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COVID-19 Patients in Bangladesh: A Qualitative Investigation on Social Exclusions and Stigmatization

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ABSTRACT

The COVID-19 pandemic has snatched away the lives and livelihoods of many people throughout the world. The number of infected and death from SARS-CoV-2 has still been increasing in Bangladesh. The fear of the unknown, uncertainty, knowledge gap and high communicability have fed into the social stigmatization of COVID-19 patients and survivors. Considering the research gap, this study looks at how stigma and prejudice caused by COVID-19 are prevailing in Bangladesh. This research was carried out on purposively chosen 200 COVID-19 positive patients who were hospitalized in a government-run COVID-19 dedicated hospital in Dhaka from the end of March 2020 to August 2020. All ethical concerns were maintained during data collection. The qualitative approach was used for in-depth interviewing through telephone. The present study finds some phenomenal examples and experiences of marginalization and stigmatization due to the highly contagious nature of the virus among the patients, relatives, neighbors, health care workers etc. COVID-19 patients or their relatives are found to pass much-stigmatized life with a feeling of hopelessness. Even though many of the COVID-19 patients died, their family members are still bearing the brunt, making them stigmatized. The discourses of self-stigmatization, social harassment, treatment, prejudice, and stigmatized funeral etc., have been discussed critically.

Introduction

The World Health Organization (WHO) has declared a worldwide alert for the outbreak of COVID-19 as a pandemic when globally people become stressed, frightened and panicked. As of 18 August 2021, there has been a total global infection case count of 208 million, with a death count of 4.4 million (WHO, 2021). The infection of Coronavirus (SARS-CoV-2) has still been continuing and the virus might sustain in the coming days, which will increase COVID-19 cases (Bruns et al., 2020). This pandemic has already caused an enormous death toll, terrific health impacts on people and consistent downturn status of the global economy (Donthu and Gustafsson, 2020; Nava et al., 2020; Proaño, 2020). Furthermore, imposing lockdown at the local to national level has created incomprehensible suffering for the people (Paul et al., 2020; Sotgiu and Dobler, 2020). This global crisis adds a burden on people by creating fear, anxiety, psychological problems, and huge socio-economic impacts (Dubey et al., 2020; Nursalam et al. 2020). The chain transmission of Coronavirus from person to person, long gestation period and asymptomatic cases of COVID-19 have sparked fear among mass people due to the uncontrollable and congruity nature of the virus (Duan et al., 2020; Tian et al., 2020; Wu and McGoogan, 2020).

In the case of infectious diseases or pandemics, human fear often increases due to the apprehension of the adverse outcomes of the disease. Such concern arises mostly when people in the communities are kept isolated or quarantined for a particular period to control the infection (Person et al., 2004; CDC, 2003). Earlier infectious diseases had an association with stigma (Ho et al., 2020) and stigmatized patients had suffered discrimination that negatively impacted all members of society (Abdelhafiz and Alorabi, 2020; Mak, 2009). Stigma is not only an isolated sociological concept but is also more closely wrapped up with many other aspects of the human condition, leading to discrimination and marginalization. The term 'stigma' refers to an attribute that serves to 'discredit a person or persons in the eyes of others' (Franzoi, 1996: p.403) or 'devalues the person' (Hopper, 1981); it can be seen as a 'principled refusal' (Fischhoff, 2001) or in terms of 'socially disqualifying'

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attributes (Katz, 1981). Social stigma is defined as discrimination against a person who possesses characteristics that visibly discern them from others in a society, such as race, ethnicity, gender, intelligence, and health (Goffman, 1963). In Goffman's conception of stigma, there is the implication that the attributions spoil the person's identity permanently. The experience of stigma has a profound effect both in its emotional impact for the individual concerned and its social repercussions for the marginalized group. At an individual level, the impact of stigma and social exclusion can be devastating, leading to low or diminished self-esteem (Hogg, 1985), poor social relationships, isolation, depression, self-harm (Mason et al., 2001), and feelings of loss of control, embarrassment, and the deficiency (Paul, 2020; Benjamin, 2001).

Stigma in the era of COVID-19 can be perceived as a social attribute that excludes the infected people considering them as a potential source of spreading the disease and they are also thought as harmful for the peaceful living of other members of the society (Barreto et al., 2015; Phelan et al., 2008). The association of stigma with the pandemic is a well-established matter (Person et al., 2004); however, the way it develops may differentiate depending on the context (Bhanot et al., 2021). The dead bodies of COVID-19 patients even did not get the mercy of social stigma. There are pieces of evidence of violation or restriction imposed on the COVID-19 death funerals (Mitra, 2020) and burials (Bhanot et al., 2021; Press Trust of India, 2020). Furthermore, the infected patients and the people associated with the COVID-19 positive (e.g., family members) have been bearing the brunt of stigma (Duan et al., 2020). The impoverished people in society, the lower working class and the minority are stigmatized as potential bearers of the contagious virus (Srivastava, 2020). COVID-19 positives are stigmatized and therefore endure the consequences that are more malignant than the physical condition they face (Earnshaw, 2020; Waxler, 1992). Social rejections have created a barrier between the infected people and society (Williams and Gonzalez-Medina, 2011). The patients are stigmatized and in fear of being humiliated by society, demonstrating hysteria (Bhanot et al., 2021; Balakrishnan, 2020).

Bangladesh reported its first COVID-19 positive case on March 8, 2020, and total positive cases rose to 1,581,343 as of 20 December 2021 including 28,050 death cases (IEDCR, 2021). This outbreak has caused widespread fear, hatred, and stigma against the COVID-19 patients in Bangladesh. Moreover, there's a growing emotional protest against the beneficial activities related to COVID-19 (Mahmud and Islam, 2020). A female doctor from Dhaka Medical College and Hospital was threatened by her neighbors to leave the apartment. Her neighbors suspected her of being a potential spreader of Coronavirus, as she was the frontline supporter to COVID-19 patients; such behavior of nearby people made her stigmatized (Kamal, 2020). Another case of women reported in Bangladesh shows the merciless behavior of family members. She was having COVID-19 like symptoms, including sore throat, fever and breathing problems. Her family members threw her in a deep forest, assuming she got infected by the Coronavirus (Bdnews24, 2020). On the other hand, many people were seen to show reluctance in burying the dead bodies of COVID-19 infected persons. A garment worker died from the coronavirus infection, but the deceased person's villagers did not allow to bury the dead body in the village (Hossain et al., 2021; Jahangir, 2020). Many such cases of social negligence and prejudices reported in Bangladesh were harsh enough to stigmatize COVID-19 positives or their family members. COVID-19 induced stigma causes a severe threat to the lives of health providers, corona infected patients and the people who survived this infection (Bagcchi, 2020).

The COVID-19 pandemic has significantly restructured different sectors of human civilization, such as education, economy, and health. Stigmatization can arise from and present itself in various ways across communities and nations on patients and survivors, but such studies are scanty because most scholars tend to highlight more on the physical impacts of the pandemic. A substantial number of studies have already been conducted focusing on different aspects of COVID-19. Although a few pieces of research are visibly mentioned above, no significant research on social exclusions and stigmatization regarding COVID-19 has yet been conducted in Bangladesh. Considering the research gap, this study is a pioneer project in searching the relationships between stigma and prejudice caused by COVID-19 in Bangladesh.

Materials and Methods

This research was carried out on the COVID-19 positive patients using the qualitative data collection instrument. This study is mainly based on primary data and to some extent, supportive secondary materials have also been gathered. Primary data was mainly collected through telephone interviews by efficient and trained team members.

COVID-19 Patients' Database

A database of 1005 COVID-19 positive patients was collected from a COVID-19 dedicated government hospital in Dhaka. Due to ethical reasons, the hospital's name is not mentioned. The database includes only patients admitted to that hospital from the end of March 2020 to August 2020. This record consists of the patient's name, age, contact number and address. Data shows that two-third of the respondents were male (above 50 years old) and city dwellers, especially from Dhaka and Narayanganj. Following an ethical procedure,

the database was used for collecting primary data from the listed patients.

Study Area

The collected database from a government-run hospital includes patients from almost all neighboring districts of Dhaka. Even patients from other divisions of Bangladesh admitted to that hospital after being infected by COVID-19. People living in rural and urban areas were found in the list and all of them were approached randomly.

Sampling

The collected database has been used for tracking all the COVID-19 patients. Following the contact number, all the listed people of the database were communicated and 807 of them responded through phone call. Based on a pre-set theme for this study, the team members have purposively selected 200 COVID-19 positive patients or family members of COVID-19 deceased for further in-depth telephone interviews. Though all 807 people were interviewed, only 200 responses have been purposively selected for this study, considering their relevance, depth of sufferings and stigmatized conditions expressed by them.

Primary Data Collection
Telephone Interview

A theme for telephone interviews was developed focusing the objectives of the study. Total eight open-ended questions are listed under the theme for conducting telephone interviews. A team of 10 people has conducted telephone interviews throughout one month (May 2021), although some procedures of ethical clearances took a long time. The telephone conversation started with seeking consent from the participants for their time and recording the whole conversation on smartphones. The conversation started with some basic information checking from the participants. The first few questions were kept understanding the level of the suffering of the interviewee during or after coronavirus infection. Interviews were only advanced if they had any stigmatized condition faced during or after the coronavirus infection. From the total 807 people who responded in the phone call, only 200 patients were found eligible for this study and they were the worst sufferers due to the COVID-19 in terms of social exclusion. Interviewers have proceeded with an in-depth and long conversation with the selected 200 people. Some of them were communicated for more than one time, considering their convenience and availability. These interviewees shared their stories of negligence from their surroundings and their mental sufferings. Information regarding both COVID-19 survivors and family members of the deceased patients is taken into consideration. Each in-depth telephone interview had a duration of 30 to 50 minutes. Default call recording software of the smartphone was used to record the conversation for the convenience of transcription.

Data Analysis
Qualitative Data Analysis

Qualitative data is gathered through In-depth telephone interviews. At first, the recorded conversations are transcribed, and then the 'Grounded Theory Method' (Kitchin and Tate, 2000) has been followed to analyze the qualitative data, which consists of the description, classification, and making connections between the data. Different relevant quotations of various respondents are presented as direct and indirect speech. Considering the ethical issue, all names of the participants were changed or kept anonymous.

Results

According to a WHO report published in 2020, COVID-19 patients reportedly suffer social stigma, hatred, and denial of treatment across the globe, especially in developing countries. Due to the COVID-19 pandemic, fear, hatred, and social exclusion have become common issues for patients across Bangladesh. There are plenty of media reports on social stigmatization and discrimination against COVID-19 patients or suspected cases. The present study also found some phenomenal examples and experiences which increased marginalization and stigmatization due to the highly contagious nature of the virus among the patients, relatives, neighbors, health care workers etc. discussed in the following.

Self-Stigma

Stigma often occurs for lack of understanding or fear. Self-stigma takes place when people internalize the public attitudes and may suffer numerous negative magnitudes as a result. Inaccurate or misleading media representations contribute to increasing self-stigma about any health risk. Among the COVID-19 patients, the phenomenon of self-stigma has been widely observed in Bangladeshi society. Many of the patients did not inform their families in fear of being mistreated or abandoned. Some other patients and their family members chose to hide the news of Coronavirus infection. This turned out to be challenging for the patients too, because some of them could not go to the hospital duly for treatment and thus, their condition degraded. A patient named Jamil, who had died from COVID-19, his sister reported that: *"We were afraid of our neighbors, we were afraid of the neighborhood, afraid of the landlords, we had nowhere to go. We kept my brother at home for 11 days. Finally, my brother's condition was worsening, and he died."*

Bangladeshi people didn't have much clear idea about Coronavirus initially, mainly how it spreads and what should be done after being infected. As the most

people had misinformation about Coronavirus, they became panic, and rumors circulated widely. Patients tried to hide their disease identity to the outside family after seeing the anarchy with COVID-19 patients. In most cases, when family members noticed any symptoms of COVID-19 in anybody at an early stage, they mostly avoided testing for Coronavirus; however, when he/she got sick, they took the initiative for testing. If person tested positive for COVID-19, family members tried to keep him/her in the house rather than inform any relative or neighbors. Meanwhile, the family provided general medicine to the patient from their knowledge. Even in most cases, they avoided physicians for consultation. In an emergency, they shifted the patient to the hospital if the situation worsens than expected. Even family members were not interested in sharing the message of hospitalization to anybody because of the fear of stigmatization. Here, the risk was when any patient stays at home with having all symptoms and signs of COVID-19; he/she would fall in more health risk along with other family members.

This problem of self-stigma has attracted more attention after investigating a deceased's (Shopno Sorkar) relative who said, *"He was suffering from fever from the day of Eid. Later we went for a COVID-19 test because the fever was too high. When he saw the report coming positive, he became petrified. At home in the evening, began to have difficulty breathing."* This patient died after two days of testing COVID-19 positive. Some families become too rude to the patient. They isolate the patient and didn't take care of him or her properly. Misbehavior from close people is sort of mental torture. A patient named Munni Akter faced similar consequences. She said, *"My family didn't treat me well. My brother asked me to stay in another house for 15 days. He was too worried for his other family members. I felt very depressed"*. However, we found some different scenarios too. Like a deceased's (Halim) son said, *"After the COVID-19 test, when my father found out that he had tested COVID-19 positive, he was scared. He thought we would probably abandon him. Then we immediately hugged him thus, he gained some courage."*

In this study, we found that people were terrified to share their disease status with the landlord because of the fear of eviction from their present living space. Anjuman Ara said: *"Honestly, I didn't tell anyone about my illness in my apartment because of fear. There could have been much trouble, so I didn't want to take any risk. We didn't have anyone in Dhaka, so we couldn't let them know."* In some cases, fearing public embarrassment, many people did not want to report that they had been COVID-19 positive. When asked about this, they said that if people knew that they were positive, they would be compelled to stay in a 14-day quarantine which was considered shameful by the patients. They also don't want to stay in a room for 14 days. Again, those who held small jobs hide the positive report of the COVID-19 test for the fear of losing their jobs. Moreover, a patient named Rashid phoned his close friend to inform his positive result of the COVID-19 test. His friend switched off his phone and did not maintain any further contact. By this, Rashid felt ashamed and even slightly afraid of further social rejection. Many people did not want to be tested for corona despite having symptoms since the corona test was expensive for them.

Hatred from Relatives and Neighbors

The main practical problem that we discovered was the negative attitude received from patients' family members, relatives, and neighbors while they suffered from COVID-19. To address the question adequately, we investigated the respondents very carefully and asked them if they had received an unfortunate treatment. Many patients have experienced diverse family reactions. In many cases, family members ignored, isolated, and blamed the patients for being infected. Some unfortunate patients were humiliated by family members and considered the matter shameful. In a few cases, family members have abandoned the patient. Malek Sheikh, a survivor, said: "*I was alone in the hospital bed when my family members stayed away from me. I hired a nurse to take care of my health*". There are plenty of media reports about stigmatization. For example, BdNews24.com published that a 50-year-old mother was left by her children in a forest in Tangail on April 19 as they suspected her of being infected. A patient named Md. Najmul shared his frustrations about his family. He said, "*My blood relative has done the worst. My brothers and my brothers-in-law did not allow me to enter the village. They asked not to come here anymore. Later I went to my father-in-law's house*." Farida Yasmin shared her unfortunate experience. "*My elder sister lives in our next apartment. She didn't even come to see me".*

In fear of being infected, relatives maintained distance from the disease-ridden family in many cases. The COVID-19 survivor's side did not find relatives; some even assaulted the patients verbally and physically. A patient named Motahar, who survived the disease, spoke in grief, *"I was questioning myself why I was alive! I would rather die than see nobody is coming near me, even after I was tested negative."* Jamil's sister cried over the incident that no one of their relatives wanted to talk to them and help them when they were tested COVID-19 positive. While fighting with the disease at home, a patient named Jashim Uddin (47) was neglected by his relatives. Regarding this, his wife said, *"We had to go through a tough time during the period of his illness. We have relatives nearby, but they refused our call-outs for help."* Another patient, Nazmus Sakib said: "*My aunts used to live next to my house. Our family relationship with them was much better. Nevertheless, she didn't come to see me as I was infected with the Coronavirus.*"

It was widespread to see that the neighborhood threatened the sufferer and their families not to go out from home. As a result, the COVID-19 patients and their families faced more trouble. They could not get daily groceries and continue normal life as well. We found cases where house owners or neighbors forced/ evicted the infected patients and their families to leave the houses or apartments after knowing about this disease. A patient named Alam reported, *"As I returned from the hospital, my landlord had refused to let me in and told me to vacate the house".* On the other hand, Hasina Banu, a survivor, stated that "*I had to sell my house and leave my hometown and shift to Dhaka only because of the people of my village*". Villagers even didn't talk to them after hearing about their recovery from the hospital. Mahbuba Akter, a patient, shared her experience. She said, "*I live in a colony. My son lives in the back room of the house. When my son was Corona infected, neighbors did not go through the back of our house. They did not even walk in front of the house. They used to taking turn the other way. I still feel much pain when I think of those days. We received negligence even after we recovered*". A patient, Jakir Hossain said, "*My children couldn't go out to play. The neighbors strictly forbade them. As they thought my kids would spread the disease*." This is how general people used to keep a distance from the family members of an infected patient. This may cause short time mental trauma for the patient's family. Moreover, the COVID-19 patient has gone through lots of social disturbances. Hospital staff Shahinur Islam shared his experience of being refrained from entering their area for 15 days because of his infection. These examples show how a suspected or infected COVID-19 patient has been socially stigmatized. However, there are some different stories of being helped by neighbors too.

Unexpected Behavior from HCWs

In Bangladesh, COVID-19 patients were kept under remarkable observation after being admitted to COVID-19 dedicated hospitals. However, many health care workers (HCWs) worked hard to give their best efforts to the patients. But most COVID-19 survivors complained about how much careless behavior they received from HCWs. The doctors, nurses, and supporting staff have shown a lack of dedication to the patient's treatment due to their ignorance about the virus. Most of the complaints about the HCWs were not treating patients directly; being unavailable when patients need them; insufficient number of HCWs; keeping a distance and not serving the patients well. The following issues can be considered as examples of negligence towards the patients in the hospital setting.

Many patients or their relatives mentioned that some doctors did not treat patients directly in many hospitals. A patient's relative or attendant plays the role of a 'bridge' between the patient and the doctor in that case. Like many patients, the son of Dipali Rani faced this consequence and said: "*We used to go to the doctor's room with the patient's file and described the patient's situation from outside of the room. The prescription file had to be kept near the door of the doctor's room. That's how the treatment was going on and served our patients*." The same incident happened with Late Tahera Begum. Her son said, "*We admitted our mother in a reputed government hospital in Dhaka, but their treatment was not satisfactory. My mother was unconscious. She couldn't say anything by herself. We, family members, used to go to the doctor's room to describe her condition. The doctor then prescribed medicines. They didn't come to see on their own. They prescribed medicine without seeing the patients and listening to their relatives*". Regarding the doctor's attitude, Rokeya Begum mentioned: "*When we went to the hospital, the doctors did not come near us and (they) were standing outside of our room. Now, imagine how much they took care of us"!* Many doctors were terrified to take care of patients due to the high risk of virus transmission. People claimed that they had received medical support from the intern doctors rather than general physicians on their hospitalization. Moreover, interns were not very friendly and professional with their responsibility and attitude. Prodeep Kumar, who was admitted to a government-run COVID-19 dedicated hospital in Dhaka, was tested as COVID-19 positive. His son said, "*Surely doctors tried their best to treat the patients, but their availability was a problem. When the doctors were not present in the hospital during the nights, intern doctors could not make decisions on their own, which was a serious concern and some unnecessary hassles we had to face".* Samiha added how they felt hopeless to see negligence of HCWs in the ward: "*Doctors sleep in the AC room wearing PPE, and they are not available even after calling a thousand times. Nurses do not know where to provide blood or how to take it. They didn't have any medical knowledge and experience of dealing with the COVID-19 patients".*

Moreover, during the survey, there was a common complaint by the patients that nurses and other supporting staff behaved roughly, and they didn't look after and handle the patients carefully and adequately. For nurses, patients complained that they didn't even listen to them or examined them physically. A patient named Nomita said: "*We have been mistreated by the nurses. Even nobody instructed us to take the medicine doses. We took our own medicine"*. A patient's relative said: **"***I was in the Corona unit with my patient, so I can say undoubtedly that some of them (doctors) worked hard in front of my eyes, if the nurses were a bit sincere, the situation would have been different"*. Regarding the supporting hospital staffs, they caused hassles for patients. Many hospital staffs behaved with the patients and their serving attendants badly. Several respondents reported that the ward boys behaved like corrupted workers since they took bribes from the patients though the staffs were responsible/liable to do for free. Patients

and relatives also suffered from harassment by the helping staff. A man said (with anger): "*The hospital ward boys misbehaved with the patients. There was no proper supervision upon them, I have nothing to say*". Another patient complained: "*I was hurt with the behavior of the supporting staffs of the hospital. We requested them for fixing oxygen supply to the patient, but they never came in time*". Many health care professionals took leave as a cause of fear for the unknown virus infection. These are examples of how patients were behaved and neglected by the HCWs in hospital settings due to infection or suspicion of Coronavirus.

However, on the contrary, many respondents praise the role of doctors and the medical staff during a health emergency. They received sound treatment from the hospitals and were fully satisfied with the HCWs behavior. On being asked about the attitude of the doctors and nurses, A COVID-19 survivor Tariqul replied positively, "*Their treatment was excellent, beneficial and tried their best to save my life. Especially, the doctor's kind words gave hope to us (the patients)"*. Many respondents were very much thankful for the doctors and nurses' dedication and the treatment they got when they were admitted. Many HCWs have been infected and died while serving the patients. Therefore, they sometimes became over-cautious and ceased to give proper treatment. Therefore, it can be said that at the beginning of the pandemic, HCWs were in panic and could not serve the patients properly due to fear.

Prejudice in Hospital Services

Bangladesh's healthcare delivery system has been facing massive challenges since the pandemic started, especially in government-run hospitals. Most hospitals in Dhaka had to treat an excessive number of patients than they can hold and treat. Many patients complained about the quality of medical care during this sudden health disaster. We investigated several COVID-19 patients with some critical open-ended questions about their experiences of receiving healthcare services from the hospitals. Based on their answers, we have been able to know about some mismanagement of the hospitals, including inadequate capacity and supply shortage, especially the lack of ICU, proper hygiene, ventilation, trained HCWs etc.

After the pandemic started in Bangladesh, the situation became a nightmare for the health care delivery system. Initially, the government could not manage the enormous testing facilities and treatment capacity for the suspected and infected patients. As a result, most hospitals rejected patients or were placed in the COVID-19 dedicated ward with seasonal flu or breathing problems, which ultimately enhanced prejudice. A relative of a deceased patient complained: "*When I took my father to a district hospital, they placed him in (suspected) Corona unit without any diagnosis. I told them to check first whether he was infected with the virus, but they didn't listen to me*". On the contrary, many people have complained that most hospitals failed to provide proper treatment, especially those suffering from other chronic or non-communicable diseases. We found many patients who had faced much negligence while admitted to the hospital with other diseases. A girl named Urmila felt sorrow and said: "*My mother had been suffering from a kidney problem. She needed to be taken to the dialysis room earlier. But hospital authority asked to take the COVID-19 test first. People were terrified about their lives at that time. The hospital took no care*".

The patient's attendants were very anxious about proper oxygen supply to prevent oxygen saturation decrease. Unfortunately, most hospitals were not ready at the beginning of the pandemic as the supply of oxygen cylinders was not adequate. Therefore, hospitals became a place of chaos for the issue of oxygen supply. Many respondents reported that hospital staff had no training and guidelines for supplying oxygen to patients suffering from severe breathing problems. Many respondents blamed the hospital authority for their patients' improper oxygen supply, ultimately responsible for many deaths. A man spoke with regret: "*When I was in COVID-19 ward with my mother, I saw many hospital support staffs who had no guidelines or training for providing oxygen to the patients. My mother died of the scarce of oxygen finally*". On the other hand, ICU beds in government and private hospitals were almost occupied by severely infected patients. The beds were vacant mostly because of the patient's death. There is a long list of patients who needed ICU support and they had to wait until an ICU bed was vacant. People have been complaining about not getting ICU in critical condition. A patient's relative said (patient demised), "*There is no vacant ICU bed. If any patient dies in the ICU bed, then they call for other patients. We needed oxygen*". Sometimes doctors become hopeless when they cannot provide ICU beds or oxygen supplies due to shortage. Some respondents indicated the hospital authority's failure to provide proper treatment to the patients.

The management in COVID-19 dedicated hospitals was not up to the mark at the beginning stage. The hospital authority failed to control the attendants with the patients. Omar Ali experienced some mismanagement at the hospital. "*Many patients and attendants were kept together, without maintaining a social distance. There was only one sink and toilet for all of us and no safe drinking water source*". The hospital's washrooms and toilets were very unhygienic and did not have an environment to go there due to its filthy nature. One hospitalized woman Ayesha described the inside of a COVID-19 ward. "*I was in the ward for seven days. The room became dirty due to the lack of maintenance. I saw the elderly patients were suffering badly. I couldn't sleep at night. Some patients were*

coughing, some were talking on the phone loudly, and there was nobody to take care of or serve the patients. I felt miserable". Daughter of late Salina Begum considered the hospitals' service as awful. She accused the hospital's service of her mother's death. However, the hospital authority didn't supply a death certificate mentioning the actual reason for death. Son of late Aleya Begum said, "*You can keep a note in your research. My mother died in Corona ward. In the death certificate, they mentioned that she died because of heart failure, which was not true*". Finally, not all the COVID-19 patients go through the hospital's mismanagements. Some fortunate people praised the hospital's service they received during their hospitalization.

Stigmatized Funeral

The funeral of the COVID-19 patients was a very miserable story in Bangladesh. Furthermore, there were many problems with burying the deceased from Coronavirus. Family members faced many problems in organizing the funerals. Each death due to COVID-19 would take along a tough time for each family. It was widespread to see media reports about the stigmatized funeral of the COVID-19 patient's death. Local people have created problems during the burials of the COVID-19 infected patients. Different rumors and a lack of proper knowledge were the reason for such behavior. People avoided funeral programs in fear of infection transmission, including prayers and even family members and relatives. Although Coronavirus cannot transmit from a dead body if proper guidelines are maintained, most people were severely panicked.

Finding a graveyard for the deceased affected by Coronavirus was a big challenge. The relatives and attendants faced many difficulties with performing the obsequies of the corpse. The wife of late Kabir Hossain, Samiya mentioned: "*None even came to see my husband in the hospital. After his death, we wanted to bury him in a local graveyard. But people objected and it was a hostile environment as if we were criminals. No one was kind enough to take his corpse".* Since it was a big issue, most of the burial activities were done in secret. For a proper funeral, family member(s) usually suffered a lot and could not manage time to give their beloved ones a proper farewell. When a husband was asked about how he handled the situation after his wife's death, he replied: "*When she died, I immediately gathered money and buried her in a graveyard. My family members tried their best not to let more people know about the situations in order to avoid unnecessary troubles.*" It is mentionable that the local authority of Dhaka decided to bury the corpses demised in Dhaka at the Khilgaon-Taltola graveyard. But local people protested and asked the authorities to search for a 'safe' place outside of Dhaka for funerals.

Many of the dead Muslims were buried without janazas (the Islamic funeral prayer). Local people refused to attend janazas or avoided the burial services of the deceased in most cases. The media also reported that the family members of many deceased cases did not attend in the burial activities or funerals for the fear of infection. Locals often tried to avoid the funeral of a patient who had died of COVID-19 lately. One of the close persons of late Moniruzzaman cried over the fact and said "*When I took the dead body from Dhaka to the village, all the relatives in the area had moved away. No one has talked to us, no one has kept in touch with us. In my case, only Allah knows how I managed everything. I had to pray for Janaza on my own and then I did the burial myself*." Nevertheless, we have some more cases where the relatives of the deceased did not have to struggle much to manage the funeral. Many more cases have been reported in the newspapers; for instance, an incident was reported in *KalerKantho* on 24 April 2020, stating-Ansar Uddin Hawladar (55) died with COVID symptoms in Damudda Upazila, Shariatpur. His family and local people denied providing him with a funeral. But later, some young activists buried him anyway. In some cases, people did not care about social distancing at all during burial. A relative of Babul Hossain said, "*Many neighbors joined in his Janaza. The dead body has been given a bath and buried with the presence of many*. *"*

Like Muslims, the Hindu community also faced severe stigmatization at funerals. A respondent told us that they had to bury the dead body instead of cremation/burning. It can be considered as a violation of his fundamental rights. A Hindu lady, Reema Roy, lost her husband due to the Coronavirus. No relatives came forward to help her. Some Muslim volunteers helped her to perform her husband's funeral. Similarly, another woman waited in the crematorium with her husband's body in the rain all night. No one came forward since her two sons and their entire family were infected with Coronavirus. Then volunteers stepped forward to help her the next day. A relative of late Dulal Chandra Mandal said, "*No one wished to visit. Those who came maintained a distance and left soon. Then we didn't have enough people to carry him to the crematorium except for the family members. People didn't want to join us because of his death by Coronavirus*". Many people considered this stigma as justified. They believed that Coronavirus can transmit even from a dead body. On the other hand, some people think it's good if the local people keep a distance from the dead body and appoint trained and selected volunteers for burial work.

Discussion

Like HIV/AIDS, COVID-19 becomes an epidemic of fear and hatred. Some infected people have been concealing their symptoms to avoid stigma, social isolation, or quarantine. Many people believe that if they get infected, their houses will be locked down and their family members will be treated negatively. Negative-minded neighborhoods and relatives are a curse that is

realized again during the pandemic. Fear of virus transmission and having misconceptions cause prejudice in society. This study discussed these behaviors and attitudes from the perspectives of COVID-19 survivors.

Self-Stigmatization

Social stigma, discrimination and exclusion have been described in detail in the discourses of tuberculosis and HIV/AIDS (Datiko et al., 2020; Paul, 2020). COVID-19 is still relatively new that can fuel stereotyping and stigmatization (WHO, 2020) and stigmatizing language has been used during the current pandemic (e.g., "COVID-19 suspect") (Sotgiu and Dobler, 2020). Social isolation and losing friends can lead to increased levels of psychological distress (Dar et al., 2020). Long periods of quarantine, fear of illness, insufficient and inconsistent information, financial issues and stigma have been identified as influencing adverse health outcomes (Schoch-Spana et al., 2010). Self-stigma developed from conflicting information and advice that led to difficulties and poses challenges by impacting social relations and creating psychological distress (Lohiniva et al., 2021). The study found that self-stigmatization has been one of the common phenomena during this pandemic time, which makes people helpless and suffer from loneliness. Self-stigmatization drives people to hide their illness, increasing more risk of infection and further spreading. It also prevents people from seeking health care immediately and discourages them from adopting healthy behaviors. Deshpande (2020) and Chari (2020) mentioned a similar context. The stigma around COVID-19 is becoming nearly as extreme as mental health illnesses, where fear of social ostracism prevents people from getting tested. In Bangladesh, a police constable allegedly committed suicide when he became COVID-19 positive, as he felt isolated from his community and family members (Al Javed, 2020). The present study shows that most infected people didn't want to inform others, including relatives, about the disease because of fear of social exclusions and blame for infection. People hide their illnesses for fear that families might be separated from society. During the early days of the coronavirus outbreak, everyone was in a state of panic and almost everyone hides their illness. Similar results were reported by other researchers (Lohiniva et al., 2021). They described that perceived stigma among respondents was driven by fear and blame for infection. It manifested in various ways leading to a reluctance to disclose their Coronavirus status to others. Moreover, people were found to be in a discrimination cycle due to the decline of their respect and rights (Figure 1). Brooks et al. (2020) mentioned that people who have been quarantined are more likely to report stigmatization and face social exclusion in the form of avoidance, withdrawal of social invitations, and crude comments. A knowledge gap and fear of the unknown have also been linked to the source of the stigmatization (Agyemang-Duah et al., 2020). The workflow of being fallen into the cycle of stigmatization has been demonstrated in figure 1. It begins with the loss of respect and sequentially all basic human rights ultimately leading to marginalization and discrimination with a definite consequence of stigmatization.

Figure 1: Discrimination cycles of COVID-19 patients due to the loss of rights and respect

Social Harassment

COVID-19 stigma is primarily based on community fear (Dar et al., 2020) and stigmatization and societal rejection by neighborhoods and discrimination in everywhere are very common. Stigma has been seen in many domains of everyday life, like the workplace, schools, health services, restaurants, and shopping malls (Lee et al., 2005). In Bangladesh, COVID-19 positive often become a victim of social harassment and embarrassment. Social exclusion and negligence make their life miserable. Like Lohiniva et al. (2021), respondents of this study believe that they were stigmatized because of fear of getting infected with SARS-CoV-2 and become social victims. We explored many findings on the fact that some COVID-19 patients faced harassment from their neighbors and relatives. Many people faced negligence from their colleagues, roommates, best friends, and family members too. People used to hate, despise and insult coronavirus-affected or suspected people. Even the patient himself and their family received much threat from society. Brooks et al. (2020) have similar findings on COVID-19, which revealed that people experienced discrimination, suspicion, and avoidance by neighborhood, insecurity regarding properties, workplace prejudice, and withdrawal from social events, even after containment of epidemics. There were many media reports in Bangladeshi newspapers on social harassment. For example, hospital's refusal to accept patients, avoidance from family members, difficulties in performing rituals, a threat from house owners, sufferings from proper burial etc. This pandemic shows how society affects people's personal lives and provoked social harassment. A COVID-19 patient often becomes a burden to their family. Even after recovery, society does not welcome the COVID-19 patient sincerely. Some other qualitative

studies reported a similar context. For example, Guo et al. (2020) mention a sense of powerlessness subdued COVID-19 patients and families. Bagcchi (2020) pointed out that their neighbors' mocked COVID-19 patients and socially boycotted etc. Singh and Subedi (2020) focused that many recovered patients denied re-entry into the community. Thus, COVID-19 infected or suspected patients face harassment by the neighbors, friends, relatives and community due to the misconception that the patients may be re-infected and pass on the virus to others.

Stigmatized Funeral

Stigma brings disgrace that sets a person apart from others (Pescosolido, 2013). Other than anxiety, depression etc, in the families due to the horrific death of COVID-19 patients, it has led to discrimination and stigmatization of its survivors (CDC, 2020). COVID-19 pandemic provoked worldwide discriminatory behaviors (van Daalen et al., 2021). The social stigma in terms of discrimination, harassment, and hatred is rife in social communities because it is hard to determine who is carrying the virus and who is not (Riyasad, 2020). The present study shows that stigmatization can be considered one of the most prominent issues associated with COVID-19. As the Coronavirus makes people panic and fear virus transmission, most people refuse to be involved in the burial activities of suspected COVID-19 patients to show consolation or condolence. The present study also finds many tragedies of 'secret death rituals' where the virus snatched away the infected man's right and respect. Many respondents consider the virus as a curse and consequently a 'symbol of death'. In Bangladesh, some voluntary or charity organizations like Quantum Foundation took responsibility for burial or funeral activities of dead bodies, irrespective of religion or caste. There are also many sensitive reports on the stigmatized funerals in the media, though the situation has changed a little bit now. Thus, rumor-prone stigma raises health risks and the insecurity of dead bodies (Nasereen and Caesar, 2020). Hossain et al. (2021) examined the causes and consequences of psychosocial stress and trauma during the COVID-19 pandemic. The increasing cases of apathetic stigma cracked all kinds of social relationships, producing unmeasurable frustration, alienation and estrangement in full-bloom (Mahmud and Islam, 2020). These physical and mental sufferings make many social exclusions and stigmatization in Bangladeshi society, impacting short-term and long-term consequences.

Prejudice in Hospital Services

Discrimination is the behavioural expression of prejudice (Hogg and Vaughan, 2002). Stigmatization and stereotyping may contribute to unequal treatment (Ware et al., 2005). Frost (2011) discussed that when populations face stigma and abuse from the health sector, they become unable to access health rights. Medical staffs have been stigmatized as 'possibly infected' (Aacharya and Shah, 2020) because stigmatized community seeks health care late and hide important medical history which may increase the risk of community transmission (Dubey et al., 2020; Fischer et al., 2019). Globally many COVID-19 infected people have faced discrimination from medical care. Stigmatization ultimately contributes to discrimination, especially towards patients in medical settings who receive less treatment from HCWs. Due to stigma and prejudice by the societal response, most patients consider COVID-19 as a 'bad disease'. Stigma and social exclusion related to COVID-19 have numerous effects and it harms their treatment-seeking behaviours. Imran et al. (2020) focused on patient's loss of trust and respect in HCWs and their impact. Rizvi et al. (2020) highlighted maltreatment by hospital administration and health care practitioners' neglect and abuse for treatment support and dealing with comorbidities. In Bangladesh, like many other developing countries, social stigma regarding COVID-19 is extreme for those who do not receive treatment. COVID-19 is still considered a disease of 'confirm death' to many people. At the beginning of the COVID-19 outbreak in Bangladesh, the health care system faced enormous challenges for patients dealing. COVID-19 pandemic has thrown a question to many whether health care centers as a place of hope. This study finds that COVID-19 infected or suspected patients worry that they will receive less medical care due to HCWs fears about highly contagious Coronavirus. As a result, patients face outright discrimination by HCWs, including doctors and nurses, especially in dedicated government hospitals for COVID-19 treatment.

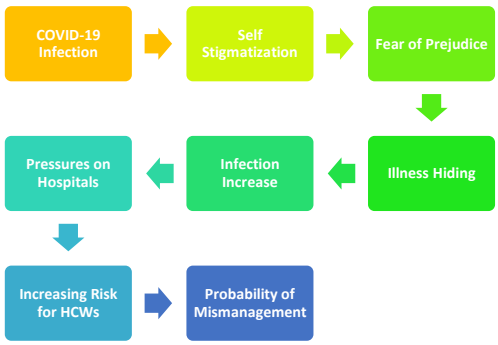

Figure 2: COVID-19 infection and chain impacts on the Health care system

Nevertheless, according to the WHO (1992), negative attitudes from health care professionals and responsible institutions have further worsened a situation that violates the WHO's policy that 'the right to health is the most basic of all human rights'. However, throughout this study, we found different opinions regarding the services received by COVID-19 positives from government-run hospitals and their management.

We used narratives to address patient inflow and workforce issues, hospital environment, hospital bed and ICU, oxygen supply, food and hygiene, medical care quality, HCW's sincerity, etc. This study finds that many mismanagement issues were prevailed in the health care delivery system due to high fear and stigma, which has made things even worse (Figure 2). Figure 2 shows the most prominent concerning sides of COVID-19 infection and the sequential process of the issue as it starts with self-stigmatization right after being tested out as COVID-19 positive which is also related to the issue of prejudice, which eventually increases the tendency of being secretive about the illness and as a result infection rather increases on the contrary. Consequently, the rapid rate of infection gives the hospitals a hard time dealing with such an influx of patients and providing the required facilities that increase the pressure on hospitals and also it increases the risk for the HCWs. Ultimately it creates a sort of chaos and mismanagement in hospitals are observed. Lack of capacity and planning, insufficient caregivers, and inadequate logistics supply were the main reasons for the patients' poor service. Although many respondents reported HCW's fear, reluctance etc., issues in this study, some patients were delighted with the health workers. Some respondents face much discrimination, such as refusing to admit to the hospital and offer medical support. Similar findings can be seen in Saeed et al. (2020). They mentioned that the stigmatized population distrusts the health care staff or authorities and resists cooperation in a social health emergency. It is well documented how healthcare workers became stigma and discrimination targets (Villa et al., 2020). Families of frontline healthcare workers pressurize them to quit jobs and de-motivate them in carrying out their routine duties (Dar et al., 2020). COVID-19 is still perceived as a stigmatized and challenging health problem. As stigma is the outcome of widespread fears and perceptions of risk, COVID-19 patients had to tolerate aspects of discrimination and neglect in the neighborhoods as well as medical care centers. A better future for proper hospital management should be expected for the patients based on lessons learned from the present miseries and complaints.

Conclusion and Implications

COVID-19 has become a vehicle for the growth of discrimination against various groups of people, including those who were affected and have survived the disease. The anticipation of social stigma has hindered people from getting tested or seeking healthcare and has significantly contributed to their psychological distress. Fear of the disease has led community members to treat patients as well as their family members with avoidance, fear, discomfort, unkindness, and even abandonment. Patients and their families have also been subject to mockery, humiliation, and verbal harassment and have faced issues with the regular progress of their daily lives and pursuit of employment opportunities. Stigmatization has caused significant damage to social capital and has led patients and survivors to develop mental health issues and suffer from distress, anguish, guilt, and shame. The study has provided an in-depth understanding of the mental condition of COVID-19 positive people, who have been experiencing a great afterwards brunt of COVID-19 infection. Since awareness and knowledge gap has been the most prevalent cause of the perpetuation of stigmatization of patients, the revealed facts about COVID-19 patients' stigmatization would support policy experts to think beyond the physical sufferings and health impacts of this pandemic. This study recommends that health care facilities in the country be made more COVID-19 patients friendly that can support the physical and mental ailment of the patients. Infected patients and their family members should be provided with counseling to make them believe in the possibility of a cure for this virus. Furthermore, mass awareness and legal support should be ensured to shelter the family that has COVID-19 positive patients so that they can lead a free and independent life in their society. Those families who have lost their dearest ones in this pandemic should be provided with financial means or jobs to lessen their fear of survival. Mass media can perform a noteworthy role in making people more sympathetic and well-behaved to the Coronavirus infected or dead people to eradicate the inferiority of patients, survivors and family members of the deceased from COVID-19. This study expects that the government authority and development organizations will come forward to supporting the stigmatized community through proper counseling or financial means to recover from impoverishment following the rapid dissemination of accurate information.

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