

COVID-19 knowledge, perceptions and practices of the urban extreme poor in Dhaka and Chittagong

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Background

The COVID-19 (or 'coronavirus') outbreak was declared a Public Health Emergency of International Concern (PHEIC) by the Director-General of the World Health Organization on January 30, 2020. As of 13th of July, there have been over 12.5 million confirmed cases globally, with 566,654 confirmed deaths due to the virus (WHO 2020). Bangladesh is no exception to the pandemic and according to the Institute of Epidemiology Disease Control and Research (IEDCR), the first case of COVID-19 was on March 8, 2020. The first confirmed death in the country was on 18 March. Since then, daily numbers of infected in the country have risen rapidly. As of the 13th of July, 2020, Bangladesh has confirmed cases of 183,795 and 2352 confirmed deaths (WHO 2020). The average rate of daily infection over the last 30 days has been consistently over 3000 cases and has yet to reach a plateau (WHO 2020).

The urban poor face many challenges and constraints to preventing COVID-19 (Wilkinson 2020). Urban areas, such as Dhaka and Chittagong, are 'hotspots' of the country's virus outbreak according to official data (NAWG 2020). In Dhaka, over 7 million people reside in squatter settlements and slums, with an additional 40,000 residing in the streets (BBS 2015). For the extreme urban poor, many of the recommended strategies to prevent COVID-19 such as washing hands, self-isolation, and physical distancing are not possible to the same degree as other city dwellers (Wilkinson 2020). Informal settlements and squatter settlements are characterized by overcrowded dwellings, limited access to soap, water and sanitation facilities (Arias-Granade et al. 2018). Furthermore, those sleeping on the pavement often have very limited access to safe water and sanitation facilities (Uddin et al. 2009). Lockdown measures have had a significant adverse impact on the livelihoods and food security of the urban extreme poor who depend on daily earnings and have limited savings (Rahman & Matin 2020; Williams, Dristy & Alam 2020). Maintaining 'physical distancing' is challenging, if not impossible for many urban poor due to economic necessity and shelter limitations (Cash & Patel 2020). Economic necessity and a lack of comprehensive social safety nets have resulted in many of urban extreme poor, particularly men, recommencing engagement in income-generating activities in order to survive. A longitudinal study with the urban extreme poor in Dhaka and Chittagong found that the urban poor, particularly men, are increasingly engaging in income earning opportunities as the pandemic continues, but remain under-employed and are earning less than before lockdown (Williams & Shahabuddin 2020). These risk factors place the urban poor at high risk of COVID-19 outbreaks within their communities.

There is an urgent need to understand the current perceptions, knowledge and practices of the urban poor surrounding preventing and addressing the symptoms of COVID-19. A recent country-wide survey of low-income households found that whilst the overwhelming majority (99.6%) are aware of the pandemic,

the urban poor are less likely to have accurate understanding of the virus symptoms, treatment options and prevention measures. 56% of urban poor respondents within this stated they 'had no idea about how to prevent the spread of the disease' in comparison to 16% of rural respondents (BRAC 2020). Furthermore, 61% of urban respondents stated they 'have an idea about where to go or whom to contact if the virus infected them' (BRAC 2020). The BRAC study sample does not widely capture the urban extreme poor. The study utilized a convenience sample, with data collectors conducting the survey with respondents they 'met on the streets.' As such, the survey predominantly captured those in 'service' roles (40% of respondents), with only 1% of respondents currently unemployed. Given that over half of the most extreme poor are currently unemployed this survey does not provide an overview of the knowledge and perceptions of the urban extreme poor who are facing considerable challenges during the pandemic (Williams, Drishty & Alam 2020; Williams & Shahabuddin 2020). In addition, the study did not explore the preventative practices currently utilized by low-income communities, the logistic barriers and enablers to self-isolation and engaging in preventative practices and health seeking behaviors of the urban poor.

The urban poor, especially the homeless, experience ongoing stigmatization, blame and violent policing measures surrounding their health and living conditions (Williams 2018; Wilkinson 2020). There is a need for NGO's, government actors and health service providers to work in collaboration with the urban poor to ensure barriers to accessing information and health care are reduced. Health information and interventions should build on existing knowledge and acknowledge the specific contextual constraints experienced.

SAJIDA Foundation's Urban Poverty team conducted a Rapid Response Survey (Survey #3) with a group of 515 urban extreme poor who are service users of the 'Amrao Manush' project. The Amrao Manush (we are people too) project aims to improve the lives and livelihoods of pavement, squatter and 'under-developed' slum dwellers. The survey aimed to investigate the knowledge, perceptions and practices regarding COVID-19 amongst the urban extreme poor in Dhaka and Chittagong. The survey was conducted to ensure SAJIDA's ongoing project work with the urban extreme poor is evidence-based and responsive to the contextual factors and emergent needs of this population.

Methods and sampling

The survey was conducted by nine Amrao Manush and SAJIDA call-center staff via mobile phone. Data collection occurred from the 16th June to the 2nd of July. Surveys took approximately 20 minutes to complete. Verbal informed consent was acquired from participants before proceeding with the survey. Following the completion of the data collection period, the research team conducted two FGD's with staff, to discuss their perceptions and observations throughout data collection and program recommendations.

The survey utilized a convenience quota to sample survey participants. The program has a database of approximately 2400 phone numbers of active service users. The survey aimed to capture a wide range of participants who access services, including a range of ages, genders and living locations (pavement, squatter and slum). Call lists were developed by paramedic/ para-councilor and call center staff, to try and

capture this range of characteristics. Calls were made to the listed database numbers, and data collectors talked to whomever answered the phone or who was available to talk.

Please Note: Overall survey call success rate was 53.4%. 'Success rate' was defined as those calls that were answered and the individual provided informed consent to participate in the survey. Amrao Manush staff had a higher success rate (68%) compared to call center staff (46%).

Participant Demographics

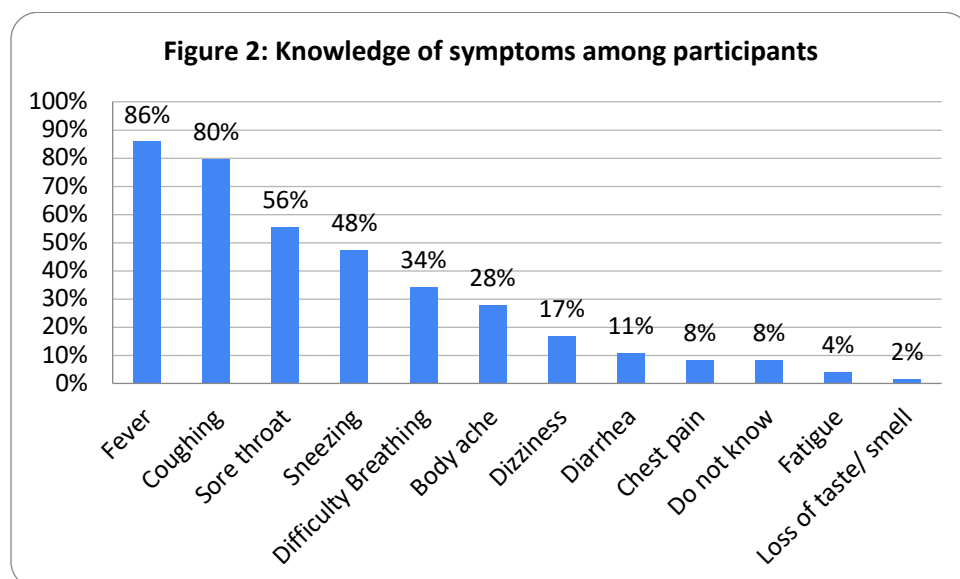
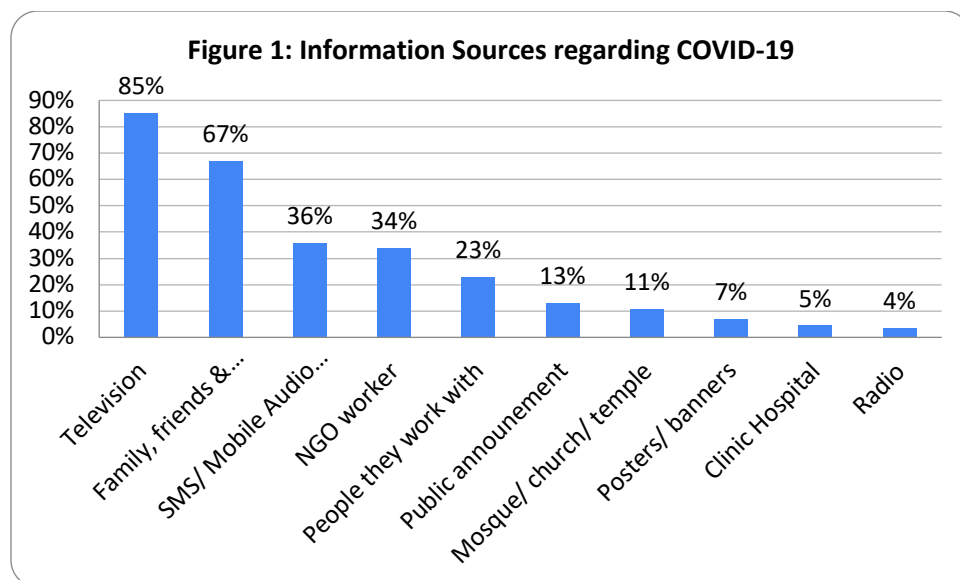
Amrao Manush service users are typically women and children, who access the program for shelter, daycare, advocacy, livelihoods and health support services. Participants of the survey were service users of the Amrao Manush program with a recorded phone number. 71.8% of the participants were women and 28.2% were men. The survey covered a wide range of ages from adolescents to those who are aged over 50, with the majority (65.6%) aged between 21 to 40 years of age. Most participants currently live in an 'under-developed' slums (68%), whilst 23.2% currently live on the pavement, and 8.8% in a squatter settlement.

The urban extreme poor have key knowledge regarding COVID-19

There is widespread knowledge regarding COVID-19 amongst the urban extreme poor. Only three respondents (0.6%) had not heard of COVID-19. Most respondents had learnt about COVID-19 from TV (85%), whilst other key information sources included social networks via word of mouth (67%) and Government SMS/mobile audio announcement (36%). See Figure 1.

30% of survey respondents stated that 'everyone' could be infected with the virus. There appears to be a widespread understanding of the risk the virus poses to the elderly, with 48% reporting that the elderly were most likely to be infected, whilst 58% reported that the elderly were most at risk from COVID-19. However, some mis-information persists, with 12% of participants reporting that they believed 'inevitable death' was a consequence of contracting COVID-19.

There was a widespread understanding of the key symptoms of the virus. When asked 'what are the symptoms of COVID-19?' - Symptoms reported included fever (86%), coughing (78%), sore throat (56%), difficulty breathing (34%) and body aches (28%). However, some rarer symptoms of COVID, such as sneezing (mentioned by 48% of participants) were also thought to be common symptoms. There was limited awareness that anosmia (loss of taste and smell) could be a symptom of COVID-19, reported by 1.6% of respondents. See Figure 2.

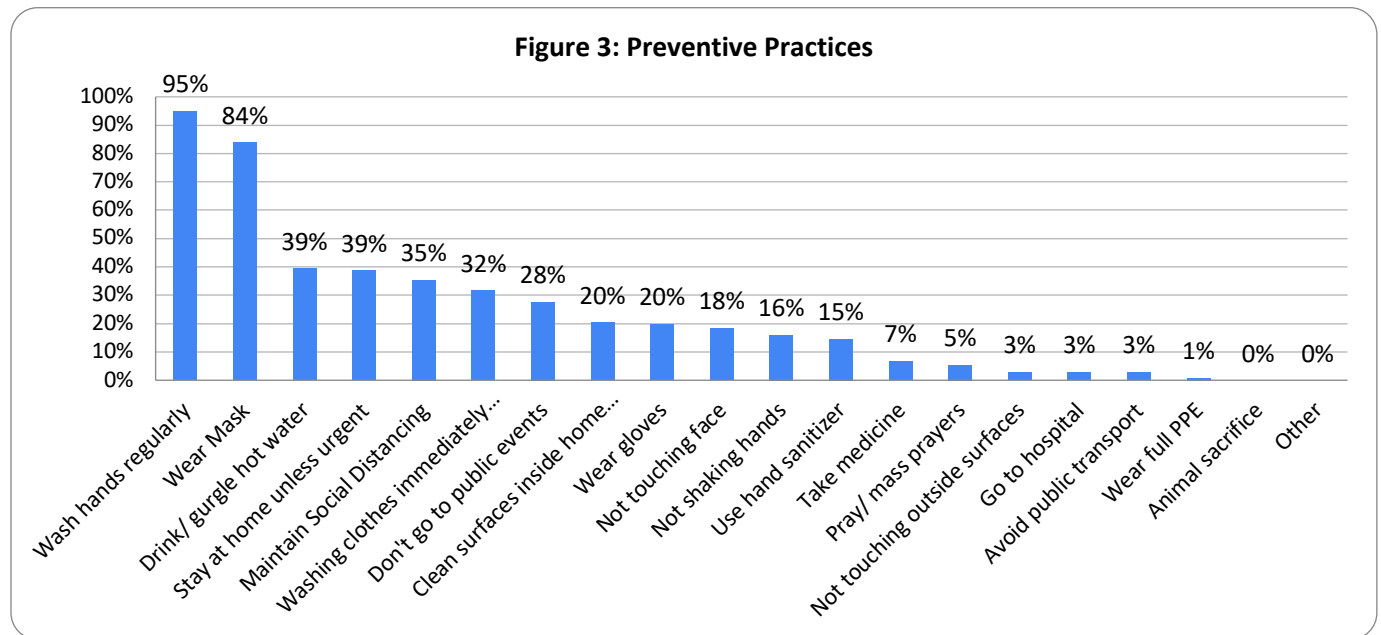


Widespread engagement in recommended preventative practices

An overwhelming majority (99%) of respondents reported being engaging in preventative practices against COVID-19. Crucially 38.7% understand the importance of staying at home during the pandemic and the need for social distancing (35.2%). 94.9% of respondents are regularly washing their hands, with 82.3% of respondents report that they wash their hands at least four times a day with soap and water. Other preventative measures being utilized include drinking and gurgling hot water (39%), washing clothes immediately after returning home (32%) and prayer (5%). See Figure 3.

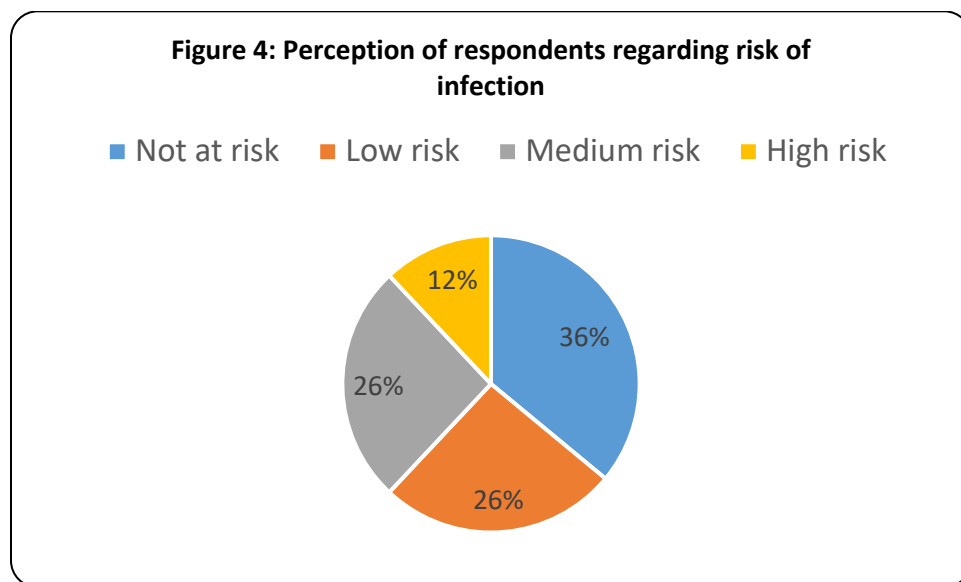
Whilst 84% of respondents report they are wearing masks, FGD’s with data-collectors revealed that respondents who engaged in a highly physically demanding job (such as a rickshaw puller or day-laborer)

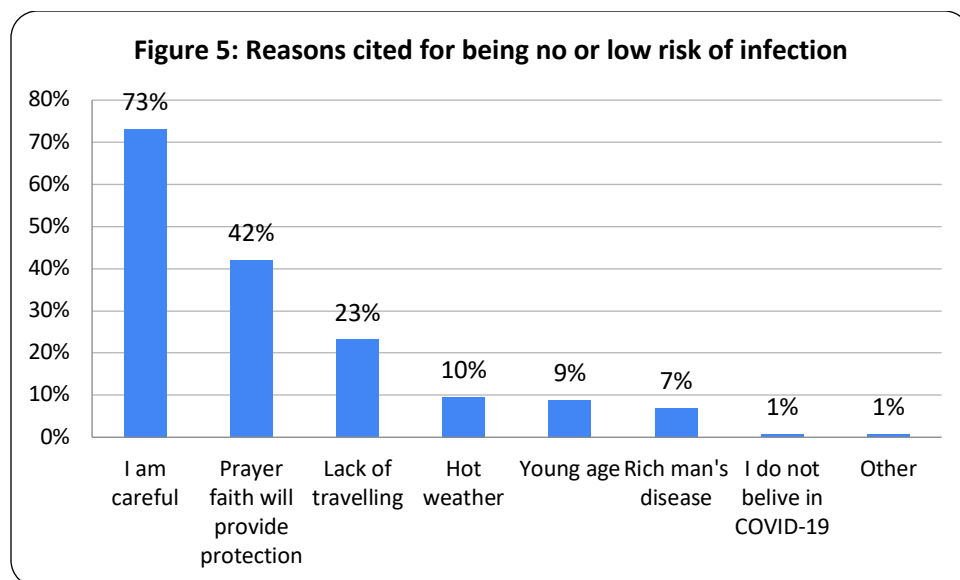
reported challenges in wearing a mask for the duration of the day, and would often wear a mask around the neck or hanging from their ear in order to breathe (FGD 2).



Many urban extreme poor believe they are at little to no risk of COVID-19 infection

Respondents were asked, ‘What do you think is your likelihood of getting infected with Coronavirus - no risk, low, medium or high risk?’ 62% stated that they are at low or no risk of being infected with COVID-19, see Figure 4. Of this group, 73% said that they were at lower risk because they are ‘careful’ or diligently engage in preventative practices and/or that their faith and prayers are keeping them from harm (42%), see Figure 5.



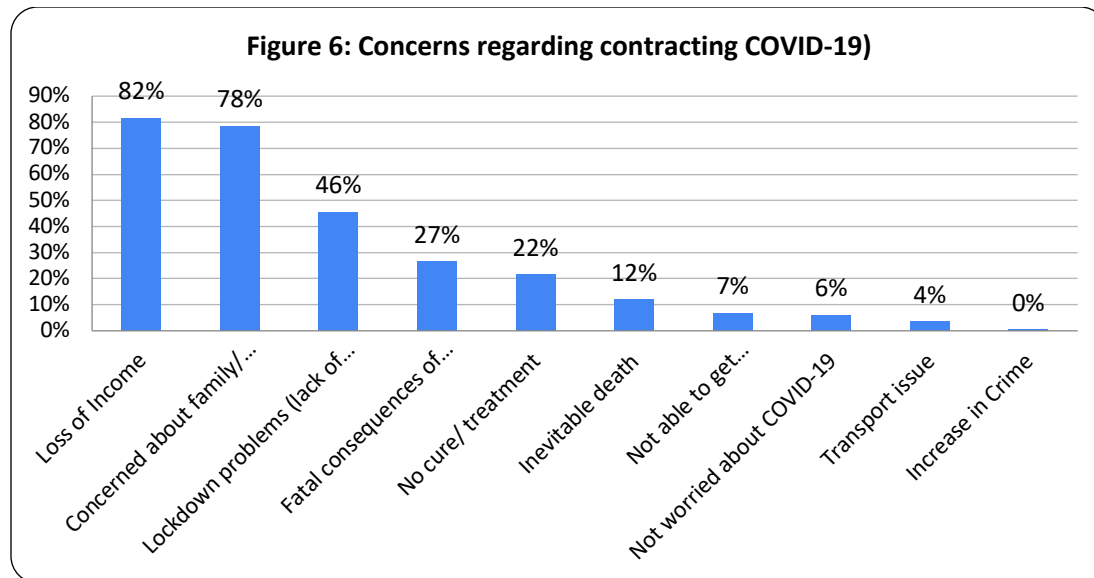


COVID-19 'is a rich man's disease.'

There are indications that the urban poor is subscribing to the view that COVID is 'a rich man's disease.' FGD's with data-collectors revealed a wide-spread belief that a lack of visibility of COVID within urban poor communities is contributing to this belief (FGD 2). In addition, COVID-related infections and deaths in the media disproportionately focus on wealthy and powerful figures in Bangladesh. Staff reported within FGD's that respondents specifically mentioned media representation as influencing their perceptions of risk surrounding COVID-19 (FGD 2). This observation by data collectors is somewhat supported by survey findings, with 15% of respondents mentioning 'rich people' as being at risk of contracting COVID-19.

Widespread concerns regarding contracting COVID-19

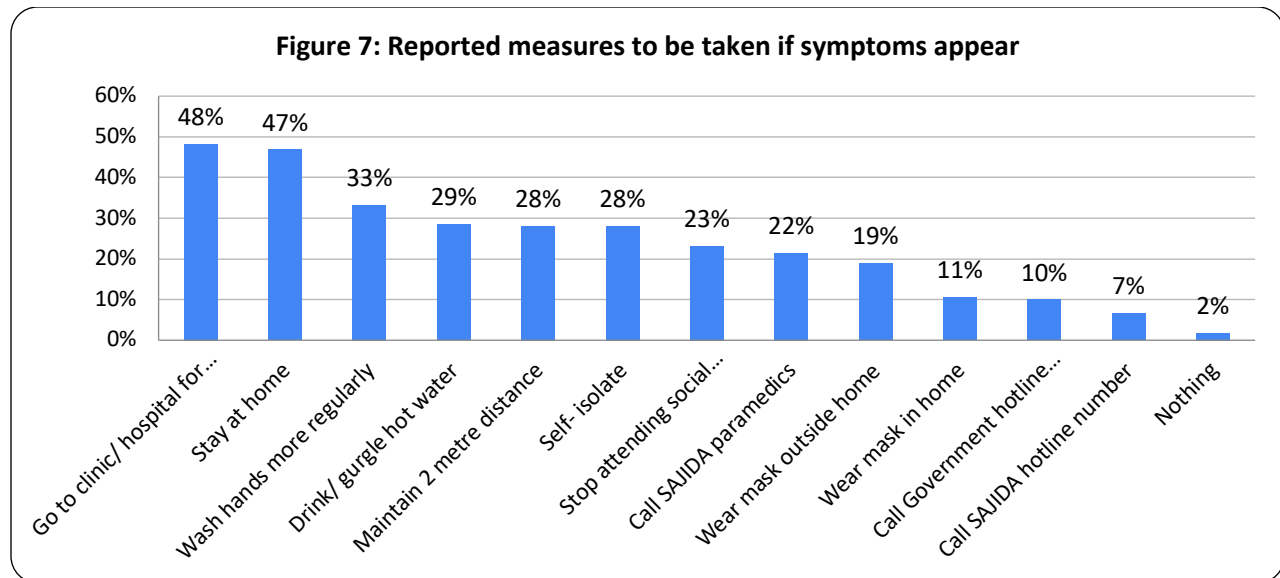
Respondents are concerned about a wide range of potential implications of COVID-19. Concerns included concerns about others and the financial and health-related implications of contracting COVID, see Figure 6. There is a widespread concern of a loss of income due to COVID, particularly if someone is tested as positive, with 82% of respondents citing a loss of income as a key concern. Other key concerns include the impact on their family (78%), fear of potential death (27%) as well as issues with complying to self-isolation measures (46%).



Various containment measure and health-seeking behaviors mentioned if symptomatic

Respondents were asked ‘what will you do if you start to show symptoms of COVID?’ Visiting a face-to-face service provider is the preferred treatment option. Hospitals and clinics were the preferred location for treatment and testing, reported by 48% of respondents. Calling a hotline appears to be less appealing, with 10% reporting they would call a Government hotline, and 7% the SAJIDA tele-health hotline. The length of the SAJIDA hotline number and a lack of clarity regarding cost were key barriers to the national tele-health line (FGD 2). However, 22% of respondents did report that they would call a SAJIDA paramedic, see Figure 7. Familiarity and rapport service users already have with the service provider may overcome some barriers to accessing tele-health services.

Respondents also reported a wide range of practices they would adopt to prevent the transmission of the disease including staying at home (47%), washing hands (33%), attempting to social distance (28%), self-isolation (28%) and wearing a mask inside (11%) or outside the home (19%), see Figure 7. These results indicate that most respondents are aware of key preventative practices, and acknowledge that leaving the home may be necessary, given the challenges associated with effective self-isolation.



Self-isolation will be challenging

Respondents will experience high economic and logistical barriers to effectively self-isolate if they become symptomatic. 98.8% of respondents live with at least one other person, with 54% living with five or more other household members, see Figure 8. 46% of respondents discussed external washing facilities as a key barrier to self-isolation, see Figure 10. Water sources are a key shared space, with 64% sharing with more than 10 people, see Figure 9.

In addition, economic barriers to self-isolation were a crucial concern for respondents. 48% of respondents discussed that a 'lack of food' and an inability to work and earn income for their family (42%) was a key challenge, see Figure 10. One data collector recollected a respondent stating, "How will corona kill us if starvation kills us first?" (FGD 2).

Figure 8: Number of persons sharing a shelter

■ I live alone ■ 2 to 4 ■ 5 to 7 ■ 8 to 10 ■ 10+

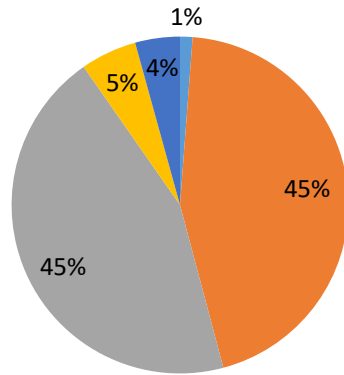
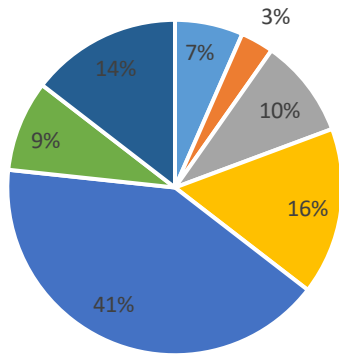
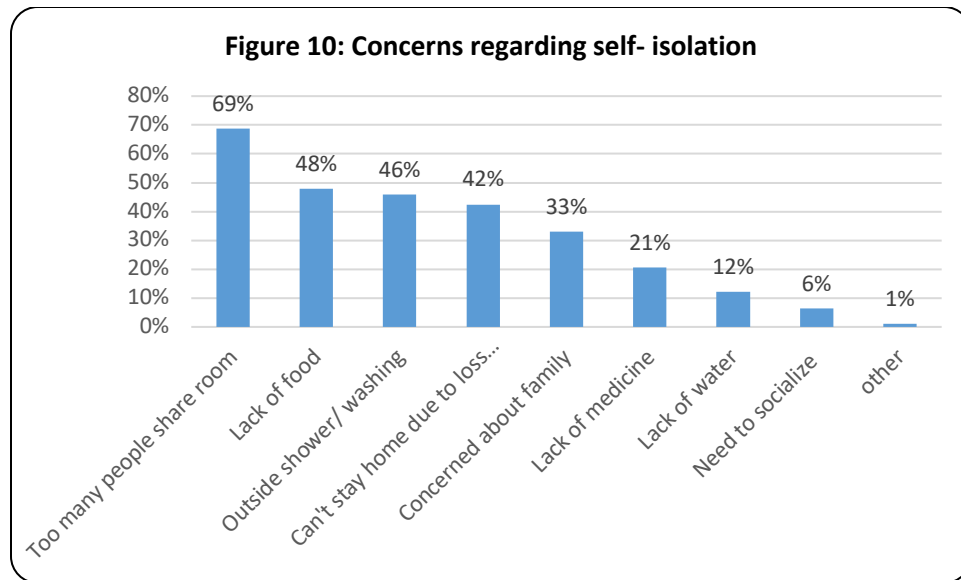


Figure 9: Number of persons sharing water point

■ Nobody else ■ 2-4 ■ 5-7 ■ 8-10 ■ 11-50 ■ 51-100 ■ 100+



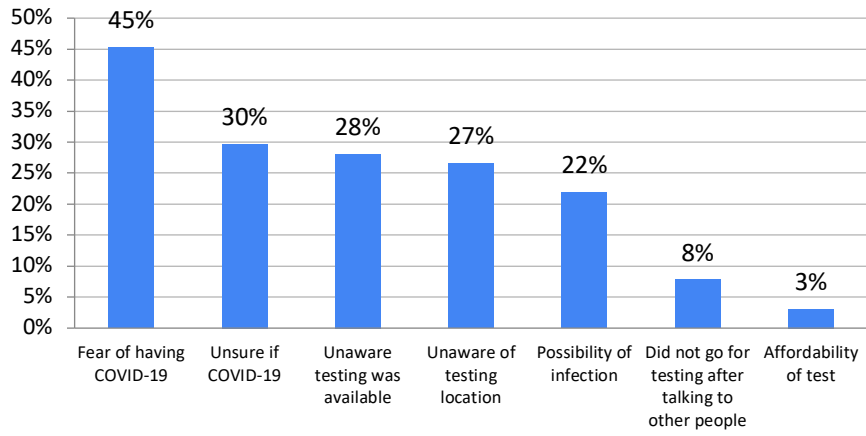


Confusion regarding testing for COVID-19

Survey results revealed that 5.1% (n=26) of respondents reported that they had been tested for COVID. However, FGD's with staff revealed that respondents had believed thermal temperature screening was a COVID-19 test. These respondents had undertaken a thermal temperature screen in order to access their workplace. Of these, all had been admitted to the workplace, and thus had not considered that they had tested positive for COVID-19 (FGD 1 & 2).

12% of all respondents believe they may have had COVID-19, but had not been tested. Key barriers to testing included fear of having a confirmed diagnosis (45%) or not being sure if symptoms warranted a test (30%). Other key barriers included a lack of knowledge regarding the availability of testing (28%) and testing locations (27%) as well as a fear of contracting COVID if they visited a testing site (22%). Social pressures appeared to have some influence, with 8% of respondents stating that they had not gone for a test following a conversation with another family or community member, see Figure 11.

Figure 11: Reported barriers to accessing COVID-19 testing



Recommendations

Recommendation	Intended Outcome	Rationale
<p>1. Work to develop an accurate and sensitive representation of the COVID-19 amongst urban poor communities.</p> <p>Eg. Work with community leaders to host a 'talk show' with a radio jockey to share their community experiences and strategies. SAJIDA AMP can work with leaders to build the skills and confidence to engage in the program.</p>	<p>Voices and experiences of the urban poor regarding COVID-19 are represented in accessible media platforms</p>	<p>Some of the urban poor perceive themselves to be at low risk of contracting COVID and term it as “Rich man’s disease” due to a lack of media representation and discussions regarding their contextual and specific needs.</p> <p>Increasing media representation of urban poor voices and experiences will promote conversations and awareness within communities, whilst addressing stigma.</p>
<p>2. Develop targeted awareness raising campaigns to address mis-information and reduce stigma/ unfounded beliefs regarding COVID-19</p>	<p>Ensure the urban poor are equipped with the knowledge and tools to engage in effective preventative practices and health seeking behaviours regarding COVID-19.</p>	<p>Some misinformation is occurring regarding symptoms, effective prevention practices and where/when to seek health services. Several barriers, including stigma, are preventing access to testing and health services.</p> <p>Some participants have inaccurate information regarding COVID-19 testing. Results have revealed that many believe the thermal temperature screening to be the actual test for COVID-19 identification. Urban poor require accurate information regarding where and when to seek testing when appropriate.</p>

3. Develop a COVID action plan with the aid of WASH officers and paramedics.	Ensure urban poor are equipped with information and health support to ensure they engage in contextually appropriate actions if they exhibit health symptoms.	AMP does not currently have a SOP regarding how to work with families if they exhibit COVID-19 symptoms, beyond training given to paramedics. Each family and context will require a different response depending on living location and services available. Some families may be able to self-isolate, whilst others would benefit from isolation centers. Additional training and agreed SOP within AMP will enable staff to be equipped with knowledge to effectively and efficiently support families.
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