODATA

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