Stigma and Moral Panic about COVID-19 in Sri Lanka

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Abstract

Drawing from sociological perspectives relating to stigmatization and panic associated with newly emerged diseases, this paper examines the collective response to and social fallout of COVID-19 in Sri Lanka. It argues that the pandemic has served to reinforce social prejudices and cleavages already established in society with the social media playing an important role in promoting stigma and the related process of blaming the other as a source of all evils including a moral panic related to drugs, organized crime and contagion of deadly diseases including COVID-19. The paper calls for a more enlightened approach to deal with the pandemic ensuring the rights, dignity and needs of affected people.

***Keywords**:* Stigma, Moral Panic, COVID-19, Biopolitics, Pandemic

Introduction

Globally stigma and discrimination triggered by COVID-19 have received both research and intervention attention. This is partly because COVID-19 is a new deadly disease of unknown origin that has quickly gripped the entire world irrespective of their level of development, pattern of governance or nature of health services. As at present, the absence of any effective cure for the disease or an effective vaccine against the infection has added to the growing anxiety about the disease all over the world. The stigma and panic related to the pandemic have also added to the complications of control and prevention of the disease as the uptake of interventions has been hampered by the fear of identification and concern about potential public reaction once diagnosed with the disease. Describing why a sociology of pandemics is necessary, Dingwall, Hoffman and Staniland, way back in 2013, noted that "Emerging diseases are sources of instability, uncertainty and even crises that can make visible features of the social order ordinarily opaque to investigation" (2013). COVID-19 has brought into sharp focus structural inequalities between and within societies in a way no previous calamity has done.

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Sociology of Stigma and Panic

Stigma and panic have been two important topics of sociological research for over 50 years from the angles of every day human behaviour and periodic upsurge in collective behaviour respectively. Erving Goffman, who was one of the earliest sociologists to reflect on stigma, described it as “an attribute that is deeply discrediting” to those who experience social stigma (1963). He identified it as an example of a spoiled identity for those subjected to stigmatization. One’s identity may be spoiled because of some physical marker clearly discernible such as skin colour, body size, physical handicap like loss of limbs or something hidden and not readily discernible but nevertheless can be resurrected by potentially antagonistic players in a discrediting manner as in the case of a criminal record, depressed caste background, mental illness or HIV infection. Goffman’s analytic gaze was on how stigmatized or potentially vulnerable persons manage stigma in the performance of their day-to-day behaviour in ways that minimize its impact and continue their daily lives and presentation of self as normally as possible.

Panic is a collective psychological group reaction to a common threat emanating from a natural disaster, an unfolding epidemic, a riot or a general breakdown of law and order. While stigma is understood as an individual state of mind shaped by repeated experiences of a wide variety of people and circumstances, panic is an attribute of group psychology characterized by a rapidly expanding collective fear and anxiety about the unknown and the dangers yet to unfold. Sometimes panic can lead to a sudden upsurge in irrational collective behaviour such as panic buying or hoarding as was evident in the panic buying and hoarding sanitary items like toilet paper in several countries during the early phase of the corona pandemic. A moral panic emerges when the threat is perceived as a challenge to the moral order of society affecting mutual trust, faith and existential security of people in general. According to Stanley Cohen who launched this concept in 1973, moral panic breaks out when "a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests" (1973).

Stigma and moral panic surrounding COVID-19 have made it difficult to respond to the pandemic merely as a physical illness that can be handled with medicines and public health interventions alone. This is because the stigma against the disease has been transferred to affected communities adding to their burden of disease related morbidity and mortality in some cases enhancing existing patterns of discrimination against them, inducing denial of treatment and denial of other essential services and civil and political rights by those with deep seated prejudices and widely-held but unverified stereotypes against the affected communities. As people become objects of panic and stigmatization due to the fear of them spreading the disease to others, they also become targets of discrimination, avoidance and even outright violence against them. This is where a virus becomes an actor or actant as configured in the Actor Network Theory of Latour and others in accentuating a process of social disintegration already set in motion by other processes unfolding in society.

Pandemics as Collective Behaviour

In a seminal essay titled "Epidemic psychology: a model", Strong (1990) described the social psychology of epidemics using the plague of the 13th century and HIV/AIDS around 1980 to illustrate the collective behaviour associated with what he described as epidemics of new diseases. Both plague and HIV/AIDS can be identified as earlier pandemics that the world had to deal with, prior to the emergence of COVID-19. Strong referred to "the waves of fear, panic, stigma, moralising and calls to action that seem to characterise the immediate reaction" (1990: 249) to deadly epidemics caused by previously unknown viruses or other disease-causing agents. Further, he noted that "the subjective experience of the first social impact of such epidemics has a compelling, highly dramatic quality ... Societies are caught up in an extraordinary emotional maelstrom which seems, at least for a time, to be beyond anyone's immediate control. Moreover, since this strange state presents such an immediate threat, actual or potential, to public order, it can also powerfully influence the size, timing and shape of the social and political response in many other areas affected by the epidemic" (1980: 249).

By 'epidemic psychology' Strong meant a certain epidemic of psychological states among populations directly or indirectly affected by an unfolding

epidemic. In his view, psychology has its own epidemic character, quite separate from the epidemic of disease itself. Like the disease, related mental states triggered by the rapid outbreak of the disease too can spread rapidly from person to person, thereby creating collective as well as individual outcomes. Epidemic psychology, however, can take a variety of forms. Strong identified three types of the psycho-social epidemic. The first is an epidemic of fear. The second is an epidemic of explanation and moralisation. The third is an epidemic of action, or proposed action. Any society gripped by epidemic psychology simultaneously experiences waves of individual and collective panic, contesting interpretations of why the disease has occurred, narratives of moral controversy, and competing control strategies, aimed at containing the disease and reducing is fallout.

According to Strong, the epidemic of fear has several attributes. Firstly, the epidemic of fear is also an epidemic of suspicion as well. "There is the fear that I might catch the disease and the suspicion that you may already have it and might pass it on to me." (Strong 1990: 253). Second, "a widespread fear that the disease may be transmitted through any number of different routes, through sneezing and breathing, through dirt and through door- knobs, through touching anything and anyone. The whole environment, human, animal and inanimate may be rendered potentially infectious. If we do not know what is happening, who knows where the disease might not spring from." (1990: 253). Further, Strong stressed that fear and panic can set in even places where no one has been actually infected. People who are best informed about the disease, including health workers themselves are not completely free of the epidemic of fear of death and related calamities repeatedly mentioned in describing the unfolding developments. The epidemic of fear also triggers an epidemic of stigmatization whereby some people may be avoided, socially condemned, segregated or even harmed being identified as carriers of the disease. "Personal fears may be translated into collective witch-hunts…such avoidance, segregation and persecution can be quite separate - analytically at least - from actions aimed at containing the epidemic. Such behaviour can occur with all types of stigma, not just with that of epidemic disease. We are dealing here with magic and taboo, not just with quarantine." (Strong, 1990: 253-254).

As for the epidemic of explanation and moralization, they stem from the novelty of the disease and the associated syndrome of fear and panic. Some people may identify the disease as a relatively mild problem while others recognize it as a major calamity. The collective mood may swing back and forth, depending on the information received from mass media and other sources. Denial of the disease can also be a common occurrence especially at the early stage of an epidemic. Both plague and HIV were attributed by 'moral entrepreneurs' at the times to collective moral weaknesses of people prior to the onset of the problems. For instance, at the beginning of the epidemic some people identified HIV as a 'gay plague' and even characterised is as a divine punishment for pervasive sexual misconduct (Strong 1990: 254). The pattern, however, radically changed as the epidemic progressed and harm reduction rather than moral condemnation was increasingly identified as the way forward.

The epidemic of disease control measures relates to debates about which measures work and which do not. This is of course a domain where science and technology play a critical role, but magic, folk therapies and religious ritual also have their place within a competitive space of multiple remedies. "Many suggestions for limiting the contagion may cut across and threaten our conventional codes and practice. Trade and travel may be disrupted, personal privacy and liberty may be seriously invaded, health education may be enforced on matters that are normally never talked about" (Strong, 1990: 255). Strong also argued that epidemics can become fruitful grounds for moral crusades of different kinds, with social reformers taking advantage of the crisis in hand to advocate anything from strict disciplining of society to purifying society, crime prevention, spiritual advancement, cultural revival and human co-existence.

Strong (1990) argued that, when the situation finally stabilizes the epidemic psychology gradually makes way for normalcy in society, human behaviour and lifestyle in general. Panic responses progressively give way to restoration of rational action as normalcy is gradually restored and the disease increasingly managed through development and application of effective remedies as happened in the case of HIV/AIDS control within two to three decades of its emergence as a public health emergency. Moving away from the emotional outbursts and irrational diversions triggered by

epidemic psychology, through advances in disease control, societies finally get back on track with the rationalization process following the well-known Weberian trajectory.

COVID-19 as a True Pandemic

COVID-19 can be identified as a true pandemic for a number of reasons. Firstly, the WHO designated it as a pandemic in order to guide global action as the health crisis was unfolding. Secondly, it was a truly globalized event with the initial discovery of the disease in Wuhan in China in December 2019 followed by rapid spread of the disease to various other countries with nearly 95% of the world population directly exposed to the disease as of mid-2020. Thirdly, information about the pandemic covering sensational reports such as casual daily workers in India walking thousands of miles in order to get home following the instant lockdown launched by the Indian central government as a pandemic control measure, COVID-19 dead bodies being allowed to rot by the wayside in Ecuador and prisons and elderly care institutions in the US being overwhelmed by the news about COVID-19 infections and related deaths instantly disseminated all over the world through the electronic media, is a clear manifestation of advancing globalization (Appadorai, 1996).

The media coverage of the pandemic has been comprehensive in terms of identifying global hotspots, assessing the impact of various control strategies pursued and giving publicity to people poorly serviced and subjected to discrimination and stigmatization such as migrant casual workers with disadvantaged social background in India. On the negative side, the media coverage, social media gaze in particular, has been deeply problematic when it comes to pursuing the blame game and branding and stigmatizing certain communities as disease vectors or even deliberate infectors targeting their enemies. Along the lines of epidemic psychology delineated by Phillip Strong, signs of a ‘pandemic psychology’ or more appropriately ‘pandemic psyche’ are triggered by the raging corona pandemic in various parts of the world. The emerging sociology of the pandemic has already taken a number of useful paths in uncovering the sociological underpinnings of the pandemic. In this essay, only the selected lines of sociological enquiry directly relevant to the theme of this paper will be referred to.

The current paper addresses three important questions relevant to global debates around stigma and panic surrounding the pandemic focusing on Sri Lanka. The first is the pandemic of hate targeting affected populations as evident from mass media and social media. Building on seminal ideas relating to epidemic psychology discussed in the preceding section, this paper will examine how hate speech and related stigmatization have become an inherent part of media reporting about the pandemic as well as its possible impact on treatment seeking and compliance and health and well-being of potentially vulnerable people in the affected areas. In one of the earliest references to the pandemic of hate triggered by COVID-19 in the European context, an editorial in the American Journal of Tropical Medicine and Hygiene mentioned that the disease "has unleashed a raging pandemic of hate and widespread stigmatization, especially against the Chinese and the East Asian diaspora, in many countries" (Ng 2020: 1). The Chinese and Chinese looking people, however, were not the only targets of pandemic-triggered hate and they varied from place to place depending on social histories and local dynamics relating to the pandemic and preceding patterns of social tension. Sri Lanka is particularly relevant here because of its history of ethno-religious tensions with anti-Muslim violence from 2012 onwards and the Easter Sunday attacks on April 2019 by Islamist extremists directly preceding the onset of the pandemic.

Second, the paper explores multiple interpretations about the origin of and response to the pandemic. This ranges from official explanations, social media interventions to anti-establishment contestations. The extent to which hegemony is achieved by the authorities within the context of a raging pandemic is examined also taking into consideration global experiences. For instance, the Italian philosopher Agamben (2020) created a major controversy when he argued that the regime of social distancing, lockdown and coercive measures introduced by health authorities constitute an extreme form of biopolitics as defined by Foucault, going against democratic traditions and political values established through a long process of abandoning of autocratic regimes in Western Europe. This interpretation has already been questioned by researchers in and outside of Europe. For instance, in East Asian settings like China, Hong Kong and Taiwan the pandemic response has led to the emergence of a new era of populist politics of a pro-establishment nature (de Kloet, Lin and Chow 2020). Sri Lanka experienced a political regime change immediately before the pandemic started

and the newly elected president of Sri Lanka, openly identified with a Sinhala nationalist political agenda, consolidated his power in the subsequent national election by showcasing his relative success in containing the early phase of the pandemic through coercive disease control strategies and also by deploying the army and other security forces in intelligence and quarantine work relating to disease control. The long-term effectiveness of this approach, however, remains questionable as evident in a raging second wave of COVID-19.

The third research question directly relates to the role of nationalist politics in containing the pandemic and guiding the pandemic response. In a provocative analysis of the pandemic in East Asia, de Kloet, Lin and Chow (2020) identified 'biopolitical nationalism' as a counterpoint to state-mediated biopolitics in that citizens of geopolitical entities willingly and self-affirmatively take up disease control measures in a conscious effort to assert themselves through helping their countries to contain the disease and achieve success in the global struggle against the disease. They argued that the 'virus is not only infecting but also affecting' (2020: 636). However, biopolitical nationalism can be politically advantageous only in so far as it serves to contain the disease. Its legitimacy and affective hold may be seriously undermined where the disease spreads fast and the public faith in control measures decreases correspondingly. Another issue that the concept of biopolitical nationalism totally ignores is how diverse population groups within a country relates to majoritarian nationalism held by a ruling elite from that community. This is where Sri Lankan polity with a politically dominant Sinhala ethnic majority and at least three separate minority ethnic communities, namely Sri Lankan Tamils, Indian Tamils and Muslims, may be a useful contrast to East Asian examples explored by de Kloet, Lin and Chow. The virus may infect and affect different communities differently with corresponding implications for stigma and panic being mobilized vis-à-vis each other as well. This is something being explored in more detail in the current essay.

As for methodology, this paper relies on official statements issued by health authorities, mass media (both print and electronic media) reports and facebook posts collected during different stages of the unfolding pandemic in order to explore the stigma and panic related to the pandemic. This was supplemented by limited information gathering using the personal social network of the researcher. This was obviously not the methodology of choice as direct first-hand experience

with affected populations would have been much more informative about the processes of stigmatization in particular. Interviews with and observations of affected people or health care workers, however, was not feasible given the logistic and ethical difficulties for any fieldwork throughout the study period. This is, therefore, more of an exploratory enquiry, assertions of which need to be validated or refined through future empirical research in affected communities.

State Response to the Pandemic

Sri Lanka's response to the COVID-19 outbreak was swift and comprehensive, but it relied completely on a politically powerful but resource-scarce state machinery relied on a heavy participation of security forces along with medical professionals and health workers operating side by side with the security forces personnel. A 22-member National Operation Centre for the Prevention of COVID-19 (NOCPC) was established on March 17 under the leadership of the army chief. This facilitated the establishment of a mandatory quarantine process mediated by the security forces targeting Sri Lankan and international travellers arriving from selected countries. With a view to containing the epidemic, countrywide national public holidays were announced from March 10th onwards. Continuous curfew with short breaks in between was introduced as a measure for containing the epidemic from March 18 to May 31. This in turn affected the supply of essential commodities and delivery of services. On March 26, the president appointed a special task force under the leadership of his brother, Basil Rajapaksa to coordinate provision of essential services and supply of goods.

It is important to point out here that with the possible exception of the participation of the largely pro-government, Government Medical Officers Association (GMOA), the civil society was not represented at all in these two national committees either as members or observers. A military-led statist response to COVID-19 was launched in Sri Lanka. Sri Lanka's advanced health infrastructure built over several decades, inclusive of emergency, curative and preventive services, and accumulated knowledge in dealing with multiple disasters ranging from war to tsunami, helped launch a satisfactory response during the first wave of the pandemic. Side by side with public health officials, the security forces were fully mobilised in developing and implementing quarantine services, contact tracing and

mobilization of military intelligence services during the process of contact tracing. As of June 2020, some 45 health facilities were reportedly established in carefully selected locations for COVID-19 testing and treatment, with required protection for staff and patients. This worked reasonably well during the first wave of the pandemic to contain the number of infections, help access health services and quarantine centres and facilitate the supply of consumer goods, relief services and emergencies of diverse kinds. There was no community participation whatsoever in the COVID-response in Sri Lanka with decision making concentrated in the hands of key political leaders with some consultation with health professionals and security forces personnel, there was no consultation whatsoever with social scientists, social workers, psychologists and community representatives of any kind. The high-level decision-making bodies also excluded any kind of minority representation by default or by choice clearly affecting the level of sensitivity towards cultural diversity in the country and minority concerns in particular. Muslim burial issue is one such concern which will be returned to later in this essay.

The monitoring and surveillance of lockdown and curfew as well as public health prescriptions in the wake of the pandemic such as social distancing, wearing of face cover and hand washing were done mainly by the police with or without the participation of public health inspectors. The lockdown and quarantine operations in the hands of the police and the security forces increasingly took a coercive character, particularly in dealing with the unruly public, and infections among substance abusers and prisoners and the like. The households of infected persons and their first contacts were identified through a public notice posted on their entrances by the local public health personnel so as to prevent any contact with non-infected persons. There were some protests against the quarantine centres established in their vicinity by certain local communities, but they were of no effect. There was also a limited resistance against the quarantine process on the part of Sri Lankan workers returning from overseas, but in a curious paradox at the point of completion of the quarantine process many thanked the security forces profusely in front of television cameras. In a meeting with newly appointed members of NOCPC, the president referred to “Irresponsible citizens” who

obstruct the country's fight against COVID-19.[2] On October 15, 2020 the Minister of Health issued a new gazette notification legalizing health and safety measures relating to prevention and control of COVID-19.[3] Obviously, the government relied heavily on coercive measures in containing the pandemic. The numbers arrested for various violations relating to the pandemic increased substantially as the pandemic progressed.

A kind of biopolitical nationalism was deployed by the Sri Lankan state for securing compliance for disease control measures. In his press statements, the army commander frequently used nationalistic pronouncements. For instance, "we have never failed as a *Jathiya* (a complex term that can indicate nation, Sinhala ethnic community or both), so we will prevail over the corona virus too''. The President of Sri Lanka highlighted Sri Lanka's success in controlling of the epidemic in a number of international forums. For instance, at a high-level meeting on the 75th Anniversary of the United Nations, President Gotabaya Rajapaksa reiterated the point that Sri Lanka has successfully achieved control over the pandemic through proactive timely interventions by the state.[4]

In a rather healthy development in keeping with the tradition of medical pluralism in the country, during the early stage of the pandemic, several quarantine centres run by the security forces, the navy quarantine centre and even the National Institute of Infectious Diseases in Angoda treating confirmed patients used *Inguru Kottamalli* (a popular remedy against common cold and other ailments) prepared by boiling ginger and coriander) and some herbal porridges (*Kolakenda*) as dietary supplements in these establishments. This was an organic development in line with medical pluralism in the country, but perhaps it was the first time that these herbal therapies became informally accepted in Western health care institutions. As an artificial extension of the biopolitical nationalism referred to earlier, several products reportedly derived from indigenous medicine were invented and presented as effective remedies against the disease, in some instances

[2] https://economynext.com/sri-lanka-president-angry-at-irresponsible-citizens-in-fight- against-covid19-59645/
[3] http://www.colombopage.com/archive_20B/Oct15_1602782555CH.php
[4] https://www.un.org/en/un75/commemoration/sri-lanka

supported by members of the political and social elite. One such invention was *Dhammika Paniya* invented by a previously unknown actor and widely publicized in the mass media with the tacit approval of certain politicians and health workers with a Sinhala nationalist orientation. There was no evidence that this *paniya* (lit. thick herbal drink with a sweet taste) had any foundation in ayurveda or indigenous traditions in the country. Under the pressure of political authority, Western style clinical trials were launched in order to assess the efficacy of this *paniya* and the results were yet to be announced at the time of writing this essay.

Containment of COVID-19 in Sri Lanka suffered a major setback with the discovery of a new disease cluster in a garment factory in Minuwangoda in early October 2020, marking the onset of the second wave of the pandemic in Sri Lanka. A related disease cluster was identified at the Peliyagoda fish market on October 20, 2020. This was initially identified as a sub-cluster of the Minuwangoda cluster, but it proved to be far more infectious, the Paliyagoda fish market is the leading fish market in the entire country and since it is a significant node in fish distribution throughout Sri Lanka, the disease spread all over the country especially to other fish markets and other fishing communities. The number of reported COVID-19 cases that accumulated over 8 months was less than 3000 cases as at the end of September. It jumped to over 30,000 cases by early December within a period of two months with a corresponding increase in COVID-19 deaths from 13 to 130 during the same period. The disease rapidly spread in low-income neighbourhoods and high-rise housing in the Colombo municipal council area increasing its visibility and livelihood disruptions for a large segment of the informal sector workers such as daily paid workers, payment hawkers, porters (*natamis*), shop assistants and the like. A wave of protests by residents of low-income urban communities against food scarcities triggered by lockdowns was launched in December. The emergence of several new institutional clusters such as prisons, police forces and hospitals directly under the purview of state authorities further added to the complications and social and political fallout of the disease during the second wave. On November 30, 2020 a major prison riot broke out in Mahara prison killing eleven inmates and injuring many others including some prison officials, reportedly due to a panic among inmates over possible

collective infection in the light of a questionable transfer of a large group of infected patients from another prison and the failure of authorities to arrange rapid PCR testing.

Patterns of Stigmatization and Panic

COVID-19 triggered stigmatization and panic impacted several categories of people during the various stages of the pandemic in Sri Lanka. The electronic media and the social media in particular played a significant role in the process of stigmatization with certain decisions taken by responsible government agencies and officials involved also contributing to the process. With the available information, some inferences can be made about the processes involved and their possible impact on the people affected, but verification of all effects and impacts were not possible due to the inability to gain first-hand information from the affected people within an environment of mobility restrictions, public health prescriptions and stipulations and ethical issues pertaining to exploration of sensitive topics within a pandemic environment. Two privately owned popular Sinhala TV channels inclined to target Muslims as potential infectors and socially irresponsible people contributing to the pandemic, perhaps due to the political orientations of these channels and their connections with the state. They will be identified as Channel A and Channel B in order to maintain their anonymity. Social media posts in Sinhala were skimmed in order to capture their representations of the disease and claims about who is infecting whom.

This paper examines media representation of the role played by different social groups in disease transmission. These groups are socially excluded categories from the angle of the socio-economic mainstream in contemporary Sri Lanka in one way or another. They include garment factory workers in export processing zones, with a female garment worker from the so-called Brandix cluster identified by some as the index case marking the commencement of the second wave of the pandemic in Sri Lanka, urban poor communities in Colombo who pushed the second wave from October onwards, a number of Muslim clusters that reportedly persisted over time, and those addicted to substance abuse and prison inmates both having problems with law enforcement agencies. The last two groups are largely overlapping categories in some ways represented as public enemies

by the media and certain representatives of law enforcement agencies privately and in some instances publicly as well. All these are in some ways marginalized social groups, who became further stigmatized by the media and to some extent, by authorities giving media briefings on reported association with these marginalised groups' corona infections in Sri Lanka. Of these five groups the current paper deals with two, namely Muslims and those addicted to substance abuse in order to illustrate the process of stigmatization during the various stages of the pandemic in Sri Lanka. This selection helps us explore their diverse representations in selected media within the context of the pandemic.

Pandemic of Hate Speech Against Muslims

Prior to the onset of the pandemic, Muslims were already a vicious target of the pro-Sinhala mass media in particular. The rising tide of *Islamophobia* in five Western media also reverberated in the mass media in India and Sri Lanka fuelling existing fault lines in these countries. In the run up to waves of anti-Muslim violence in Sri Lanka from 2012 onwards, media reports on events such as inflammatory statements by some extremist Buddhist campaigns, and the so-called campaign of forced sterilization of Sinhala women by a physician of Islamic background and the publicity given to this so-called infertility causing substances served with food to Sinhala customers visiting Muslim hotels had served to establish a distinctly anti-Muslim mindset in the communally oriented Sinhala population. The Easter Sunday attacks in Colombo and elsewhere by an extremist Islamist group reportedly connected with ISIS on April 21, 2019 (4-11) added to the anti-Muslim propaganda in the mass media and the social media so as to register the obviously unfounded view that Muslims are the public enemy number one in Sri Lanka. Politically too Muslim political parties were mainly aligned with the ruling *Yahapalanaya* regime at the time and the pro-Sinhala SLPP used this alliance to mobilize the Sinhala masses to eventually defeat the ruling regime at the presidential election held in November 2019.

A potential Islamic trigger in the onset of the corona pandemic in India and elsewhere had already been stressed in the Western and the Indian media, adding to the prevailing media hype about Islamophobia. This had to do with the possible role of several Tabligh Jamaat congregations held in Kuala

Lumpur, New Delhi and Sulawesi in February and March 2020 in the cross-border transmission of the disease in those countries and elsewhere (Silva, 2020). Even though some Islamic devotees from Sri Lanka may have participated in these religious gatherings, what impact it had on the disease outbreak in Sri Lanka is unknown at this stage. Media gaze on the pandemic in Sri Lanka was also influenced by the rising tide of anti-Muslim sentiments in the mass media and the social media referred to earlier. During the first wave of the epidemic, certain Muslim communities in which the disease was reported were subjected to widely publicized surveillance by the media, health workers and security forces. The Muslim communities located in Puttalam, Kalutara and Akurana were among those subjected to heightened surveillance during the various stages of the pandemic. In the electronic media, typically they were not identified as Muslim communities as such but visuals depicting mosques, women in abaya and some commentaries by security forces and health professionals interviewed directly or indirectly conveyed the Muslim identity of the communities under surveillance. People in the relevant communities were also blamed for hiding relevant information, not coming forward for diagnostics and not complying with lockdown imposed on these communities. Following a pattern already well-established in TV channels such as A and B where Easter attacks were attributed to the entire Muslim community and mosques were presented as harbouring weapons and extremists, Muslim communities were identified as reservoirs of COVID-19 infections and indirectly blamed for the irresponsible behaviour contributing to the escalation of the pandemic. During the second wave, the invasive nature of the surveillance work appears to have increased resulting in the use of drone cameras in communities like Atalugama in the Matugama area.

The official morbidity and mortality statistics relating to COVID-19 in Sri Lanka are not segregated by any socio-economic criteria such as income level, livelihood, ethnicity or religion, so that if not possible to do any analysis as to the role of these socio-economic variables on morbidity and mortality levels in the different communities. Quoting an unpublished survey conducted by the government using an unspecified date base, an organization called Independent Professional Alliance stated on April 14, 2020 that only 6.3% of 191 COVID-19 confirmed corona patients at that point in time was

Muslim.[5] While this may very well be true, an analysis of COVID related deaths in the early phase of the pandemic conducted by the current author revealed that of the 7 COVID-19 deaths reported as of April 15, three were identified as Muslims (Silva, 2020). The religious identity of the dead people was established through observation of summary funerals held in front of television cameras in order to dispose the dead bodies. This gives a Muslim ratio of 43% COVID-related deaths at that stage. This certainly gives a disproportionate ratio of Muslim mortality caused by the disease, surpassing their 10% presence in the population as a whole. This should, however, be not understood in any sense as an overall reflection of the morbidity pattern, infection rates among different communities or an index of the level of responsibility for disease transmission. This perhaps points to a greater vulnerability of certain communities to the pandemic because of the nature of housing, physical proximity and livelihoods in these communities. Muslims in Sri Lanka are obviously an important trading community with considerable mobility within and outside Sri Lanka with corresponding implications for their vulnerability to infection. A rigorous statistical analysis is not possible in the current juncture due to lack of official data and the impossibility of collecting relevant primary data from the affected communities in the current pandemic environment. In any case, media reports profiling certain communities and attributing blame is certainly unwarranted. That can cause stigmatization of the affected communities also possibly resulting in discrimination against them by their neighbours and service providers in some instances.

In one such incident TV channel B in its news telecast showed a large gathering in a mosque, reportedly violating a ban on public gathering at the time. This was later shared in a Facebook group with over 70,000 members as a distinctly anti-social move by the relevant group of Muslims. [6] Widely circulated stories like this were deployed to create a narrative of Muslims as super spreaders of the disease in Sri Lanka. However, subsequent enquiry revealed that this story was false and that the gathering had been organized

[5] https://srilankabrief.org/2020/04/status-statement-ii-sri-lankas-response-to-covid-19-alliance-of-independent-professionals/

[6] https://www.boomlive.in/world/coronavirus/false-muslims-ignore-covid-19-curfew-convene-at-mosque-in-sri-lanka-7603

by the health authorities in the area to conduct PCR testing. Moreover, similar stories were deployed to justify the cremation of Muslims who either died of a COVID-19 or were suspected of having been infected. The reasons given by so-called experts for insisting on mandatory cremation were rather dubious in some instances. For example, BBC spoke to a Consultant Forensic Pathologist attached to the Ministry of Health who was dealing with the disposal of dead bodies. While insisting that the government had nothing against Muslims as such, he also noted that there was "a small fear about whether the virus can be used for unauthorised activities, maybe an unwanted person could get access to a body and it could be used as a biological weapon." In a similar vein, the director of a leading cancer hospital in Colombo referred to a Muslim cancer patient admitted to his hospital who was later found to be COVID-19 positive as a veritable suicidal terrorist (*maragena marena bombakaruwek*) reminiscent of Easter Sunday attackers in a cancer hospital with a large cohort of immunologically compromised patients. These post 4/21 narratives are clearly reminiscent of similar fears about biological terror in the aftermath of 9/11.

Funeral arrangements for the dead Muslim COVID-19 patients led to a serious controversy, as mandatory cremation of COVID-19 deaths advocated by health authorities in Sri Lanka, was not acceptable to the Muslim community in general. As burial is the religiously sanctioned practice prescribed in Islam by the Koran, Muslims protested against mandatory cremation of Muslims who died of COVID-19. In a letter addressed to the President and other authorities dated April 2, 2020, a group of civil society activists representing different communities noted that compulsory cremation went against Clinical Practice Guidelines on COVID-19 patients issued by the Ministry of Health on March 27, 2020allowing for either cremation or burial. These guidelines, however, were abrogated by a subsequent circular that made cremation compulsory even though burial is culturally and religiously prescribed in Islam.[7] In these debates Sinhala and ethnic Tamil news media in Sri Lanka, invariably took an anti-Muslim stand identifying the demand for burial as unjustified and even fundamentalist at a

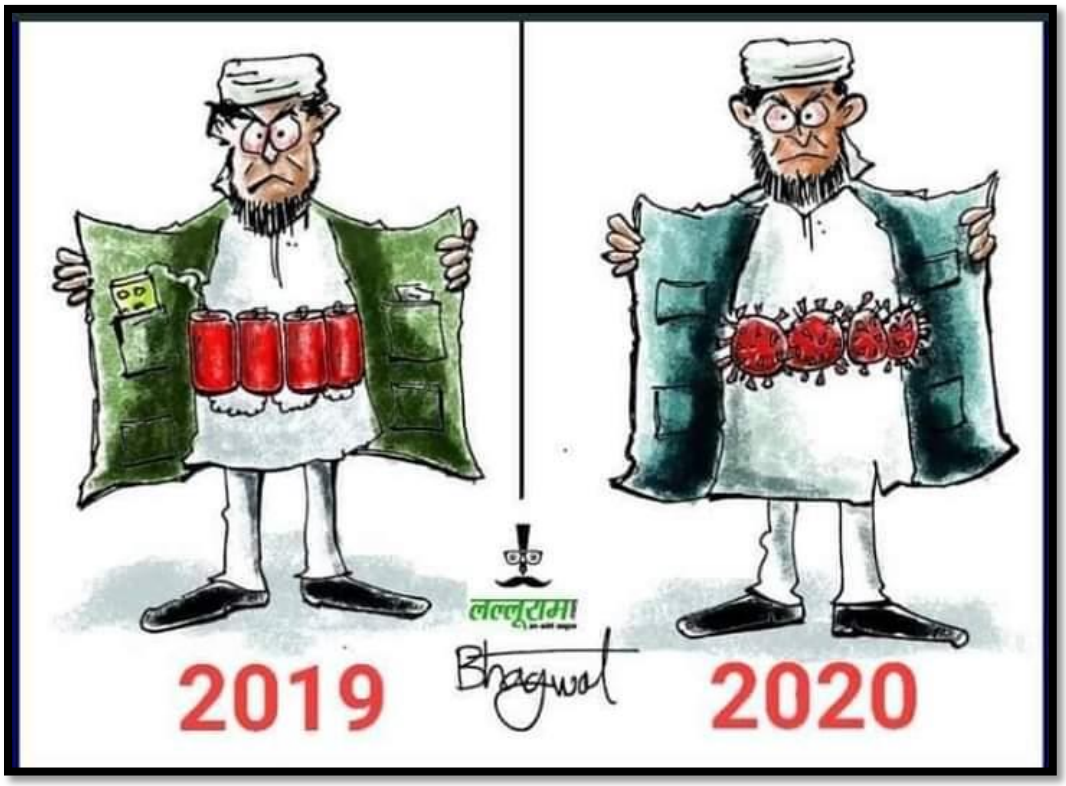
[7] Letter of April 4, 2020 addressed to the President of Sri Lanka and other authorities by civil society actors titled ‘Disposal of Bodies of Deceased Persons Who were Infected with or Suspected of Being Infected with COVID-19”.

time of a devastating national disaster. Interestingly, for the most part the medical and scientific community too stressed the need to go for cremation on scientific grounds going against the opinion of the WHO and the standard practice in most countries in the world.

A Facebook post clearly identifying a linkage and continuity in the involvement of Muslims in 4/21 and the pandemic is presented in Figure 1. This post clearly blames Muslims for both the terrorist attack in 2019 and the pandemic that broke out in 2020. These two vastly different disasters are interpreted as examples of biological terrorism mediated by the Muslim actors, projected as the public enemy implicated in the two disasters that affected Sri Lanka one after the other.

Similar themes were captured in a variety of other Facebook posts circulating during the early phase of the pandemic in Sri Lanka. Figure 2 gives a slightly different twist to the above narrative. This powerful Facebook post composed in pungent Sinhala mischievously attributed an uncomplimentary role to Muslims in the propagation of the corona epidemic in Sri Lanka (Figure 2). Importantly, Muslim traders, the same people who were subjected to much of anti-Muslim violence as well as communal-minded shop boycott campaigns in Sri Lanka, carried out concomitantly with violence, are the targets of this Facebook post which is composed deploying the neoliberal language of mass production, marketing and consumption and attributed figuratively to the Chinese and Muslim traders and the Sinhala consumers respectively. There is pun intended in the rhyming words such as '*cheena'*, '*nana'* and '*corona'*, all identified as inevitable neoliberal evils confronting "we the Sinhalese". Even though the actual social history of the epidemic in Sri Lanka is far more complex with multiple factors contributing to the epidemic outbreak, this stereotypical formulation is likely to find many acceptors among people because they already have a prejudiced mind set shaped by popular culture and mass media.

Figure 1[8]



Source: www.facebook.com

[8] Facebook Post Suggesting a Muslim Involvement in both Easter Sunday Attacks in 2019 and COVID-19 Pandemic 2020 https://www.facebook.com/photo/?fbid=120994422874508) Accessed on April 2, 2020.

Figure 2[9]

Source: www.facebook.com

Translation

Made in China
Brand Name Corona
Distribution throughout Sri Lanka
By none other than Nana
(Nana is a Sinhala slang word for the ubiquitous Muslim trader in the distribution chain)
Composition and Art Work by
'Athal Fun Lovers'

[9] A Facebook Post in Sinhala https://www.facebook.com/photo/?fbid=120994422874508) Accessed on April 2, 2020.

The blame narrative is twisted in Figure 2 in order to blame the Muslims for both the neoliberal push and the pandemic thrust in Sri Lanka, identified as related calamities in the local context. In these narratives Muslims are repeatedly blamed for all the calamities encountered by Sri Lanka in recent years including neoliberal disorders, security threats posed by terrorism and public health disorders caused by the pandemic.

In another social media post which is not reproduced here because it contains a picture of a middle-aged Muslim person from the town of Akurana claiming that he brought corona from India where he went in order to get his supplies (footwear) and he distributed corona in the towns of Kurunagala, Gampola and Galagedera, that he visited in order to supply his merchandise to retail shops. His trip to India as well as frequent travels to the said towns in Sri Lanka are seen here as deliberate moves to first acquire the disease and then distribute it in Sri Lanka in a rather irresponsible fashion.

These examples indicate how the mass media and the social media in Sri Lanka targeted Muslim community in their reporting on COVID-19. These reports may or may not have a factual basis but what is important is that in an epidemiological setting where there are multiple parties and diverse factors contributing to disease transmission, Muslims are singled out as the super spreaders of the disease in a way that discredits the community and holds them accountable for triggering the pandemic at critical points. These obviously distorted and twisted narratives may resonate with the experiences of certain popular Sinhala and perhaps popular ethnic Tamil perceptions about Muslims informed by the digital culture to which they are accustomed to rather than the actual living experiences from which they may derive certain aspects selectively to support the confirmation biases. How this representation and attribution actually impact on access to health care resources and other services in a country where Sinhala nationalist actors increasingly serve as gate keepers of various kinds has not been established. The denial of Muslim burial rights for persons who died of the disease is one instance where biased opinions clearly serve to deny a cultural right of Muslims recognized in most countries in the world.

Media Reports on Drug Addicts as Super Spreaders of COVID-19

A war against drugs had already been launched in Sri Lanka since the latter part of 2019. This involved a vigorous campaign to arrest drug dealers and addicts by the police, increased surveillance on the local and international networks involved in drug trafficking and organized crime that involved killing of rival drug dealers including those under arrest and heightened media coverage of related events. The arrest of Makadure Madush, a Sri Lankan king pin of the drug mafia also renowned for a number of high-profile organized crimes, who had escaped to Dubai and finally deported to Sri Lanka only to be gunned down while in police custody added to media hype around the drug problem in Sri Lanka. With some 60 to 70 percent of all prison inmates being held in connection with drug and alcohol-related offences, there is a high degree of overlap between prison population and substance abusers in Sri Lanka. Both these groups became important disease clusters during the pandemic in Sri Lanka, with the drug addict emerging as an important driver of the first wave and the fear of infections in crowded prisons causing prison riots and an intractable public health and security problem during the unfolding second wave.

Addicts and their contacts became an important disease cluster by itself. As of October 5, 2020, the so-called Kandakadu cluster, centred around a drug rehabilitation and a quarantine centre with the same name established in Eastern Sri Lanka accounted for a total of 651 out of a total case load of 3471 COVID-19 morbidity (18.8% of all cases) in Sri Lanka at the time. Moreover, addicts were also blamed for triggering the infections in the Navy, reporting a total of 950 cases (27.4 % of all cases), as of October 5, 2020. The authorities and the media directly blamed an addict in the Suduwella community located near the navy headquarters in Welisara infecting navy camp with disease. The addicts who were suspected of being exposed to the disease because of a previous detection in the area, reportedly resisted arrest by the Navy soldiers who themselves became exposed in the process. Some of the print media and TV channel A typically reported this as an infection by a *kudda* (a derogatory Sinhala term for an addict lit. one who is given to dust) to a group of *ranaviru* (war heroes) responsible for saving the nation during the war and the ongoing pandemic. The prisons reported their first

case on July 7, 2020 in the Welikada Prison and that too happened to be a transferee from the Kandakadu drug rehabilitation centre. Thus, apart from forming their own disease cluster triggered by their reported irresponsible behaviours such as close physical contact during drug use and avoiding safeguards such as wearing face covers, and breaking of quarantine regulations in order to secure drugs, addicts are also blamed for contributing to the triggering of other COVID-19 clusters in the country, including the largest Navy disease cluster at the time.

On 28 April 2020, *Mawbima* a Sinhala newspaper, carried an article titled "*Suduwelle Kudda*: the turning point in the corona scourge in Sri Lanka" in which a youth addict from this community was identified as patient 206, a super spreader equivalent to infamous patient 31 in South Korea.[10] This infected person reportedly gave it away to many other people in the community with whom he shared drugs. "Most importantly in a roundup of addicts in Suduwella conducted as a quarantine operation, navy soldiers were forced to chase and apprehend him through a scuffle that resulted in these *ranaviru* being infected. This resulted in rapid disease transmission within the navy, which reported 129 new cases within a few days." Media briefings by high-ranking military and police officers reported in Channel A and B openly blamed the '*Kuddo*' for infecting the navy without mentioning any contributory factors from within the navy. The stigmatizing labels *kudda* (singular) and *kuddo* (plural) already widely registered in the mass media and the social media, as part and parcel of organized crime connected with the underworld, were extended to the public discourse on COVID-19 in some ways legitimizing the militarized response to the pandemic in Sri Lanka.

In a further development widely publicized in the media, a COVID-19 positive drug addict who had been transferred to the National Infectious Disease Hospital in Angoda from the Kandakadu quarantine centre, ran away from the hospital in the early hours of the morning of July 24, 2020, causing public panic and a mass fear of him being an indiscriminate infector in the

[10] https://mawbima.lk/news

capital city.[11] His pictures obtained from hospital records and video clips captured from CCTV were widely disseminated in order to help identify him. His name and place of origin also leaked to the mass media and his Muslim identity was conveyed and further added to the stigmatization process. He was apprehended later in the day, but efforts to trace his possible contacts continued using his own reports, CCTV footage and reports of people who had seen him during the time he was out of hospital. After causing considerable public panic about this incident, health authorities later revealed that the person concerned had largely recovered from the disease and that he was probably non-infective at that stage.

The fear and panic about the disease was not merely a result of mass hysteria connected with the fallout of the disease. In some instances, it was deliberately used by the authorities as a security devise at a time of mass crisis. For instance, following the prison riots in Mahara prison, a high-ranking defence official justified the shooting of prisoners by the authorities on the grounds that if infected prisoners were allowed to break away, they would have infected many civilians in the capital city.[12] The imagery of bio-terror by a collection of COVID-19 patients, whether they are addicts, criminals or members of a particular socio-economic category or an ethnic community, as both a security and a public health threat to the uninfected civilian population was deployed by certain persons in authority and media circles as a public statement without seriously considering its possible implications and long-term impact of criminalization of a public health emergency.

In consequence, there was a wave of social media posts condemning the addicts, always labelling them as *kuddas*, for their contribution to the pandemic in the navy cluster in particular (See figures 3 to 5).

[11] https://economynext.com/covid-positive-inmate-from-kandakadu-is-on-the-loose-after-escaping-from-idh-police-72309/

[12] https://www.newsfirst.lk/2020/12/02/mahara-prison-riot-could-have-led-to-serious-consequences-defence-secretary/

Figure 3[13]

Source: http:// www.Facebook.com

Figure 4[14]

Source: http:// www.Facebook.com

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[13] Facebook post condemning the neglect of safety procedures by addicts referring to them as balu kuddo (dog-like addicts) who should be shot

[14] Facebook post attributing the navy cluster to the misbehaviour of addicts in Suduwella

Figure 5[15]

Source: http:// www.Facebook.com

That Facebook posts always refer to the addicts using the derogatory label *kudda* (Mr. dust) clearly indicate the successful hegemonic impact of state propaganda in shaping the mind-set of a section of the population. Obviously, there is a convergence between the mass media and the social media with regard to branding people using derogatory labels such as *kudda*. The tendency is to blame the addicts not only for becoming addicted and getting infected but also infecting others, including the very people, who are deployed to safeguard the nation (*ranaviru*). While this does point to the deep penetration of a certain hegemonic ideology, creating a pro-establishment narrative, it may not necessarily be a public opinion conducive to reducing panic and promoting compliance to safe practices on the part of certain vulnerable groups. Biopolitical nationalism may be in operation here in so far as the state interventions are admired and condoned by a majoritarian mindset (de Kloet, Lin and Chow 2020), but resistance against

[15] Facebook post asking the state not to release addicts (*kuddan*) to society even after they recover from COVID-19

these measures may be growing as evident in the prison riots, protests against food scarcities in urban areas affected by lockdowns and poor compliance for disease control measures on the part of certain marginalized groups also reporting high incidence of disease. A more enlightened approach is necessary in order to avoid stigmatization of victims and restore human dignity among all parties, including the infected addicts, prevent further infections in society and achieve improved compliance for disease control measures from all segments of the population, inclusive of socially and politically marginalized groups.

Conclusion

Clearly the unfolding pandemic in Sri Lanka has also given rise to a parallel pandemic of fear and stigmatization resulting in a number of social problems and related public health crises. The public health consequences include certain people belonging to vulnerable social groups not coming forward to get themselves tested, lack of earnest compliance for safety and disease prevention interventions on the part of certain disaffected population groups, possible persistence of reservoirs of infection in particular segments of the population with bourgeoning stigma against them serving to retain patterns of infection within such groups and an overall alienation of certain marginalized groups from political allegiance to the state as well as public health and curative services of the state. From this angle, the examples of individuals running away from health services can pose a serious threat to the control of the pandemic in time to come unless the current patterns of stigmatization and related discrimination are satisfactorily addressed through required interventions and policy changes.

From the angle of social problems related to the pandemic, the outbreak of stigma has reinforced and further deepened the already existing social cleavages along ethnic, religious and class lines. For instance, hate speech against Muslims already well-established in sections of Sinhala and Tamil societies during the past decade also escalated due to the Easter Sunday attacks have been reinvigorated during the pandemic at least in part due to pandemic related grievances such as the legitimate demand for burial of Muslim dead bodies. In our view, hate campaigns are not isolated events but important indicators of extremist views in society that are potentially

inflammatory and inclined to push actors on either side of the ethnoreligious divide to violent extremisms of one kind or another. Similarly, it may be necessary to revisit the war against drugs currently being aggressively pursued in the country in the light of more enlightened harm reduction policies that seek to decriminalize addictions and bring it under the purview of public health interventions designed to wean them away from drugs considering it as a public health hazard rather than a crime as such. In any case, the overcrowding in prisons by people convicted or being tried for alcohol and drug-related offenses and the emergence of prisons as a safe house for reconvicted criminals who end up as more serious criminals during the process can only be addressed effectively by developing appropriate social policies through a sound understanding of the processes involved.

As for the biopolitical nationalist project in Sri Lanka, its relative success during the first pandemic wave in containing the disease and gaining political acceptance of the majority community may be increasingly challenged during the second pandemic wave due to the fallout from increased infections, livelihood and supply chain disruptions caused by sudden imposition of lockdowns, increased pressure on health services, state policies and coercion targeting prisoners, drug addicts, the urban poor and selected minority groups in particular. Unlike in East Asian examples noted earlier in this paper, political resistance in Sri Lanka is more ingrained and majoritarian or minoritarian nationalism can swing in favour of or in opposition to the establishment far more rapidly and in rather unpredictable ways (Spencer, 2012). Organic developments of a healthy character such as natural blending of Western medicine with evolved practices of indigenous origin may be undermined due to politically motivated ad hoc initiatives such as invention of *Dhammika Paniya* guided purely by biopolitical nationalism without any basis in traditional medicine as such. In any case, the notion of biopolitical nationalism which may be useful as an explanatory frame in some contexts, does not fully capture the political complexities associated with a raging pandemic and its devastating fallout. This, may in turn, push the authoritarian character of the state or in the alternatively facilitate democratic reforms, a greater respect for diversity, pluralism and inclusive social development. As of now Sri Lanka is obviously at the cross roads as to where it is heading.

In order to facilitate inclusive social change, there is an urgent need to provide an appropriate social science training to high level decision makers in health, defence, law enforcement and criminal justice. This training should draw from recent developments in social science subjects such as sociology, social work, political science, psychology and criminology. It should also provide an opportunity for the participants in these training programs to learn from the experience of relevant interventions in other countries in areas such as crime prevention, drug rehabilitation, elderly and disability care, reconciliation, conflict resolution and promotion of primary health care.

The analysis pursued in this essay also points to a clear need to develop appropriate social policies and educational programs and prepare youth, media personnel and civil society activists to play a proactive role in democratization of society, promoting human rights and social justice, tolerance and diversity and prevention of violent extremism of all kinds. This is a serious challenge that calls for concerted action and collaborative efforts by multiple stakeholders including academics, researchers, civil society leaders, religious personnel, private sector agencies and media houses. Only a mass social movement reaching out to various sectors of society vigorously campaigning for required social and political reform can possibly push Sri Lanka out of the current crisis, inclusive of but not limited to the pandemic and its fallout.

References

Agamben, G. (2020). The enemy is not outside, it is within us, *The Book Haven*, 14 March. Available at: https://bookhaven.stanford.edu/2020/03/giorgio-agamben-on-coronavirusthe-enemy-is-not-outside-it-is-within-us/

Appadurai, A. (1996). *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press.

Cohen, S. (1972). *Folk Devils and Moral Panics*. London: MacGibbon and Kee.

de Kloet, J., Lin, J. and Chow, Y.F. (2020). We are doing better: Biopolitical nationalism and the COVID-19 virus in East Asia, *European Journal of Cultural Studies* 2020, Vol. 23, No.4, pp. 635–640.

Dingwall, R. Hoffman, L.M. and Staniland, K. (2013). Introduction: why a Sociology of Pandemics?, *Sociology of Health & Illness*, Vol. 35, No. 2, pp. 167–173

Ministry of Health, (2020). *COVID-19 Situation Report*, 5-10-2020. Colombo: Epidemiological Unit, Ministry of Health, Epidemiological Unit.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Touchstone.

Ng, E. (2020). Editorial: The Pandemic of Hate Is Giving Novel Coronavirus Disease (COVID-19) a Helping Hand, *American Journal of Tropical Medicine and Hygiene*, Vol. 102, No. 6, pp. 1158-1159.

Silva, K.T. (2020). *Identity, Infection and Fear: A Preliminary Analysis of COVID-19 Drivers and Responses in Sri Lanka*. Colombo: ICES, 2020. http://ices.lk/publications/identity-infection-and-fear/

Spencer, Jonathan. (2012). Performing Democracy and Violence, Agonism and Community, Politics and not Politics in Sri Lanka, *Geoforum*, Vol. 43, No. 4, pp. 725–731.

Strong, P.M. (1990). Epidemic psychology: a model. *Sociology of Health and Illness*, Vol. 12, No. 3, pp. 249–59.