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Invisible Scars: Understanding Discrimination faced by COVID-19 infected people in Kushtia, Bangladesh

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ABSTRACT

The COVID-19 pandemic has revealed and escalated different forms of discrimination, especially in vulnerable populations such as Bangladesh. This study tries to uncover the experiences of discrimination among people infected with COVID-19 in the Kushtia district. To achieve this goal, this research adopted a qualitative Interpretative Phenomenological Approach (IPA) and conducted 15 in-depth interviews with individuals who were infected with COVID-19. By integrating a data-driven inductive and deductive strategy, the author coded and analyzed the data using a thematic method. The data analysis step was streamlined using the Granheim model and NVivo 14 software, which allowed for more efficient concurrent processing and coding. Through qualitative analysis, the study reveals five key themes: social discrimination; workplace discrimination; family discrimination; health discrimination; and relational stigmatization. This research is not just about documenting discrimination but also about using the findings to foster a more inclusive, supportive, and resilient society in Kushtia and beyond.

INTRODUCTION

The COVID-19 pandemic triggered massive global responses. The novel coronavirus strain designated as SARS-CoV-2, responsible for the disease COVID-19, is believed to have originated in Wuhan, China on March 11, 2020, COVID-19 was officially categorized as a pandemic by the World Health Organization (WHO), owing to its rapid and unrestrained dissemination globally (Talevi et al., 2020). Around 6.9 million deaths have been documented, and over 770 million cases have been confirmed globally (Mathieu et al., 2020). As COVID-19 is a contagious disease, countries around the globe enforced 'Home Quarantine' 'Self Isolation' 'Lockdown' and 'Social Distancing' to prevent the the new physical contagion (Usher et al., 2020). As a result, People have experienced a significant transition from their ability to engage in mutual connection to an urge to exercise discrimination. Apart from the anxiety, stress, and grief, people's feelings of frustration have begun growing up (Bhanot et al., 2021).

COVID-19 is not just a health issue, nevertheless, it has additionally discriminated against people (Bhanot et al., 2021). Globally, people of Chinese or Asian descent have faced widespread discrimination and social exclusion since the start of the COVID-19 outbreak (He et al., 2020). Stigmatization grew to various groups throughout the Chinese language–speaking world, including Hong Kong, Taiwan, and overseas Chinese populations in Western countries (Chaturvedi et al., 2023). Studies from Jordan, Uganda, and Lebanon demonstrated COVID-19-related discrimination to be

widespread within the public community (Abuhammad et al., 2021; Amir, 2021; Haddad et al., 2021). Furthermore, stigma generates limits to accessibility to healthcare and social services, affects healthcare-seeking behavior, and causes social discrimination, rejection, mental discomfort, and hostility (Mistry et al., 2022). COVID-19 suspected and affected people experienced social marginalization all over the world, thus producing the emergence of societal stigma among numerous nations (Ramaci et al., 2020).

The COVID-19 epidemic turned into a worldwide health catastrophe that not only impacted healthcare systems but also aggravated prevailing societal stigmas. As of 19 December 2023, Bangladesh has registered a cumulative figure of 2,046,165 confirmed cases of COVID-19. The aggregate mortality figure remains at 29,477. The nation has sustained an elevated recovery rate of 98.41%, with recoveries surpassing 2 million (bdnews24, 2023; WHO, 2023). In Bangladesh, people affected with the virus frequently experience discrimination from family, relatives, neighbors, and workplace, which results in social exclusion and behavioral difficulties (Rahman et al., 2021). Stigma and discrimination against COVID-19 patients in Bangladesh are prevalent due to misinformation, insecurity, fear of responsibility, administrative malfunction, and lack of trust in treatment (Mahmud & Islam, 2020). In addition, it was found in a study that Migrants and their family members who returned home from Italy faced several challenges and discrimination because they were regarded to be the principal carriers of coronavirus in Bangladesh (Parvez, 2021). Previously comprehensive research work has been done which revealed that the COVID-19 epidemic bolstered the spread of societal stigma throughout the people in the Bangladeshi population (Mahmud & Islam, 2020). However, Stigma and discrimination are likely to persist for an extended period, even after quarantine has been lifted and the pandemic has been effectively controlled (Ramaci et al., 2020). The stigma of COVID-19 has a devastating influence not only on those affected in the form of harassment, intimidation, neglect, mental health difficulties, fear and anxiety, and possibly death (Kumar & Nayar, 2020).

Previously Many studies at the national and international levels on the COVID-19 pandemic have been done to find out the Discrimination, stigmatization, challenges, and impacts such as stigma towards Hijra (transgender) communities, stigmatization, and social vulnerabilities, stigma as a barrier, discrimination towards disabled people, discrimination toward Vaccinated and Non-Vaccinated people, social exclusion, discrimination to factory workers, impact on mental health, discrimination to health workers, etc(Amir, 2021; Bagcchi, 2020; Bhanot et al., 2021; Chaturvedi et al., 2023b; Das et al., 2021; Dollmann & Kogan, 2021). Although several researches have been done concerning the COVID-19 pandemic, no article has been found directly that portrayed this study's objectives. This study aims to seek the answer to the question: How the COVID-19 pandemic has amplified experiences of discrimination and social stigma for individuals in Bangladesh, specifically in family dynamics, close relatives, community relationships, society, healthcare settings, and workplaces. This study attempts to explore the multidimensional nature of discrimination faced by COVID-19 victims in Bangladesh, in relation to family members, friends, relatives, neighbors, society, colleagues, and workplaces, with special emphasis on the influence of societal perceptions and behavior toward them. The present study tries to bring out the social and psychological burdens of stigma and discrimination through the assessment of individual experiences and societal reactions. It further stresses the great need for supportive interventions to alleviate the adverse effects of such discrimination, especially in times of health crises.

MATERIALS AND METHODS

Study Area and Location

Kushtia, primarily a rural district, offers a unique context in which to examine COVID-19-related discrimination. Rural characteristics of the community—tight social networks—can increase stigma and intensify discrimination against the population affected by COVID-19. Unlike urban city dwellers who have more heterogeneous populations and access to better health facilities, rural areas like Kushtia often face a scarcity of resources and a spread of misinformation. Research on discrimination in Kushtia will fill a critical gap in the literature by detailing rural-specific challenges and guiding locally relevant interventions to fight stigma.

Research Approach

The Interpretive Phenomenology Analysis (IPA) approach chosen for this study is rooted in the philosophical underpinning of phenomenology, a paradigm uniquely suited to exploring and understanding the essence and meaning of human experiences (Alase, 2017). This approach is used worldwide and is very popular in social science and public health research (Mandal et al., 2021; Sohel et al., 2021; Parkinson et al., 2019)). A qualitative phenomenology research method is appropriate to understand phenomena from the participant's perspective (Smith & Osborn, 2014). Because it focuses on how people interpret and understand the experiences in which they live and human experience through participant descriptions (Wheeler et al., 2010).

Sampling and Sample Size

The standard size for numerous qualitative investigations is 15-20 for homogeneous respondents. According to Sandelowski (1995), ten sample sizes would be sufficient for qualitative research on homogeneous people. Crouch & McKenzie, (2006) proposed that less than 20 participants could assist the investigators in improving exposed and caring contact by forming and keeping close bonds. We decided on the purposive sampling technique for this study and conducted 16 in-depth interviews using the data saturation method. We selected the COVID-19-infected individuals as respondents for an in-depth interview.

Instruments and Data Collection

We selected COVID-19-affected individuals as respondents who can provide direct insights into any discrimination or stigma they experienced. In the in-depth interview, 13 participants were male, and 3 were female. We collected data from April 2020 through January 2021 by maintaining social distancing. We made use of a cell phone to record. In-depth interviews lasted between 23 and 39 minutes on average. The researchers then attentively transcribed the recorded interviews and double-checked them for accuracy. A semi-structured questionnaire and a face-to-face data collection method were used for the study. Moreover, the field staff was intensively trained on the background of the study, detailed objectives, methodology, individual sections of the instruments, and interviewing techniques for this study area. In addition, the Bengali version of the questionnaire was pre-tested as non-sampled participants in the community to get feedback on the questions' suitability, appropriateness, and sequencing. Furthermore, the conducted study data was coded in English as per variables to analyze through NVivo 14 Software.

Instruments and Data Collection

NVivo, which enables more in-depth study and better tools for data analysis is essential for qualitative analysis since it analyzes massive amounts of textual material (Patton,

2002; Gibbs, 2002). The NVivo software is used for coding, classifying, and theme design. Using NVivo-14 software, the interview transcripts have been coded thematically, classified, and arranged, making it more straightforward to manage crucial details and generate high-quality results. A thematic approach was applied to examine qualitative data. We followed Graneheim and Lundman's systematic approach in qualitative research to analyze and interpret textual data (Graneheim & Lundman, 2004). It provides a structured framework for identifying, organizing, and categorizing themes or patterns within the data.

Table 1: Thematic data analysis procedure using the Granheim and Lundman approach

Steps	Description
1. Interview transcription	After hearing the recordings several times, the interviews were taped and read again to comprehend the contents.
2. Unit for the formation of meaning analysis	All interviews were analyzed as a single unit. Creating primary codes by abstracting meaning units
3. Comprehensive sorting of similar codes	The grouping of similar fundamental codes into more comprehensive categories.
4. Comparison of codes and establishment of subcategories	In contrast, all codes and data identified similarities and differences. This process resulted in the formation of categories and subcategories.
5. Comparing subcategories and establishing primary categories	The initial interviews yielded an initial set of codes, categories, and subcategories, and the emerging codes were considered the results due to the thematic analysis approach.

RESULTS

The socio-demographic profile reflects in Table 2 that a majority of the respondents were males, 81.2%, while females constituted only 18.7% of the sample. The age distribution indicates that the majority of them were = 35 years old or less, about 75%, followed by 18.7% between the age bracket of 36-50 years, and a small fraction of 6.25% between 51-65 years of age. This was further reflected in the number: a high school complete 43.7%, education below the primary level 25%, complete primary education 18.7%, and 12.5% were noted as being illiterate. Further, on marital status, married was the highest in the order of frequency at 68.7%, followed by single at 18.7%, and lastly, widowed at 12.5%. This kind of demographic distribution is important in the contextualization of the findings.

Table 2: Respondents demographic profile

Category	Variable	Respondent no.	Percentage
Gender	Male	13	81.2
	Female	03	18.7
	≤ 35	12	75.0
Age	36-50	03	18.7

	51-65	01	6.25
	Illiterate	02	12.5
Education	Under Primary	04	25.0
	Primary	03	18.7
	High School	07	43.7
Marital status	Married	11	68.7
	Single	03	18.7
	Widow	02	12.5

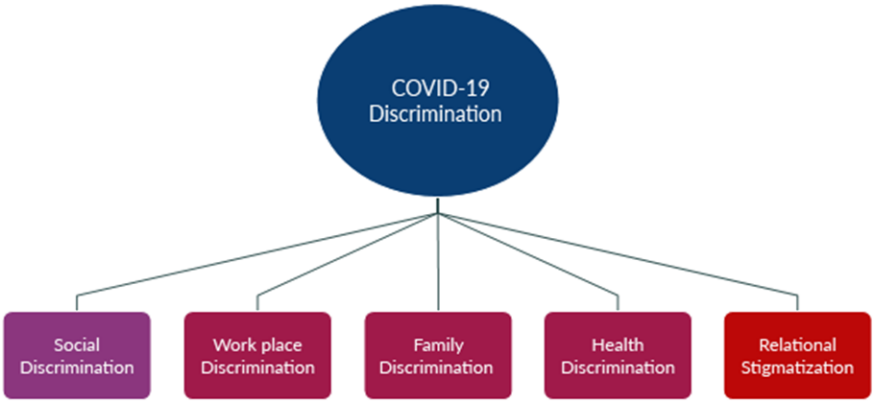

Figure-1: Discrimination faced by COVID-19 affected people

Social Discrimination

Social discrimination is reflected significantly in local interactions. Victims were looked at with distrust and treated as misfits by neighbors, who often withdrew themselves and engaged in bullying activities. This section digs into the community's attitude to COVID-19 fatalities, including the refusal to participate in burial rites and the lack of collective grief. The consequences of social discrimination are severe, which results in intensified mental wellness issues for those affected.

> *"My grandfather died during Corona time but it is seen that socially according to the rules of Islam, the burial became difficult. Because everyone in the village thought that my grandfather had died of corona. Finally, an organization helped us and through this, my grandfather's body was bathed and his Janaza was held in the presence of a few people and then buried." (Male R# 11)*

COVID-19-infected persons have faced extreme isolation and stigmatization in their communities. Respondents reported having experienced a serious breakdown of social relations; they were often made to feel as if they had committed a heinous crime. Social Stigma depicts how intense the level of social ostracism was, as affected persons were marked and excluded from their communities. One participant described experiencing public ostracism, stating,

> *"After it was known that I was infected with corona, everyone in the area put up a red flag at my house. It seemed like our house was a criminal's house. No one came around, and everyone thought that even if they went near, they would get the virus." (Male R#5)*

Others described how social ostracism extended to everyday life:

> *"After everyone found out that I was infected with corona, red flags were put up in my house. People in the area used to gossip about my family. They did not come around our house and behaved as if our house was cursed. Many times it is seen that local people are trying to humiliate me by posting about me on social media." (Male R#2)*

Furthermore, the stigma reached beyond just avoidance and rejection; it led to bullying, rumors, and gossiping. The discrimination highlights how misinformation and anxiety may grow into a culture of exclusion, leaving people who are affected along with their families feel separated and helpless.

> *"My family has been subjected to harassment from neighbors because of me. None of my friends would come to my house. They would call to inquire about me, but when someone did come over, people were forbidden to visit them because they thought they would get COVID if they came to my house." (Male R#6)*

Workplace Discrimination

In the working sphere, COVID-19 victims experienced various challenges. Many lost their jobs owing to lengthy rehabilitation times, while those who eventually returned frequently confronted unpleasant workplace environments. This section explores the obstacles faced by these people, including harsh treatment from colleagues and the negative perception associated with having contracted the virus. The economic cost of discrimination in the workplace underlines the critical need for regulations that protect the rights of impacted individuals.

The impacted person frequently leads to loss of employment and financial difficulties. Respondents pointed out the uncertain circumstances of their employment positions, demonstrating the greater effect of the epidemic on their way of life. The experience of the victims underlines the vulnerability of employees during health crises, where transitory health-related absences might end in permanent unemployment.

> *"I was initially given leave after contracting the coronavirus, but later I was terminated from my position due to a long stay, which left me in a financial crisis. In this situation, my family is in danger along with me. I am mentally depressed due to being unemployed and home-quarantined for a long time". (Male R#13)*

COVID-19-infected people have led to considerable isolation and discrimination in their societies. Respondents reported having experienced a major breakdown of social interactions; they were often made to feel as if they had committed a horrific crime. Social Stigma illustrates how intense the level of social ostracism was, as affected folks were marked and alienated from their societies.

The repercussions of such job loss extend beyond financial difficulties; it also threatens the stability of affected individuals' families which heightens stress and anxiety to the affected persons. Moreover, the psychological toll of unemployment and prolonged isolation is profound. This reflects the intersection of mental health and economic instability, emphasizing the urgent need for support systems to assist those affected by COVID-19 in both their professional and personal lives.

> *"As soon as I came to know that my corona test was positive, my boss called me and told me not to go to the office again. I was dismissed from the job. When I requested, he told me that if I go back to the office even after I recover, it may bring the company*

into disrepute. I was almost depressed after losing my job. Because on the one hand, the hardship of running a family while unemployed, on the other hand, I feel lonely socially. (Male R# 9)"

These accounts describe in detail how workplace discrimination heightened the struggle of living through a health crisis-one that put at risk any semblance of financial stability and also targeted mental well-being.

Family Discrimination

The family has been often viewed as a source of support in facing different challenges; however, the pandemic of COVID-19 has changed such interpersonal relationships. People affected by COVID-19 often experience involuntary isolation because of being subjected to strict quarantine actions by their family members. The findings of this study analyze how such measures led to the development of insecurity and emotional trauma in the affected individuals. Personal accounts provide evidence of the psychological consequences of family rejection and show that a lack of acceptance and empathy worsens feelings of isolation. All the respondents shared one common theme: forced isolation from family and feelings of rejection by the same family. One respondent commented on the significant impact caused simply by being separated from their family. Indeed, such measures can be psychologically devastating because the need for high protection broke support networks.

"Ever since I got COVID, I had to stay in isolation. Everything that was used was kept separate. I always felt guilty. My parents, mother, brothers, and sisters all considered me a kind of burden. Even after recovering, I feel that my acceptance has decreased." (Male R #3)

According to many of the respondents, there was an overall decrease in their perceived importance within their families after the arrival of COVID-19. The lack of empathy and understanding exacerbated feelings of rejection and alienation, making many people feel they had lost their position as appreciated members of their families.

"I had to stay in quarantine due to corona infection, so it was seen that I could not go out of the room. I had to depend on my family for any of my needs and since I needed special care, most of the time it seemed my family members got annoyed with me." (Male R#15)

"After contracting corona, my importance to my family and my relatives decreased. Especially my relatives tried to bring me down. All things including clothes, dishes, and food used by me were kept separately. Staying at home, I felt like I was in a prison. Although sometimes my parents supported me when I was depressed. I could never go out even if I wanted to." (Male R #8)

However, it may be that the active and engaged involvement of family members provided critical psychological and emotional support hence improving the coping mechanisms of the individual. Another Respondent shared a different story;

"When I was infected with Corona, the neighbors from the society forced me to quarantine for 14 days. I didn't know anything about the new virus so I was very scared and always wondered what would happen. But my parents never wanted me

to live alone. They always encouraged me and visited my room every day. They tried to solve my every need." (Male R#10)

It was evident that families, in trying to avert transmission, would often undertake extreme measures to separate the infected person from the family and foster an environment filled with silence and misunderstanding.

Health Discrimination

The discrimination suffered by COVID-19-afflicted persons extends into the healthcare system, where many encounter major impediments to receiving effective medical treatment. Respondents noted a number of issues, mainly on the affordability and accessibility of care. One individual respondent their experience:

"At first, I didn't realize I had corona. Later, after all the symptoms appeared, I went to the hospital for a test, but seeing my symptoms, they kept me apart at the beginning. The doctor saw me from a distance, asked me to take a test quickly, and then took me out of the room." (Male R #1)

This highlights the stigma that still exists in medical facilities, frequently leading to isolation even during the initial stages of seeking medical treatment. Financial barriers also slow down the availability of healthcare. Many persons had difficulties obtaining healthcare services, resulting in a dependency on government hospitals, which tend to be congested and unsatisfactory for Covid-affected persons. One respondent noted,

"I had to go to a government hospital where it was difficult to wait with a sick body. After getting corona, I faced a lot of financial difficulties to continue the treatment." (Male R #16)

The study explores the fact that COVID-19-affected persons are at the same time burdened with health access and financial difficulties, hence an indication of the structural inadequacies in the health system that lead to stigma and inadequate medical access. These findings have shown the importance of enhanced health access and assistance methods for those affected by COVID-19 negatively, ensuring financial limitations are not keeping patients from acquiring the medical services they require.

Relational Stigmatization

COVID-19 victims were also stigmatized by relatives outside of their immediate family. The COVID-affected persons were frequently experiencing hatred and judgment as if they had done a crime. They often felt marginalized, isolated, or unsupported by their family members and close relatives. Instead of familial support, respondents often received aid from external volunteers, thus underlining the absence of care from their own families during a moment of distress. These findings underline the essential need to address the stigma and develop understanding among families, ensuring that persons afflicted by COVID-19 do not endure isolation and discrimination.

"I was scared and depressed all the time due to the coronavirus infection. In case of other illnesses or accidents, relatives have been by my side, but this time no relatives are by my side. But it can be seen that my daily necessities were given to me by outside volunteers but these should have been done by my relatives. They would not come to

see me for fear of being infected themselves." (Male R #7)

The study examines the social repercussions of this behavior, where affected persons reported a lack of support and understanding from their relatives. Each of the cases sheds light on different features of social stigma, family support limitations, and mental health challenges faced during quarantine and illness. In some cases, gender roles and social expectations may intensify the stigma surrounding the illness due to prevailing superstitions surrounding the virus. Women had more difficulties to cope with due to social gender expectations.

> "In our society, girls have already faced a lot of discrimination. Since getting infected with coronavirus, I have had to endure a lot of mental torture from in-laws to many relatives. Only my husband supported me emotionally from the beginning. My parents called me every day to inquire about my health. But some of my relatives used to say bad things to me and gossip about me behind with other members." (Female R#14)

Many respondents reported a marked shift in their relationships with relatives, often feeling ostracized and looked down upon.

> "I used to have a job, but due to the coronavirus, I had to come home. At that time, I had acceptance from everyone. But now it seems that all my relatives whom I used to consider close are avoiding me." (Male R #4)

The lack of family care during health crises underlines the extent of stigma that the disease has brought about and points to the need for interventions in order to regain trust and build community understanding.

DISCUSSION

The COVID-19 pandemic has exacerbated prevailing stigmas and discriminatory behaviors in society, a phenomenon observed globally and one that Bangladeshi society is no stranger to. The present study discovered that the COVID-19-affected people of Bangladesh suffered discrimination in family, relatives, friends, neighbors, health access, social, and work settings. A previous study found that in Dhaka city over fifty percent (53.1%) of the COVID-19-affected people faced stigma and discrimination (Kibria et al., 2022).

Many participants in this study reported being shunned in their neighborhoods and society, where some of them were avoided or put with a red flag on the doors to indicate possible contagion, and some were harassed and bullied through social media. This affirmed them as being an "outsider," and brought shame and long-term isolation to the whole family of an infected person. A similar study found that the outbreaks of the COVID-19 epidemic had generated social discrimination against putative coronavirus bearers (Bhattacharya et al., 2020). Another study has comparable findings on COVID-19, which demonstrated that people faced discrimination, suspicion, and rejection by their social community, insecurity about assets, employment prejudice, and absence from social gatherings, even after the control of epidemics (Brooks et al., 2020). People associated with COVID-19 faced prejudice and discrimination, including brutal and humiliating treatment (Gazi, 2020). COVID-19-affected patients were significantly abused and socially excluded by neighbors and several recovered patients were prohibited from rejoining the society (Bagcchi, 2020; Singh & Subedi, 2020). Since humans are social animals, a lot of dependence on acceptance and support from the

community is needed to maintain emotional health. Long-term ostracism can cause psychological effects or anxiety, depression, and sometimes post-traumatic stress disorder (PTSD). Studies from Sri Lanka and India report that up to one-third of patients experienced social discrimination, including barriers to accessing basic needs, insults, and rumor-spreading (Jayakody et al., 2021; Sangma et al., 2022).

Workplace discrimination against COVID-19 survivors became a serious issue as respondents reported being treated differently by employers and coworkers. The findings included the following: respondents experienced being left out of group activities, job loss, people making comments that made them feel "contagious", and diminished work, thus affecting their financial stability. This aligns with a previous study that stated in the workplace, patients faced job loss, salary deductions, and reduced work efficiency (Chandra et al., 2021). COVID-19-affected factory workers experienced stigma and discrimination both in their workplace and in their local community (Wali, 2020). Patients who recovered from COVID-19 in China frequently experienced stigma and discrimination in daily life and at work (Zheng, 2023).

Whereas family structures in Bangladesh traditionally provide sources of emotional support, the study reveals that COVID-19 weakened these relationships severely. Respondents described being isolated inside their houses, compelled to use separate meals and sanitary facilities, which, although meant as preventive measures, produced emotions of rejection and abandonment. Similar tendencies were identified globally; for instance, research showed that family quarantine procedures, although essential for infectious management, unintentionally generated social disconnection and encouraged feelings of discrimination among COVID-19 survivors (Brooks et al., 2020). Previous study Paul et al., (2022) demonstrated that Family discrimination against COVID-19 patients is widespread in Bangladesh, driven by fear of infection, social stigma, and misconceptions regarding the virus, resulting in neglect and even abandonment.

One of the crucial issues discussed in this study is the discrimination COVID-19 patients face in accessing health services. The respondents' access to care was delayed or poorly taken care of because healthcare providers mostly kept their physical distance or avoided direct contact with patients showing symptoms. This agrees with a previous study that found discrimination in healthcare against COVID-19 patients in Bangladesh which mainly affects the older males and city dwellers who reportedly faced negligence and inadequate treatment from the healthcare staff (Paul et al., 2022). There is an added dimension to the problem in Bangladesh, given that the health system is already overburdened: crowded public hospitals strained under the rise of COVID-19 patients, thus giving way to poorer quality care and increased patient suffering. A similar conclusion can be seen when respondents experience considerable prejudice, such as denying to be admitted to the hospital and offering healthcare support (Paul et al., 2022; Saeed et al., 2020). A lot of COVID-19-infected people have experienced discrimination from healthcare providers around the world. Due to stigma and discrimination by the society response, most patients perceive COVID-19 as a ‘bad disease’ (Imran et al., 2020).

Moreover, the social stigma did not end within the family; neighbors and relatives continued treating those affected as potential virus carriers even after they had been discharged from hospitals and had regained full health. Affected individuals were met with suspicion and distrust from their close relatives and neighbors, whereby in most cases they marked their homes to warn others. These findings align with previous studies conducted in Lebanon and Jordan that identified community-based stigma as perpetuating fear and misconceptions about survivors of COVID-19 and most often bringing about chronic social isolation (Abuhammad et al., 2021; Haddad et al., 2021).

CONCLUSION

The present findings highlight the high degree of stigma and discrimination against people affected by COVID-19 in Kushtia, Bangladesh. The pandemic has tested not only public health infrastructures but also deep-seated social prejudices. Many survivors of COVID-19 have been socially ostracized; they have become outcasts in their own communities, with disrupted family ties, loss of jobs, and poor care in health facilities. The above accounts show how the anxiety and misinformation about the virus increased the level of stigma and discrimination against survivors, thereby increasing their psychological and economic suffering amidst the pandemic. Such a challenge requires a holistic approach that goes beyond the walls of the healthcare sector into the social sphere. Public health campaigns to sensitize the communities on infectious diseases, while encouraging understanding toward those affected, are very essential in controlling stigma. Support mechanisms, such as counseling services and community reintegration programs, are essential in the process of facilitating social and psychological recovery among survivors. In rural areas, like Kushtia, where communities are tight-knit and most often lack access to resources, these interventions carry special importance in overcoming the discriminatory consequences on individual health and collective cohesion. In conclusion, a more supportive and inclusive environment should be created for people who have been through COVID-19 since it will lead to speeding up their recovery and maintain and uplift the general health and resilience of society. Further research is called for in line with exploring the ways to reduce the stigma and understanding the long-term effects of pandemic-related discrimination on those affected.

This study has a few limitations that must be considered in interpreting the results. First, although a participant sample size of 15 is enough for qualitative analysis, it may limit the generalizability of the results, since experiences of COVID-19 survivors in Kushtia might not reflect those in other settings with different cultural, economic, and health care conditions. Second, this study depends on self-report data, collected via interviews, and is thus subject to biases when respondents reflect on the sensitive or traumatic events they had. This study should be replicated using a larger and more diverse sample from both rural and urban settings, enhancing generalizability. Longitudinal studies and use of the quantitative approach will capture changes in the levels of stigma and even determine its prevalence over time.

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Consent for Publication

Not applicable

Competing Interests

The authors have no competing interests to declare that are relevant to the content of this article.

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