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COMMENTARY

Ethical dimensions of stigma and discrimination in Nepal during COVID-19 pandemic

Dimensions éthiques de la stigmatisation et de la discrimination au Népal pendant la pandémie de COVID-19

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Summary
COVID-19 pandemic has ultimately brought down the world in a status of standstill as a result of lockdown as one of the measures to combat the situation and to prevent cross transmission. On the other hand, it has raised issues like ethical obligation of medical doctors and other staff to attend COVID-19 patients without proper PPE and resources increasing the risk to the staff and their family. In addition, it has resulted in compromise of the services provided to the people like non-availability of medical services to chronic and non-urgent patients. Non-COVID-19 patients attending ‘Fever Clinic’ were harmed due to inappropriate management. Medical staff dealing with testing or working in hospitals, isolation wards or quarantine centres have been stigmatized as ‘possibly infected’ and even denied food and accommodation.

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Background
The globe has come to a standstill with the ‘lockdown’ policy to contain the contagious disease COVID-19. During the pandemic, doctors, nurses, paramedics and other healthcare staff’s duty to provide care is the key to good ethical practice [1]. Human duties override human right during the extraordinary emergency situations like this.

Quarantine of the potentially infected and isolation of positive patients is the standard management of COVID-19 but health care providers must be aware of the socio-cultural implications, and potential for stigmatisation which
could inadvertently affect certain population [2]. Returnees from abroad, COVID-19 positive cases and their suspected contacts, even health care workers are facing stigmas. To deal with the present context several academia and professional organisations have published management guidelines [3]. The principal values included in the guidelines are accountability, inclusiveness, transparency, reasonableness and responsiveness [1]. These values promote action and decisions that are fair, reciprocal, respectful, and equitable [4].

**Discussion**

Ethical issues in the national context of Nepal during the pandemic COVID-19 particularly after the public health measures in relation to stigma and discrimination to health care professionals and patients are discussed. Four principles of biomedical ethics - autonomy, beneficence, non-maleficence and justice are attracted in some way or the other.

**Duty to care and stigma against health care professionals**

Health care professionals have duty to care the patients and due to exposure, they are at higher risk of acquiring infection. Ultimately, their family members are also at the higher risk than general population. Furthermore, they might transmit the infection to other patients. They are in a difficult situation to balance the professional and personal obligations. Incidents have been reported from various parts of the country including Sindhuli, Kathmandu and Dang districts that health care professionals have been forced to leave their rented accommodation due to their profession. Health care workers particularly those deployed in the hotspot in Udayapur district were turned away from restaurants and hotels, denying food and lodging. In another incident the paramedical staff was physically assaulted by a father whose son returning from abroad was asked to keep at quarantine shelter in the village.

**Stigma against institutions**

Identifying a dedicated hospital for the treatment of COVID-19 is intended to ease the care of patients and protect others undergoing treatment in a general hospital. However, it has increased the stigma towards the professionals working in these dedicated hospitals. In February, when the government decided to repatriate Nepali students from Wuhan, China; there was resentment from the community wherever the quarantine centre was being planned. Later on, Bhaktapur was decided but the local people including the political leaders were opposing the decision. This was an expression of fear and stigmatisation towards the establishment of quarantine centre. Fortunately, all these 195 inbound students tested negative for corona virus even in the second test carried out after two weeks of quarantine.

**'Fever Clinics' and dilemma of discrimination of fever patients**

When the second case of corona positive was reported in the media, regular medical services started closing down. On the one hand, patients with fever were seeking consultation even when they were not that sick. In the meantime, health care professionals were not comfortable to handle fever cases as there was no way to rule out COVID-19 in every case due to lack of laboratory resources and test kits. Once the government declared lockdown in the country, all the hospitals stopped their regular services except emergency. Ministry of Health and Population directed all government hospitals to set up a separate clinic for COVID-19 which was labelled as 'Fever Clinic'. As personal protective equipment (PPE) were inadequate and health care professionals were at risk while collecting swab samples and caring the suspected cases in isolation ward, the government decided to disburse 1 million rupees to 25 hospitals to help them run fever clinics. All patients with fever were referred to hospitals having specified fever clinic. When COVID-19 was suspected, they were kept in isolation ward. Several incidents including deaths in isolation wards due to other febrile illness including case of polytrauma in sepsis were reported. This is an example of discrimination against the patient with fever resulting in ultimate harm. Fever clinic is a sort of triage clinic but somehow it was perceived as a COVID-19 specialist clinic. Avoidance of patients with fever by other clinics and hospitals led to lack of services and inappropriate management of febrile patients other than COVID-19.

**Lack of services to patients other than COVID-19**

Immediately after the lockdown decision of the government, hospitals throughout the country stopped regular services and the public perception was that only the patients with COVID-19 will be taken care of. The potential harm of this situation was on those patients who were on treatment for chronic diseases, and in some cases, delay in the management of emergency and semi-urgent cases. In general, fair allocation of resources that prioritizes the value of maximizing benefits applies across all patients who need resources and there should be no difference in allocating scarce resources between patients with COVID-19 or with other medical conditions [5]. The current context of COVID-19 demands revised emergency ethics that is reasonable, transparent, fair and broadly agreed by everyone [6].

**Impact of lock down**

COVID-19 crisis and resultant turmoil might endanger and further marginalise already at-risk population particularly in rural areas [7]. Discriminatory denial to purchase agricultural products produced in disease-hit areas will have long-term impacts on the livelihood of people from the affected districts. Quarantine, social isolation and travel restrictions had negative impact not only on livelihood but also for access to health care. Paying capacity for health
care cost went down as the period of unemployment was protracted.

Government actions, such as lockdown and quarantine can exacerbate power imbalances between civilians and the state. Incidents of maltreatment including physical assault by the police for not complying with lockdown order, was commonly observed in Nepal and some of them required hospitalisation. Such incidents were denounced by several concerned authorities including human right activists and media; then, these became less frequent.

**Herbal remedies: Non-scientific treatment advices**

Amidst chaos and rumours, there is no treatment of COVID-19 in allopathic medical system was highlighted in social medias and claims were made for the effectiveness of herbal remedies which had no scientific evidence. Those claims of homemade remedies might have positive sense of safety, but their adverse effects cannot be ignored.

**Cross-border issues and feeling of fear in foreign land**

Upon implementation of lockdown, hundreds of migrant workers were stranded in Nepal-India border on both sides and kept in quarantine centres. In far western border of Nepal, several people risking their lives swam across Mahakali river to avoid quarantine in Indian side. Ultimately, they were quarantined in Nepal.

**Importance of appropriate communication**

Providing appropriate information, truth-telling, and transparent actions augmented the sense of civic responsibilities and voluntariness was observed in the public [8]. Risk communication and community engagement is a critical component of the response to COVID-19 that helps people make the right decisions about how to protect themselves, when to seek care, and to avoid contributing to panic about the disease. Managing the ‘infodemic’ and maintaining trust in public health authorities is critical to ongoing management of the outbreak. Trust begins with communication, and communicating information during outbreaks is challenging, especially as our knowledge of a disease evolves [9]. Nyblade et al. suggest interventions to mitigate stigma should address not only the driving factors like existing knowledge and misinformation but also the facilitators like health policies and institutional practices [10].

**Disclosure of interest**

The authors declare that they have no competing interest.

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