COMMENTARY

Social Stigma as a Barrier to Covid-19 Responses to Community Well-Being in Bangladesh

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Abstract

This commentary looks at the social stigma as a barrier to Covid-19 responses to community well-being in Bangladesh. The Covid-19 in Bangladesh particular the way the people respond this has many dimensions to view from sociological perspective. The main objective of this commentary is to analysis how this response is related to social stigma. Gathering information from the recent literature, results showed that there are number of causes around such stigma that include misinformation, feeling of insecurity, fear of responsibility, administrative malfunction, and lack of trust on treatment. These causes of stigma have number of forms such as humor-prone stigma, residential stigma, organizational stigma, community-stigma, and apathetical stigma. Results also show that there are many effects of stigma such as health-risks, harassment, discrimination, life-insecurity, psychological disorder, loss of social capital and emotional capital, shattering family bond and social solidarity that work as barrier to community well-being. This commentary recommends to overcome the barriers through strengthening and decentralization of the COVID-19 medical facilities including testing, tracing, formal quarantining, and special treatment for coronavirus in coronavirus hospitals by allocating a large figure of the state budget and also by taking initiatives of public-private partnership for health management.

Keywords Bangladesh · Covid-19 · Social stigma · Social barrier · Community well-being

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Introduction

The COVID-19 pandemic is a newly global catastrophe that is beyond the scientific postulations of the epidemiological model, philosophical insights and sociological imaginations. This pandemic, a global health emergency and the greatest challenge that humankind has faced since the 2nd World War, emerged in Wuhan, Hubei province, China in December 2019, and was named by the World Health Organization as COVID-19 (Chakraborty and Maity 2020). The devastating outbreak defeated all of the historical calamities, mostly the natural disasters infringed in the scientific and technological era of the past century. Till date, COVID-19 cases have exceeded 8.1 million globally, with over 440,000 fatalities and more than 3.9 million recoveries, according to the latest tally from Johns Hopkins University ("Global Coronavirus" 2020).

In this devastating situation, billions of people are staying at home to minimize the transmission of the virus and adopting preventive measures like remote office activities, international travel bans, mandatory lockdowns, and social distancing in the form of formal and informal quarantine systems (Anwar et al., 2020). Bangladesh, a densely populated country in South Asia, officially declared its first identified COVID-19 case on 8th March 2020 and stands at 102292 confirmed patients, ranking 18th in the world with 1343 deaths and 40,164 recovered from COVID-19 until 18 June 2020 (IEDCR 2020). The rising ratio of the infection and deaths has been alarming since it would cause uncounted deaths and massacres in overpopulated Bangladesh. Bangladesh witnessed tremendous crises in combating COVID-19 due to inadequate logistic support, health facilities, health and treatment management, administrative initiatives and social dilemmas.

Moreover, there is a potential of heightened mass panic, stress and discrimination in the up-coming days which can be predicted from recent protests in different communities, the spread of rumors, falsehoods, non-scientific information, limitations in governance and growing discrimination towards certain groups of populations in Bangladesh (Hasan et al. 2020). This pandemic crisis is not only associated with the crisis of health but also with the crisis of maintaining social relations, productions, distributions, marketing, job functioning as well as multifaceted services. The obligatory lockdown, social distancing, and maintaining isolation created enormous impacts on social relation, communications and networking that affected the livelihoods of the majority of people, but its psychological and socio-psychological outcomes need to be analyzed.

The pressure of maintaining social distancing has been so strong that people have been forced to pass their time in a state of fear, anxiety, stress, and loneliness during physical contact, physical attachment, face to face communication and in activities of emergency. More importantly, providing care has become emotionally difficult for healthcare professionals as they often have complex and conflicting thoughts and feelings about balancing their roles as healthcare providers as well as parents, feeling professional responsibility but also fearing their association with coronavirus patients (Ramaci et al. 2020). This complicated situation has caused stigma towards these patients due to the virus's contagious nature.

COVID-19 Pandemic in Bangladesh

It was reported that an asymptomatic family member who travelled from the epidemic center of Wuhan was most likely responsible for a familial cluster of COVID-19

infections through human-to-human transmission via droplets as the main route of transmission within a susceptible population (Ciotti et al. 2019). Regarding the issue, an airways strike was established in order to inhibit the entrance of people from the infected countries. But the late decision created the situation to be out of control in Bangladesh and many other countries. On earlier March 2020, 142 Italy returnees were allowed to go home and were advised to maintain self-isolation. A compulsory 14-day quarantine period was not ensured under the governmental surveillance of formal the quarantine system (Hasan 2020) and this case was the elementary cause of the entrance of the COVID-19 pandemic in Bangladesh.

Since 7 March 2020, when Bangladesh announced its first confirmed cases of COVID-19, the number of infections in the country has grown significantly due to limited testing for coronavirus infections, that made it difficult to treat patients and to confirm isolations for which the fragile public health infrastructure was highly responsible (Ramachandran 2020). The inadequate testing facilities, late decision of airstrikes, a limited number of formal quarantines centers, scarcity of intensive care units, lower supply of testing kits, the administrative system of lower ratio detection and lack of special hospitals for coronavirus treatment are the prime reasons of spreading COVID-19 in Bangladesh. The lockdowns became weak, and social distancing rules were not followed because of rising outward movement for earning bread, soaring public gatherings in markets for purchasing and in mosques for praying, mostly in the month of fasting (*ramadan*). Those unstructured reasons caused administrative mismanagement, weak regulatory mechanisms and emotional social relationships.

Apart from the crises, the treatment of coronavirus patients has become a greater challenge since there is no special coronavirus hospital established in Bangladesh. Blaming the lack of PPE support, Bangladesh Doctors Foundation (BDF) informed that 251 doctors were found to be tested positive to COVID-19 (Mahmud 2020). As a result, all of the general public and private hospitals have been the main hub for spreading the virus, causing hospitals to be a place where nobody can feel safe, further heightening fear, anxiety, and stigma.
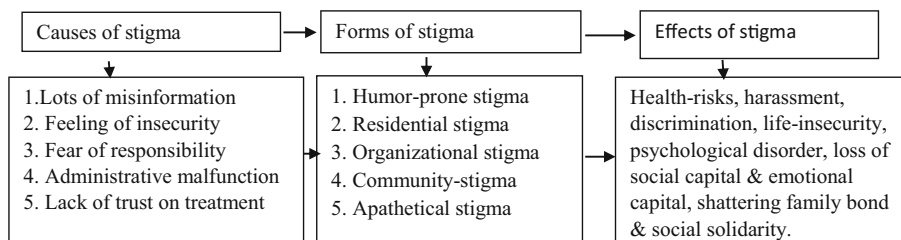
Social Stigma as a Barrier to Well-Being

Stigma is stated as a simplified, standardized image of the disgrace of certain people that are commonly held where stigmatized people present a threat to effective group functioning (Smith 2007; Neuberg et al. 2000). The accelerating spread of COVID-19 and its upshots has led people to fear, panic, concern, and anxiety (Ahorsu et al. 2020), and thus, it constitutes stigma as the socio-psychological disease. Among various significant factors, feelings of existential insecurity and strong aloofness with diffused fear (Baumann 2007), expectations about the responsibility for the infected (Dietrich et al. 2004), and labelling behavior with a psychiatric diagnosis (Angermeyer and Matschinger, 2005) are the prime reasons for growing social stigma upon the coronavirus patients. The social stigma in terms of discrimination, harassments, and hatred is at rife in social communities because it is hard to determine who is carrying the virus and who is not (Riyasad 2020). Moreover, a disproportionate fear, rising over a lack of information, an abundance of misinformation and an absence of trust on the health system triggered the rise of the social stigma (NEWAGE 2020).

The intensifying stigma culture is not confined into hatred and discrimination, rather it triggers emotional protest against the COVID-19 patients and even against the construction of a hospital for the treatment of said patients. The daily New Age reported that construction works, projected by the *Akij Group* and *Gonoshasthaya Kendra,* of a dedicated hospital for coronavirus infected patients came to a halt on the last week of March 2020 in Dhaka's Tejgaon industrial area after panicked locals protested against setting up the health facility there, fearing the spread of the virus in the neighborhood ("Protests halt coronavirus" 2020). Before that, the planning of treatment for the coronavirus patients in Regent hospital of Uttara, Dhaka and the initiative to set up a quarantine centre in Uttara's *Diabari* were cancelled after facing protests from scared people, which further created a massive health risks in Bangladesh (Kamal, 2020). When the government of Bangladesh decides that the bodies of the patients who died from Covid-19 would be buried at Khilgaon-Taltola graveyard in Dhaka city, the Daily Star reported that the locals protested the decision, insisting on finding a "safer" place outside of Dhaka instead (Nasereen and Caesar 2020). Thus, rumor-prone stigma rises health risks and the insecurity of dead bodies (Fig. 1).

The heightened picture of social stigma is manifested when we see that the historically and socially discriminated and stigmatized people of the Bihari community living in the Geneva Camp of Dhaka city are rejected by the local hospital where coronavirus patients are regularly treated, and instead they are forced to self-quarantine in their crowded residences. ("Bangladesh virus hospitals" 2020). Alongside the organizational role of stigma, the residential stigma is newly created by COVID-19. As per the newspaper report, on mid-March, a female doctor working at Dhaka Medical College received an ultimatum from her neighboring apartment owners in Old Dhaka to leave the apartment or the job – otherwise, they threatened to throw her out of the building (Kamal 2020).

Another 'community-stigma' manifested an astounding state of social grievance. As per example, 'The Business Standard' reported that-after knowing an 18-member family from an Upazila medical officer at *Kutubpur Delpara* of *Fatullah* in *Narayanganj* as coronavirus positive, local people attacked the house throwing brickbats and stones instead of showing any kind of sympathy towards the victims ("Locals set on" 2020). The effects of the stigma associated with COVID-19 have been so catastrophic that in many cases the corona-affected patients would not get sympathetic and technical support from their relatives, close friends and even from their family members. As per media report, on 13 April, a 50-year old mother was thrown into a jungle of *Shal* in *Sakhipur Upazila* (sub-district) by her one son, two daughters, and sons-in-law after perceiving coronavirus symptoms, and they falsely assured their mother saying that 'Mother, stay in the jungle only for a night, then we will come back to rescue you'

Causes of stigma	Forms of stigma	Effects of stigma
1.Lots of misinformation 2. Feeling of insecurity 3. Fear of responsibility 4. Administrative malfunction 5. Lack of trust on treatment	1. Humor-prone stigma 2. Residential stigma 3. Organizational stigma 4. Community-stigma 5. Apathetical stigma	Health-risks, harassment, discrimination, life-insecurity, psychological disorder, loss of social capital & emotional capital, shattering family bond & social solidarity.

Fig. 1 Social stigma associated with COVID-19: Causes, forms and effects. Source: Developed by authors

("Mother was kept", 2020). This kind of apathetic stigma has caused the disappearance of any feelings toward people's own parents, family members, close friends and relatives. The increasing cases of apathetic stigma cracked all kinds of social relationships, producing unmeasurable frustration, alienation and estrangement in full-bloom.

Conclusions

With the outbreak of the COVID-19 pandemic, people who are infected and suspected with symptoms are labelled, stereotyped, and discriminated against because of a perceived link, and therefore, the rising stigmatization among the diverse community people increases unmeasurable miseries (Ramaci et al., 2020). This situation is highly fitting to the communities of Bangladesh. All of the traditional practices of social stigma have been submerged under the powerful force of COVID-19-related social stigma. For the cause of rising social stigma, the community well-being is threatened in terms of social security, health security, livelihood, social relationship, and even safety of the burial of dead bodies. The massive effect of social stigma associating with COVID-19 is so disastrous that the previous social norms, social values, and social relations, as well as social capitals, have been destroyed with an astounding manner. The prestigious social groups such as Bangladeshi immigrants, professional doctors, and administrative officers receive social disgrace and shaming from the local people.

The most vulnerable situation is that COVID-19 newly formed 'rumor-prone stigma', 'organizational stigma', 'community-stigma', 'residential stigma' and 'apathetic stigma' deepening social distance, social isolation, social ostracism, and social discontents. For those multi-faceted forms of social stigma, the social bond in our communities which caused elation and is a sign of well-being is now shattered. The traditional norm of mechanical solidarity in rural communities, and the modern form of organic solidarity is seen to be fractured. In brief, this abnormal practice of social stigma is the prime responsibility of rising unbelievable deprivation of coronavirus treatment, treatment from other diseases, and the crisis of emotional and social capital. Thereby, the COVID-19 related social stigma transforms all of the social relations into one thing- 'self', but 'self' exists without well-being, and thus society exists without cooperation, and all of the artificial social relations disappear.

To check the pandemics and social stigma, strengthening and decentralization of the COVID-19 medical facilities including testing, tracing, formal quarantining, and special treatment for coronavirus in coronavirus hospitals for all should be ensured by allocating a large figure of the state budget and also by taking initiatives of public-private partnership for health management. Government and various voluntary organizations should form a Central Stigma Management Committee (CSMC) and district-wise subcommittee using the relevant experts and authentic guidelines that can motivate people of every community to support their family, locals and neighbors as a form of moral responsibility.

Compliance with Ethical Standards

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