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CONTENTS

"I have to live for myself": Exploring Isolation Experiences of Former COVID-19 Patients in Bangladesh

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Abstract

COVID-19 patients risk their psychological well-being during the period of their morbidity. In Bangladesh, few studies have investigated the psychological state of COVID-19 patients during their isolation period. This study intends to understand the isolation experiences of former COVID-19 patients in Bangladesh. In-depth interviews were conducted among former COVID-19 patients residing in rural and urban areas in Bangladesh. The respondents felt fearful, distraught, and traumatized during their early stages of isolation. Their emotional distress was concerned with not only themselves, but also with their family members. They upheld an optimistic attitude in hope of surviving against COVID-19. Their attitude led them to adopt different coping strategies that included communicating with others, entertaining themselves, praying, and becoming busy with daily chores. Their approaches, aggregated with support from their family members and acquaintances, nurtured their psychological well-being during the isolation period. Therefore, alongside providing familial and social support, the patients should be introduced to various coping mechanisms to avert psychological problems during COVID-19.

***Keywords*:** COVID-19, Isolation, Coping mechanism

Introduction

COVID-19 is a highly infectious disease that spreads through close contact and droplets (Bedford et al., 2020; He et al., 2020; Heymann and Shindo, 2020) and has become a global threat since December 2019. Its clinical features range from asymptomatic to severe respiratory complications and organ failure (Singhal, 2020). As of February 14, 2021, globally there were 108,153,741 active COVID-19 cases and 2,381,295 COVID-19 related deaths (World Health Organization, 2021).

As some lower and middle-income countries struggle to confront the epidemic through social distancing and isolation (Bedford et al., 2020), Bangladesh finds itself among one of these countries with 540,592 confirmed cases and 8,274 deaths from March 8, 2020, to February 14, 2021 (World Health Organization, 2021).

Bangladesh has been trying to make it possible for its citizens to maintain social distancing and other precautions for the safety of their physical health (Anwar et al., 2020). But alongside protecting physical health, quarantine and isolation can have adverse effects on psychological health (Gunnell et al., 2020; Khan et al., 2020). The global population is facing stress, fear, anxiety, depressive symptoms, and psychological negativities due to the pandemic (Gunnell et al., 2020; Khan et al., 2020; Torales et al., 2020; Xiong et al., 2020). COVID-19 patients struggle with psychological distress and discrimination is merely a corollary to this scenario (Torales et al., 2020).

Review articles and systematic reviews have pointed out that the majority of COVID-19 patients heavily suffer from anxiety, depression, and other psychological morbidities (Deng et al., 2020; Krishnamoorthy et al., 2020; Talevi et al., 2020). This is an alarming finding, as a deteriorating psychological state risks a lower quality of life for these patients (Talevi et al., 2020). Exploratory studies from different countries on isolation experiences attest and elaborate various personal reasons for deteriorating psychological conditions (Dehkordi et al., 2020; Dishman and Schroeder, 2020; Moradi et al., 2020; Sahoo et al., 2020; Sun et al., 2021).

Moreover, social negativities are responsible for escalating psychological trauma (Dehkordi et al., 2020; Moradi et al., 2020). Social negativities stemming from stigma are a product of society's fear that escalates psychological distress among patients (Karim et al., 2007; Mahmud and Islam, 2020; Paul et al., 2015). In the case of the Bangladeshi society, stigma has shown to be important in creating further psychological and social difficulties for patients suffering from a contagious lethal disease such as tuberculosis (Karim et al., 2007; Paul et al., 2015). Currently, due to a lack of adequate health care facilities, many patients with mild symptoms of COVID-19 often remain isolated at home (Anwar et al., 2020).

Given the intensity of the situation and a dearth of relevant literature in Bangladesh, this study explores the isolation experiences of former COVID-19 patients. The study focuses on the psychological turmoil that patients face during isolation. Furthermore, it details coping mechanisms adopted by patients, and the success of these strategies.

Methodology

Study design

Data was collected through in-depth interviews (IDI). These contained semi-structured questionnaires, and a descriptive qualitative approach was undertaken.

Study sample & settings

The study population was any Bangladeshi citizen who suffered from the COVID-19 virus and had been certified as recovered post ailment. Following the methodology mentioned in Anieting and Mosugu (2017), this study used exponential non-discriminative snowball sampling to reach 19 participants residing in different urban and rural areas of Bangladesh. This technique was quite useful, given the researchers had difficulties contacting these respondents.

The second and third authors of this article had approached their networks of family, friends, and acquaintances, requesting introduction to any known former COVID-19 patients. The first two respondents were introduced through the second author's friends who worked in the health sector. The third respondent was an acquaintance of the third author. The first two respondents gave names of others who also responded. This process was continued until the rest of the respondents were reached. The respondents were each other's isolation mates, co-workers, subordinates, or neighbors. In this manner, the researchers interviewed 19 respondents from different socio-economic backgrounds.

Given the pandemic situation, the team carried out interviews on mobile phones. Thus, during the interviews, the respondents were residing at their residence in different regions of Bangladesh.

Data collection

The interviews were conducted from May to August 2020, using semi-structured in-depth interview guidelines. The interview process was developed by using references from Novick (2008). The mobile phone interviews allowed all respondents to be reached over a short period of time with limited resources. The first three authors had conducted interviews both individually and in groups of two. This gave the researchers a scope for investigator triangulation, which can help avoid biases (Thurmond, 2001).

All interviews were conducted in Bangla (Bengali). The interviews started with basic demographic questions and were followed by questions regarding the respondents' experiences regarding isolation and their coping mechanisms during that period. This was followed by further probing and asking for examples to construct a comprehensive understanding. The interviews ranged from 35 to 60 minutes.

Data analysis

The interviews were transcribed verbatim followed by data familiarization. A codebook was developed based on interview guidelines. During the analysis, newly emerged codes were added to the codebook. All these codes were clustered into themes. Data was analyzed using the *Atlas.ti* software. Inter-coder reliability was ensured as the researchers proceeded with the analysis.

Ethical approval

Ethical approval was obtained from James P. Grant School of Public Health, BRAC University. As the interviews were conducted via mobile phone, the researchers had no other option but to take verbal consent. After an introduction, the researchers explained the research objective to each interviewee. They then promised to maintain confidentiality and anonymity by not disclosing the interviewee's anthropometric information such as name, place of residence, and workplace. At the behest of the majority of the respondents, the researchers did not disclose the specific titles of their profession. The interviews were recorded only after gaining permission from the respondents.

Findings

Profile of Participants

The table below provides socio-demographic data of 19 participants based on their age, educational status, marital status, occupation, isolation areas, and other factors.

Characteristics	Frequency	Characteristics	Frequency	Characteristics	Frequency
Age		**Isolation Areas**		**Educational Qualification**	
25-34 years	8	Isolation Centre	2	Primary	4
35-44 years	7	Hospital	7	Secondary	2
45-55 years	4	Home	10	Bachelors	2
Gender		**Symptom Type**		Masters	5
Male	14	Asymptomatic	5	Diploma	6
Female	5	Only Cold	5	**Occupation**	
Marital Status		Fever with Cold	7	Health Worker	9
Married	16			Nurse	5
Unmarried	3			Lab Technician	1
Religion				Health Facility Cleaner	1
Muslim	13			Accountant	1
Hindu	6			IT Officer	1
				Former Garments Worker	1

Encountering a positive diagnosis of coronavirus

Fear of death

All respondents became frightened and distressed upon learning about being positively diagnosed with COVID-19. Fear of sudden death shattered them to the extent that the majority broke down crying. Psychologically disturbed, every respondent had a sleepless night.

> *"They just ruined my sleep that night. If they had called me the following morning, I could have slept that night… I worried what if something happens accidentally, it's all up to God, then again I may survive, by the blessings of my parents… there are no specific medications for this ailment, but then people survive as well."*
>
> *— 52-year-old male health worker*

Concern for family members

Respondents became equally concerned about their families as soon as they learned that they had the virus. Few became apprehensive about possible financial difficulties that their children may face from their death. Many others who were living with family suffered angst regarding the possibility that their family may get infected by them.

> *"I was worried about my family. Before I received my COVID-19 test result, I was in close contact with my parents, wife, and kid. After receiving the result, I was overwhelmed by tension… my child has some lung problems, my aged parents… what if they get affected? My whole neighborhood got frantic just because I came out positive. What will happen when the whole family becomes affected?"*
>
> *— 37-year-old male accountant*

Few who did not reside with their families intended to protect their family members from psychological distress by concealing the news.

> *"I didn't share about my COVID-19 positive status with my family. I am my parents' only child. They will just pass out from tension! That's why I shared this news after I recovered."*
>
> *— 27-year-old female nurse*

Others' reactions to learning about the COVID-19 patients

Distress among family members

The respondents who shared their COVID-19 positive news with family members reported that their families were psychologically distressed upon hearing the information. Some patients were admonished by apprehensive family members who believed that working in the health sector had caused them to contract the coronavirus.

> *"My brother berated me for testing for COVID-19. He thought it would have been better if I hadn't tested because I was in good health. Panic struck the whole neighborhood that time, the whole village was locked down because of me; my brother became so frightened by this event that he started behaving like this."*
>
> *— 30-year-old male health worker*

Enduring social pressure

News of the patients' positive status with respect to COVID-19 spread rapidly on social media among the local people, particularly in villages and small towns, unlike in the urban areas. This resulted in forms of societal aggravation from which many patients and their family members suffered. Some were berated via mobile phone by people in their locality for contracting the disease. Mostly, however, anxious locals tried to prevent the spread of disease by not allowing any family member or acquaintance of the patients to cross the boundary of the patients' home. To ensure

this, members of the locality even tried to block the roads leading to the houses of the COVID-19 patients. Thus, patients and their families struggled to access their daily necessities until local governmental authorities intervened.

> *"At first, the locals were unaware of my condition but then they posted my name and picture on Facebook! Then everyone knew about me and some tried to prevent my family members from coming out of the home… There was this woman who worked at our house, people locked her inside her house as well!!! Then a member of the local administration had to intervene to control the situation…"*
>
> — *37-year-old male health worker*

Non-local residents who had to rely entirely on institutionalized isolation were exempted from these sorts of societal pressure.

> *"I live in this area for work purposes, my family lives in another village. So, I stayed in the Center and didn't tell my family, in case they rushed to see me and got infected… I thought about my daughter, she may get socially berated because of my condition. They may have locked down my house and won't allow anyone to get near to them. So, thinking about all these, I didn't go home, didn't tell my family, and stayed at the center…"*
>
> — *40-year-old male health worker*

Isolation phase

Psychological effects of isolation

The majority of the patients were either isolated in hospitals in COVID-19 wards, or in isolation centers. Those who could manage a separate room in their homes went for home isolation. Being at home in isolation allowed the respondents to have direct interaction with their family members while maintaining distance. Yet, irrespective of their isolation sites, respondents felt depressed and desolated during isolation.

> *"Just thinking about the first three days of isolation makes me distraught, especially the pain of being confined in a room… that's it, the loneliness… you even get to meet two to four people in jail but I couldn't meet anybody over here… I was all alone in my cabin."*
>
> — *37-year-old male health worker*

This particular respondent could not psychologically bear with living in the isolation ward and opted for home isolation.

> *"For the first week, I remained isolated at the hospital cabin by myself but then it became unbearable. My cabin is at the corner of the hospital. People didn't frequent there due to restrictions. At night when it got darker, the whole place would become quiet… even the slightest sound of anything is creepy enough to scare someone. So, I convinced the hospital authority that I can maintain isolation at home and moved over there."*
>
> — *26-year-old female nurse*

Regaining self-composure

Although the respondents became despondent after learning about their disease status, they mustered their composure after some time. Their attempts to regain self-control were driven by their firm belief that their physical wellness strongly depended upon their mental wellbeing. Hence, to survive COVID-19, they tried to maintain a positive attitude during the isolation period.

> *"If you get depressed, you will become debilitated and your immunity will weaken. You will enfeeble your resistance power against the disease. To avoid getting dejected we must keep ourselves cheerful… it can be in anyways, laughter or talking with others."*
>
> — *52-year-old male health worker*

Personal coping strategies

Facing towards faith

Respondents turned towards their religious beliefs and practice in the hope of getting divine sanction for recovery. Many asked for blessings from families and peers believing God would heed these prayers and cure them.

> *"I calmed myself by praying to Allah and asking for salvation. I called everyone and asked for their blessings. My family, my whole neighborhood prayed for me… I believe in blessings, that is why I survived COVID-19… Surely Allah heeds to prayers and grants them. I used to spend my time praying to Allah asking for recovery and to look after my family."*
>
> — *40-year-old male health facility cleaner*

Engaging in entertainment and communicating with others

To create a more positive environment for themselves, respondents busied themselves with electronic devices such as smartphones, laptops, and televisions. Through these devices, they regularly enjoyed videos, played games, and communicated with people via social media. Having access to the internet and electronic media was advantageous, as it breached the patients' detachment from the outside world keeping them occupied.

> *"I used to watch YouTube videos using the internet… videos on religious doctrines, information on COVID-19, songs, entertainment just to cheer myself up. Confinement in a room is itself desolating, I often recalled my wife and kid… just for a bit of entertainment I used to do internet browsing, chatted with friends over Facebook, IMO, WhatsApp, after all, I needed to pass that period."*
>
> — *29-year-old male nurse*

Not all had access and affordability to smartphones and the internet. These few respondents had struggled to adjust to their isolation period.

> *"I don't have a smartphone. I merely have this simple button phone… when the doctors used to visit me, they used to advise me not to stress and to remain in a good mood. I used to ask them how I can be in a good mood in that lonely place. My room didn't even have a television!"*
>
> — *40-year-old male health facility cleaner*

Remaining healthy

To maintain their health, respondents focused on their diet and tried to ensure that they received sufficient protein, vegetables, and fruit items. Irrespective of their financial conditions, respondents spent additional money to maintain these dietary recommendations.

> *"I used to rotationally have fish or meat for lunch. For breakfast, they would provide me with pieces of bread, an egg, an apple, and a banana. But the fruits were not suitable for eating. Not of good quality. So, these additional foods… I had managed on my own. I spent twenty-three to four thousand takas for this food."*
>
> — *52-year-old male health worker*

Along with having an appropriate diet, prescribed medications, and performing exercise, respondents undertook certain home remedies to alleviate the effect of COVID-19. These remedies included inhaling hot water vapor, having citrus, and drinking an herbal tea made from locally available spices. Known as *Aada Cha (ginger tea)* this herbal tea mostly consists of ginger, cardamom, cinnamon, black pepper, and clove boiled in hot water. We learned from varied sources that these simple home remedies not only relaxed the patients, but also eased some of their anorexia and breathing problems. Therefore, many respondents argued that regular consumption of hot water, citrus, and the particular herbal tea can be a potential cure for the coronavirus.

"People told me to frequently consume warm water with ginger and lemon in it. So, I followed that, and whenever I felt cold I used to have lots of lemon juice and citrus. It always relieved me and I found it quite beneficial. And there was this ginger tea which I made from ginger, cardamom, clove, and simmering water. Having it, I never had to deal with cough, cold, or sore throat! I never stopped having it as long as I was in isolation. I am still maintaining this habit."

— *25-year-old male former garments worker*

Performing daily chores

While in isolation, these COVID-19 patients were obliged to perform regular chores such as cleaning clothes, utensils, and the room. Respondents briskly performed these chores believing that regular cleaning habits appease the ailment.

"I always used hot water for bathing, washing clothes, etc. As recovery from COVID-19 depends on your habit of cleanliness. You must clean the room, where you are isolating, 2-3 times a day. Regularly clean your bathroom, wash the bedsheet every alternative day and often spray disinfectants. I used to do all these things by myself."

— *29-year-old male nurse*

Support during isolation: experiences and expectations

Emotional support

Receiving positive attitudes and words from family, friends, and colleagues augmented the mental strength of the patients during isolation.

"My husband was there for me all along. He was concerned that I might get alarmed. Honestly, without his support, I may not even have survived. He would always encourage me to be strong… Then he would always ensure that I was having lemons and made my lemon juice whenever I got tired."

— *28-year-old female nurse*

Respondents who did not tell their family about their ailment relied on these support networks of friends and colleagues during isolation.

"One of my senior colleagues used to encourage me a lot. I mean he almost called eight-ten times a day. And then there was another colleague who also supported me a lot. I am grateful to two of them. They would ask whether I was eating properly and having adequate rest. They would say that soon I would be fine… After one week, one of them told me that I have come out of the danger period and nothing will happen to me… Their encouraging words constantly uplifted my spirit, reducing my anxieties."

— *40-year-old male health worker*

Tangible and Intangible support

Extra food, medicine, and money for other necessities such as phone and internet bills were regularly provided to the patients by their families, friends, and colleagues. These forms of kindness strengthened the camaraderie between the patients and others.

"I have some family members who live in the town. I called them and shared how the villagers are preventing us from purchasing groceries. Upon hearing this, they came with groceries and put those at our doorstep before heading back."

— *30-year-old male health worker*

Apart from these networks, the local government also helped some respondents by occasionally providing them with groceries. Also, in some cases, the local government pacified enraged locals from harassing the patient and family members.

> *"They blocked the front road of my house, because of my COVID-19 status. They were not allowing anyone to pass over there. Then the chairman intervened and took care of the matter. That led to the neighborhood being appeased."*
>
> — *55-year-old male health worker*

Expectations from society

According to these former patients we interviewed, different forms of emotional and tangible support are crucial for the COVID-19 victims and their family members. They strongly suggested that society's negative attitude severely affects the self-esteem of patients and makes them even more vulnerable to the virus.

> *"Of course, people should console and support the COVID-19 patients. They should assure them that they will provide these patients with daily necessities if needed. That will psychologically bolster the patients. And if someone is in home isolation then neither he nor his family members can go out to purchase the groceries. Some families have 5-6 members and they struggle in this situation. People should help them either with cash or groceries or in other ways they can."*
>
> — *55-year-old male health worker*

Expectations from the government

Respondents' expectations from the government varied by their economic status. Low-income people had struggled with managing additional money for nutritious food and other necessities, unlike their higher-income counterparts. They, unlike those who were well-off, believed that the government should financially help COVID-19 patients and their families.

> *"I believe that a COVID-19 patient gets befuddled during this time. The government must fully support that person during that period. The suffering I had endured that time cannot be compared with anything else… by support I mean receiving financial support, that would have been favorable for us."*
>
> — *37-year-old male accountant*

Discussion

To our knowledge, this qualitative investigation is the first one in Bangladesh that extensively focuses on the experiences of former COVID-19 patients. The survivors experienced a range of psychological adversities during the early stage of their ailment. Using an optimistic attitude, the survivors fought their mental distress by adopting different coping strategies. These strategies included praying, engaging in entertainment, attending to their health through exercise and diet, and performing daily chores. Alongside this, psychological and other support from familial and non-familial networks bolstered their mental health during the isolation phase.

Like other COVID-19 patients around the world, these respondents feared death and were despondent (Dehkordi et al., 2020; Dishman and Schroeder, 2020; Sahoo et al., 2020; Sun et al., 2021). The fear for their families' risk of catching the virus, the risk to their families of facing social stigma, and their worry about the wellbeing of their family exacerbated the patients' psychological distress (Dishman and Schroeder, 2020; Sahoo et al., 2020; Sun et al., 2021). This kind of stress is not uncommon among people with contagious lethal diseases. Studies on TB patients have shown similar concerns for family members among the TB patients (Juniarti and Evans, 2011; Karim et al., 2007). But unlike TB patients, the COVID-19 patients stressed about their families' possible financial difficulties in case of their sudden demise. This was because unlike TB, the outcome of COVID-19 is quite uncertain and could result in sudden death. The literature has seldom focused on this point, and we urge future researchers to examine this topic.

This study found that COVID-19 patients in Bangladesh had been ostracized by society, just as Dehkordi et al., (2020) found the same in Iran. Similar to the findings of Mahmud and Islam (2020), this study also found that this ostracization resulted from the society's fear and anxiety around the unknown course of the pandemic. Social attempts to protect themselves from COVID-19 pushed many COVID-19 victims we spoke to into a situation of alienation. These attempts led to difficulties in receiving technical support among these COVID-19 patients and their families. These forms of stigmatization were often fueled by an abuse of social media, breaching the confidentiality of COVID-19 patients, and putting them and their families at risk at an early stage of the ailment. The Information and Communication Technology Division of the government, along with the Ministry of Health, should monitor these issues and develop advocacy measures to prevent the harassment faced by COVID-19 victims.

Isolation can cause severe psychological distress for individuals, and they become particularly forlorn during the early stages of isolation (Dishman and Schroeder, 2020; Sahoo et al., 2020; Sun et al., 2021). However, we found our respondents to have overcome their adversities by adopting optimistic attitudes. As pointed out in Scheier et al., (2001), optimistic attitudes can lead to the embracing of strategies for the betterment of health. Our coronavirus survivors adopted various coping strategies that elevated their physical and psychological health.

Similar to the finding of Carver et al., (1989), this study found that the coping strategies survivors undertook included both emotional and problem-focused approaches. Religion, the most common form of emotional coping among survivors, engendered positive outcomes. Similar outcomes were noticed among cancer patients (Holt et al., 2009), chronic kidney disease patients (Chatrung et al., 2015), and Ebola survivors (Rabelo et al., 2016).

As in the case of other cohorts elsewhere (Dishman and Schroeder, 2020; Sahoo et al., 2020; Sun et al., 2021), the patients we spoke with also provided themselves psychological support through entertainment and communication. This form of active coping was possible due to the patients' access to the internet and electronic gadgets (Azam, 2007). Access to technology had mediated their psychological distance from their families and friendswithout additional worries of infecting them. In the context of the pandemic, this simple coping strategy can ease mental health conditions among the COVID-19 patients and other health care professionals dealing with the pandemic.

Scientists have emphasized to the world the importance of a strong immune system (Iddir et al., 2020) and hygiene habits (World Health Organization, 2020) to assist in tackling COVID-19. Technology has facilitated outreaching this information over the world (Budd et al., 2020). Having access to information via technology (Azam, 2007) eased survivor initiatives with respect to self-care and managing the situation of COVID-19. As seen in other studies on COVID-19 patients (Dishman and Schroeder, 2020; Sun et al., 2021), our study respondents engaged in selfcare activities that included nutritious diet and exercises. The unique and most beneficial among these initiatives was the consumption of herbal tea, found to have alleviated their symptoms. One finding of this study is that herbal tea is not only beneficial (also found by Poswal et al., 2019), but that there has been increased consumption of herbal products among Bangladeshi people during COVID-19 (also found by Ahmed et al., 2020). Further research on the benefits of herbal tea on COVID-19 is strongly recommended. In recent years, researchers have advocated for self-management activities that can alleviate disease conditions and improve quality of life (Holman and Lorig, 2004), and we recommend promoting these activities during COVID-19.

The study confirms the positive contribution of social support to psychological outcomes of patients suffering from morbidities (also found by Mak et al., 2009). Echoing the experiences of other COVID-19 patients (Sahoo et al.,2020; Sun et al., 2021), this study suggests that future researchers explore this matter among individuals, especially health workers quarantined during COVID-19 in Bangladesh.

Unlike psychological support, financial support was not a necessity for all the survivors. The respondents did not express worry about their jobs as did some patients in Iran (Dehkordi et al., 2020); but those who had a modest income struggled and were constantly stressed about their finances during the period of their illness. Few had received financial help from the local government. But this was neither sufficient, nor widespread. The Bangladesh government has taken different initiatives to financially support COVID-19 patients from low-income groups; this program can be more promising if attached to a monitoring system (Islam et al., 2020).

Conclusion

This study is one of the first in Bangladesh to explore the isolation experiences of former COVID-19 patients. COVID-19 patients interviewed in our study had overcome their psychological distress by adopting a variety of coping mechanisms. To our knowledge, this is also the first study to highlight the benefits of the particular herbal tea found to be beneficial for coronavirus survivors.

Electronic devices and internet had proved to be useful during this time, as was any social support that patients had. Program implementers can learn from this and use digital platforms to reach patients and help them to alleviate their fear and stress during the morbidity period.

Given the snowball sampling method and sample size, there are limitations as to how well the sample represents the entire country. In addition, these patients were affected during the first wave of COVID-19 in Bangladesh. It will be interesting to understand the experiences of patients, who were affected during the subsequent waves of the coronavirus in Bangladesh.

Declarations

This was a self-funded study. The authors declare no conflict of interest with respect to the research, authorship, and/or publication of this article. Transcripts used and analyzed during the current study are available from the corresponding author on reasonable request.

References

Ahmed, I., Hasan, M., Akter, R., Sarkar, B. K., Rahman, M., Sarker, S., & Samad, M. A. (2020). Behavioral preventive measures and the use of medicines and herbal products among the public in response to Covid-19 in Bangladesh: A cross-sectional study. *MedRxiv*, 23. https://doi.org/10.1101/2020.08.15.20175513

Anieting, A. E., & Mosugu, J. K. (2017). COMPARISON OF QUOTA SAMPLING AND SNOWBALL SAMPLING. *Indian Scholar*, 3, 4. https://doi.org/10.15406/bbij.2016.03.00055

Anwar, S., Nasrullah, M., & Hosen, M. J. (2020). COVID-19 and Bangladesh: Challenges and How to Address Them. *Frontiers in Public Health*, 8, 154. https://doi.org/10.3389/fpubh.2020.00154

Azam, S. (2007). Internet Adoption and Usage in Bangladesh. *Japanese Journal of Administrative Science*, 20(1), 43–54. https://doi.org/10.5651/jaas.20.43

Bedford, J., Enria, D., Giesecke, J., Heymann, D. L., Ihekweazu, C., Kobinger, G., Lane, H. C., Memish, Z., Oh, M., Sall, A. A., Schuchat, A., Ungchusak, K., & Wieler, L. H. (2020). COVID-19: Towards controlling of a pandemic. *The Lancet*, 395(10229), 1015–1018. https://doi.org/10.1016/S0140-6736(20)30673-5

Budd, J., Miller, B. S., Manning, E. M., Lampos, V., Zhuang, M., Edelstein, M., Rees, G., Emery, V. C., Stevens, M. M., Keegan, N., Short, M. J., Pillay, D., Manley, E., Cox, I. J., Heymann, D., Johnson, A. M., & McKendry, R. A. (2020). Digital technologies in the public-health response to COVID-19. *Nature Medicine*, 26(8), 1183–1192. https://doi.org/10.1038/s41591-020-1011-4

Carver, C. S., Weintraub, J. K., & Scheier, M. F. (1989). Assessing Coping Strategies: A Theoretically Based Approach. *Journal of Personality and Social Psychology*, 56(2), 17. https://doi.org/10.1037//0022-3514.56.2.267

Chatrung, C., Sorajjakool, S., & Amnatsatsue, K. (2015). Wellness and Religious Coping Among Thai Individuals Living with Chronic Kidney Disease in Southern California. *Journal of Religion and Health*, 54(6), 2198–2211. https://doi.org/10.1007/s10943-014-9958-4

Dehkordi, M. A., Eisazadeh, F., & Aghjanbaglu, S. (2020). *Psychological Consequences of Patients with Coronavirus (COVID- 19): A Qualitative Study,* 2(2), 12. https://doi.org/10.30473/ijohp.2020.52395.1074

Deng, J., Zhou, F., Hou, W., Silver, Z., Wong, C. Y., Chang, O., Huang, E., & Zuo, Q. K. (2020). The prevalence of depression, anxiety, and sleep disturbances in COVID-19 patients: A meta-analysis. *Annals of the New York Academy of Sciences*, nyas.14506. https://doi.org/10.1111/nyas.14506

Dishman, L., & Schroeder, V. (2020). A COVID-19 patient's experience: Engagement in disease management, interactions with care teams and implications on health policies and managerial practices. *Patient Experience Journal*, 7(2), 33–38. https://doi.org/10.35680/2372-0247.1487

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., Khan, M., O'Connor, R. C., Pirkis, J., Appleby, L., Arensman, E., Caine, E. D., Chan, L. F., Chang, S.-S., Chen, Y.-Y., Christensen, H., Dandona, R., Eddleston, M., Erlangsen, A., … Yip, P. S. (2020). Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry*, 7(6), 468–471. https://doi.org/10.1016/S2215-0366(20)30171-1

He, F., Deng, Y., & Li, W. (2020). Coronavirus Disease 2019 (COVID-19): What we know? *Journal of Medical Virology*, jmv.25766. https://doi.org/10.1002/jmv.25766

Heymann, D. L., & Shindo, N. (2020). COVID-19: What is next for public health? *The Lancet*, 395(10224), 542–545. https://doi.org/10.1016/S0140-6736(20)30374-3

Holman, H., & Lorig, K. (2004). Patient Self-Management: A Key to Effectiveness and Efficiency in Care of Chronic Disease. *Public Health Reports*, 119(3), 239–243. https://doi.org/10.1016/j.phr.2004.04.002

Holt, C. L., Caplan, L., Schulz, E., Blake, V., Southward, P., Buckner, A., & Lawrence, H. (2009). Role of Religion in Cancer Coping Among African Americans: A Qualitative Examination. *Journal of Psychosocial Oncology*, 27(2), 248–273. https://doi.org/10.1080/07347330902776028

Iddir, M., Brito, A., Dingeo, G., Fernandez Del Campo, S. S., Samouda, H., La Frano, M. R., & Bohn, T. (2020). Strengthening the Immune System and Reducing Inflammation and Oxidative Stress through Diet and Nutrition: Considerations during the COVID-19 Crisis. *Nutrients*, 12(6), 1562. https://doi.org/10.3390/nu12061562

Islam, Md. T., Talukder, A. K., Siddiqui, Md. N., & Islam, T. (2020). *Tackling the Pandemic COVID-19: The Bangladesh Perspective* [Preprint]. LIFE SCIENCES. https://doi.org/10.20944/preprints202004.0384.v1

Juniarti, N., & Evans, D. (2011). A qualitative review: the stigma of tuberculosis. *Journal of Clinical Nursing*, 20(13–14), 1961–1970. https://doi.org/doi: 10.1111/j.1365-2702.2010.03516.x

Karim, F., Chowdhury, A. M. R., Islam, A., & Weiss, M. G. (2007). Stigma, Gender, and their Impact on Patients with Tuberculosis in Rural Bangladesh. *Anthropology & Medicine*, 14(2), 139–151. https://doi.org/10.1080/13648470701381440

Khan, K. S., Mamun, M. A., Griffiths, M. D., & Ullah, I. (2020). The Mental Health Impact of the COVID-19 Pandemic Across Different Cohorts. *International Journal of Mental Health and Addiction*. https://doi.org/10.1007/s11469-020-00367-0

Krishnamoorthy, Y., Nagarajan, R., Saya, G. K., & Menon, V. (2020). Prevalence of psychological morbidities among general population, healthcare workers and COVID-19 patients amidst the COVID-19 pandemic: A systematic review and meta-analysis. *Psychiatry Research*, 293, 113382. https://doi.org/10.1016/j.psychres.2020.113382

Mahmud, A., & Islam, R. M. (2020). Social Stigma as a Barrier to Covid-19 Responses to Community Well-Being in Bangladesh. *International Journal of Community Well-Being*, 1–7. https://doi.org/10.1007/s42413-020-00071

Mak, W. W. S., Law, R. W., Woo, J., Cheung, F. M., & Lee, D. (2009). Social support and psychological adjustment to SARS: The mediating role of self-care self-efficacy. *Psychology & Health*, 24(2), 161–174. https://doi.org/10.1080/08870440701447649

Moradi, Y., Mollazadeh, F., Karimi, P., Hosseingholipour, K., & Baghaei, R. (2020). Psychological disturbances of survivors throughout COVID-19 crisis: A qualitative study. *BMC Psychiatry*, 20(1), 8. https://doi.org/10.1186/s12888-020-03009-w

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health*, 31(4), 391–398. https://doi.org/10.1002/nur.20259

Paul, S., Akter, R., Aftab, A., Khan, A. M., Barua, M., Islam, S., Islam, A., Husain, A., & Sarker, M. (2015). Knowledge and attitude of key community members towards tuberculosis: Mixed method study from BRAC TB control areas in Bangladesh. *BMC Public Health*, 15(1), 52. https://doi.org/10.1186/s12889-015-1390-5

Poswal, F. S., Russell, G., Mackonochie, M., MacLennan, E., Adukwu, E. C., & Rolfe, V. (2019). Herbal Teas and their Health Benefits: A Scoping Review. *Plant Foods for Human Nutrition*, 74(3), 266–276. https://doi.org/10.1007/s11130-019-00750-w

Rabelo, I., Lee, V., Fallah, M. P., Massaquoi, M., Evlampidou, I., Crestani, R., Decroo, T., Van den Bergh, R., & Severy, N. (2016). Psychological Distress among Ebola Survivors Discharged from an Ebola Treatment Unit in Monrovia, Liberia – A Qualitative Study. *Frontiers in Public Health*, 4. https://doi.org/10.3389/fpubh.2016.00142

Sahoo, S., Mehra, A., Suri, V., Malhotra, P., Yaddanapudi, L. N., Dutt Puri, G., & Grover, S. (2020). Lived experiences of the corona survivors (patients admitted in COVID wards): A narrative real-life documented summaries of internalized guilt, shame, stigma, anger. *Asian Journal of Psychiatry*, 53, 102187. https://doi.org/10.1016/j.ajp.2020.102187

Scheier, M. F., Carver, C. S., & Bridges, M. W. (2001). Optimism, pessimism, and psychological well-being. In E. C. Chang (Ed.), *Optimism & pessimism: Implications for theory, research, and practice* (pp. 189–216). American Psychological Association. https://doi.org/10.1037/10385-009

Singhal, T. (2020). A Review of Coronavirus Disease-2019 (COVID-19). *The Indian Journal of Pediatrics*, 87(4), 281–286. https://doi.org/10.1007/s12098-020-03263-6

Sun, N., Wei, L., Wang, H., Wang, X., Gao, M., Hu, X., & Shi, S. (2021). Qualitative study of the psychological experience of COVID-19 patients during hospitalization. *Journal of Affective Disorders*, 278, 15–22. https://doi.org/10.1016/j.jad.2020.08.040

Talevi, D., Socci, V., Carai, M., Carnaghi, G., Faleri, S., Trebbi, E., Bernardo, A. D., Capelli, F., & Pacitti, F. (2020). Mental health outcomes of the CoViD-19 pandemic. *Riv Psichiatr*, 55(3), 8. https://doi.org/10.1708/3382.33569

Thurmond, V. A. (2001). The Point of Triangulation. *Journal of Nursing Scholarship*, 33(3), 253–258. https://doi.org/10.1111/j.1547-5069.2001.00253.x

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, 66(4), 317–320. https://doi.org/10.1177/0020764020915212

World Health Organization. (2020). *Water, sanitation, hygiene, and waste management for the COVID-19 virus: interim guidance, 23 April 2020* (No. WHO/2019-nCoV/IPC_WASH/2020.3). World Health Organization.

World Health Organization. (2021). *WHO Bangladesh COVID-19 Morbidity and Mortality Weekly Update (MMWU)* (No. 51). World Health Organization. https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/

Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M. W., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020). Impact of COVID-19 pandemic on mental health in the general population: A systematic review. *Journal of Affective Disorders*, 277, 55–64. https://doi.org/10.1016/j.jad.2020.08.001