



Final report

**FEAR AND STIGMA IN THE CONTEXT OF CORONA EPIDEMIC IN
BANGLADESH: A RAPID RESEARCH**

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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.

With this background, we have carried out 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.

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, such as social media content analysis, netnography and telephonic interviews of key informants, and shadow ethnography. In order to ensure reliability and validity, we have triangulated data either by methods or by respondents, whatever deemed as necessary. This study used two widely acknowledged theoretical frameworks, respectively by Bauman (2006) and Goffman (1963), to understand fear and stigma and their interplay in the Coronavirus context.

Findings included a narrative timeline of the emergence of fear and stigma against certain known national/international events related to Coronavirus. The timeline provided a clear explanation of how the fear shifted from the structural zone to the cultural and liquid zone, which intensified the stigma behaviour and transferred the “stigma power” 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 known 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, mezzo 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.

Acknowledgement

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Time line

The research work is performed during the second half of April 2020, from 15 April to 30 April 2020. First draft was submitted on 30th April to BHW, and this version accommodates comments and feedback from the BHW team and the webinar participants.

Introduction and study objectives

Because of their inherent uncertain nature and evolving clinical features in real times, and the existing socio-political structure they embark upon, all epidemic outbreaks generate a considerable amount of fear, stigma and discrimination (Person *et al* 2015). These categories are essentially interdependent, and fed on each other. The pandemic of COVID-19 is no exception. The fear of this novel Coronavirus primarily arose from the underlying anxiety about a disease with an unknown cause and possibly a fatal outcome. This fear is further fuelled 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 with the following aims:

- To conduct a rapid situation assessment of the localized nature of fear and stigma related incidences
- To investigate the source of fear, stigma and rumour
- To 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
- To recommend possible culturally informed and socially relevant recommendations to mitigate the fear, stigma and discrimination towards Corona victims or associates.

As we are undertaking this rapid study, the incidences of fear and stigma keep running ahead of us even more rapidly and have been piled in our media archives and memories up to an alarming level. We now know how people are escaping isolation, avoiding tests, threatening infected people and their relatives, conducting violence, lying about the cause of deaths if these are by novel Corona, deserting dear ones in jungles, or leaving them alone at home if they are suspected to have the virus, so on and so forth. While Zizek (2020) would love to call COVID-19 an "equalizing factor" because it does not discriminate between rich and poor, and can behave equally across the classes, but ironically, the inherent fear-factors make it again

discriminatory against certain groups or populations. So, it is very important to address this issue immediately, and with accurate strategy, or it would make the whole epidemic situation even more grim and unmanageable.

Methodology

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. In order to ensure reliability and validity we have triangulated number of methods to generate data as follows:

Content analysis of print, visual and social media: This gave us the insight of the actions of fear and violence of the population on Corona related issues, against their demographic, educational and geographic patterns

Netnography: This is a data collection method that includes observation of online activities in various social media platforms. This method helped us to find out how the fear, violence and stigma related posts have been shared across the social media platforms, whether they fan the flame or take an opposite stance, what are the key arguments being put by them in cases of supporting/resisting these cases of violence.

Telephone interviews: We have conducted 23 telephone interviews with respondents from different classes, gender and locality. In terms of sample size we followed the principle of qualitative sampling of interviews to the point of data saturation. The respondents were selected purposively from existing qualitative samples of an earlier study where possible. New respondents were also selected purposively.

Shadow Observation: This is an alternative way to replace the participant observation where the researcher uses the observation of his/her trusted source who has access to the real-life situation. The observation note was shared through telephone interviews or video conference calls. Our research assistants were trained to find one or more “key observers” from a particular locality whom they virtually contacted on a number of occasions, and based on that they produced ethnographic reports.

Literature Synthesis: A synthesis of the available literature on stigma and fear during epidemics was reviewed and synthesized. This gave us a comparative understanding of the factors that played a role in generating fear and stigma in previous global epidemics and helped us refine our recommendations for Bangladesh.

Ethical Clearance

This study concept and its data collection instruments obtained a clearance from the ULAB Ethical Review Committee (ULAB-ERC) on April 20, 2020 (Reference no. ERC 2020S-003)

Conceptual framework

In this study we have used two famous frameworks of fear and stigma respectively developed by Zygmunt Bauman and Erving Goffman in their monumental works (Bauman 2006 & Goffman 1963). While discussing the nature of modern fear, Bauman (2006) divides it into three categories: primary fear, secondary fear and liquid fear. Primary fears are those which humans and animals share together. Secondary fears derive from primary fear, this is why it has also been called as derivative fear. Derivative fear is a primary fear which has been “socially and culturally recycled” (Bauman 2006). But still it is in the realm of reason, pushing itself into the grey zone -- the zone of “liquid fear” -- which is “diffuse, dispersed and not very clear; when it floats elsewhere, without bonds, anchors, home or a clear cause” (Bauman 2006). Bauman (2006) classifies this derivative or liquid fear into three categories: (a) fears that threaten the person physically, (b) threaten the durability of social order, and (c) threaten the phenomenological person’s place in the world.

Needless to say, both fear and stigma can produce each other. That is why Goffman (1963) is still instrumental in understanding the basic tenets of social stigma. For him, stigma is an attribute, behaviour, or reputation which is socially discrediting in a particular way: it causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one. Goffman (1963) sees stigma as a process by which the reaction of others *spoils* normal identity. Goffman defines stigma as a special kind of gap between virtual social identity and actual social identity (Goffman 1963). More often, stigma is fed on existing power-relations between the stigmatizer and the stigmatized. The class in power gains authority over the “other” by means of, among others, its “stigma-power”.

As mentioned by many, stigma is a process of “othering” the Other. Goffman (1963) sees this process as a process of making a deviant or spoiled identity. For him, stigma occurs when an individual is identified as deviant, linked with negative stereotypes that engender prejudiced attitudes, which are acted upon in discriminatory behaviour. Goffman illuminated how stigmatized people manage their “spoiled identity” (meaning the stigma disqualifies the stigmatized individual from full social acceptance) before audiences of normals.

Narrative of fear and stigma in Bangladesh during Corona epidemic: a timeline analysis

After a careful content analysis of fear and stigma-related media reports, people's narratives and online behaviour, we attempted to develop a framework to understand the sources and pathways of fear and stigma in Bangladesh using the conceptual tools discussed in the earlier section. But before approaching that, it would be wise for us to remind our readers about certain narratives that would support the framework we are proposing.

Phase of false safety: During the period of January to February 2020 while news of the Corona outbreak was traveling from China to Europe, the prevailing narrative in Bangladesh symbolised 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. Moral judgement of diseases is historical. For example, Leprosy, HIV.AIDS- have been narrated as a consequence of moral decay. This is how we registered a moral-disowning to the possibility of having this disease here.

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. Ironically, this *de-potentializing* process of the disease was thus collaboratively undertaken by representatives of science and religion. 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. This is how these narratives offered a fertile ground for a sudden fear and stigma to play its role.

While the first instance could be considered as the "othering of the other", the next incidence was rather "the othering of the self". It started with migrant returnees who rushed back from Europe, Italy in particular. The Corona narrative was no longer a remote possibility in Bangladesh by that time. Rather, these people were immediately perceived as potential carriers of this virus. Measures were taken for screening them in the airport and keeping them in quarantine zones. But these people avoided and escaped the makeshift and almost unliveable quarantine camps and gradually disappeared in the mass, leaving a faint line of liquid fear behind.

Formalizing stigma: On 15 March, 142 migrants returned from Italy, who were also taken to the Ashkona Hajj camp, the makeshift quarantine zone. After they complained about the unsanitary conditions there, 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. However, reports emerged that the returnee migrants

hardly followed any self-isolation directives. Necessarily, fear and anger were generated within the community against these migrants. At this point, local government authorities put red flags in the migrant returnees' houses. This was the official endorsement of othering the migrant returnees as deviants which in other words was the beginning of formal stigmatization of a particular group of people.



Flagging a migrant's house

Source: <https://bit.ly/3c74PBI> (accessed on 5th May 2020)



The seal of quarantine

Source: <http://rottenviews.com/?p=1087> (accessed on 5th May 2020)

Community gaining “stigma power”: As Goffman (1963) argues, a formalized stigma would invariably invite a social space for the community to informally exercise the ‘stigma power’ (Goffman 1963). On 17 March 2020, with the country having 8 confirmed cases, the government closed all schools, for the remainder of March. The fear in the community raised. Incidences of attacking migrant returnees took place. Migrants were prohibited to enter local shops. It worked with the cultural framework of □□□□ □□□ □□ □□□□□□□ □□□ (□□□□□□□□□□□□□□□□).



The stigma in operation

Source: <https://www.youtube.com/watch?v=fVeD1qxuroE> (accessed on 5th May 2020)

Many of our respondents from rural/semi-rural areas confirmed transfer for “stigma power” into the hands of the micro-community. This has also been viewed in a way to escape “social distancing”, because if the community can prevent outsiders, they can lead their “normal” lives. This thought led them to become more watchful and aggressive about receiving outsiders into the community.



A funeral procession in Brahmanbaria

Source: <https://bit.ly/2W3P0px> (last accessed 5th May 2020)

Awareness of proximity of the disease: On 18 March, Bangladesh reported its first coronavirus death. The patient was aged over 70 and had other morbidities. By the end of March, Bangladesh had reported 51 confirmed cases and five deaths. It started to become clear to the people that Corona is no longer a distant probability, rather at their door-steps. 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.

These events generated a considerable amount of fear among the educated mass, as our interview data suggests. This fear worked in a curiously twisted manner: the educated people become fearful to see how the universal imperative of “social distancing” during this epidemic has been rejected by thousands of people who are either unconcerned, or unafraid, or fatalistic. But in any way, they can surely become the silent agent of Coronavirus in the society, the space which has been shared by both of the classes.

Community transmission and the *liquefaction of fear*: On March 21, the second coronavirus death in Bangladesh was announced. The death of this 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 neighbourhood of Mirpur, Dhaka. With such narratives of untraceable sources of infection, the fear of corona started to be “liquefied” (Bauman 2006). Along with, several paradoxes made it even more difficult to rationalize the fear, such as, the collapse of the health infrastructure of developed countries, the evolving nature of the virus, shutting down of age-old socio-cultural practices in different countries, and so on. Corona became truly a deviant disease. This is a disease that has no cure, no prevention and a disease which, even the high-income countries cannot tackle. The information-hungry media took no time to spread all these global confusions and contradictions among the mass, often not considering the potential impact of an information. However, this deviance generated a deep sense of uncertainty.

The semiological disaster: On 23 March, when Bangladesh had 33 confirmed cases, the government declared a ten-day “chuti”(nationwide holiday) for the period 26 March–4 April, ordering all public and private offices to be closed, with the exception for emergency services. People have been asked to practice social distancing and stay at home. Public transport would be limited and advice was given to avoid them. 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. However, after such a “semiological disaster”, Dhaka was made disconnected from the rest of the country. At this point ‘Dhaka’ also became a source of fear. The government deployed the armed forces, including police and army, to ensure that people maintain social distancing and quarantine to prevent the spread of the deadly COVID-19. On 4 April many RMG workers came back to the capital under the assumption that they would return to work on 5 April, only to find out that the closure would continue until 12 April. This chaotic atmosphere fuelled the fear further. The threat to livelihood developed another layer of fear, which is more intense than the fear of death, particularly for the poor.

Phase of mistrust: On 5 April, Bangladesh reported 18 new cases, representing a 26% increase on the previous day. From then till the present day, the day-on-day increases have exceeded 20%, representing a steep rise in cases. Bangladesh crossed the figure of 100 confirmed cases on 6 April and 1,000 confirmed cases on 14 April. Bangladesh has extended a nationwide lockdown till May 5 as part of measures to stem the spread of coronavirus pandemic. Meanwhile people were further confused with excessive and conflicting information (info-demic). Reports of mismanagement of cases in the dedicated corona hospital at Kurmitola, lack of PPE for the health providers, the closing of private hospitals, all of these generated an atmosphere of deep mistrust on the health system in the country.



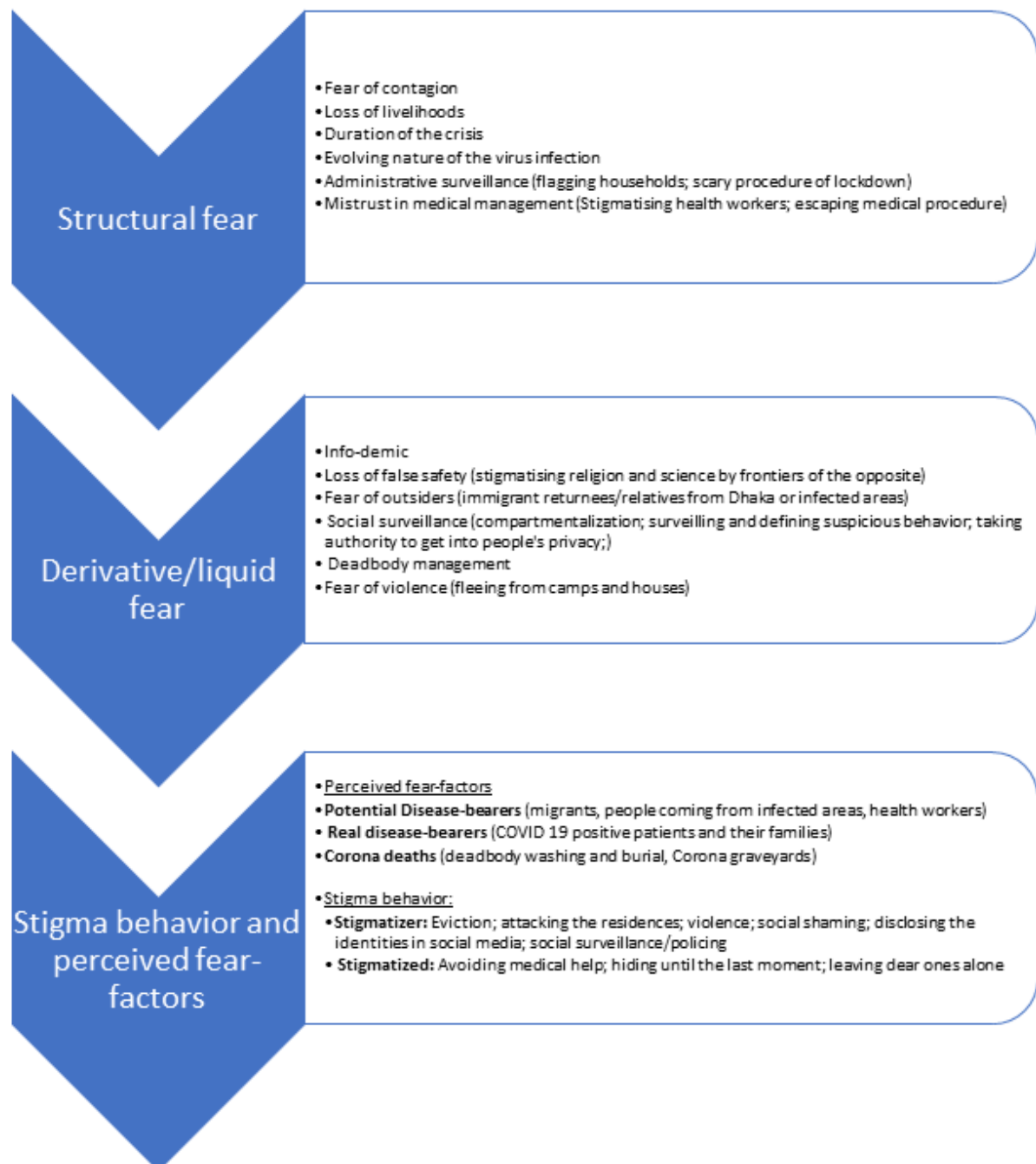
A health worker deserted in her own village

Source: <https://www.youtube.com/watch?v=9n2UDE3PG5w> (accessed on 5th May 2020)

Class-based fear and panic: From the second week of April several horrific fear and stigma related incidences started to emerge. For example, 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. As if Corona patients are personifications of the unknown fear, who needs to be punished. Anyone outside the neighborhood -- *para, moholla, elaka* -- is subject to suspicion. Individual's mobility and actions are now under strict public scrutiny. Meanwhile, an inevitable structural fear towered up: the fear of hunger. People depending on the informal economy immediately lose their livelihoods and economists witness an emerging class of "new poor" who previously lived on the margins of the middle class. The fear of losing class became prevalent in this population group. However, this is also perceived by relatively affluent classes who could fearfully forecast an outburst of violence from people in need. 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:



Source: author's creation

Stigma power, new “subjects” and internalizing stigma

Although most of the stigma is functional with different categories of fear and vice-versa, these are reported to be reinforced in the local context, depending on the socio-cultural standing of the stigmatized. Goffman (1963) terms it as “stigma power” and it gives the mass a moral license over the stigmatized bodies. This is also being perceived *a priori* by the stigmatized “subjects”, which causes them to hide the illness, avoiding the diagnosis and treatment, as so on. In the local context, we found cases where certain people are stigmatized and offended, while others are not, for the same reason. People coming from the Middle East are forced to join the quarantine, while a few people coming from the Western countries are able to avoid this. Hence, we see the existing class and power structure is very much in operation in the stigmatization process.

Stigma power has another very alarming indication: it has enabled a scary type of compartmentalization in different areas. Mob surveillance has been reported by many of our respondents from outside of Dhaka. This is a small body of people from the neighbourhood who remain active and concerned about potential outsiders, disease-bearers and infected households, not with a mood of cooperation of course. They keep surveilling even to the drug stores, wondering if someone buys medicines for fever or cough, then follow them to their destinations. If any outsider or infected person/family is detected in this process, they force them for an immediate eviction from the neighbourhood. They reveal their identities to the other members of the neighbourhood who then together attack the household. This is how they claim the authority of practicing stigma power over the others.

Historically, often the subjects of stigma power have a class and vulnerability connotation in the context of an outbreak: either they are the disease-bearers or people from the lower classes (in most cases they are the same). It has a gender pattern too: the women get mostly stigmatized and violated. The stigma about Coronavirus epidemic in Bangladesh is no exception, but it has included in its basket a few other categories, such as health workers, as the new subjects of stigma. Both from our netnography and interviews, we have learned how medical doctors, nurses, ward boys are being stigmatized by their neighbours, and often being forced to leave rented houses or areas they live in. A recent case in Narayanganj shows how a family of a doctor who got infected along with their family members was about to be evicted by their neighbours, until the local administrators interfered and saved them. Another doctor, who worked in a hospital of Brahmanbaria, was evicted from her leased house after she got the virus. She then went to Mymensingh where her family resided, but again faced another fierce resistance by people around her family residence as soon as she reached there. Nurses, ward boys and other health workers have the similar experience, and they are often pursued from within the family to leave the job, not because they can bring the virus and infect them,

rather for the fear that any incidence of infection would cause them the eviction from their households.

In response to the possibility of being subjected to the stigma-power, we notice people internalizing the stigma as a precautionary measure. This is how we can explain the incidence of a family who deserted their sick mother in a jungle of Tangail Sakhipur, or the family who fled while leaving their disabled and corona-infected father at home. Burial of dead bodies of close relatives are not attended, and in some cases, we found Muslim volunteers undertaking the cremation process of a deceased Hindu patient, as his family was not willing to take part. Many individuals, some are renowned as well, are forced to hide their infections and keep themselves confined at home. This keeps stigma a longer shelf-life, enough to remain alive and reinforced.

Conclusion

*“Fear has many eyes,
and can sees things underground”*

- Miguel de Cervantes, *Don Quixote*

As this study revealed, the nature of fear shows an extraordinary mobility between structural and cultural patterns, and a cultural fear is relatively very difficult to be sourced and addressed, particularly in the time of an epidemic. During this time of uncertainty and unpredictable deaths, people have enough reasons for not sharing thoughts, anxieties and infections. Along with, the existing power structure in society is still in operation, and has been translated in different ways. People experience a loss in transparency and accountability, which leads them to mistrust information and believe in rumours. Of course, fear cannot be abolished as long as the virus persists, but the state can effectively address derivative fears within people, by being transparent, kind and positive.

The act of stigmatization is most often an act of violence. The “stigma power” has already been enacting acts of violence in different places of Bangladesh. The more the incidences of infections and death will happen, the more stigma-induced violence we would witness. While the pandemic is given utmost medical attention, the stigma will be left untreated and cause enough ground for people to avoid diagnosis, treatment and cooperation from relatives and neighbours. Instead, this provides the mob a moral license to practice violence over people who require help and cooperation. At the same time, health service providers will be grossly discouraged to provide service, as this would cause them social distress. Burial of bodies would be disrupted, as family members are not participating, and not in all places burial-volunteers are available. Taken together, this would make the overall management of the epidemic more difficult and complex.

Recommended Interventions

Authors have argued that 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.

Studies have shown that during serious disease outbreaks, when the general public requires immediate information, a subgroup of the population that is at potentially greater risk of experiencing fear, stigmatization, and discrimination will also need special attention (Person, B *et al* 2004). Numbers of authors have suggested multi-level interventions to mitigate stigma and fear (Pascosolido, M *et al* 2008, Campbell 2005). Following best practice interventions to address fear and stigma, we recommend the following culturally informed and socially relevant intervention in three different levels, namely, macro, meso and micro:

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 neighbours 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

Learning from BRAC's experience during Ebola in Liberia:

BRAC International, Bangladesh based largest global NGO played a crucial role in tackling the Ebola outbreak during 2014-15. BRAC team particularly took a number of interventions to mitigate Ebola related fear and stigma. They have taken following specific steps in this regard:

- Adaptation of WHO psycho-social first-aid tool-kit and train the GO and NGO workers
- Massive campaign on Ebola prevention using pictorial leaflets and posters
- Welcome ceremony for Ebola survivors
- Community theatre on Ebola prevention
- CCC – Community Care Centre (Quarantine centre for suspected cases)

The transferability of BRAC's experience with Ebola could be considered for adaptation during the current Corona crisis.

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