Moral panic and othering practices during Nepal's COVID-19 Pandemic

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Abstract

The COVID19 pandemic which started in early 2020 has a major socio-economic impact through both the burden of the diseases as well as the consequences of lock down and travel restrictions. The pandemic has also exposed serious inequities in access to health care facilities and delivery of services, especially for poorer and marginalised communities. The article outlines some of the key marginalised groups in Nepal, the history of the pandemic to date in relation to these groups. Next, we introduce the role of so-called fake news, in the form of misinformation and disinformation in the mass media and social media channels, and the fear, stigma and moral panic it seemed to create.

This resulted in our research aims, which are to: (a) explore the media's role in creating public fear and stereotypes; (b) assess how migrants workers and Muslims perceive such rumours and responses, and their coping strategies and resilience; (c) explore the wider impact of such mis/disinformation and rumours and societal response; and (d) institutional responses.

Seven themes emerged from our interview data: a) rumours & mis/disinformation; b) fear & moral panic; c) health & social impact; d) othering practices-stigma, discrimination, abuse, humiliation, blame, social exclusion; e) resistance & resilience; f) institutional response; and g) preventive measures against rumour & mis/disinformation. And from our media analysis we distilled in six key themes: a) negative media tone; b) stigma, fear & panic responses in the community; c) inappropriate actions from officials & local representatives; d) demoralising, disrespect & criminal behaviour against returnee migrants & their families; e) impact on health care access & treatment of returnee migrants; and f) response & resilience.

These some of findings are address in more detail in this paper which closes with some final considerations that include COVID-19 vaccine hesitancy.

Introduction

COVID-19 Pandemic

Since its first appearance in China in late 2019 COVID-19 continues to have a large impact on individuals, societies, and on national health systems across the globe. Due to its novelty, uncertainty, and world-wide impact, it has challenged societies, politicians, the media, economy, and health care systems everywhere, including in Nepal. The COVID-19 pandemic has exposed serious inequities in health care delivery and access to services both within and between countries (Adhikary et al. 2020a).

Similar to several other countries, but not the UK and the USA, Nepal reacted rapidly to the first wave of the virus in spring 2020. On March 18, 2020, Nepal imposed a travel ban for visitors from the most affected regions at the time (Europe, West Asia and the Gulf Countries, Turkey, Malaysia, Japan & South Korea) (Dept of Immigration Nepal, 2020). This seemed to help containing many cases of COVID-19 (and death) in the country, however, affected people were mostly among travellers returning over land from India, or those who had direct contact with returning migrants. Both India and Nepal implemented a lockdown at more or less the same times (mid-March 2020), but after a few months, travel restrictions were eased in India and Nepali migrants started returning home. Lockdown helped Nepal to delay the spread of COVID-19 in the wider population, although it was not enough to prevent it. The second wave of COVID-19 in early 2021 was based on the so-called delta variant (originally called the Indian variant) which seemed to be easier to transmit than COVID-19 in the first wave.

Adhikary et al., (2020a) state that governments and health systems have responded in a variety of different ways across the world. We argue it is not just politicians and social systems that have responded in various different ways, but also people and communities have acted differently, which is reflected in different countries' mass media and social media.

Marginalised populations

There are many marginalised groups in any country, and this is not unique to Nepal. In Nepal marginalised groups include, amongst others, migrant workers (Aryal et al., 2020; Regmi et al., 2019; 2020b), *Dalits* (Thapa et al., 2021), people with disabilities (Simkhada et al., 2012), transgender people (Regmi et al., 2020a), Muslims (Ashworth et al. 2020), and trafficked women and children (Dhakal Adhikari & Turton, 2019). Despite success in health

and education indicators among general population in Nepal, many marginalised groups in Nepal still face wide ranging issues such as discrimination, stigma and exclusion while accessing health and social care. Our paper focuses on the effects/impact of COVID-19 misinformation and rumours on two specific marginalised groups in Nepal, namely Muslims and returnee migrant workers from India.

Why Nepali migrants and Muslims?

Long-term and seasonal migration to India for work is a very common livelihood option for many Nepali (Adhikary et al. 2020b), particularly in four provinces in Nepal (out of seven) namely *Sudurpaschim, Karnali, Lumbini* and Province No. 2. There are no recorded figures about number of Nepali living in India due to free movement between Nepal and India, estimate suggests that about one million Nepali population live and work in India mainly as daily wage earners on a very low salary (Regmi et al., 2020b). Due to the second COVID-19 lockdown in early 2021 in India, tens of thousands of Nepali returned home after losing their livelihoods. However, poor and vulnerable migrant workers were stopped at the border by both state officials and even local Nepalis blocking roads. Similarly, some Muslims who attended religious gatherings in Nepal were subsequently diagnosed with COVID-19 and their religious community was smeared on social media and even television (https://www.youtube.com/watch?v=RwNxFuLi9zk), and some have experienced incidents of hate speech (Sijapati, 2020).

The COVID-19 pandemic has highlighted so-called 'fake news' and its repercussions for many marginalised groups including migrants and Muslim populations in Nepal. In the case of COVID-19, Nepali returnee migrants (especially in India) and Muslims living in the border areas with India are blamed for bringing COVID-19 to Nepal (Sijapati, 2020). There was a need to explore extent and impact of such misinformation and rumours on vulnerable and marginalised groups of Nepal.

Misinformation and disinformation

Misinformation (inadvertently) and disinformation (advertently) are not a novel threat to public health, especially during disease outbreaks (Oi-Yee et al., 2020). People are desperate for information to assess their risks of getting the disease, its severity, and possible preventive and curative measures. Evidence is equivocal that the misleading information has the tendency of spreading faster than accurate information through social media outlets (Wang et

al. 2019). Evidence on misleading information in popular social media platforms (e.g. YouTube, Facebook, Twitter) during COVID-19, Ebola and Zika outbreaks suggests that at least one-quarter of popular content (in terms of shares, likes, visits) is misleading (Balami & Meleh, 2019; Bora et al., 2018). Studies show how mass media and social media's presentation/interpretation of disasters/crises (e.g., earthquake, infectious disease outbreaks) both cause moral panics and public fear (Montgomery, 2011; Gilman, 2010; Ahmed et al., 2018). Moral panics often target marginalised groups based on ethnicity, class or religion. Such media manufactured/propagated threats to public well-being contribute towards further marginalising, stereotyping and stigmatising certain groups (Muzzatti, 2005). Misinformation and rumours can therefore disproportionately take a heavier toll on specific groups than others.

Rumour and media

The pandemic has highlighted several cases of so-called 'fake news' across the globe and its repercussions for marginalised groups such as migrants. Mainstream mass media in Nepal have frequently reported on probable risk of COVID-19 from the arrival of thousands of returning migrant workers from India. Nepali media, including social media such as Facebook and YouTube most likely contributed to a moral panic and promoted negative public perceptions against migrant and other vulnerable communities, e.g., Muslims, as possible virus carriers and spreaders. Such COVID-19 misinformation and disinformation - often spread by social media – raised concern and anxiety amongst many Nepali (Asim et al., 2020; Amgain et al., 2020). Fake news, misinformation and rumours about COVID-19 in Nepal have proliferated widely on social media and online news portals. These rumours have been particularly targeting returnee migrant workers from India and members of the Muslim community (who had attended religious gatherings in Nepal and India). These rumours identified them as COVID-19 carriers responsible for spreading the infections into communities.

Fear and stigma

Many unknowns around COVID-19 and fear of being infected has given rise to stigma in local communities which can be induced by a variety of factors including misinformation, feeling insecure, discrimination, stress and panic that impeded to seek services and supports from others (Kumar & Nayar, 2020). COVID-19 pandemic has highlighted so-called 'fake news' and study shows that a witch hunt bordering on hysteria developed worldwide fuelling

discrimination and attacks against certain groups of vulnerable people (Sotgiu & Dobler, 2020). Nevertheless, how these rumours and social stigma act as barriers to the prevention of the COVID-19 outbreak remain unclear. Although, evidence shows that marginal groups have historically been targets of blame and scapegoating during disease outbreaks and stigmatising them as "disease breeders" that leads to increase racism and xenophobia (Castañeda, 2010; Dionne & Turkmen, 2020). There are several South Asian studies reporting on increase of suicides related to fear of COVID-19, for example in Bangladesh (Mamun & Griffiths, 2020), Pakistan (Mamun & Ullah, 2020), Nepal (Acharya et al., 2020) and India (Goyal et al., 2020). The fast spread of COVID-19 and its associated lockdown has increased fear, panic, concern, and anxiety in many communities, according to Ahorsu and colleagues (2020), this constitutes stigma as a socio-psychological disease (Ahorsu et al., 2020). People faced discriminatory behaviours, abuse, humiliations, and social exclusion that had heightened fear between individual and community because of negative public perception against migrants and Muslim travelled from the India as possible virus carrier and spreader (SijapatI, 2020). The stigmatisation of the whole Muslim community has been at the forefront to COVID-19 and labelled to the Jamaat event as "corona terrorism" which reactions fuelled the feelings of hatred and blamed for the spread of the virus (Bhanot et al., 2020).

Aims and objectives

Drawing on Stanley Cohen's (1972) notion of moral panic, our study aims to: (a) explore media's role in creating public fear and stereotypes (b) understand how migrants workers and Muslims perceive such rumours and responses, and their coping strategies and resilience; (c) explore the wider impact of such mis/disinformation and rumours (e.g. on health, social, psychological, livelihood) and societal response (e.g. border closures, isolation); and (d) institutional responses.

Methods and materials

This interdisciplinary study (van Teijlingen et al., 2019) uses a sequential multi-methods approach (Morse, 2003) to address our objective above (see Figure 1).

Figure 1 Data collection methods in this study

Data collection

We collected interview data in the middle of 2020. Data were collected from two districts of Nepal namely *Kapilvastu* and *Banke* which are located in the *Terai* and both have a higher proportion of migrants and Muslims than the average district of Nepal. These districts border districts of India and both districts have the border check points. Our participants were: (a) returnee migrants from India, who had returned in the six months prior to the interview who wwere18 years and above; (b) Muslim residents in the districts who were 18 years and above; and (c) key stakeholders such as journalists, specially who have reported migrants or Muslim issues during COVID-19, health workers and representatives working with migrants and marginalised populations in Nepal.

Based on the literature, the research team, in collaboration with key stakeholders in Nepal, drafted an interview guide to facilitate the interviews. The interview guide was pre-tested (van Teijlingen and Hundley, 2010) before going it live with the study. All the interviews were conducted in Nepali by experienced and same sex researchers (Regmi et al., 2019). Interviews were audio recorded with the permission of the participants.

For media data, a template was developed, pre-tested, and data were recorded in Microsoft Excel. For YouTube videos information extracted were as follows: title, number of views, likes, and dislikes, length of video, theme, content type, source, degree of truth, and tone. Media data included COVID-19 related coverage published between 1-31 January 2021. Inclusion criteria were: media contents focusing on COVID-19 related to (i) public fear, moral panic, stigma, and othering practices experienced by Muslims and returnee migrants, and (ii) subsequent impact on these population groups (including health), responses from the communities and authorities, and resilience from Muslims and returnee migrants. We included 56 relevant news items from national newspapers (print), 36 from online publications and 18 from YouTube.

Data organisation, management and analysis

Interviews data were transcribed and translated into English. Transcripts were crossed checked with original recordings by PR, NA, SW and SDA. Any disagreements were discussed in detail between team members for appropriate translation. Each transcript had a cover note describing the interviews, settings, how the discussion had been, any differences from other interviews, particular incidents, the interview environment and a reflection on the issues identified in the session. We performed thematic analysis (Green & Thorogood, 2018: 258-68). for interviews data and media separately.

Ethical consideration

We sought and received ethical approvals from Bournemouth University (UK) and Nepal Health Research Council (NHRC, Nepal). Through an information sheet in Nepali, participants were provided with enough information about the study purpose and procedure, voluntary participation, confidentiality, risk and benefits to the participants, complaint procedure (Regmi et al. 2017).

Characteristics of interview participants and media

Most interview participants were male (83.3%), fairly young (mean age 32.2 years, range 18-65 years). Only seven participants (23.3%) completed higher secondary education or above and the majority of them (60%) lived in different part of India as a migrant worker. Most migrants worked in the hospitality sector, e.g. hotels, restaurants, teashops. Of the eight key stakeholders, seven (87.5%) were male with an average epereicne of working years in their field for 11.6 years.

We captured 56 items from newspapers, only two were opinion pieces and both were published in Kantipur daily and one was an interview published in the same newspaper. The opinion pieces and the interview focused on the views of the author and interviewees where they talked about how stigmatisation was creating a barrier to social harmony and emphasised stopping it. Just five news items on the selected themes were published on the front page of the newspapers (three articles in Nagarik & two in Kantipur) and the rest were published on the inside pages. News was covered from 20 of 77 districts of Nepal, mainly from the areas bordering India, e.g., Banke district (n=10), Kailali (n=6), Rupandehi district (n=4). Results of online news portals reported the highest number of news from Kathmandu district (n=15) in Bagmati province, and five news each from Morang district (Province 1),

and Parsa and Rautahat districts (Province 2). The highest number of news was covered in April 2020 (n=19), followed by May 2020 (n=14) and June 2020 (n=8).

The relevant videos identified from the YouTube search ranged from one minute to one hour. Two videos were in the Hindi language- one television report from an Indian news channel, another user-generated content and both videos accused Nepali Muslims of spreading COVID-19 to India. Other videos included short footage of *Jame* mosque in Kathmandu, an isolation centre in Bara district, locals shouting and chasing migrant returnees from quarantine, and interviews with Muslim leaders in Nepal clarifying the alleged role of Muslims in spreading the virus and keeping social harmony intact. A television interview of a public health expert on mismanagement of quarantine centres for migrant returnee received the highest views (39,097 views) followed by a user-generated video in Hindi language presenting his opinion on the possibility of truth in the news that claimed Nepali Muslims were spreading Coronavirus to India (19,214 views). Views of the rest of the video ranged from 100 to 5,000. The number of these views were recorded as of June 17, 2021.

Key findings

Seven themes were emerged from our interview data: a) rumours & mis/disinformation; b) fear & moral panic; c) health & social impact; d) othering practices-stigma, discrimination, abuse, humiliation, blame, social exclusion; e) resistance & resilience; f) institutional response; and g) preventive measures against rumour & mis/disinformation.

Similarly, our media analysis resulted in six key themes: a) negative media tone; b) stigma, fear & panic responses in the community; c) inappropriate actions from officials & local representatives; d) demoralising, disrespect & criminal behaviour against returnee migrants & their families; e) impact on health care access & treatment of returnee migrants; and f) response & resilience.

Our findings suggest that rumours and misinformation were fuelled by social media and online news portals during the initial months of the lockdown. All interviewees equivocally blamed some Indian TV new channels, Nepali online news portals, and social media (mainly Facebook and YouTube) for spreading rumours against Muslims as COVID-19 carriers. The media propagated moral panic which led returnee migrants and Muslim populations to experiencing both self-perceived and enacted fear. Participating returnee migrants, Muslims, and key stakeholders acknowledged that Nepali mainstream media could not effectively

tackle rumours and mis/disinformation. Furthermore, there were no systematic efforts by governmental and non-governmental institutions to tackle media rumours in Nepal.

Although most of the participants did not report any issues accessing healthcare, they however encountered various forms of othering practices (Cohen 2002; Gilman 2010) such as stigma, discrimination, abuse, humiliation and blame at the border and within their own communities. Othering is a process that identifies those that are thought to be different from mainstream which reinforces positions of domination and subordination (Johnson et al., 2004). The experiences of participants varied as the poorest, Dalit, and females were disproportionately affected and Muslims workers (particularly shopkeepers) experienced more othering practices. Some groups may experience so-called double discrimination (Addo 2020), for example Simkhada et al. (2018) highlighted in a recent study that 24.1% of female migrant workers were Dalits. Resistance and resilient strategies against othering practices and effective institutional response to dispel rumour were limited. Community-based organisations/non-governmental organisations were virtually non-existent for awareness raising during the initial months of COVID-19.

There was a wider impact of COVID-19 mis/disinformation and rumours on marginalised groups on their overall wellbeing. Misinformation fuelled by rumours, mis/disinformation and stigma have potentially severe implications on public health. Due to the fear of being stigmatised by the community, few Muslims participants felt that people would say or act something different than usual. Muslim participants themselves generally feared that people would say or act something against them and blamed them as a COVID-19 carrier. This ties in with research by Ashworth et al. (2020) conducted prior to COVID-19 that Muslims in the rural areas of the Terai were vulnerable to discrimination on religious and economic bases and are at higher risk for marginalization.

Similarly, a number of migrants' participants stated that despite having negative test results they usually stayed at 'self-imposed' home quarantine for at least seven more days even after two-weeks stay at government quarantine. During the health emergencies disease may cause fear and anxiety leading to prejudices against community and social stigma to the marginalised community. Such behavioural issue may culminate to promote hostility and unnecessary social disruptions. People faced discriminatory behaviours, abuse, humiliations, and social exclusion that had heightened fear and misinformation about the COVID-19 pandemic between individual and community. At the same time, coping strategies and institutional response were non-existent.

To some extent, Nepali media set the tone on migrant returnees and Muslim as increased threat or concern of COVID-19 transmission within their community upon return. It was frequent reported in the Nepali media including the social media which have contributed to creating moral panic and fear (Cohen, 1972). Our media analysis clearly noted the negative remarks and terms used by even highly influential and otherwise responsible news media of the country towards returnee Nepali migrants and Muslims. For example, the media frequently used the term 'hiding' and 'flee' when referring to Muslim religious preachers who were staying in the mosques or Madrasas may have fuelled rumour and misconception against these groups. The way in which the situation is initially interpreted and presented by mass media is the way public perceive both disasters and deviance (Cohen, 1972).We also observed that during the initial wave of COVID-19, media tended to report and highlight the number of Muslims contracting COVID-19 (and not for other religious groups) which could imply Muslim as a culprit for COVID-19 transmission. It is also worth considering that Indian media have a huge influence in Nepal, particularly Indian television channels in a border area. Inaccurate and sensationalised videos targeted at Muslims from Indian news channels might have contributed to creating moral panics and public fear and thus contributed to developing a negative perception against this community in Nepal.

Interestingly, the present study could not find news reports on discriminatory behaviours against returnee Nepali migrants from countries other than India (e.g. Gulf, European). Usually, those who migrate to India for work are from low socio-economic status and with little or no education (Bhattarai 2007). Thus, the differential treatment of society to returnee migrants from India may suggest that poor and helpless people are vulnerable to scape-goating, suffering, and dignity violation during the crisis.

Our media analysis suggests that the immediate impact of stigmatising behaviour was mainly seen in the form of denial to transport to hospital and treatment. However, it is very likely that this stigma could prevail in a society for a long time and could hinder social cohesiveness and integration (Bhattacharya et al., 2020). There could be a long-term psychological impact on these population groups. An early indicator of this was an incident where a returnee migrant from India hung himself saying that he wanted to avoid COVID-19 transmission to other (Acharya et al. 2020).

Social stigma against the people who had contracted or suspected to have disease/infection during an epidemic is not a new phenomenon. This was also observed during the epidemic of severe acute respiratory syndrome (Person et al., 2004), H5N1(Barrett & Brown, 2008)

towards people being treated for mental ill-health (Trani et al., 2015), HIV and AIDS (Bharat, 2011). Society usually exhibited a hatred attitude or behaviour in a fear of contracting the infection/disease (Cohn, 2012). Some incidents of stigmatising behaviour against frontline health workers were also observed in Nepal which further underscore this social perception (Singh & Subedi 2020).

Final thoughts

To conclude, the present study indicates that moral panics especially created by media contributed to develop social stigma and othering practices towards returnee migrants from India and Muslims during the first wave of COVID-19 in Nepal. This maybe a reflection of perpetuating social blaming and undermining attitude towards the poorest and marginalised communities which were further ignited by rumours and misinformation. Consequently, these groups who are treated as other often experience marginalisation, decreased opportunities, and exclusion (Johnson et al., 2004).

Nepal government and other agencies must understand the patterns of COVID-19–related rumours circulating in the community about migrants and Muslims, such as carriers of the virus and virus spreaders. This urgently calls for the relevant stakeholders including media to help develop strategies, which could dispel rumours and mis/disinformation and protect the socio-economically disadvantaged and/or minority populations in the country. Interventions are needed to help build resilience and mitigate the consequences (hatred, tensions) at the community level. COVID-19 offers a striking example of a 'social media destruction' in Nepal. Furthermore, a strong government resilience and surveillance system should be in place to track rumours or misinformation associated with the COVID-19 to minimise the media-induced moral panic and otherings issues faced by returnee's migrant from India and Muslim community during the COVID-19 and future pandemics.

Figure 2 highlights issues the research team considers worth reporting and discussing with policy-makers, community leaders, media personal and fellow researchers.

- Migrants and Muslims faced severe discrimination upon return, both from the community and the local authority. For example, access denial for foods/drinks and taking currency (notes), limited access to fresh water, ostracising behaviour, road blockage (from both public and local authority), marking houses of returnees with a COVID-19 sign (from local authority).
- Migrants who returned from the Gulf countries, Malaysia, and developed countries did not face similar discrimination as returnees from India. It could be related with long existing differential treatment with poor and marginalised group in the society.
- Female returnee migrants and *Dalit* returnee migrants reported a high level of fear and discrimination (=double discrimination)
    - Migrants received poor services in quarantine, e.g., health workers did not see them regularly in quarantine and few reported seeing them only at the last day of quarantine stay.
- Due to perceived fear of social stigma, they were reluctant to seek health care.
- COVID-19 induced social stigma towards returnee migrants and marginalised group which could have a long-term impact on social cohesion due to the 'othering' practices.
- Rumours & misleading information has a tendency of spreading faster than accurate information through social media outlets.
- Even the trusted mainstream media (newspaper and television) and political leaders had a negative tone/attitude towards migrants.
- Misinformation (inadvertently) and disinformation (advertently) are not a novel threat to public health, especially during disease outbreaks and these often target marginalised groups based on ethnicity, class, or religion.
- Capacity building of charities (Non-Governmental Organisations) working for migrants and disadvantaged groups may help disseminating right information
- Institutional responses target mainstream populations. Marginalised groups are often ignored.
- The Government has no mechanism for systematic handling of rumours and misinformation, whilst social media and mushrooming online news portals should be better monitored with affecting the freedom of the press.
- The extent and impact of misinformation and rumours on vulnerable and marginalised groups of Nepal

Figure 2 Key questions

We also have a notion that Nepali media should be sensitive on how they portray specific population groups and the impact this could have, particularly at the time of pandemic and crisis. There are few examples of media defiance against misinformation and derogatory remarks. However, such defiance could be stronger and more persuasive in mainstream Nepali media in the current infodemic of mis/disinformation in social media. We noted that the voice of mainstream media was timid to raise the issue of the unscientific and unreasonable practice of road blockage to returnee migrants. As we also identified YouTube videos that could sensationalise and create public hysteria against returnee migrants and

Muslims, government surveillance of social media seems urgently and incredibly important to minimise media-induced moral panic.

Mahato et al., (2020) note that the COVID-19 pandemic is a long-term issue and that social distancing, improved hygiene and lifestyles and the use PPE (personal protective equipment) measures need to continue in the medium to long term and all of us need to keep working on the big public health issues such as poverty reduction, improving access to health service to achieve universal health coverage. The next step is, of course, mass vaccination and the media can help promote vaccine efforts by public health officials programme and eliminate the social stigma about vaccination. However, there are bound to be obstacles as experiences in other countries have taught us. For example, Abedin et al. (2021) noted in Bangladesh that "the approved COVID-19 vaccine has been shown to be safe and effective, mass vaccination in Bangladeshi people remains a challenge." It is likely that some media / social media channels in Nepal will hinder public health efforts to reach high levels of vaccination in the population.

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