"They Won't Even Touch the Money We Touched": Stigma, Shame and COVID-19

I. Background

Pandemics are frightening and highly disruptive events that not only cause an insurmountable number of deaths but destroy social systems and fabric that bind communities. From global fear, there are local consequences. A certain level of fear can be useful especially for policymakers to bring about desired behavioral changes to control the outbreak. But fear is also the basis of untrusting and stigmatizing behaviors that have a negative impact on individuals and society.

This research study therefore aims to explore how the national discourse around COVID-19 has given rise to stigmatizing behaviors in Bangladesh. This study looked into where stigmatizing behaviors emerged and how the behaviors transpired in everyday life, especially against those who were either perceived to be or were COVID-19 positive.

II. Key Findings

The narratives and rhetoric around COVID-19 have largely been shaped by the media. Such narratives play a significant role in shaping people's knowledge and perceptions about COVID-19, including tacit beliefs on who may be the "carriers" of this disease. The research was done in a fast-paced manner, including a rapid online survey, content analysis of news articles, and in-depth interviews.

Content analysis was carried out on newspaper articles of seven significant moments in Bangladesh's COVID-19 management decisions and events directly related to fear, shame and stigma. The analysis showed that the intersecting themes of fear, isolation, abandonment and untouchability, transmission and infection, urban areas, low-income groups, and the foreign nature of the virus have collectively given rise to stigmatizing perceptions of the "diseased body" in the media. The online survey results pointed towards an overwhelming bias against men, in terms of being a carrier of COVID-19, as well as strong biases against foreign visitors/returnees and residents of urban areas which are viewed as places where the disease is concentrated. Both the news content analysis and survey results showed that the novel coronavirus is largely viewed as a disease that is "foreign", brought into the country by migrant returnees and spread by low-income communities, such as RMG workers, via urban-to-rural or rural-to-urban travel or migration. Case studies demonstrated that stigma and fear are not only affecting people's access to health services but also access to daily essentials such as food.

III. Conclusion

The current infodemic unfortunately seems to have created multiple misconceptions regarding the possible carriers and sources of COVID-19. At the root of the problem is the fear of the unknown. People seem to have limited knowledge about the virus -- how it actually functions from a scientific point of view -- allowing for assumptions and therefore stigmatizing perceptions to seep in. The various forms of stigma and discrimination have severe and tangible implications for access to health care and health rights, such as refusal to medical treatments and care. Along with laypeople, the medical community also has a strong sense of stigma which requires debunking to build a more effective and responsive medical system during the lockdown. There is a need for much more effective Bengali messaging based on scientific facts of COVID-19 at various levels to debunk myths and rumors. Such messages should be widely disseminated through easy-to-understand video campaigns, infographics and articles in

easy-to-understand video campaigns, infographics and articles in English and Bangla news websites, infomercials for TV channels, and social media platforms. The messaging should also include the importance of empathy towards suspected and confirmed COVID-19 positive patients and their families and the drastic effects of stigmatizing perceptions on the community as a whole.

RESEARCH REPORT

I. Background

Social behaviors and beliefs such as stigma affect the ways in which people understand sickness for themselves and others, behave with others, and therefore access healthcare services. The novel coronavirus (COVID-19) has brought waves of fear, panic, anxiety globally – Bangladesh is no exception.

Numerous incidents pertaining to COVID-19 related xenophobic abuse have been reported across the globe. Even countries celebrated for their liberal attitudes and civil liberties have seen a spike in anti-Asian racism. In the United States for example, hate crimes against the Chinese and Asian Americans have increased as a result of the COVID-19 outbreak, according to the FBI.[1] Much of this fear, anxiety and panic comes from the view that Wuhan, China is the ground zero of the novel coronavirus. At the initial stages of the outbreak, images and videos circulated all over social media on the trading and consumption of exotic animals and the unsanitary practices of the Chinese wet market that led to animal-to-animal-to-human virus contraction and spread. In two months of the initial reported case, the virus had spread to the far corners of the world due to international travelling, resulting in global lockdowns and imagery of the virus being a foreign disease.

The global narrative has thus largely centered on the foreign nature of the virus. The "foreignness" prompted fear worldwide which led many countries to close their borders even against their own nationals. While on the one hand restricting travel and movement may have stemmed community transmission and helped flatten the curve in many places, the dominant rhetoric about the virus infiltrating national borders from a foreign place has led to fear and backlash against those who look like an "outsider", leading to widespread discrimination against people based on race, class, ethnicity and places of origins/travels.

In the context of Bangladesh, the narratives revolving around COVID-19, especially in the early stages (March 2020), were not too dissimilar. The "foreignness" of the virus was both directly and indirectly highlighted repeatedly. The print and online media heavily focused on migrant returnees from coronavirus-affected countries such as Italy (and later the Gulf states).[2] This marked a false sense of a "start period" of the virus when regular travel continued till 25th March 2020 from all over the world and into Bangladesh.[3]

The focus then shifted to the movement of garment workers in early April, when they returned to Dhaka from rural areas.[4] Fear and anxiety were also evidently prevalent among frontline health workers, which largely stemmed from the lack of personal protective equipment (PPE).[5] In shaping people's perceptions and attitudes, these multiple narratives had the unintended consequence of fomenting fear, stigma and discrimination against certain sub-groups of the population who are either infected with COVID-19 or seem as the "possible carriers" of the disease.

It was therefore imperative to systematically record and analyze the emotions that led to stigmatizing behaviors and the experiences of those at the receiving end of it, as part of understanding national response to the crisis of a pandemic. These social behaviors directly influenced ongoing health and economic initiatives to control the pandemic. Furthermore, such behaviors can sometimes take on a deadly, violent nature, fuelled by mob mentality, resulting in physical harm or even death of members of the stigmatized group(s).

Limitations:

This research undertaking is a rapid study conducted in less than three weeks. The findings of this study are very context-specific, and not to be generalized to the population at large. The primary purpose of this study is to shed light on the extent of stigma, fear and discrimination revolving around COVID-19 in Bangladesh, and create awareness and sensitize communities about these issues.

This research study was conducted from April 19, 2020 to May 6, 2020. Data collection was carried out through (i) online rapid surveys in Bangla and English (April 22 - May 6, 2020); (ii) content analysis of 50 news articles in Bangla and English; and (iii) detailed case studies of experiences of COVID-19 positive patients in government cordoned off residences.

The sample size of the online surveys, as of May 6, stands at 173. Respondents for the surveys were selected using a combination of the purposive and snowball sampling methods. With regard to news content analysis, Bangla and English news articles were purposively selected across seven categories: (i) migrant returnees; (ii) concerns about health professionals' safety put forward by FDSR; (iii) announcement of lockdown; (iv) return of garment workers to Dhaka; (v) residences of COVID-19 positive patients being cordoned off; (vi) abandonment of people by family members; and (vii) suspected and confirmed COVID-19 patients fleeing. These categories were selected based on what the researchers thought were pivotal moments that largely shaped the dominant narratives related to shame and stigma surrounding COVID-19 in Bangladesh. The news articles were coded on the software Atlas.ti using a priori coding mechanism and the outputs subsequently underwent deductive thematic analysis. Seven in-depth interviews were carried out to develop case studies to highlight the day-to-day stories of people either living with COVID 19 or fearing the disease.

[1] Liu, E. (2020, April 11). Covid-19 has inflamed racism against Asian-Americans. Here's how to fight back. CNN. Retrieved from https://edition.cnn.com/2020/04/10/opinions/how-to-fight-bias-against-asian-americans-covid-19-liu/index.html

[2] Italy returnee tests positive for coronavirus. (2020, March 18). The Daily Star. Retrieved from https://www.thedailystar.net/city/italy-returnee-bangladeshi-tests-coronavirus-positive-1882453

[3]https://www.aa.com.tr/en/asia-pacific/bangladesh-imposes-total-lockdown-over-covid-19/1778272

[4] RMG workers returning to Dhaka amid virus fear. (2020, April 4). Financial Express. Retrieved from https://thefinancialexpress.com.bd/national/rmg-workers-returning-dhaka-to-save-jobs-amid-virus-fear-1586003905

[5] Tithila, K. K. (2020, March 20). Coronavirus: Inadequate protective gear leaves Bangladesh health workers at high risk. Dhaka Tribune. Retrieved from https://www.dhakatribune.com/bangladesh/2020/03/20/covid-19-inadequate-protective-gears-leave-health-workers-at-high-risk

III. Key Findings

A. Media's Role in Shaping Fear and Stigma

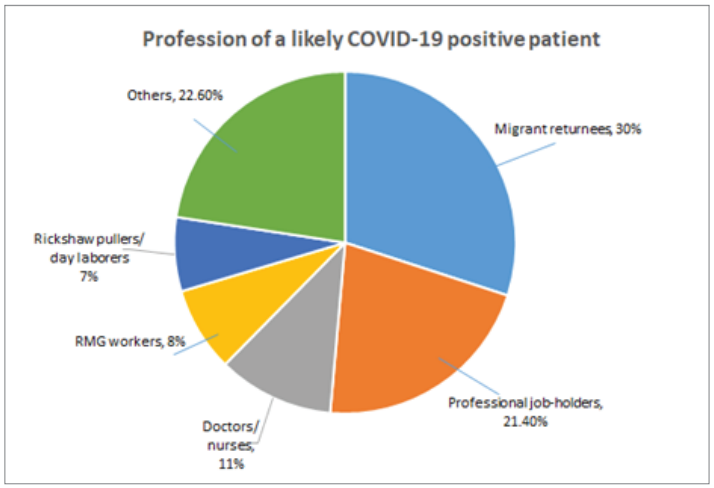
Content analysis of 50 Bangla and English news articles across the seven selected categories found recurring themes of fear, isolation (both self- and externally imposed), lockdown, low-income groups, foreignness of the virus, untouchability and abandonment, images of the "diseased body", urban areas, data representation (both global and national statistics of confirmed patients and deaths), and intense, descriptive language.

Many of these themes overlap and reinforce one another. A number of news articles we analyzed contain the use of the word "fear" itself or similar words to describe the feelings of passers-by who refused to come to the help of a sick, elderly man who was abandoned in a char land by his family. In another news article about the abandoned dead body of an elderly woman in the street, locals were "scared" to touch her. Similarly, the word "fear" was used to describe the anxieties of health workers who felt that their risk of contracting the virus is increasing as they do not have adequate PPE. Thus an atmosphere of fear had already taken hold across socioeconomic classes regarding the virus and its transmission.

Only urban residents took part in the Bengali and English online surveys which was also indicative of access to information/internet and level of education. Respondents in our online survey were given the option to indicate their level of anxiety and fear when they go outside, on two separate five-point Likert scales (1 being "not scared" and "not anxious", and 5 being "extremely scared" and "extremely anxious"). Most respondents (33.5%) reported their level of anxiety at 5 and their level of fear (28.3%) at 4.

A class bias against low-income groups was also prevalent. Much of the hysteria surrounding the spread of COVID-19 in Bangladesh revolved around the return of laborer migrant returnees and RMG workers whose representative photos were used along with the articles, helping to create the image of a "diseased body". In the case of migrant returnees, an overwhelming majority of the photos used are of men, while in the case of RMG workers, photos used represented both men and women. Furthermore, although some news articles mentioned the residences of COVID-19 positive patients (e.g. Mirpur, Old Dhaka), in the case of slums the data about the number of families (300-350) who live there was presented, pointing to the crowded spaces slum-dwellers live in, i.e. higher risk of transmission.

Figure 1



As the online surveys demonstrated, 30% of the respondents believe that the virus was brought by returning migrant workers. Almost half (48%) imagine COVID-19 positive patients to belong to low-income groups.

Urban areas were repeatedly insinuated as places where the disease could spread. Phrases such as "RMG workers returning to Dhaka" and "experts fear growing risk of coronavirus in the capital", along with the fact that many residences with COVID-19 patients that have been visibly cordoned off are in Dhaka city, created the perception of associating urban areas with COVID-19.

In terms of intensity of language, we found the overuse of fear-triggering terms such as "COVID-19 scare", "deadly", "fast-spreading" to be repeatedly applied in the English newspapers. In Bengali, the term for pandemic itself -- mohamari -- is quite dramatic as it literally means that which destroys/kills on a mass scale. Also, the reporting in Bengali often explained the perceived COVID-19 positive patients to have the disease inside of their bodies, resonating with the notion of a "diseased body" and therefore the threat of it. Content analysis of the newspapers also found sensationalization, to an extent, of events such as cordoning off of buildings where COVID-19 positive patients were found. Personal stories and interactions on various messaging platforms also showed the high level of rumor and gossiping that went on around these marked houses and families who were initially found to be COVID-19 positive.

The intersecting themes of fear, isolation, abandonment and untouchability, transmission and infection, urban areas, low-income groups, and the foreign nature of the virus have collectively given rise to stigmatizing perceptions of the "diseased body", i.e. migrant workers, garment workers, elderly and middle-aged men. This, along with the near-absence of scientific and evidence-based information in the media about how the virus works, has created a space for misinformation and misconceptions to thrive. Many suspected or confirmed COVID-19 patients also harbor self-stigmatizing perceptions, leading them to hide their symptoms or flee hospitals or institutionalized quarantine.

B. Perception bias against men and urban areas

In our news content analysis, we found an overrepresentation of men and urban areas. These findings were reflected in our online survey results as well. Findings showed that 32.4% subconsciously imagined an elderly man (age 65+) as a COVID-19 positive patient, 31.8% pictured a middle-aged man (age 45-65), and 27.7% believed it to be an adult man (age 20-44). There exists an overwhelming bias against men in terms of being a carrier of the disease.

Figure 2

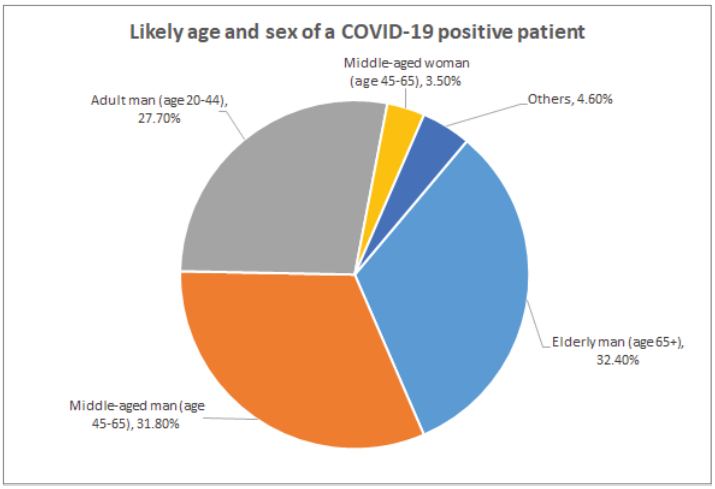


Figure 3: Likely residence of positive COVID-19 patient (English online survey results)

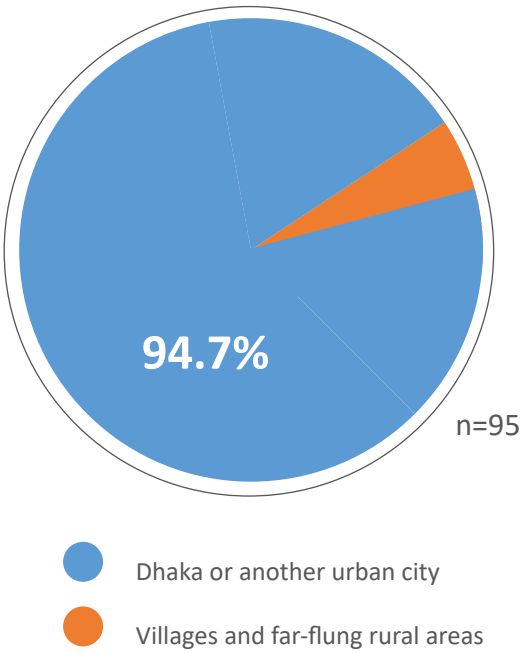
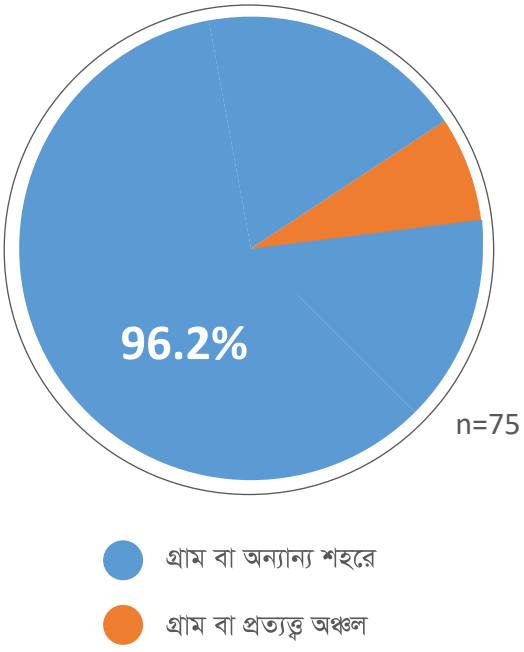


Figure 4: Likely residence of positive COVID-19 patient (Bangla online survey results)



95% (as per combined findings of English and Bangla surveys) imagined that the highest concentration of the virus is in urban areas, mainly Dhaka.

C. Increased household burden on women

Case studies shed light on the disproportionate burden of work on women in households. There exists an indirect form of social shaming against women because with the lockdown, white-collar-position-holding women feel the compulsion to take care of the household while working from home. Traditional gender roles have set into the urban households whereby women internalize certain expectations such as cooking, cleaning, care-giving, children's education, etc. It must also be pointed out that the burden of work and the gendered experience of social stigma and shame during the time of pandemic is deeply class-based, whereby low-income women such as garments workers were heavily scrutinized as one of the "diseased bodies" that would infect and spread the virus in urban areas. These women also had no other option but to go back to work due to sectoral mismanagement of wages and factory reopening policies.

D. Knowledge about COVID-19

In both the English and Bangla surveys, the majority of responses described infectious diseases as diseases that are "contagious" or diseases that "spread from person to person". A number of respondents described it as diseases that are caused by microbes, bacteria, virus or fungi. In many instances, it was obvious that the respondents had copy-pasted the WHO definition. This indicates that respondents are not always clear on what the term "infectious disease" means.

This particular insight is also in alignment with the ways in which COVID 19 reporting was done in the English and Bengali newspapers. While there was an infodemic, there was little to no explanatory information especially in the Bengali dailies. There was and still remains a stark information gap in the Bengali news outlets in explaining exactly what is an infectious disease, why a lockdown was imposed, what is community transmission, and how to minimize spread and threat of the virus. In addition, case studies demonstrated that doctors themselves are not entirely certain of the science, symptoms, and therefore treatment plan for COVID-19, resulting in fear, misbehavior with patients, and denial of care.

A more appropriate term for diseases that spread via human-to-human transmission is "communicable" or "contagious diseases" rather than "infectious diseases". While a large number of infectious diseases are in fact contagious, there are infectious diseases that are not "contagious" or "communicable" via human-to-human transmission such as tetanus and malaria. It is important to understand these subtle distinctions between "infectious" and "contagious"/"communicable" diseases.

When asked where the respondents were receiving their COVID-19 related information from, most of them stated online English news portals and Facebook, followed by international research-based and public health websites such as WHO, worldometers, and Johns Hopkins Coronavirus Resource Center, and TV. Bengali survey responses were similar to those of the English responses. For both sets of respondents, social media was the most critical source of information.

Table 1: COVID-19 news sources

Online English news websites	65.3%
Facebook	65.3%
Int'l public health and research-based websites	64.7%
TV	60.1%
Online Bangla news websites	53.2%

Along with online English news portals, Facebook is a top news source for most of our respondents. Given the paramount of unvetted information that is readily available on Facebook, this response is quite revealing as it indicates that there is a high possibility that people are being influenced by unvetted information regarding COVID-19. This is also in alignment with some of the online content tracing that was done during the research period whereby religious leaders were seen to post videos on false and unscientific aspects of the virus. For instance, 19.7% of online survey respondents stated that they believed the virus to be the result of human sins and God's wrath, further illustrating the gaps in lay-termed information on the science of pandemics and viruses.

There were other interesting responses related to respondents' knowledge around COVID-19 where 23.7% believe that environmental reasons are to be blamed for the emergence of COVID-19, while 12.1% believe it might also have something to do with pollution.

E. Case Studies

A critical finding of this study is the ways in which social stigma surrounding COVID-19 is restricting access to health care for many. There is a palpable sense of fear among doctors and other frontline health workers about patients coming in and hiding their symptoms. Since there is no way of testing, and no way of knowing who is positive and who is not, doctors are refusing to provide medical services in many parts of the country. Stigma and fear are not only affecting people's access to health services but also access to daily essentials such as food, as the case studies below show:

Doctor's Well-Being Before Anyone Else's

A woman in Moulvibazar town area, pregnant with a pair of twins, was to deliver with a planned C-section in the first week of May 2020. Her regular Ob/Gyn decided at the last minute that she would not perform the scheduled C-section out of fear of COVID-19. The expecting mother had no COVID-19 related symptoms and this was her scheduled operation. Yet her doctor did not want to take the risk.

After requesting various different people, also given the limited number of trained Ob/Gyn outside of Dhaka, one trained doctor agreed to perform the C-section. Mother and children are both fine but the family was left with severe tension and uncertainty at a time when three lives were at stake.

"They Won't Even Touch the Money We Touched"

Dr. Kaniz and her family are residents of Old Dhaka. She is a trained doctor who also has a diagnostic center in the neighborhood where she grew up. Both her parents and in-laws are Old Dhaka natives, with most family members living there. A few weeks ago, Dr. Kaniz's father-in-law died of symptoms similar to those of COVID-19. Being aware of the symptoms, she pushed IEDCR to test the remaining family members. Both her and her mother-in-law tested positive. The mother-in-law had mild symptoms, while Kaniz, in her early 30s, had serious flu-like symptoms. With two young children, Kaniz was determined to not only get better but to help everyone in her neighborhood to boost their immune system and fight the virus should someone test positive.

A neighboring family of 14 members all tested positive. When someone from that household went to buy food from the local grocery, they were turned down, because people did not want to touch the money, in fear of contracting the virus. Kaniz's father offered to buy food/grocery for the family and drop it off so that they could go on for at least some time.

IV. Conclusion

News content analysis and online survey results both show the power of the media in terms of creating and shaping the narratives and perceptions of people regarding public health crises. An overwhelming amount of information is flooding both the print and digital spaces. The bombardment of the "infodemic" unfortunately seems to have created multiple misconceptions regarding the possible carriers and sources of COVID-19. The novel coronavirus is largely viewed as a disease that is "foreign" which has been brought into the country by migrant returnees and is now being spread by people, such as RMG workers, via urban-to-rural or rural-to-urban travel or migration. At the root of the problem is the fear of the unknown.

Both medical staff as well as laypeople seem to have limited knowledge about how the virus actually functions from a scientific point of view, which makes it easy for stigmatizing perceptions to seep in. There is little to no scientific, evidence-based information regarding the virus in TV, print and digital media. Moreover, while global English news and information sites have developed a wide range of explanatory videos and communication materials, till date, no such communication materials exist in Bengali. There is a need for much more effective messaging based on scientific facts of COVID-19. Such messages should be widely disseminated through easy-to-understand video campaigns, infographics and news articles in English and Bengali news websites, TV channels, and social media platforms. The messaging should also include the importance of empathy towards suspected and confirmed COVID-19 positive patients and their families and the drastic effects of stigmatizing perceptions on the community as a whole.

Researchers:

Shahana Siddiqui
Adjunct Faculty
BRAC James P. Grant School of Public Health,
BRAC University, and
PhD Candidate in Medical Anthropology,
University of Amsterdam

Nahela Nowshin
Research Associate
BRAC James P. Grant School of Public Health,
BRAC University

For further information,
please contact shahana.siddiqui@bracu.ac.bd
or nahela.nowshin@bracu.ac.bd.