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SPECIAL ARTICLE

Addressing the COVID-19 related stigma and discrimination: a fight against "infodemic" in Bangladesh

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ABSTRACT

The COVID-19 pandemic is evolving rapidly as an overwhelming burden on human health and health systems of many countries includes low resource settings like Bangladesh. The country is facing crisis and several challenges to manage confirmed and symptomatic cases with limited administrative and logistic support, inadequate governance and widespread panic and stigma throughout the country. As the number of persons with COVID-19 and death are increasing there is a potential of heightened mass panic, stress and discrimination in coming days which can be predicted from recent protests in different parts of the country, spread of rumors and falsehoods, non-scientific information, limitations in governance and growing discrimination towards certain group of population and professionals. As World Health Organization (WHO) speculated this trajectory of pandemic is uncertain, this emerging body of stigma and discrimination needs to be addressed by proper authorities, "infodemic" should be controlled by legal steps and mass awareness campaigns should be launched without further delays.

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The coronavirus disease 2019 (COVID-19) pandemic is evolving rapidly as an overwhelming burden on human health includes physical, mental and psychosocial health, health systems, and authorities responsible to respond with effective and appropriate interventions, rapid response policies, and health promotion messages.[1] Perceived lack of consistency, adequate competencies, fairness, objectivity, empathy and sincerity in crisis response are proven indicators leading to distrust and fear in the public.[2] On the contrary, when public easily understand the risk and response initiatives in crisis communicated timely through trusted and accessible channels with availability of necessary services, people are apprehended with suggested health, hygiene or social practices includes making informed choices, protecting themselves by approaches like physical distancing.[3, 4] At the same time misinformation and over information, stigmatization and herd behavior (such as hoarding of food or toilet paper) should be monitored to help estimate their prevalence in the concerned community and to identify potential sources. Trusted national authorities and other stakeholders, such as authentic media, government representatives should access to valuable insights into information need, contextualization of certain phenom-

ena (*e.g.* stigmatization and discrimination), and which target groups need additional attention[1] includes children, youth, marginalized and vulnerable population.

Bangladesh, a limited-resource and densely-populated country in South-East Asia, officially declared its first identified COVID-19 case on March 8th 2020 which stands at 145,483 confirmed patients (71% male and 29% female), 1847 deaths (77% male and 23% female) and 59,624 recovered from corona until June 30th 2020.[5] With the increasing morbidity and mortality of COVID-19, the country is facing crisis and several critical challenges to manage confirmed and symptomatic cases with limited administrative and logistic support, weak governance and widespread panic and stigma throughout the country. Four sets of people are discriminated somehow similar to the neighboring country India[6] as stated by a renowned Indian public health expert (Table I).

Consequently, on March 28th, the construction site of a proposed temporary hospital in Tejgaon which was supposed to be a center for treating COVID-19 patients was destroyed by locals. Interestingly, a couple of weeks back, the similar news of an interim hospital construction in Wuhan and transforming of an auditorium to COVID hospital in London were appreciated by all, but when something similar was supposed to happen in Dhaka, the locals perceived it differently and acted violently. A recent newspaper article argued that there was fear among the locals that the hospital could possibly spread infection to all. In Diyabari, Uttara, the locals did similar sort of protest and managed to stop a government plan to operate a quarantine center from there. An inhuman banner was seen on the entrance of a graveyard in Khilgaon, Dhaka stated by the locals that no COVID-19 positive or suspected case are welcomed to be buried there. They even requested the government authorities to take steps to implement the statement to ensure safety of the local population. If we look outside Dhaka, in Manikganj, Madaripur, Gazipur police faced protests during managing lockdown. In Bogra, police faced resistance from locals whilst burying a person with COVID-19 symptoms.[7] As the number of positive cases and deaths are increasing there is a potential chance to observe heightened mass panic, stress and discrimination in coming days.

One of the prime reasons behind stigma and discrimination about COVID-19 in Bangladesh is little knowledge on the novel virus. This is amalgamated by large amount of fake news and false information throughout the globe. The WHO has already labelled the spread of fake news on this outbreak as "infodemic" and speculated that manipulated and non-scientific information are spreading faster than the virus.[8] Based on these, people wrongly consider any flu symptoms as signs of COVID-19; it is mistakenly believed that the virus will kill every infected person, or that COVID-19 is an airborne disease, so if the virus stays in the throat for couple of days or 23 degrees or more, temperature will kill the virus so nothing will happen in hot, temperate countries. The existing perception about the disease, influenced by the widespread social media propaganda, fame seeking attitude, social media hits and unauthentic reports claiming that the state authorities do not have the capac-

TABLE I.—*Person and patters of stigma.*

Who is facing discrimination?	How are they being discriminated?
COVID-19 positive cases and families	Those in quarantine or isolation, whether they have tested positive or not. Many law enforcing agencies are invariably violating medical ethics codes by publishing their location details, marking doors of their homes with colored stickers and even social media stories are coming in of people being thrown out of their homes to streets after developing mild to moderate signs/symptoms.
Front-line health workers (*e.g.* doctors down to the nurses, medical technicians, hospital cleaners etc.)	HCWs are facing far wide stigma and discrimination. Many doctors are requested by their landlords to leave the home as soonest to minimize spreading of infection.
Police officers	Police are being perceived as contagious considering their nature of the job.
Traditionally vulnerable population	Those who traditionally face discrimination like domestic workers, garment workers, slum dwellers, public transport workers and in general pro-poor population are discriminated and stigmatized and receiving blaming for spreading disease.

ity for controlling a pandemic, generated a sense of powerlessness among the masses. The fear, not limited to possible physical consequences of an affected person or death of a loved one, it is also about uncertainty of surviving during the postcrisis time. The visible incoordination in leadership, inconsistent statements from the authorities, messed up preparedness strategies with overall shutdown of the country has contributed to this mass panic situation. It is fueled by the less known infection control techniques such as quarantine and isolation. Though these techniques are very effective to flatten the disease curve in Bangladesh no visible attempts were made to orient mass people with these terms. Some government strategies contributed to build this attitude. Primarily, health screening of inbound travelers was mandatory only if they were travelling from China. Moreover, many Chinese workers of government construction projects were sent on leave. Henceforth, people were fearful or suspicious of all people who looked Chinese regardless of their nationality or actual risk factors. Many conspiracy theories against China contributed to this behavior. Later, as the government started health check-ups of every inbound passenger, the stigma shifted to all travelers coming from abroad with special attention to Italy, Iran, France and USA returnees. At present, people do not want to meet or greet anyone who has come from abroad even after they have passed 14 days of quarantine. Recently, in many parts of the country, law-enforcement officials are marking houses of foreign returnees with red flags. Such actions caused stigma and marginalization at a large scale. Many symptomatic cases lied to health care professionals and hide their travel history potentially leading to risking of his community and lockdown of the area. The panic of contamination has raised so much that seasonal flu symptoms are perceived as COVID-19 and follow-up of regular cases, surgeries has become a challenge for physicians in government and private settings. Potential conflicts between public, doctors, front-line health workers, health administrators and journalists is emerging and will evolve as a severe crisis where limited resources (*e.g.* lack of PPE) are already aggravating frustration among physicians.

The WHO has indicated that the trajectory of the pandemic is uncertain and public information sharing with key messages is critical at this point. Mass denial of early symptoms leading to further heightened spread of infection may occur due to fear of being socially stigmatized and discriminated. The previous SARS outbreak revealed that, to contain panic, the spread of stigmatization must be lowered. Preventing stigma and discrimination require a full-throated public campaign by government with clear, completed, and authentic information in a country like Bangladesh. Involvement of popular political, sport, entertainment personnel in this process might work. However, this hysteric panic, mass racial and class discrimination and stigmatization cannot be eliminated through better communication of information only rather a detailed analysis of the pre-existing socioeconomic conditions, underpinning risk factors deserve further exploration to understand such panic and stigmatization. There may be limited way to prevent a COVID-19 pandemic fear in Bangladesh and similar low resource setting in this time of uncertainty, fear and stress whilst verified information from state specified authentic sources is the most effective strategy to fight against "infodemic."[9] Thus, social media monitoring and prompt legal steps are equally needed to fight against propaganda, falsehood and conspiracy theories. Now, the whole world is using the same symptom checklist and the same prevention strategies regardless of ethnicity, gender, age, or socioeconomic group. As Ahmad *et al.* expressed hope,[10] we are also optimistic that there is a chance to bring people of all cultures together and reduce prejudice and stigma considering the global nature of COVID-19 and transform the society with precise information, evidence based recommendation and practicing social solidarity.

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