



IMPACT OF COVID-19 Lived Experiences of the Urban Poor in Slums during the Shutdown

HIGHLIGHTS

Perceptions about Coronavirus

- The study found that all the respondents have a basic understanding of the virus along with some level misinformation, which was creating fear, panic and stigma around coronavirus
- All the respondents perceived the virus to be a '*mohamari*' (pestilence), '*choyache rog*' or '*choyachuyi rog*' (contagious disease) that transmits from infected persons through touch or through coughing and sneezing.
- There was general confusion as to the symptoms of coronavirus.

Stigma

- The fear of death by being infected with Coronavirus was wreaking havoc on residents' lives, particularly given their high levels of insecurity with regard to the virus spreading quickly.
- Led to suspicion of each other, stigmatization, discrimination and victim-blaming
- Monitoring of one's own health and others has become the new reality of life for many
- Emotional and mental anxieties have been reported due to the increased uncertainty in their lives

- Rumours of infected persons being picked up by police and locked away in isolation centers create more panic and fear
- A few cases of drug sellers turning away respondents and asking them to go for blood tests; not wanting to provide service

Preventive measures and ground realities

- Most are unable to maintain the recommended precautionary guidelines due to their living conditions (i.e. share space with several family members in one room) and poverty (i.e. unable to purchase soap or masks for the entire family.) Some women reported using own cloths (scarves/ saree) to cover their face when they go out of home.
- A few of the house owners have taken the initiative to avoid overcrowding taking place near their water points, latrines, kitchen and bathing spaces in their own compounds.

Economic and Social Impact and Increased Distress

- Almost all of the respondents are not working and have no income
- Increased strife in the households and disruption of social relationships and networks in the communities; with women more affected

Introduction

In early March 2020 the World Health Organization declared the novel coronavirus (COVID-19) outbreak as a pandemic. According to WHO, the virus, as of 2:00 am CEST, April 17, has spread to 213 countries with over 2 million confirmed cases and just over 135,000 deaths. While the virus is a threat to all socio-economic groups, the poor and vulnerable segments of society, similar to pandemics in the past, are at risk of being disproportionately affected.

In the absence of any vaccine or cure or standard treatment protocol, many countries have resorted to precautionary measures comprising of travel restrictions, mandatory lockdowns, health hygiene, and social distancing to decelerate or flatten the spread. In densely-populated and economically less developed countries such as Bangladesh, however, the strategies being promoted by global health bodies are often next to impossible to put in practice and do not necessarily pay attention to the social, economic, and contextual factors on the ground. Nowhere is this disconnect more pronounced than in the densely populated informal slums that are known as bastis (slums).

In Bangladesh's capital city Dhaka, an estimated 7 million people reside in approximately 3,394 slums^[1]. Characterized by over-crowding and poor living conditions, where families comprising an average of 4.3 members reside in single 12 square meter rooms^[2]. While most slums in Dhaka have access to piped water, they do not run directly into the dwellings and are shared on average between 20 to 40 households.^[2] Sanitation facilities are shared by 91% of households with one toilet used by around 70 people on average^[2]. Given the dense living conditions, inadequate water and sanitation arrangements, and economic constraints in affording sufficient supply of soap, it is anticipated that the slums will be more prone to the spread of the disease.

The residents of the slums are mostly engaged in the informal sector and/or as daily wage earners. They work as rickshaw pullers, domestic help, day laborers, small tea stall vendors, street peddlers, beggars, and so forth^[1]. Following the first cases of COVID-19 in early March, Bangladesh initiated a countrywide shutdown from March 26 to April 25, 2020 resulting in their livelihoods being severely threatened. For many, the crisis of the pandemic is being overshadowed by the crisis of lack of food, of hunger.

To better understand the lived experiences of the slum dwellers against the backdrop of the social and economic constraints resulting from the nationwide COVID-19 shutdown, the BRAC James P Grant School of Public Health, BRAC University undertook a rapid research study from 30 March to 12 April, 2020. Along with documenting the impact of the pandemic, the research hopes to bring to the attention of policy makers and service delivery organizations, issues of importance that may not necessarily be receiving the attention needed and thereby enable them to prioritize and implement appropriate interventions.

The research delved into many aspects of the slum dwellers' lived experiences. This brief will focus on issues related to local health beliefs, practices and stigma, impact on mental and emotional health, impact on their economic and social life, and residents coping mechanisms.

Limitations: This is rapid qualitative assessment done in a very short period of time. Responses are from 51 case interviews, and the findings cannot be generalized to the entire country, and are very context specific to slums.

Methodology

A total of 80 in-depth interviews were collected from residents of six selected slums (Kollanpur Pora basti, Dholpur, Nama Shayampur, Dokkhin Khan, Helal Market and Chalbar) in Dhaka North and South City Corporations were conducted via telephone from March 30 to 12 April 2020. These slums were selected on the basis that we had access to some organisations with existing programs there. Considering the current state enforced shutdown and mobility restrictions for minimizing the spread of the virus, it was not feasible nor safe for the research team and the respondents to physically meet at the study sites for face-to-face interviews hence phone interviews were the only feasible option. For the purpose of this brief, 51 out of the 80 respondents' experiences have been presented with the remaining interviews still being transcribed and under analysis at this current time. The interviews will continue to track the respondents as much as possible over time as the pandemic continues in order to assess the disruptions and levels of personal, health social and economic vulnerabilities. Given the situation on the ground, we felt that it was important to share evidence gathered from these 51 cases as soon as possible.

Respondents were selected using snowball and opportunistic sampling methods. Phone numbers of frontline workers working in the selected urban slums were first collected from the respective contact persons. These frontline workers, many of them who live in the slums, were the first point of contact for recruiting respondents for the study. Each interview date and time was set as per the respondents' convenience. This entailed having to reschedule two or three times to accommodate their time schedules, and through them, we also received additional phone numbers of other respondents willing to speak to us.

The interviews were conducted using a semi-structured interview guideline. All the interviews were conducted in Bengali with the average duration of each interview ranging between 60 to 90 minutes. A group of five trained researchers, under the supervision of two senior researchers, conducted the phone interviews while another two researchers carried out the data analysis.

Each interviewer took detailed interview notes and prepared summary transcripts. Inductive coding was done manually following which the coded data was clustered under different themes and sub-themes. The thematic analysis was completed at the final stage.

Verbal informed consents were taken from all respondents. Each respondent was also provided with BDT 100 (Taka one hundred) transferred via mobile banking to cover their mobile interview talk time costs.

^[1]Bangladesh Bureau of Statistics (2015). *Census of Slum Areas and Floating Population 2014*.

^[2]Arias-Granade, Y., Haque, S.S., Joseph, G., & Yanez-Pagans, M. (2018). *Water and Sanitation in Dhaka Slums: Access, Quality and Informality in Service Provision. Policy Research Working Paper - 8552*. Retrieved from The World Bank website: <http://documents.worldbank.org/curated/en/607511534337128809/pdf/WPS8552.pdf>

Demographic Profile of Respondents:

Table 1 presents the demographic characteristics of the respondents. Majority of the respondents were female and all belonged to the Muslim faith. Among them 15 were NGO frontline workers. Mean age of the respondents was 35 years. Most had migrated from different parts of the country in search of better livelihood and were residing in the study slums for more than 20 years, while some had been there from their birth. The family size ranged from single nuclear families of 2 members to extended families of 11 members living together in their one to two roomed homes. All of the respondents stated that either they themselves or their family members had a source of income from diverse occupations prior to the shutdown (Table 1). Just over 60% (32 out of 51) were earning on a monthly basis. Most had temporarily lost their means of livelihood. The fortunate three respondents whose families were still able to continue working during the period of the interviews reported that their earnings had drastically reduced.

Table 1: Demographic characteristics of respondents

Characteristics		Frequency (N=51)
Gender	Male	7
	Female	44
Religion	Muslim	49
	Christian	2
Age Range		19-79 years
Duration of Staying in Study Slum		2-42 years
Average Family Size		5
Occupation of the Respondent	Frontline Worker	15
	NGO Staff	1
	Domestic Help	2
	Small Business	5
	Homemaker	9
	Landlord Fund Collector	1
	House Owner	2
	RMG Worker	3
	Day Laborer	3
	Sweeper/ Cleaner	3
	Student	3
	Tailor at Local Shop	3
	Factory Worker	1
	Occupation of Main Earning Member	Day Laborer
Driver		2
RMG Worker		3
Factory/Shop Worker		9
Domestic Help		3
NGO Worker		4
Overseas Worker		3
Rickshaw puller		4
Small Business		7
Tailor		4
Sweeper		4
Type of Income		Daily Wage Earner
	Monthly Wage Earner	32
Number of Earning Members in the Family	1 Member	18
	2 or More Members	33
Family's Monthly Income	<5000 taka	4
	6000-10000 taka	15
	11000-20000 taka	25
	>20000 taka	7

Living Conditions of Respondents:

Similar to the millions of other slum dwellers across the country, the physical area of the study sites are characterized by congested and densely populated living conditions making social distancing an impossible task. Two-thirds (31 out of 51 respondents) of the respondents were using community toilets and bathing spaces, with one toilet stall being shared by eight families on average. Majority (45 out of 51) reported having access to uninterrupted water supply with half (26 out of 51) having to collect drinking and household use water from communal water sources. Each water source was availed by eight families on average. Two thirds (34 out of 51) of the respondents said they had their own kitchens either inside or outside their dwellings. However, as clarified by the respondents, this actually meant that the cooking stoves were actually placed in the alley just outside their doors due to the scarcity of space. Even though the women in these households did not have to gather at the community kitchen area, being in the open meant that they nevertheless cooked in close proximity to their neighbors and passing pedestrians. Only two respondents said that they used LPG gas stoves which were placed inside their homes. Among the 17 respondents who were using community kitchens, 16 respondents informed that there were four cooking stoves in one community kitchen and on an average four to five families used each stove. In the Dholpur slum, however, one respondent stated that her family uses a community kitchen where 10 cooking stoves were installed and each stove was assigned to one family.

Table 2: Respondents' Living condition

Living condition		Frequency (N=51)
Type of house	Own house	23
	Rental house	28
Type of toilet	Own toilet	20
	Community toilet	31
Type of water source	Water supply at home	25
	Communal water source	26
Type of kitchen	Own kitchen	34
	Community kitchen	17
Type of bathing space	Own bathing space	21
	Community bathing space	30

Perceptions about Coronavirus

The study found that all the respondents had a basic understanding of the virus along with some level misinformation, which was creating fear and stigma around coronavirus. All of them said that they learnt about the disease mostly from television while also receiving information from other sources such as via announcements made through microphones, from NGO frontline workers including community health workers, leaflets and social media.

There was general confusion as to the symptoms of coronavirus. For some the symptoms of seasonal flu and coronavirus are very similar and a few shared that if a person has flu-like symptoms for only 2-3 days then it is not coronavirus. However, many respondents also shared that a cold, cough and fever was an indication of the person becoming infected with coronavirus. A few also shared that having a fever for 14 consecutive days was a sign of the infection.

The respondents mentioned a range of virus symptoms with the most common ones listed from high to low frequency in Table 3.

Table 3: Symptoms and Bangla terms mentioned by respondents

Symptoms	Bangla term mentioned
Fever	<i>Jor, thanda jor, halka jor</i>
Cough	<i>Shukna Kashi</i>
Cold	<i>Thanda laga</i>
Sore throat	<i>Gola betha</i>
Sneezing	<i>Hachi, Hachi-kas</i>
Body ache	<i>Ga betha, shorir betha</i>
Breathing problem	<i>Shasher shamasha, Shashkosto</i>
Loose motion / diarrhoea	<i>Diarrhoea, Patla paykhana, Pet kharap</i>
Headache	<i>Matha betha</i>
Runny nose	<i>Shordi</i>
Vomiting	<i>Bomi bomi vab</i>
Pneumonia	<i>Pneumonia</i>
Arly given the Chest pain	<i>Bukey betha</i>
Shoulder pain	<i>Ghar e betha</i>

Death, Stigma and the Fear of being socially ostracised

All 51 respondents understood the virus to be a **'mohamari'** (pestilence), **'choyache rog'** or **'choyachuyi rog'** (contagious disease) that transmits from infected persons through touch or through coughing and sneezing. One female respondent said, "I heard about coronavirus from television. It is a 'chuyachuyi rog' (contagious disease). It spreads from one person to another - **'nisshash theke choray'** (through breathing) **'dhorley chhoray'** (through touching)"

Many of the respondents perceived the virus to be **'moroner baedhi'**, **'kothin rog'**, **'otimarattok rog'** (fatal or deadly disease). One woman said, "Corona is a deadly disease and no medicines are available to treat it. Death is must due to this infection." The fear of death by being infected with Coronavirus was wreaking havoc on residents' lives, particularly given their high levels of insecurity with regard to the virus spreading quickly. This in turn has led to stigma and discrimination within the slums.

Forty three out of the 51 respondents shared that residents were far more anxious about their own safety and this had disrupted their social networks as many had reduced socializing inside the paras (locality). The possibility of an infected person spreading the contagion throughout the whole slum was of the upper most concern among most respondents.

Case story 1: Enforced Isolation

"Today my daughter locked me in the room. That's why I could make some time for the interview or else I would have been busy outside serving society in this crisis situation"- Mr. Karim (pseudo name).

Mr. Karim is a 51 year old man who lives in a rented house in Kalyanpur. He is the only earning member of the family and has to feed 6 members. He has been residing in that area for the past 42 years. He has a small business of tin sheds and also works as a contractor.

The levels of fear people are exhibiting is demonstrated in the case below, where a daughter concerned for her father, forces him to stay inside the room and locks him in. She is concerned that he will become infected if he meets people in the slum. Several respondents shared that in their community that residents consider anyone with any coronavirus-like symptoms, such as fever or cough, as a suspected corona positive patient. One male respondent shared, "Specialists have said that the virus spreads through human cough and sputum and these can be passed through the air if you stay very close to the infected person."

It was commonly shared that if someone was showing symptoms of a cold, cough and or fever, that person is avoided, and in some cases forced to self-isolate and even harassed to leave the slum. Some of the respondents also reported that if someone coughs in public, that person may be accused of having the 'Corona'. Rumors can spread very quickly in these slums and any talk of a person being infected creates panic and the sick person is targeted and discriminated against. As one man shared, "if someone has a fever or cough, the neighbors start passing negative comments about the individual risking all the families living in the slum..."

Monitoring of one's own health and others has become the new reality for many. The levels of anxiety and fear that one can be afflicted with the virus and the resulting loss of community social support is mentally and emotionally taxing on individuals. A number of respondents shared that they would not let anyone know that they were feeling sick, even if it was a slight fever, cough or a cold.

One woman said, "Many are scared that people will avoid them if they come to know of their illness. Everyone is worried as they don't know who might have this disease."

This has resulted in individuals hiding symptoms of fever, cold, or cough for fear of social ostracism. Another woman shared, "The community people are very scared about this corona, everyone is panicking. If any member of the community gets sick, he/she does not disclose it and they hide it from others as the police might take them away."

Some of them mentioned stories that they had heard of identified cases being forcibly taken by the police to the isolation center. Given the rumors swirling around this 'dangerous stigmatized disease' and the paucity of information as to what an isolation center is, the mere thought of being picked up by the police, has created further panic in many. Some of them mentioned that they had heard that if they fall sick they may be taken away and would never return to their families. Already powerless, many residents remain fearful of the law which has ordinarily not treated the poorest well.

The level of fear and apprehension is so widespread, that even a community health worker mentioned the need to turn in a sick person to the police or enforce quarantine.

Like most of the population of the country, most of the residents in the slums seek treatment from local drug sellers for health problems including the common cold, fever, and cough. However, one woman in Dholpur slum and another female community health volunteer in Helal market slum alleged that if someone with such symptoms now goes to the local pharmacies, they are not prescribing medicines but asking people to go to hospitals for blood tests. In an incident reported by a male respondent from Dholpur slum, a woman in their neighborhood had a fever and went to the local pharmacy for treatment. The pharmacy owner, who was also an informal healthcare provider, did not touch her and did not provide any medicine because he suspected that she was infected with corona. When word got out that she may be a corona infected person, people in the locality began abusing her and asked her to lock herself in her room. Traumatized and depressed, the woman later fled from the area.

If this is more widespread than the three cases reported, it further magnifies the fear amongst the poor. Suddenly the local drug sellers who are familiar to them are refusing to treat them and instead asking them to get blood tests done. Not engaging with the person seeking care, and or asking individuals to get a blood test signifies for many a serious illness and instead of reassuring them with appropriate messaging, this further reinforces the perceived fatality of this virus. This leads to further silence around coronavirus and residents being reluctant to share about their health problems. Below are two case stories which highlight the mental stress and discrimination faced by individuals and their families.

Case story 2: Kicked out of the slum

In one slum, a woman's husband who worked in Italy returned to Bangladesh after the declaration of the COVID-19 pandemic. Upon his arrival at Dhaka airport, he was kept in quarantine by the authorities at the Ashkona Hajji Camp. However, all the community people in that slum started harassing the woman and her children and pressuring them to leave the slum and go back to their village. The community people were scared that if the family stayed in the slum, at some point that man would come back to the slum to stay with his family and he would end up spreading the disease in the slum. Rumors started spreading that everyone would get infected with the coronavirus because of him. The family had to ultimately return to their village because of the constant harassment and anger directed at them. There were high levels of insecurity at being infected or getting it from someone else in the slum or from outsiders coming in from abroad, particularly China and Italy.

In the same slum, when a 7 year old girl had cold and fever, the community people started saying that she might have coronavirus. Fortunately, after visiting the doctor and taking the prescribed medication, she recovered and people realized that she wasn't and were relieved. However, the stress and comments her family faced during this period was traumatizing and they felt alone and abandoned even by their neighbors.

"If someone is showing signs of corona then we should inform the police so they can make sure the person stays in home quarantine or call the numbers that are shown in the TV- we should not all die for the sake of one person" (Ekjoner jonno toh ar shobai morbo na)."- said one community health worker

Perceptions about the Transmission of Coronavirus

Other perceptions related to the Coronavirus infection was the impact of the dirty environment and lack of cleanliness which could result in one becoming ill. A few of them shared that they had heard that the virus is spread through dust (*'dhulabali'*), and if one was walking bare feet and didn't wear shoes outside their home, they would be vulnerable to the infection.

One woman who worked in a scrap metal shop (Bhangari dokan) as a day laborer said, *"This disease spreads from 'rastar dhula' (dust). Now everyone is keeping the streets clean. We have requested people working in the City Corporation to clean our roads and lanes with bleaching powder. There is less dust in the streets now. This is why we do not have coronavirus in our area."*

Other perceptions blamed the Chinese for their dietary habits, which would have been gleaned most likely from social media. A few respondents shared, "This corona came from bats and the Chinese people ate those infected bats and day by day it is spreading all over the world, even in Bangladesh", while another thought that eating snakes was the reason for getting the disease. This reveals how news from around the world travels rapidly via different sources to even the slums. There was also the misinformation that only Bangladeshi returnees from China and Italy were susceptible to this virus and the slum was safe as long as none of the returning migrants came to live in their slum.

One woman said,

"We do not have returnees from abroad in this slum. This is why we don't have coronavirus."

A little less than one third of the respondents (15) shared that this was a divine punishment from God and only through prayers and faith could one prevent oneself from being infected - *"This is a punishment from Allah (gojob or Allah er shasti) for the sins committed by humans and only Allah can cure this."* A 75 year old male respondent commented, *"Being a Muslim, I believe that Allah is angry with us. We, human beings, have done lots of bad deeds and as a punishment people all over the world are now suffering. In order to show us the right path, Allah has created this disease."*

An NGO worker who lives and works as a community organizer in Dholpur slum said because of these religious beliefs many people in that slum were reluctant to refrain from going to the local mosque to pray as they were comforted by meeting in numbers to pray for this virus to go away.

She expressed her frustration that some of them continued to believe that the virus preventive measures were futile. She said that a greater sense of fatalism has crept in, *“I hear people saying as Allah has given this disease, Allah will take care of this. If death comes, it will be Allah’s will. What’s the point of being careful?”*

For many of the poor, whose level of helplessness and lack of control over their lives has been amplified even further by the shutdown, prayers offer some form of peace and solace. Over 60% of the respondents (34 out of 51) spoke about how prayers helped to reduce their stress and anxiety. One woman said - *“When I don’t have any work, what is the point of even worrying about anything? I just pray to Allah and make dua for the people of my country.”*

Preventive Measures & Ground Realities

All of the respondents stated that the community people were well aware of the different preventive measures, and were informed of the need for social distancing, frequent washing of hands with soap, staying at home, wearing masks, using gloves, using tissue or handkerchief during coughing and sneezing, and maintaining cleanliness. Many also shared their inability to follow the preventive measures due to their living conditions and economic constraints.

Every respondent was aware of the importance of hand washing with soap for 20 seconds to prevent transmission of the virus and that the community was well aware of this. Two respondents had the mistaken notion that in the absence of soap/hand wash, they could even use *‘chai’* (ashes). They had heard of the different health messages transmitted through NGO frontline workers, television, internet, and social media. Two respondents did point out that it was very difficult for poor people in the slums to manage soap for washing hands. A female respondent said, *“Most of the community members are struggling financially during this pandemic. They can barely afford to eat twice a day. How will they buy soap for washing hands?”* The dilemma for the slum residents is great, as they debate whether they will go hungry or worry about this ‘deathly’ virus, with food being much more of an immediate concern.

All of the respondents viewed masks to be important for preventing spread of the infection, along with protecting them from dirt and bad odor. Two NGO community health workers, one residing and working in Dokkhinkhan slum and another in Chalbon slum, said that masks are important for their own protection as well as to protect others. All of the respondents shared that they try to wear masks when they go outside and some alleged that sometimes the police also forces them to wear a mask. They were unable to afford surgical masks (with each surgical mask costing 30–50 taka), so they bought low cost cloth masks while some made their own masks from old clothing. A male respondent said, *“We can’t afford good masks. We use what we can manage. It’s better to use something than using nothing (nai mamar theke kana mama valo).”*

According to the respondents many poorer families in the slums are not able to afford to buy masks for each family member. One 35 year old female respondent, whose husband used to work as a rickshaw puller but was now unemployed

because of the travel restrictions stemming from the shutdown, shared that *“there are many families who can’t afford masks for all their members.”*

Most resort to purchasing one or two for use by the male family members as they are perceived to be primarily responsible for outside work. The sad reality is that in most of the families, gender vulnerability is heightened as women may end up compromising their own needs. Instead of using masks, some women shared that they use scarves or cover their face with cloth - *“My husband needs to go out more, that’s why he needs it (mask) more. I only go out to buy groceries, I can manage with my orna (scarf).”* For many, being poor means that risks and choices have to be weighed. For these women, the choice is a pragmatic one as they are scared to lose the main or only earning member of the family to the virus.

Around 60% (31 out of 51) of the respondents had heard about quarantine as a preventive measure. They mentioned that if someone has symptoms of the disease or recently came back from abroad, they need to stay separately inside their homes for 14 days and maintain distance from the other family members. The anxiety of not being able to stay separately if one falls sick creates more emotional and mental stress. As one woman explained, *“We live in a one room rented house so it is not possible for us to have a separate room when anyone becomes sick”*

Case Story 3: Distance and Space - A Luxury in Slums

“We live in a rented house and we share toilets and a kitchen. It is not possible for us to maintain all the precautionary measures. There is no use in lying to you. We need to use the toilets, bathing places. In the kitchen, we can’t maintain the distance. We need to cook altogether. As we are living in rented houses we do not have any separate facilities.”

The above is a statement by a 35 year old female respondent living in a small rented room in Nama Shyampur slum for the past 15 years along with her husband and two children. Her husband is a rickshaw puller and the family is totally dependent on his daily wage of 300-400 taka. The recent shutdown has forced him to be confined within the single small room they rent.

Her family shares the toilet, bathing space, and community kitchen with seven other families. Though she knows that social distancing is an effective way to prevent the spread of the disease, it is extremely difficult given the living conditions. Residing in a single room rented space has made it next to impossible. According to her, if one is infected in this slum then he or she can easily spread the virus to 10 more people.

As she explains:

“Is it possible to maintain distance within the family? We are a family of 4 members, all living in one room. In other rooms, there are even more people living and sharing the same space.”

In the context of overcrowded slums where people live in very close proximity and mostly use shared facilities, it is nearly impossible to maintain social distancing as shared by 13 respondents. One female respondent said, *“We live in a congested area, it’s not possible to maintain distance from each other”*. In addition, almost two thirds of the respondents mentioned using communal toilets and bathing spaces. The sharing of toilets, cooking, and washing facilities is a permanent feature of slum life. Thirty-two (32) respondents said that although they were fully aware of the increased risk of being exposed to the virus due to the use of shared facilities, they didn’t really have a choice given the circumstances. A few respondents did share that they have tried to take some preventive measures in their living spaces as their landlord or landlady had pushed them to do so. The said property owners had heard the messages on prevention and were worried about not only being infected themselves but also having the entire slum affected by the virus. They had the necessary influence to set rules and restrictions and they also have much to lose if the entire slum collapses because of coronavirus. Most leaders of slums tend to own two to three households and have a fixed power base and network of support. The vulnerability from losing social standing and economic loss is much feared.

From past research and as reported by some of the respondents, it is common to see long lines outside the informal settlement toilets particularly in the morning. While waiting for their turn to use the toilet, many people gather around to have a chat. In one section of one of the slums, a community leader discussed with others on not allowing outsiders, such as guests or visitors, to use their toilets or bathing area. This was a special initiative taken by this particular group of residents under the directives of the local leader to combat the coronavirus within their constraints. In some of the other local paras, some individual house owners have made some rules to be followed by their tenants to maintain social distancing to the extent possible. Four of the respondents, who were powerful members within the community and also house owners took the initiative in their respective compounds to limit the queues outside the community toilets. One community leader mentioned that there were 30 families under his watch who share 4 toilet stalls. He had informed all of them that in this situation, only one person can wait outside the toilet stall, and that there should be no gatherings in large numbers in those spaces. He also asked them to encourage other people in the community to follow the same practice. *He said,*

“There is a risk as we share these facilities. Today all the 30 families have made the decision that in our area, we will not let anyone from outside use our toilet and bathing space facilities, not even our relatives. We will strictly follow this rule.”

The research found that four to five families on average share one stove, and each community kitchen has up to four stoves. Some slum leaders had taken initiatives to minimize gathering at communal kitchens by staggering the cooking times. Some of the respondents shared that this in turn had led to residents becoming less social with others, and that people had stopped talking with one another like they used to, even when cooking in the same space at the same time.. A few individuals have also

taken their own measures in order to practice “social distancing” such as using the kitchen when no one else was present, but this was not always possible. A landlady mentioned that she had asked four of her tenants to use the kitchen one after another, so as to avoid gathering at any one time. That 30 year old landlady said, *“I have also asked everyone to clean the kitchen after use, and made a rule that only one person can use the kitchen at one time. As 9 families share this kitchen space, we have decided to cook at different times so that many of us do not gather here at the same time. We have also stopped sitting down and talking to one another. After I am done cooking, I take a shower to get rid of the germs”*

Case Story 4: Initiative for Maintaining Social Distancing

One respondent from Nama Shyampur slum mentioned that in order to prevent the spread of the virus, the families she was sharing communal facilities with came up with a plan to keep the common spaces clean. To keep the community bathroom and kitchen area clean, they allocated one person from each family for cleaning it daily. In addition, they also collected money from each family and bought soap to keep outside the bathroom space so that everyone can maintain proper hygiene. Since the community kitchen has 4 stoves, the families made a rule that only 4 families can use the space at any one time,

“Four families will use the kitchen and once they have finished cooking, the next 4 families will use it. That’s how we are trying to maintain social distancing to save ourselves from this virus.”
- the respondent said

A few others shared that they try and stay away from sick people, and spray bleaching solution and powder in the areas surrounding their one room home. One 38 year old community health worker in Chalbon said, *“In order to keep the surroundings of my house clean, I spread bleaching powder around the house.”* Despite the constraints, many believed that that such steps may help with prevention, because the overwhelming fear among all was, *“once the virus enters a densely-populated area such as their slum, they will have no escape.”*

Economic and Social Impacts & Increased Distress

The negative impact of Covid-19 on economic growth and jobs, and the resultant upsurge in poverty will be significant in a country like Bangladesh. The projected GDP growth of 8.2% for FY20 is now expected to crash to 2-3%^[3]. The nationwide shutdown that was instituted from March 26 following the first Covid-19 cases being diagnosed on March 8, has brought economic activity to a near standstill.

^[3]<https://www.dhakatribune.com/business/2020/04/12/wb-bangladesh-must-ramp-up-coronavirus-action-to-protect-its-people-revive-economy>

This has already had and continues to have devastating consequences for large sections of society including the slums as majority of their residents were earning their livelihoods in low paid jobs in the informal sector or as daily wage laborers.

Among the respondents, 47 families out of the 51 interviewed had lost their main source of earning. Out of 51 individuals interviewed, 33 of them had at least 2 earning members in their families. Either all of the earning members or at least one member of these families have lost their income sources.

Of the 51 community members interviewed, one third were daily wage earners such as rickshaw pullers and day laborers while the rest were monthly wage earners working as construction workers, factory or ready-made garments workers, domestic help and so forth. Some of the respondents were running their own small businesses ranging from small corner shops selling food items, to tea stalls, to tailoring business, and the like. Prior to the shutdown, almost half of the respondents' average monthly family income was reported to be less than BDT 10,000. This limited income was barely sufficient to keep their families afloat and now that too has been severely disrupted. Mobility restrictions are being enforced and increasingly there are stricter laws being put in place to fine and/or punish individuals seen to be roaming on the streets. Hence, for instance, even if workers such as rickshaw pullers or three-wheeler CNG drivers venture out, there are hardly any passengers to offer rides to.

One third of the respondents who were dependent on daily wages have been the most affected due to the sudden halt in economic activities. The shock of this sudden shutdown without any advance warning or planning has been extremely traumatic for many. Very few respondents in this category have

savings, and even if they do it is minimal. Some of them in desperation went in search of work but were thwarted by law enforcement agencies.

In comparison, respondents who used to earn a monthly wage were better positioned as they were able to store some food that they bought at the beginning of the month and also had more savings. However, their money and food supplies were rapidly depleting during the time of the interviews. With the lockdown now being extended for the third time, the future of their job situation and their ability to purchase food for themselves and their families has become increasingly uncertain. A woman said, *"My husband works at a garment factory that has been closed for the last 10-12 days because of the lockdown. As he is not going to work, there is no income. We are very tense about how to manage food for our family. For the time being, we have some pre-stored groceries which we bought at the beginning of the month. However, we don't know what will happen when those groceries will finish."*

A mother of a construction site worker who is the only earning member of the family said,

"My son works as a day laborer in a construction site. For the first few days of the government announced general holiday, he worked secretly at the site. However, after 4-5 days, the army officers caught the ongoing construction work and closed the place. Now that it is closed, he has no money and even the owner didn't pay him for the last few days work. He tried to go to the site to collect his money but police chased and beat him up for going out of the house."



There has also naturally been an impact on small business owners with the common refrain among them being, “No way to operate shops, no customers to open for”. Many of these small business owners operated “*mudir dokans*.” These are local tiny grocery shops set up in the local areas, with a couple of stools where people sit or stand around drinking tea and buying snacks. Their income has since reduced significantly and they are starting to struggle with managing their basic expenditures.

A woman whose family owns a small spice shop in a slum shared her pain and anxiety: “It is very difficult to manage the household expenditure now. The shop my father-in-law used to operate is closed down and my husband is also sitting at home. Now shops are only allowed to open at certain times - from 6 am to 12 pm and then again from 5 pm to 7 pm. But these are not the times community members usually go to the shops. The police are saying to not go outside the house unless it is an emergency. Isn't earning money a necessity?”

While there exists panic and fear of becoming infected, their immediate concerns were now focused on basic survival, managing the next meal, and finding a way to earn money, any cash to pay rent, and cover other essential costs. Due to the sudden shutdown and travel restrictions, people are unable to go out for work. While daily survival is a major challenge for the poor, there is also uncertainty as to how long they can survive if this situation continues, as expressed by 31 respondents. Some of them are also worried about their children's education and future. A 35 year old woman resident of Dholpur Moddham Basti, whose husband used to work as a rickshaw puller shared the following,

“There is a lot of tension. How will we live, what will we eat? Will we die because of this virus or because of hunger? My husband is not working, when will he get the rickshaw and when will we have food in the house? What will happen to my children...all of this is just making me ill.”

- Dholpur Moddham Basti

Another woman said, “Now famine has started (*durbikkho choltese*). If you work hard, you have food on your plate, otherwise you don't. It has been 10 - 12 days that we have not left the house. How will we bring food?”

One 32 year old female resident of Dholpur slum, whose husband works as a sweeper at Dhaka South City Corporation, informed that her husband did not receive his salary for the month of March (interview was taken on 11 April) and were tensed and worried about their survival.

“We are worried. My husband has not received his salary yet. How will he collect the money? The office (City Corporation office) is closed due to the government holiday. We have a daily expenditure of 200 taka. Our salary is never enough. On the 25th of every month, I need to borrow 500 taka from someone. That's how we live. We have no savings. I need to pay the school fees of my 2 children. After the coronavirus came, the situation is much worse. There are even more worries.”

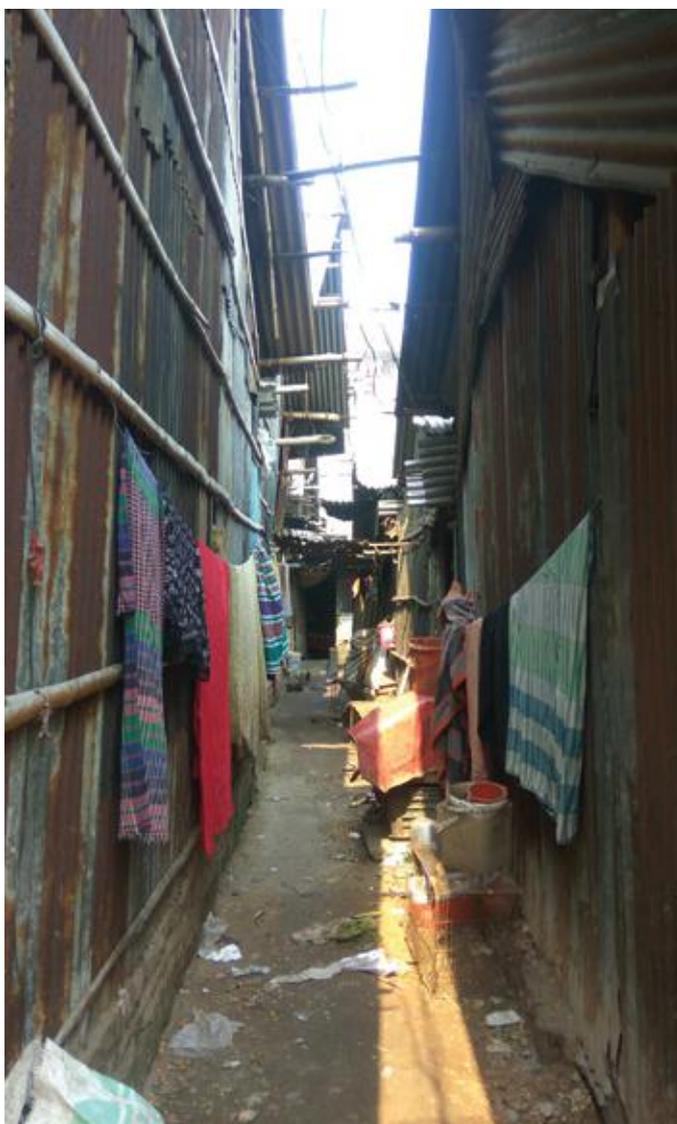
Case story 5: “Ayer cheye bayer palla beshi” (Expenditure is Higher than Income)

Aklima (pseudo name) works at a shoe factory in the outskirts of a slum making Burmese sandals. Since the pandemic, Aklima's factory closed down so as to not spread the virus within the workers who were already working in cramped spaces where the chances of infection are extremely high.

Aklima is the only earning member of her family as both her sons are young and her husband is sick and old. Her husband always used to work irregularly, so she never really had much of a stable income. Her younger daughter's husband is abusive to her daughter and that's why her younger daughter also stays with her. As the only working member of the family, Aklima can barely live on her salary after paying rent and managing food. And that was before the pandemic hit and the shoe-making factory closed down.

If her current situation was not bad enough before, just before the pandemic hit, her daughter got sick and she had to spend BDT 60,000 from her hard-earned savings for her treatment. This unexpected financial blow just before the pandemic has now left her almost destitute. All Aklima has left is one bag of rice and once that is finished, she will have to borrow from someone. She shared stories of sleepless nights lying awake worrying about how she will feed her children and her family.





A female respondent said, *“in this coronavirus situation, those who have money will survive, those who don’t will die. A few of them shared their experiences of trying to get past these barriers, standing in lines, waiting and pushing each other in the hope of getting some support. A man shared, “It was a nightmare with people pushing and shoving and yelling and screaming for food.”*

Some of the respondents also stressed the increasing anger and resentment among community residents as some were being left out of relief distribution while others were not. Disruption of social networks and relationships will increase as the shutdown continues, unless relief is distributed equally in these slums.

The precariousness of their situation combined with their fragile emotional and mental state is negatively impacting family relationships in the slums. Four respondents mentioned that some households were rationing their own food, to ensure their children or the elderly were getting enough to eat. The pangs of hunger and anxiety were also leading to increased arguments among spouses and family members as shared by three respondents, and cases of domestic violence were reported by nine respondents. Six of the female respondents shared the misery and anguish of the breakdown of relationships with their husbands and family members, and mentioned *‘monomalinno’* (misunderstandings), *‘jhograjhati’* (quarrels), *‘torko-bitorko’* (heated argument), *‘poribare oshanti’* (no peace in the family), and *‘chillachilli’* (shouting). Often when women argue or complain about the situation, they are beaten.

One woman shared, *“If there is no food in your stomach, how long will your relationship with your husband remain good? Fights among spouses are the obvious outcome of these stressful times.”*

Another 38 years old homemaker said, *“It’s a slum and there’s a saying “obhabey shobhab noshto” (necessity knows no law). When there’s no food and the family members are asking for food, it’s normal that the men will get angry. I would say such quarrels and violence have increased here”.*

Two frontline workers of an NGO, who have been working in the community for 6-8 years, reported witnessing an increase in heated arguments among spouses in their areas since the shutdown. One of the frontline workers herself witnessed such an incident with one of her colleagues. In her words,

“One day, when my colleague and I were getting out of her house for a household visit, her child asked for some money from his mother. She told him to ask his father. Hearing this my colleague’s husband got furious as due to the lockdown he didn’t have any work or income. Thus, her husband started shouting at my colleague. He started shouting and saying where will he get the money from. This created a huge quarrel between them.”

Covid-19 is understood as more than just a health problem, but as something more insidious, and is bringing obhab (scarcity) leading to unhappiness in every household. A 35-year old woman resident of Dholpur Moddham Basti whose husband used to work as a rickshaw puller shared the economic and social impact of this virus,

In order to manage food, a few respondents reported various ways of managing, such as relying on some close community members (i.e. better off families) for food, receiving money from relatives, tapping their savings or taking loans to manage. A majority of them mentioned that for slum residents surviving on relief materials is their only hope for survival. Some residents mentioned that they had received food from different non-government organizations, local politicians, some well-off families in the locality, and from their employers. The commonly supplied food items were rice, oil, pulses, and potatoes. According to the respondents, however, the coverage was very low with 16 out of the 51 sharing that they did not receive any food support. One male respondent who is a member of a local community support group said, *“Only selective people are getting it who are identified as extremely poor people. But there are more than 1500-2000 families who are also very poor in our area.”*

Fourteen respondents shared that corruption was affecting the government relief distribution and recommended systematic policies to be put in place by the government and a list compiled of the poor people to ensure that those who are most affected can receive food and other essential support. Four respondents alleged that those who voted for the ruling party (i.e. assisted with campaigns, had clear allegiance to the ruling party) and had strong links with local leaders were being favored over other residents, who were in dire need of support.

“There is a lot of tension. How will we live, what will we eat? Will we die because of this virus or because of hunger? My husband is not working, when will he get the rickshaw and when will we have food in the house? My husband fights with me all day for money. Sometimes he beats me. All this tension and anxiety makes me feel sick. Sometimes I get a headache because of the tension.” Continual worries leading to physical aches and pains were also mentioned by some of the respondents.

Some of the women reported additional stress, as they felt more responsible for ensuring their children are fed and how to arrange food every day. Coupled with the uncertainty of the length of the lockdown, this was adversely affecting their mental health.

A female respondent shared: *“Now there is a lot of tension (oshanti) and fights (jhograjhati) because of scarcity (obhab). My husband has no worries or tension at all. Everything is on me. We don’t have groceries, but he doesn’t care. All the worries are mine - managing food for my children. My husband smokes a lot. Although we don’t have money, he has to smoke. The shops are closed. I don’t know where he gets it from. We fight because of this. There is no food on the table but he has to buy cigarettes.”*

“I am very worried - from where I will get money, from where will I get food for my kids. I feel helpless. This anxiety and helplessness makes me cry every day” - said a 40 year old mother of three children residing in Nama Shyampur slum. Similar sentiments were shared by many of the women respondents.

The situation is much worse for poor women and female headed households. A woman abandoned by her husband, shared the struggles of being a woman and trying to manage food for her daughters and elderly mother. She worked as a domestic help for four families in Wari. Her husband left her and remarried another woman. She is the only earning member of her family: *“I don’t have my husband. I single handedly have to take care of my family. Other families have a male member in their family to depend upon. I have no one. I feel really bad and mentally stressed. There’s no way but Allah will help us.”*

In the interviews, all the respondents, both men and women expressed their anxieties, worries, helplessness, fears, and tension regarding their survival if the current situation continues. Almost all of the respondents mentioned grappling with feelings of *“panic, feeling restless, hopelessness, fear, and occasional break downs”* as they had no sense of how all of this was going to unfold in the coming days. Furthermore, there was the added fear of crime and insecurity increasing in the slums. A few residents in Kollyanpur slum expressed worries about how residents’ desperation will continue to increase if the shutdown continues for a longer period. One of the male respondents shared, *“When people are in ‘obhab’ (scarcity), people tend to fight more, they tend to resort to stealing. There is a chance of increasing crime in this community. I am worried that theft and crime will increase in our community”.*

Conclusion

“Whenever I feel stressed, I let my pigeons fly and then I watch them.” - 21 year old male respondent (it gives him a feeling of freedom).

The young respondent used to work as a ‘rongmistri’ (painting contractor) before the shutdown started. He and his father were the earning members of their family of five members. He has been living in Shyampur since his birth. He used to earn money depending on work availability. He addressed the current situation as a form of “harassment” for daily wage earners/day laborers like him. For him, staying inside the house is not at all peaceful - *“ghorey boshei oshantitey achi”* (I am distressed because of sitting idle at home). If the current lockdown continues they will be in serious trouble. He and his family worry all the time thinking about the future.

Respondents used many different local terms for the shutdown, including ‘lockdown,’ *‘alada thaka’* (live separately), *‘keo elakay dhukte ba ber hote na para’* (nobody is able to get in or out of a certain area), *‘poribar theke dure thaka’* (live away from family), *‘lokjon theke dure thaka’* (stay away from people).

The impact of the shutdown has disrupted social and economic lives and networks in the slums. Local beliefs combined with fears of death from being infected by the coronavirus has led to stigma and discrimination against those who are perceived to be carriers of the virus. Everyday living in overcrowded spaces, waiting in limbo, being on the edge with increased mental and emotional stress, and greater strife within families is pushing these communities to a breaking point with no hope in sight.

One of the young respondents who used to work as a ‘rongmistri’ (painting contractor) viewed the current situation as a form of ‘harassment’ for daily wage earners like himself. Being trapped in the slum for days on end is distressing and so to escape reality, he said he likes to watch his pigeons fly.

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