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An Epidemic of Stigma: The Stigmatization of COVID-19 First Responders in Pagadian City, Philippines

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Abstract

This study analyzed the experiences of public stigma and self-stigma by four groups of first responders during the COVID-19 pandemic, namely, fire responders, police officers, hospital workers, and barangay health workers in Pagadian City, Philippines. The concepts of public stigma and self-stigma developed by Pescosolido and Martin (2015) were used. A mixed-methods design guided data collection with 225 survey participants and 14 in-depth interview respondents. Data reveal that physical distancing, exclusion, and harboring the perception that first responders are health threats were common forms of public stigma. This was corroborated by the finding that hospital and barangay health workers recorded the highest levels of public stigma. Close proximity to COVID-19 patients, despite wearing personal protective equipment during work, is the only reason cited. Registering significantly lower levels of stigma are the fire responders. It is interesting to note from the data how first responders converted public stigma to self-stigma, with the latter characterized by diminished self-image and increased anticipation of discrimination from anybody. Respondents' narratives described how stigma would create tension in all the spaces they occupied. Instead of escalating tension into conflict, respondents felt empathy understanding the public's fear of infection. The findings stress that stigma, especially during widespread health crises such as pandemic, operates along a socially embedded process specifically shaped by how risk is perceived, trust in health institutions, and occupational visibility. By highlighting both external and internal dimensions of stigma, this study contributes to a more contextualized understanding of work-related stigmatization in the Philippine setting.

Keywords: *COVID-19, first responders, stigmatization, public stigma, self-stigma*

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Introduction

The rapid spread of the novel coronavirus from Wuhan, China to all directions in 2019 momentarily, yet significantly, changed societies (World Health Organization, 2020; Remuzzi and Remuzzi, 2020). The unpredictable morphing of the virus threatened all aspects of wellbeing (Pike et al., 2010), resulting in widespread but incomprehensible forms of fear. To lower the rate of transmission and death, many governments resorted to harsh lockdowns, which only compounded the public paranoia. Meanwhile, individuals in critical sectors considered essential to maintaining food supply and public services, such as first responders, endured the situation by performing their duties despite endangering their health and lives (Pink et al., 2021).

Who are the first responders? They are individuals assigned to respond to emergencies and disasters, such as firefighters and law enforcement personnel (Arble et al., 2020). During the COVID-19 pandemic, their exposure to health risks significantly increased (Bagcchi, 2020; Pink et al., 2021; Schubert et al., 2021). However, more than physical risk, these first responders were subjected to stigmatization. Stigmatization is a process wherein individuals are labeled or associated with negatively perceived traits, leading to social devaluation (Goffman, 1963; Link and Phelan, 2001; Pescosolido and Martin, 2015). Isolation, lack of support, feelings of contamination, heightened stress, and reluctance to seek help were common experiences for first responders (Zolnikov and Furio, 2020).

In this study, the term "first responders" specifically refers to workers during the pandemic whose primary roles involve immediate, on-the-ground responses to emergencies and public safety threats, specifically firefighters, police officers, hospital workers, and barangay health workers (Arble et al., 2020). While the term frontliners was widely used during the same time, it included a broader range of essential service providers, such as grocery personnel, delivery personnel, and sanitation workers. This study uses the term first responders to refer to occupational groups tasked to provide urgent assistance and maintain community order. This distinction highlights their direct exposure to physical health risks and heightened social stigmatization.

Incidents of attack, eviction, and harassment directed at Philippine first responders made headlines soon after the first lockdown in the second quarter of 2020 (UNICEF, 2020; Rosario, 2020). Nurses reported to have experienced stigmatization through social rejection, self-stigma, and emotional distress linked to community fear of infection (Panganiban and Manabag, 2021), which affected their self-image, relationships, and life opportunities (Santos, 2022). The same experience was reported for medical technologists (Reyes and Agcaoili, 2022). Frontline health workers who took on crucial roles during the pandemic complained of neighbors and friends avoiding them, believing they “bring infection” (Corpuz, 2021, p. 327).

These narratives demonstrate that stigma among the first responders operates through fear of contagion but also through symbolic devaluation and social exclusion. Quantitative research on stigma in the Philippines focuses on mental illness (Dietrich & Angermeyer, 2006) or on HIV-affected individuals (Acta Medica Philippina, 2019). Very few have extended stigma analysis to occupational settings outside hospitals. This study addresses that gap by examining the dual processes of public stigma and self-stigma among first responders, a term operationalized to include fire, police, hospital, and barangay health workers, whose visibility and proximity to the public place them at the center of stigma during the COVID-

19 pandemic.

Zamboanga del Sur's regional hub is Pagadian City with an estimated population of 210,452 in 2020 (PSA, 2020). During the pandemic, the local government enforced strict community quarantine protocols, including citywide curfew, mandatory health declaration forms, disinfection stations, and No Face Mask, No Entry ordinances (DILG, 2020). Passenger capacity in public vehicles was reduced to ensure physical distancing, while checkpoints and barangay passes controlled movement (DOH, 2021). These measures also became sites where stigma was enacted. For example, tricycle and jeepney drivers often refused to transport uniformed hospital or police personnel for fear of contagion (Rosario, 2020; UNICEF, 2020). Barangay health workers conducting contact tracing and vaccination monitoring were sometimes avoided or denied entry by residents (Rostauro, 2020). These micro-level interactions in vehicles, markets, and residential areas show that stigma in Pagadian City was deeply embedded in everyday social spaces, not limited to clinical or institutional settings.

Existing studies have largely treated frontline workers as a single stigmatized category during the COVID-19 pandemic. However, this assumption obscures potential differences in how stigma is distributed across occupational groups. It remains unclear whether stigma arises simply because individuals are categorized as frontliners, or whether it is shaped by public perceptions of their proximity to disease transmission. This distinction is theoretically important because it shifts attention from occupational labels alone to the social construction of risk. By comparing firefighters, police officers, hospital workers, and barangay health workers, this study examines how perceived exposure to infection develops both public stigma and self-stigma among first responders. Specifically, this study aims to examine public stigma experienced by first responders specifically in instances of social distance, exclusion, and being perceived; and to explore self-stigmatization and its impact on self-image and expectations of future stigma.

Drawing on Pescosolido and Martin's (2015) stigma framework, this study examines whether stigma is primarily tied to occupational identity or to public perceptions of contagion risk associated with specific occupations. This study situates the experiences of first responders in Pagadian City within broader sociological perspectives on stigma at both the public and internalized levels. By examining public stigma—manifested as social distance, exclusion, and perceptions of first responders as health threats alongside self-stigmatization that affects self-image and expectations of future discrimination, the study demonstrates that stigma is a socially embedded process intensified by crisis conditions. The research highlights the need for institutional support, public education, and policy interventions to protect not only the physical safety but also the social and psychological well-being of first responders.

Review of Related Literature

Stigmatization involves labeling individuals in ways that associate them with negative or undesirable traits, often resulting in emotional harm and social exclusion (Goffman, 1963). Goffman's foundational work remains a cornerstone of sociological research on stigma. Initially, psychologists explored the cognitive processes underpinning stigmatization, focusing on individual-level interactions and the evolutionary functions of stigma, often linked to traits such as mental illness or addiction (Clair, 2018). Over time, sociologists broadened the analysis to include both micro- and macro-level factors examining not only

individual behavior but also the societal structures and institutions, such as the legal system, that reinforce exclusion and marginalization. Contemporary research still relies heavily on Goffman's framework while also seeking to develop tools to understand how stigma produces social inequities (Clair, 2018). Critics argue, however, that these inherited frameworks often overlook the broader social contexts, actors, and power dynamics involved in the production of stigma (Tyler and Slater, 2018).

Stigma, as a process, involves identifying human differences, linking them to negative stereotypes, separating "us" from "them," and discriminating against and devaluing the labeled individuals. Such a process links stigmatization closely to broader sociological concerns such as social inequality and power structures (Link and Phelan, 2001). Pescosolido and Martin (2015) extended this by proposing four foundational premises: first, stigma is rooted in power—the ability to control and allocate both tangible and intangible resources. Second, social interaction is essential for stigma to be perceived and internalized, echoing Goffman's observations. Third, the manifestation of stigma is shaped by specific social contexts. Lastly, stigma exists on a spectrum, with both stigmatizer and stigmatized showing a range of responses from subtle to severe.

Stigma is both a cause and consequence of systemic prejudice. It serves to reaffirm existing biases and justify the marginalization of specific groups (Clair, 2018). Historically, sociological research has concentrated on conditions such as mental illness and HIV/AIDS, while studies on discrimination often focused on identity-based characteristics like race, gender, and ethnicity. However, this boundary has become increasingly blurred, particularly with the influence of interdisciplinary fields like social psychology (Link & Phelan, 2001). Sociologists have also examined collective responses to stigma, such as social movements and community-based resistance (Lamont et al., 2016).

COVID-19 related stigmatization

Historically, during the 1918 influenza pandemic, people were widely exposed to deaths in their communities and coffins, hearses, and funerals were frequently seen (Crosby, 2003). In contrast to the COVID-19 epidemic, exposure to illness and death has mostly been an abstract experience for most people, with fatalities simply reported in the news rather than personally experienced. The public's perception of their own risk of infection may be inflated due to exposure to dramatic news images of fatalities and healthcare workers caring for the sick and dying. This created an exaggerated public perception of the risks associated with interacting with COVID-19 healthcare workers (Taylor, 2019; Taylor et al., 2020). This heightened anxiety led to the stigmatization of COVID-19 frontliners. Healthcare workers were not only feared but often actively avoided. This avoidance extended beyond individuals to public spaces like grocery stores and pharmacies, driven by fear of infection (Taylor et al., 2020). In occupational settings, workers perceived as at risk of exposure faced even greater stigmatization (Schubert et al., 2021), which negatively affected their job performance, learning, commitment, and satisfaction (Einarsen et al., 2002; Dietrich et al., 2003; Weber et al., 2019). Fear of being stigmatized prompted some individuals to conceal illness, delaying diagnoses and treatments, and exacerbating anxiety (Stangi et al., 2019).

The pandemic saw a rise in workplace discrimination and even threats to the safety of frontline responders. In response, thirteen medical and humanitarian organizations, including the World Medical Association and the International Committee of the Red Cross, issued a joint statement in May 2020 condemning the harassment and violence faced by pandemic

responders (PNA, 2020). Psychological reactions to pandemics are not static; they evolve based on time, location, and perceived risk (Taylor, 2019). People who feel personally threatened by the virus are more likely to stigmatize healthcare workers. In some cases, this tendency reflects a stable trait, an overestimated sense of vulnerability to illness, which can be amplified during health crises (Taylor et al., 2020).

A growing body of international scholarship demonstrates that work-related stigmatization during the COVID-19 pandemic was not an isolated or incidental phenomenon but a structurally embedded social process with measurable psychological and occupational consequences. Schubert et al. (2021) conducted a systematic review, revealing that work-related stigma during COVID-19 extended beyond those directly exposed to patients. The review found significant associations between stigmatization and mental health outcomes, highlighting stigma as a broader public health concern requiring organizational and policy responses. Steven Taylor et al. (2020) surveyed healthcare workers in the United States and Canada (n=3,551) and found that more than one-quarter supported restrictions on healthcare workers and their families, while about one-third reported avoiding them due to fears of infection. Stigma was linked less to demographics and more to threat perception and avoidance behaviors, suggesting that pandemic fear can produce social exclusion. Other studies highlight how stigma intersects with frontline mental health. Sritharan et al. (2021 identified stigmatization as a recurring stressor alongside PPE shortages, burnout, and fears of infecting family members. Similarly, Chaudhary et al. (2021) found that oral healthcare workers in Pakistan experienced social avoidance associated with their professional roles, with institutional preparedness shaping their perceived vulnerability. Mohindra et al. (2020) reported that stigma among healthcare providers in India reduced morale and strained relationships both within and beyond the workplace. Meanwhile, Do Duy et al. (2020) showed that Vietnamese healthcare workers experienced internalized stigma after quarantine, including guilt toward family members and concerns about public attitudes.

The literature reinforces the importance of a sociological lens in analyzing work-related stigmatization. Stigma is not solely an individual psychological response but a socially structured phenomenon shaped by fear, risk perception, institutional capacity, and cultural narratives about contagion. These studies indicate that COVID-19 stigma was transnational and cross-occupational, closely linked to adverse impacts on mental health such as anxiety, depression, and burnout. They also show that stigma operates both publicly (through avoidance and exclusion) and internally (through guilt and self-blame), while institutional preparedness and social trust may mitigate its effects.

Methodology

A mixed-methods design was utilized in this study by combining both survey and interview data to examine stigmatization among first responders in Pagadian City. Using combined quantitative and qualitative approaches allowed researchers to capture both the prevalence of stigma and the lived experiences behind it (Creswell & Plano Clark, 2018). The survey aimed to measure the prevalence of stigmatizing experiences across first responder groups, while further in-depth interviews provided deeper insights into how stigma was perceived, its emotional and social impacts, and the contexts in which it occurred. Integrating these combined data sources enhanced validity through triangulation and thus offered a more holistic understanding of stigma, which is often complex and multidimensional (Tashakkori & Teddlie, 2010).

A sample size of 225 was determined using Raosoft® Sample Size Calculator at a 95% confidence level and ±6% margin of error. With an aim to represent all major first responder groups, the study used cluster sampling, appropriate for populations grouped into organizational or geographic units (Cochran, 1977; Fowler, 2014). The first responder population was grouped into four institutional clusters: (1) Bureau of Fire Protection (BFP) personnel, (2) Police officers under the PNP Pagadian City Police Station, (3) hospital-based frontliners from Zamboanga del Sur Medical Center, and (4) barangay health workers (BHW) under the City Health Office. The 225 respondents were proportionally divided across these clusters based on the 1,415 first responders recorded by Pagadian City DOLE in 2021. Larger clusters received more respondents, smaller clusters fewer, ensuring the sample reflected the actual distribution.

The survey instrument used was developed from literature and established studies of stigma and work-related stigmatization (Link & Phelan, 2001; Pescosolido & Martin, 2015; Do Duy et al., 2020; Taylor et al., 2020; Mohindra, 2021). A pilot test involving 15 respondents outside the study sample was conducted to assess clarity and reliability. Surveys were then administered in person between March and June 2021, following city health protocols with online access being limited among barangay health workers. The survey consisted of 50 dichotomous index questions (yes/no), with 10 items allocated per dimension of stigma (i.e. Social/Interpersonal Distance, Experience of Exclusion, Being Perceived as a threat to Public Health, Impacts on Self-Image, and Expectation of Future Stigma). Responses were then summed and converted to a 10-point index score using IBM® SPSS® Statistics. Higher scores indicate greater reported stigmatization. Index scores were interpreted as follows: 1.0–2.7 (Very Low), 2.8–4.5 (Low), 4.6–6.4 (Average), 6.5–8.1 (High), and 8.2–10.0 (Very High).

From the 225 samples, first responders were then selected through purposive and snowball sampling to discuss their experiences with work-related stigmatization. By the end of data gathering, a total of 14 interviews were completed. Respondents were selected based on the criteria of having been employed for at least 3 months since the first lockdown in March 2020 and on currently or previously being based in Pagadian City during data collection. Data from the conducted in-depth interviews were then thematically analyzed to identify recurring patterns and provide further narratives on stigmatization reported in the earlier survey. Aliases were used to protect the identities of respondents and maintain confidentiality. This mixed-methods approach captured both measurable trends and nuanced insights into how stigmatization manifested in first responders' daily lives, including emotional, social, and professional impacts.

Findings and Discussion

A total of 225 first responders participated in the study, specifically, 28 fire responders, 27 police officers, 84 hospital workers, and 86 barangay health workers. The Fire Responders group comprised 26 males and 2 females, aged 24 to 56 years. Most of whom, or 26, were married, and two were unmarried. All were college graduates and currently assigned to the Bureau of Fire Protection - Region XI. The Police Officers group included 22 males and 5 females, aged 24 to 50 years. Among them, 16 were married and 11 were single. All hold college degrees and are assigned to the Pagadian City Central Police Station. The Hospital Workers group consisted of 15 males and 69 females employed at the Zamboanga del Sur Medical Center (ZDSMC). The majority of them, or 6, were single, while 22 were

married and one was widowed. In terms of educational attainment, 82 were college graduates and 2 were high school graduates. Lastly, the Barangay Health Workers group included 84 females and 2 males. Sixty-seven were married, 10 were single, and 9 were widowed. In terms of education, 27 were college graduates, 30 were high school graduates, and 27 had completed vocational or technical training. Additionally, one respondent had finished only elementary school, and three had no formal education.

Experiences of Public Stigma: Social/Interpersonal Distance, Experiences of Exclusion, and Being Perceived as a Threat

This study examined public stigma among first responders across these dimensions: social/interpersonal distance, experiences of exclusion, and being perceived as a health threat. Findings indicate that public stigma varied across occupational groups. Hospital workers consistently reported the highest stigma scores across three dimensions, followed by barangay health workers. Police officers experienced moderate stigma and fire responders reported the lowest.

Social/interpersonal distance

Social/Interpersonal Distance refers to the public's reluctance to interact with stigmatized individuals (Bogardus, 1959). Hospital workers recorded the highest level of social/interpersonal distance (8.0), followed by barangay health workers (6.5), police officers (5.2), and fire responders (4.9). Interview narratives illustrate how respondents experienced avoidance in everyday settings.

Nadine is a hospital worker. Wearing her uniform to work, she was refused a seat in public transportation. In addition to this experience, passengers avoided sitting beside her. According to Nadine:

> *Atong peak as in super peak sa Covid, nag work ko sa hospital then magsakay kog tricycle pauli sa akong dorm. Pag musakay nakog tricycle na mga [driver] na dili magpasakay ana. Then, nakasakay ko one time nga naa siyay pasahero isa ra kabuok. Mura siyag kanaugon ang dayon, grabe kay siya kanang palayo gyud siya sa akua, murag nandiri bitaw siya sa akua.*

Translation:

> At the height of Covid, I was employed in a hospital and would take a tricycle to go home to my dorm. There were times when drivers would not give me a ride. Once, I took a ride and there was only one passenger. I sensed this passenger wanted to get off. This passenger distanced from me, as if disgusted with me.

Chelsea is a barangay health worker. She recalled how community members were hesitant to approach her.

> *So, naa toy mga pipila ka instances nga ang mga tao imbes na muduol sa amua kay mangayo ug tabang or ma-feel namo ilang sa pagsalig kay health workers pud biya me. Mura na pud sila nga mangdiri kay magtuo sila nga wala me ga-sanitize ug tarong kay lagi kakulangon sa pasilidad ug pagsalig sa mga barangay."*

Translation:

> So, there were a few times when residents came for assistance or we felt their trust because we are also health workers. It seemed they were disgusted with us suspecting that we weren't properly sanitized because, indeed, the barangay lacked the proper facilities and also trust in the barangay.

These findings reflect the same patterns earlier examined in times of infectious disease outbreaks. During the pandemic, studies suggested that stigma manifests as avoidance of individuals exposed to the virus. Healthcare workers and frontline responders were reported to have experienced social exclusion and avoidance due to fear that they are infected (Bagcchi, 2020; Taylor et al., 2020). In the context of the pandemic, these reactions were amplified as people scampered to protect themselves by minimizing contact with individuals believed to be at higher risk of infection.

The higher stigma index scores among hospital and barangay health workers exhibits association of fear to contaminated healthcare spaces, such as hospitals and isolation facilities. Symbolically, healthcare workers are connected to the disease resulting in discrimination and avoidance behaviors (Ramaci et al., 2020). Meanwhile, the experiences of barangay health workers highlight another dimension of stigma linked to institutional trust. This further highlights another dimension of stigma during the pandemic, one shaped not only by fear of contagion but also by broader structural inequalities, such as poorly maintained and underfunded public health infrastructure (Pescosolido & Martin, 2015).

Experiences of exclusion

The dimension of "Experiences of exclusion" refers to the public's tendency to deny stigmatized individuals access to citizen privileges and opportunities to participate in social activities or roles (Pescosolido & Martin, 2015). Survey data presented that hospital workers (7.5) and barangay health workers (5.2) reported the highest levels of exclusion from social gatherings and community activities, while police officers reported moderate experiences (4.3) and fire responders reported very low levels (0.6). First responders shared that they are often perceived as potential carriers of infection, leading families, friends, and communities to distance themselves from them or exclude them from gatherings and shared spaces.

Police officer Armie narrated his experience physically distancing himself from his own family because relatives feared infection, and how it affected him,

> *Yung effect ng relationship between your friends relatives malaki kasi nasa isip nila na because of that virus or pandemic parang takot na sila sa sayo. So, naging isolated ka na. Para bang sabihin nila, 'Uy, hindi tayo pwede magsama.' Kahit kapamilya mo. Siguro may mutual understanding between the family and to us being law enforcer or first responder kasi nasa isip naman nila for the safety of the whole family. So, parang sinasakripisyo nila yung pagiging isang pamilya para lang mabuhay.*

Translation:

> How it affects relationships with friends and relatives is serious because they believe that, because of the virus or the pandemic, they are now afraid of you. So, isolate yourself. It's

> like, they say, 'Hey, we can't be together.' Even with your own family. Perhaps, there is a mutual understanding between family and us, being law enforcers or first responders, because they would prioritize the safety of the whole family. So, it's like, they sacrificed to be with family only to survive.

Camille is a barangay health worker. She also shared her experience of not being invited to parties, which she regularly attended before the pandemic.

> *Gusto kay ko mu-visit sa akong lolo pero ingun akong mama na dili lang daw kay mahadlok sila makadala ko ug sakit. Then sa office sa akong mama nag Christmas party then sauna kay muapil gyud mi. Wala gyud me absent ana na mga gatherings pero kato nga time kay dili lang daw ko paapilon. Maka-hurt pero kasabot ra ko gyud kay ko.*

Translation:

> I really wanted to visit my grandfather, but my mother advised me not to, afraid I would bring them the virus. Then at my mother's office, they celebrated the Christmas party. Before, I did not miss these gatherings, but this time, they told me not to join. That hurts but I understand.

This physical "distancing" described by first responders can be examined using symbolic boundary-making or the distinctions social groups create to categorize people and define who belongs in the community (Lamont & Molnár, 2002). These boundaries then separate the "us" from "them," and during periods of uncertainty, such as the pandemic, become more pronounced as communities try hard to manage risks. Respondents' narratives present how boundaries were extended into intimate spaces of first responders, such as family gatherings and celebrations. Social boundaries are maintained and negotiated through everyday interactional practices that regulate who can participate in social life (Barth, 1969). During the pandemic, avoidance and exclusion served as mechanisms by which local communities attempted to control the perceived spread of infection. While these practices may have been motivated by security concerns rather than deliberate discrimination, they nevertheless reinforced social distance and emotional isolation among first responders. These boundaries developed during the pandemic served as a risk-management strategy that inadvertently reproduced stigma toward first responders associated with virus exposure.

Perceived as a threat to public health

Public stigma is a perceived threat to safety held by the public. It stems from distress and worry by the public regarding risk in relation to their safety (Link et al., 1999). Findings reveal that hospital workers were regarded as the highest threat (8.2), followed by barangay health workers (7.5), police officers (4.9), and fire responders (1.5). Take the case of Ricardo who is a hospital worker. He described relatives refusing customary gestures, such as *pagmamano* (kissing the hand of an elder) because they suspected hospital workers to be infected.

> *Nakasulay ko na nagbless ko sa akong auntie tapos murag wala ko gipabless kay tungod para saila, tungod gatrabaho kog hospital, na positive ko. Ug katong isa namo ka neighbor nga lalaki ning bless ko then iyang gitago iyang kamot. Maong hantod karon miskin magkita me dili na ko mu-bless. Feel nako kay murag basin ilang pananaw nako ba kay wala koy respeto kay di ko mu-bless.*

Translation:

> I tried to get the hand of my aunt, but did not allow me to because, for them, I am infected with the virus simply because I work in the hospital. I am already positive. Also, one of our neighbors, a male, I wanted to show my respects also to him, but he hid his hand. That's why, until now, every time I see them, I stopped asking for their hand. I feel, maybe, they think that I don't have respect because I stopped doing it.

While police officers registered low in the scale of threat, they were still subjected to exclusion and discrimination. Nico is a police officer. He shared that, despite testing negative several times, neighbors suspected him of being infected for being a frontliner.

> *Yung sa discrimination, takot sila sayo kahit alam nila negative ang test mo o kaya hindi ka prone sa mga tao na mga naging positive sa ngalan na frontliner ka na may contact ka sa mga tao na naging positive, positive kana para sa kanila. Masakit din sa isang pulis na parang ikaw mismo isolate ka na sa ibang tao. Kahit sa pamilya mo ma-isolate ka.*

Translation:

> About discrimination, they are afraid of you even if they know you tested negative or you are not interacting with people who have tested positive; but because you are a frontliner who could have interacted with people who tested positive, then they suspect you to be infected, too. It's hurtful for a police officer, the feeling that you are alone, separated from people. Even your family could isolate you.

Pandemic studies found that healthcare workers were symbolically described to carry and transfer the disease (Bagcchi, 2020; Ramaci et al., 2020). Respondents shared being judged not by their actual health situation but by presumptions connected to exposure to the virus because of their work. These narratives further demonstrated that the first responders' identity, particularly their occupation, during the pandemic was made a marker for threat to public safety and well-being. Stigma is sustained when certain individuals get to be labeled as dangerous or risky leading to avoidance, discrimination, and exclusion (Link et al., 1999; Link & Phelan, 2001).

Due to their proximity to patients, first responders were frequently perceived as dangerous potential carriers of the much-feared virus. This perception often led the public to assume that healthcare workers, police officers, and other first responders were likely to be infected, even in the absence of evidence that proves otherwise. Such perceptions transformed everyday interactions into tense situations where stigma is reproduced, disrupting social relationships and even culturally valued practices of respect. Consistent with Link and Phelan's (2001) conceptualization of stigma, this becomes now a reason to distance oneself.

The general public "us" versus first responder "them" rhetoric: Manifestations of public stigma across occupational groups

Public stigma primarily concerns how the general population responds to a group based on stigma associated with that group (Pescosolido and Martin, 2015). Stigmatization, more broadly, reflects the belief that society selectively values certain human abilities or attributes while devaluing others (Goffman, 1963; Rusch et al., 2005). A key aspect of stigmatization is the creation of a social divide between "us" and "them," where those who are stigmatized are perceived as fundamentally different from those who are not negatively labeled (Link and Phelan, 2001; Rusch et al., 2005). In the case of the first responders in Pagadian City during COVID-19 pandemic, work-related stigmatization became evident. Data reveal that public stigma among first responders was largely driven by whether an individual's occupation involved close contact with individuals infected by COVID-19. Thus, their occupation and its perceived frequency of contact with infected individuals became central to reinforcing the "us" versus "them" divide.

Survey results reveal high public stigma scores for hospital workers (7.9) and barangay health workers (6.4), while police officers had an average score (4.8) and fire responders had a significantly low score (2.3). The lower score for fire responders may stem from the public's perception that firefighters have less direct contact with COVID-19 patients, as their roles are more commonly associated with emergency and disaster response and less with healthcare provision. Interviews with firefighters detail their rare interaction with COVID-positive individuals unless it's during responding to a specific Covid-related emergency. This suggests that perceived exposure to infection, more than occupation, more likely reinforces stigma.

Public stigma scores were significantly higher for hospital and barangay health workers most likely because their roles require direct interaction with COVID-19 patients. Survey data showed that 86% of hospital workers and 80% of barangay health workers reported having experienced discomfort when with non-health workers. Interviews revealed issues of institutional trust, particularly toward barangay health centers, where perceptions of inadequate facilities and poor sanitation contributed to avoidance. Such responses reflect broader sociological findings that stigma during epidemics is shaped not only by fear of contagion but also by trust in institutions and health systems (Pescosolido & Martin, 2015). By contrast, police officers and fire responders often stationed at checkpoints and less directly mingling with COVID-19 treatment were less likely to be perceived as sources of infection, resulting in comparatively lower stigma scores.

Work uniforms also played a significant role in stigmatization. About 81% of hospital workers reported avoiding wearing their uniforms in public spaces to prevent exclusion or negative reactions. The visibility of uniforms served as a symbolic marker of occupational

identity, making frontline workers easily identifiable and reinforcing distinctions between those perceived as exposed to the virus and the general public. This dynamic reflects the role of visible markers in shaping stigma, in which identifiable attributes serve as cues that trigger devaluation and discrimination. Similarly, sociological research on symbolic boundaries highlights how visible markers such as uniforms, labels, or roles can reinforce divisions between social groups (Lamont & Molnár, 2002).

As first responders continue to face heightened occupational health risks (Pink et al., 2021), this study's findings suggest that the COVID-19 pandemic, as experienced by first responders in Pagadian City, also intensified work-related stigmatization they experience from the general public, deepening the divide between them and the communities they aim to serve. Whether due to social/interpersonal distance, exclusion, or perceived threat, these first responders experienced public devaluation and avoidance. Thus, public health crises can transform occupational roles and identities into social markers of risk, shaping everyday interactions and reinforcing symbolic, albeit stigmatizing, boundaries between frontline workers and the broader public.

Manifestations of Self-Stigma: Impacts on Self-Image and Expectation of Future Stigma

Self-stigma is a form of stigmatization that occurs when individuals internalize negative stereotypes, prejudices, or devaluation directed at them, leading them to accept diminished feelings of value and worth (Pescosolido & Martin, 2015; Schubert et al., 2021). In this study, self-stigma is examined through two indicators: first, impact on self-image and, second, expectation of future stigma.

Impacts on self-image (internalized stigma)

Self-stigma among first responders in Pagadian City was explored in the study, focusing on Impacts on Self-Image or how public stigma influenced the first responders' personal perceptions of themselves. Individuals may internalize stigma directed toward them, shaping how they view their own identity and social worth (Corrigan & Watson, 2002). Survey findings revealed that hospital workers had the highest self-stigma index (6.8), followed by barangay health workers (6.1), police officers (5.1), and fire responders (2.6). These results suggest that first responders who were more closely associated with COVID-19 treatment and community health response were also more likely to internalize public fears and stigma. Interviews conducted with respondents also revealed how public stigma translated into self-doubt, fear, and changes in overall behavior.

Jun, a police officer, shared how stigma led him and some of his colleagues to internalize public fears of infection, causing them to avoid returning home to their families: *"Pero dahil sa mga sinasabi ng mga tao about sa amin, parang kami naniniwala na rin kami na mapopositive kami, so hindi na lang kami umuuwi ng bahay"* (Because of what people said about us, it felt like we would get [COVID] positive, so we just didn't go home).

Nadine is a hospital worker. She also revealed losing confidence in interacting with other people, avoiding public transport to keep herself away from social interactions. According to her "*Dili kay ko magtricycle para dili kay ko makainteract sa ilaha as much as possible"* (I don't ride tricycles anymore so I can avoid interacting with others).

These experiences reflect what Corrigan and Watson (2002) describe as internalized

stigma, in which individuals begin to accept negative public perceptions and incorporate them into their self-concept. Rather than just experiencing stigma only from others, first respondents began to regulate their own behavior by avoiding social contact, limiting interactions, and personally withdrawing from family and community life. These findings demonstrate how public stigma can extend beyond social exclusion to influence the internal experiences of Pagadian City first responders. The internalization of fear, guilt, and responsibility for potential infection experienced from the general public disrupted not only their professional roles but also their personal relationships and daily routines. These findings show that first responders are not passive recipients of stigma but rather individuals with agency who resist devaluation. Thus, the very individuals tasked with protecting public health became unintended bearers of stigma themselves.

Expectation of future stigma (anticipated stigma)

Expectation of future stigma, another indicator of self-stigma, refers to individuals anticipating continued devaluation or discrimination from others based on their social identity or occupation (Pescosolido & Martin, 2015; Schubert et al., 2021). This form of stigma is often described as anticipated stigma, where individuals modify their expectations and behaviors based on the likelihood of negative social reactions (Earnshaw & Chaudoir, 2009). Survey results show that hospital workers had the highest index score, 8.1 (approaching very high), followed by barangay health workers (7.1), police officers (5.9), and fire responders (2.0). These findings indicate that first responders who were more visibly associated with COVID-19 response have then expected stronger negative reactions from the public. Interviews further revealed a common theme: first responders anticipated judgment from others due to their occupational proximity to the virus.

April, a hospital worker, shared, *"Murag expected na sad nga i-judge mi nila. Makasabot ra man gud ko nila gud na ingon ana gyud ilahang reaksyon*" (It seems expected that they will judge us. I understand their reaction because if I were a civilian, I would also avoid hospital workers since they are closest to Covid).

Similarly, police officer Nico said: "*Actually nafe-feel namin being first responder at tsaka being a policeman na expected na yun and wala tayong magawa*" (We feel that being first responders and policemen, it is expected and there is nothing we can do).

Despite their experience of stigma, respondents still expressed empathy toward the stigmatizing public. Barangay health worker Bell shared, "*Makasabot ra pud ko sa ilahang binuhatan, sabton ra pud nako sila* (I can understand their actions because if I were in their place, I might react the same).

These responses demonstrate how anticipated stigma can lead first responders to rationalize negative social reactions, even when such reactions contribute to emotional strain. Individuals who expect discrimination may adjust their expectations and interactions to minimize conflict or rejection (Earnshaw & Chaudoir, 2009). First responders not only faced public avoidance but also learned to anticipate such reactions as an inevitable consequence of their occupation. This expectation and otherwise a normalization of stigma reveals the broader social dynamics during health crises, where fear of contagion reshapes everyday interactions and influences how frontline workers interpret their place within the community.

When stigma penetrates the self: self-stigmatization of first responders

Self-stigma lies in how stigmatized individuals respond to the devaluation imposed on them (Corrigan & Watson, 2005). Interviews reveal that many first responders, whether consciously or not, internalized devaluation experienced from the public. Hospital workers (7.5) and barangay health workers (6.6) recorded high average index scores of self-stigma. This finding aligns with literature on the conceptualization of stigma where instances of labeling, stereotyping, and divisiveness result in internalized negative social perceptions, thereby, reinforcing feelings of difference and social distance (Link & Phelan, 2000; Rüsch et al., 2005). Interviews conducted with the first responders further revealed that public stigma significantly affected their self esteem, social relationships, and professional lives.

Survey results are consistent that groups experiencing higher levels of public stigma also reported higher levels of self-stigma indicating a strong relationship between external and internal forms of stigmatization. In this sense, stigma operates not only as an external social process but also as an internal psychological one, shaping how individuals perceive themselves within the devaluing behavior of the larger community. Self-stigma manifests in various ways, particularly through social withdrawal and heightened self-monitoring. For instance, hospital workers reported a very high affirmative response (98.8%) with the statement *"I am constantly scared that I might bring the infection home,"* illustrating their fear of harming loved ones. This fear reflects a sense of moral responsibility that many frontline workers carried during the pandemic. At the same time, some respondents described feeling pressure to prove stigmatizers wrong by being extra cautious against COVID-19, not only to protect themselves and others but also to defend their professional reputation.

Experiences of stigma also shaped expectations of future discrimination. Hospital workers scored notably high (85.7%) on anticipated stigma, with statements such as *"I expect people to feel uncomfortable when I'm around, especially when they know I'm a COVID-19 frontliner."* Interviews revealed that initial reactions of sadness and frustration often evolved into understanding and empathy toward those expressing fear or avoidance.

For Pagadian City first responders, coping with self-stigma was less about correcting public misconceptions and more about navigating and empathizing with widespread public fear. The findings suggest that the perceived proximity of a profession to COVID-19 exposure strongly influenced internalization of devaluation. Stigma on occupations viewed as closely interacting with COVID-19 patients, such as hospital workers and barangay health workers, has impacted the way they view devaluation as something to be expected. Just as a virus infiltrating and weakening the body, this study argues that stigma externally experienced has become internalized, disrupting both emotional and social well-being of the first responders

Conclusion

This study explored the experiences of stigmatization among four groups of first responders in Pagadian City during the COVID-19 pandemic. Using the stigma framework of Pescosolido and Martin (2015), it examined two action-oriented forms of stigma: public stigma and self-stigma experienced by first responders. Beyond documenting stigma, this study demonstrates that stigma brought about by one's nature of work is shaped by the public's socially constructed perceptions of contagion and how the virus spreads and is transmitted.

The findings suggest that stigma does not affect all frontline occupations equally; rather, it emerges through public interpretations of who is most closely associated with disease transmission and treatment, such as hospital workers and barangay health workers. The study also highlights a key result of stigma: occupational groups with high rates of public stigma also have a high rate of self-stigma. As public stigma is placed upon the first responders, it has a significant albeit consistent impact on the individual's self-image and anticipation of future stigma. Thus, first responders are revealed to be not just passive receivers of stigma but rather agentic individuals who internalize and navigate the devaluation they experience.

The study's findings extend classical sociological understandings of stigma by highlighting how occupational roles and identities become symbolic markers of risk during periods of collective uncertainty and how they can lead to devaluation from the public. This research contributes to the growing body of knowledge on work-related stigmatization during public health crises. However, the study recognizes several limitations and offers directions for future inquiry and policy development. Future research may expand the scope to include other frontliner groups not covered in this study, such as those in the hospitality and transportation sectors, whose roles during the pandemic also exposed them to stigma. Additionally, it is recommended that studies investigate the impact of COVID-19 vaccination on stigma, as preliminary interviews suggest that vaccinations did not significantly alter public perception toward frontliners.

Further research may also examine the influence of occupational markers, such as work uniforms, in perpetuating stigma. This study found that uniforms visibly associated individuals with their workplace, often making them targets of stigma in public spaces. Understanding how these occupational indicators affect public perception may be valuable in developing stigma-mitigation strategies. By understanding the roots and consequences of stigma during health crises, stakeholders can create a more inclusive and supportive environment for first responders, both during and beyond times of crisis response.

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Declaration on the Use of Artificial Intelligence

The authors declare that they made limited use of Grammarly and a generative artificial intelligence (AI) tool during the final stages of manuscript preparation to assist with grammar, spelling, language refinement, translation of selected text, and overall readability. The tools were used solely for editorial purposes and did not contribute to the development of the study's research questions, methodology, data collection, data analysis, interpretation of findings, or conclusions. All tool-assisted suggestions were carefully reviewed and revised by the authors accept full responsibility for the accuracy, originality, and integrity of the manuscript.