POLICY BRIEF

BANGLADESH HEALTH WATCH

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Fear and Stigma in the Context of Corona Epidemic in Bangladesh

- A rapid assessment of fear and stigma associated with the C-19 in Bangladesh
- Stigma forced people hiding their symptoms, avoiding medical attention, deserting dear ones, evicting people from their homes
- Recommended interventions to mitigate the fear, stigma and discrimination:
  * Legislative measures,
  * A combined and careful supervision by local politicians,
  * Administrators, caregivers,
  * Health workers and religious leaders and
  * Carefully use mass media against the incidences of stigmatization.

Executive Summary

All epidemic outbreaks generate a considerable amount of fear, stigma and discrimination. The fear of being socially marginalized and stigmatized may cause people to deny early clinical symptoms and may contribute to their failure to seek timely medical care. Mitigating the fear and stigma directed toward persons infected with, and affected by, Coronavirus is important in controlling its transmission and minimizing damages.

This policy brief is based on a rapid exploratory study to (a) conduct a rapid situation assessment of the localized nature of fear and stigma related incidences; (b) investigate the source of fear, stigma and rumour; (c) have a comparative understanding of Corona-related stigma with the pattern of stigma and fear of previous epidemics (such as Ebola, SARS etc) in order to provide policy recommendations; and (d) To recommend possible culturally informed and socially relevant recommendations to mitigate the fear, stigma and discrimination towards Corona victims or associates. To collect data, we have adopted various alternative online-based observations, such as social media content analysis, netnography and telephonic interviews of key informants, and shadow ethnography.

Findings included a narrative timeline which provided a clear explanation of how the fear shifted from the "structural zone" to the "cultural" and "liquid" zone (Bauman 2006), which intensified the stigma behaviour and transferred the "stigma power" (Goffman 1963) from the state to the society. Findings show stigma forced people hiding their symptoms, avoiding medical attention, deserting dear ones, evicting people from their homes, and so on. We have graphically shown the nexus between fear and stigma in the Coronavirus context by using knows cases, and validating them by interview data.

The study recommends an immediate intervention into this situation, before the culture of fear and stigma cast a permanent scar on the management of COVID-19. It proposes a set of recommendations at macro, meso and micro levels, including, among others, legislative measures, a combined and careful supervision by local politicians, administrators, caregivers, health workers and religious leaders. At the same time, it is very important to carefully use mass media against the incidences of stigmatization.

Introduction

In Bangladesh, the fear of the novel Coronavirus primarily arose from the underlying anxiety about a disease with an unknown cause and possibly a fatal outcome. This fear is further fueled when infection control techniques and restrictive practices such as quarantine and isolation are employed to protect the public's health. Thus, the fear of being socially marginalized and stigmatized may cause people to deny early clinical symptoms and may contribute to their failure to seek timely medical care. Mitigating the fear and stigma directed toward persons infected with, and affected by, Coronavirus is important in controlling its transmission and minimizing damages. While the fundamental source of fear is the same in the context of an infectious outbreak (e.g., fear of death), it can produce a variety of behaviours in different cultures and societies. Therefore, it is essential to study in a culturally contextual manner about the nature of fear, stigma and discrimination associated with this outbreak.

With this background, we have carried out a rapid exploratory study to (i) conduct a rapid situation assessment of the localized nature of fear and stigma related incidences; (ii) investigate the source of fear, stigma and rumor; (iii) have

a comparative understanding of Corona-related stigma with the pattern of stigma and fear of previous epidemics; and (iv) recommend culturally informed and socially relevant recommendations to mitigate the fear, stigma and discrimination towards Corona victims or associates.

Given the time-sensitivity and the fact that direct intervention is not possible in the current context, we have adopted various alternative online-based observations, content analysis and telephonic interviews of key informants and literature synthesis. In order to ensure reliability and validity we have triangulated number of methods to generate data.

Findings

Phase of false safety (January to February 2020): Prevailing narrative in Bangladesh symbolized the disease as a foreign one, associated it with the "immoral" lifestyle of Europeans and the "bizarre" food habits of the Chinese people. This narrative was particularly preached by Islamic preachers and wazirs. At the same time, a scientific denial was also confidently prognosticated by some doctors and scientists who promoted the idea that the Coronavirus would not survive in Bangladesh due to the warm weather. This has indeed structurally unguarded the mass from taking a rational defense against such upcoming danger, by providing us a soothingly false sense of safety.

Formalizing stigma (15 March 2020): 142 migrants returned from Italy, many of them were allowed to go home with advice to self-isolate. A seal was printed on their forearms to label them as returnees, and mentioning the end period of their quarantine time. Local government authorities also put red flags in the migrant returnees' houses.

Community gaining "stigma power" (17 March 2020): The fear in the community raised. Incidences of attacking migrant returnees took place. Migrants were prohibited to enter local shops.

Awareness of proximity of the disease (18 March 2020): On the very day of the first Corona death on March 18, despite the risks of spreading COVID-19, at least 25,000 Muslims joined a prayer named 'KhatmeShifa' after dawn to fight the Covid-19 pandemic, at Central Eidgah in Lakshmipur's Raipur. On the same day, tens of thousands joined the Namaz-e-Janaja of an Islamic scholar in Brahmanbaria, thus seriously damaging the narrative of social distancing.

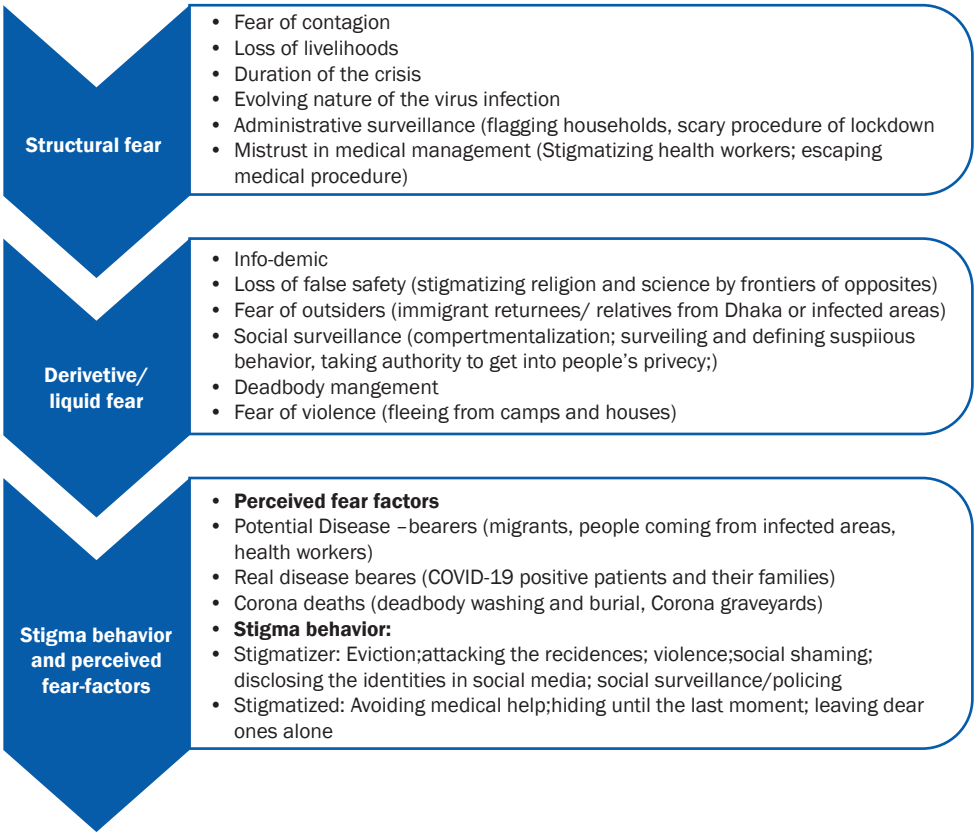
Community transmission and the liquefaction of fear (March 21, 2020): The death of a man in his 70s is likely the first known death from community transmission since how he got infected remained unknown as he and his family did not have any history of travel abroad. Following his death at the nearby Delta Medical Hospital, the authorities locked down the Tolarbag neighborhood of Mirpur, Dhaka. With such narratives of untraceable sources of infection, the fear of corona started to be "liquefied" (Bauman 2006).

The semiological disaster: On 23 March, when Bangladesh had 33 confirmed cases, the government declared a ten-day "chuti"(nationwide holiday). For some unknown reasons, the word "lockdown" was not used. In a city where most of the population has active sources of origins and a prevailing culture of going "desherbari" in holidays, the word "chuti" created the same vibration. People evidently forgot the context and advisory of social distancing and rushed into the transports. According to an informal estimate, as much as one crore people left Dhaka during that time.

Class-based fear and panic: (From the second week of April 2020) Several horrific fear and stigma related incidences were observed, such as, attacking and harassing corona patients, obstructing the burials of them, harassing health providers, deserting suspected family members in the jungle, etc. become regular features in different areas. Anyone outside the neighborhood -- para, moholla, elaka -- is subject to suspicion. Individual's mobility and actions are now under strict public scrutiny. This is how all the structural fear has been derived into cultural fear of liquid nature.

The Fear-Stigma Nexus

Based on the data both from interviews and the online media audit, we found a pattern between perceived fear and stigma behaviour among people. Using the theories of Goffman (1963) and Bauman (2006), we can conceptualize it in the following framework:



Recommended Interventions

Fear and stigma are interwoven and not primarily produced in individual encounters but are enacted due to structural causes. It is also acknowledged that the power has a significant role for the stigmatization to occur. In order to mitigate fear and stigma in the context of a pandemic intervention, therefore, needs to be targeted towards a wide range of levels from individual to structural. Following best practice interventions to address fear and stigma,

we recommend the following culturally informed and socially relevant intervention in three different levels:

Macro-level interventions: These are state-level structural interventions:

a. Legislative interventions: Law enforcement to stop discriminations towards Corona victims or their associates.
b. Softening the lock down procedure and reducing dramatizing in this process, so that it does not terrorize people, rather make them deeply alert.
c. Coordinated and targeted information dissemination to stop info-demic
d. Mass media anti-stigma campaign: with very carefully conceived messages. Endorsing Corona-survivors and health workers as heroes. Television content, small-clips in social media. Celebrity endorsements.
e. Intervention to restore livelihoods of people in the financial hardship

Meso-level interventions: These are interventions at the community level:

a. Community mobilization: to mobilize the participation of community members in anti-stigma efforts (Politicians, administrators, community health workers, medical representatives, Imams can play a crucial role).

Once a house is marked with Corona-infected patients by law enforcement bodies, they will urge the neighbors to cooperate with the house, and strongly warn them against any sort of stigmatization. The infected house will be able to contact the local administration for any sort of help and cooperation.

b. Small group interactions: Organize events to create platforms for facilitate interactions between stigmatized and non-stigmatized. This will be easier to achieve once the lockdown phase is over.

Micro-level interventions: These are interventions at the individual level:

a. Education: To educate individuals about non-stigmatizing facts and why they should not stigmatize. This could be done through mobile texting and social media.
b. Psycho-Social support mechanism: To provide psycho-social support to the individuals who have experienced stigmatization or have the potential to be stigmatized to cope with the experience

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