Qualitative Exploration of Healthcare Experiences of the 'Miya' Community of Assam during COVID-19 Pandemic

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Abstract

The study investigates the various factors responsible that influenced the healthcare experiences of Assam's 'Miya' community during the Covid-19 outbreak. Using an exploratory and qualitative research framework, semi-structured interviews were performed for three months on a sample of 20 male and female 'Miya' patients and their attendants inside the confines of a government hospital in Guwahati, Assam. An inductive, thematic interpretation of data revealed that during the pandemic, the exploitative and unfair medical system fostered discriminating and stressful experiences among the 'Miyas'. Because of their contested social identity, low occupational, literary, and linguistic status, changing hospital setting and protocols, and lack of internal connections, they have witnessed rising stereotypes, social exclusion, neglect, and distance from/by non-Miya counterparts in the context of healthcare.

Keywords: *'Miya'; Covid-19; Assam; Healthcare; Disparity; Discrimination*

1. Introduction

According to the World Health Organization (WHO), individuals' health outcomes and well-being are socially determined by non-medical factors such as where people are born, grow up, work, live, and age, as well as a broader set of forces or systems like income, education, job and food insecurity, social inclusion and non-discrimination, structural conflict, as well as access to affordable, high-quality health care, among others (Sherell, 2021).

Among marginalised populations globally, health inequalities exist depending on their age, sex, sexual identity, race or ethnicity, disability, socioeconomic position, and geographic location (HIMSS, 2020).

A study by Nottingham Trent University showcased how 'social identity' can shape group members' shared perceptions about themselves or others, as well as their experiences by either facilitating or impeding helping behaviour and supporting or undermining individual and collective resilience. As per Moran and Sussman (2015), individuals' place in a particular group and identification with its norms can influence their health-related behaviour.

In the realm of healthcare, marginalised and stigmatised social groups are often more vulnerable to stereotype threat and bias (Aronson et al., 2013), and persons in disadvantaged social positions suffer from comparatively poor health outcomes as a result of biases and forms of social exclusion (Haslam et al., 2019).

In India, for example, 'caste' as a form of social identity shapes people's social lives and every sphere, including medicine, where lower castes such as 'Dalit' health seekers are subjected to stereotypes by non-Dalit health providers, which affect the former's health seeking behaviour and encourage discrimination, thus widening the gap between Dalits and non-Dalits (Verma & Acharya, 2017). Similarly, Mohindra et al. found that rural women from lower and other backward castes with low socio-economic status reported a greater frequency of ill health than women from forward castes in 2006 research in the Indian state of Kerala.

Gender also interacts with the social, economic, and biological factors and consequences of tropical illnesses in both developing and developed nations, resulting in varied health outcomes for males and females, as well as diverse methods to prevention, treatment, and coping with sickness (Vlassoff, 2007).

Women of colour at risk for preterm delivery frequently have stressful healthcare experiences (McLemore et al., 2018), and while racial minorities believe they receive inferior quality treatment than whites in America, most whites think otherwise (Lillie-Blanton et al., 2000). The quality of treatment received by ethnic minorities may be influenced by American cultural ideas that stereotype women of colour as having less labour pain than white women (Mathur et al., 2010).

Diseases like Alzheimer's and other associated dementias could be linked to an individual's educational level, built-in settings like healthy community design or community support, social connections, and access to quality healthcare, according to the Centers for Disease Control and Prevention.

Due to the rising effect of these wider socio-cultural, environmental and economic factors, health-care gaps and inequities intensified with the commencement of the COVID-19 pandemic (Sherell, 2021).

While many regarded it as a "great equaliser," the period saw a wide range of socio-demographic risk factors, such as socio-economic and racial/ethnic minority status, household composition, and environmental factors, all of which were found to be significantly associated with COVID-19 incidence and mortality.

For instance, difficulty in maintaining 'social distancing' among communities with poor socio-environmental conditions like crowded housing and reliance on public transportation, as well as racial/ethnic groups with low-income and involvement in essential occupations, were at higher risk of person-to-person SARS-CoV-2 exposure and transmission (Karmakar et al., 2021).

The normalisation of 'social distance' as a means of containing the virus's transmission in a varied society like India has resulted in the state's control and dispensability of underprivileged bodies, causing stigmatisation, oppression, and distress among communities with marginalised identities, and

compounding existing social inequalities based on caste, class, religion, race/ethnicity, and gender (Rahman, 2020).

Furthermore, healthcare systems throughout the world have undergone substantial transformations, with the pandemic exposing their underlying issues. For example, health and service providers in the United States have seen their insurance coverage and employment decrease, while the shifting healthcare system has encouraged inequities in quality health-care access and results for people of colour (Blumenthal et al., 2020).

In this context, the study qualitatively explores the influence of numerous factors during the COVID-19 pandemic on the healthcare experiences of Assam's one of the most vulnerable groups, the 'Miya' community, who are Bengali-speaking Muslims of Bangladeshi ancestry. The term 'Miya' is derogatively used by non-Miyas to label and categorize the group as 'Bangladeshis', 'illegal migrants' and 'outsiders'. This phrase is retained in the study to emphasise their multiple marginalities in the healthcare arena.

The objective of the study is based on the following research questions:

- What variables have impacted the healthcare experiences of 'Miya' health seekers and their attendants during the pandemic?

- How has the pandemic affected the 'Miya community's current healthcare experiences?

2. Methodology

To investigate the objective among the chosen sample, the study was based on the following research design framework, which included a suitable data collection method and mode of analysis.

2.1 Fieldwork Location and Duration

The research fieldwork was carried out for three months (December 2021–February 2022) on the premises of a government hospital in Guwahati, Assam, India. As one of the city's largest and most popular hospitals, it sees a steady influx of patients from all over Assam on a daily basis. As a result, it made people from the 'Miya' community easily available and accessible, and thus it was chosen as the primary study site.

2.2 Sample Size, Composition, and Selection

The study sample of 20 included both male and female 'Miya' patients and their attendants. Since they have been visiting the hospital for a long time, either as patients seeking better treatment or as attendants accompanying their relatives, the majority of them have fair experience with both pre-pandemic and pandemic healthcare scenarios.

The sample selection procedure used two non-probability sampling techniques. The researcher used the 'purposive sampling' technique to select a few respondents who met the objective criteria, and the 'snowball sampling' technique to recruit additional informants for the interview with the help and connection of the initial respondents.

2.3 Research Methodology – Data Collection and Analysis

Because the research objective required a qualitative exploration of the pandemic scenario to understand the shifting healthcare experiences of the 'Miya' community due to multiple factors, the study was based on a 'qualitative' and an 'exploratory' research design.

To generate detailed information, the research design favoured a 'semi-structured interview' framework consisting of open-ended and flexible questions. Except for follow-up or probing questions, the questions did not deviate far from the interview guide, reducing extreme variance and divergence from the current objective. Interviews were conducted in a combination of Assamese and Bengali languages for ease of the interviewees.

Following data collection, the researcher began the analysis process by organising the 20 transcripts and translating them into English. To maintain anonymity, each respondent was assigned a pseudonym, which was followed by an inductive thematic interpretation of the gathered data, resulting in the formulation of five main themes presented in the findings section.

2.4 Ethical Considerations

The study was carried out in accordance with the following ethical considerations:

- Only after the supervisory and research body's approval were the research planning, stages, and fieldwork begun.
- The hospital's management was informed of the study's purpose, and permission was obtained before conducting interviews on hospital grounds
- The respondents provided verbal consent after being assured of complete anonymity and confidentiality of their identity, as well as their right to refuse participation before or during the interview.
- Given the current pandemic situation and rising COVID cases, appropriate physical distance and other mandatory protocols were followed throughout to protect both the researcher's and participants' health and safety.

3. Results and Discussion

The findings are organised into five main topics demonstrating the impact of multiple factors on the 'Miya' community's healthcare experiences during the COVID-19 pandemic. Subjective excerpts reflecting the voices of participants are used to highlight each theme.

3.1 Social Identity, Socioeconomic Status, and Stereotypes

It has been clearly established by the 'Miya' care-seekers and their attendants that their marginalized social identity, unfavourable socioeconomic position, and contested citizenship status impact their experiences of health-care provisioning and service.

They have always been viewed as "outsiders", regarded as "uncultured", and derogatively referred to as "Miya" by non-Miya healthcare providers, resulting in a negative medical experience.

Discriminatory and stereotyped practises towards them have increased in response to the COVID-19 pandemic's crisis scenario.

"Caregivers and medical personnel derogatively refer to us as 'Miyas', accusing us of causing havoc in the hospital. My pregnant wife was in excruciating pain and needed immediate medical assistance, but no one seemed to notice. I had to yell at the nurses to admit my wife right away, and they blamed me for bringing undue concern to others in a crisis situation. However, I acted in this manner only because polite pleas didn't work at first, and so poor people like us, have no choice but to bargain in such ways, especially in difficult times, or else we will be left behind." – Wasif (attendant)

Furthermore, during the pandemic, non-Miya health providers and hospital employees treated 'Miya' health seekers and their attendants differently, with frank ignorance, disrespectful replies, and rough behaviour.

"I visit this hospital frequently, and I've always seen that we're handled differently than other [non-Miya] patients. I understand how difficult it is for caregivers and staff to manage such a large number of patients on a daily basis, however I can't help but notice that, while being rough with most patients, they are especially mean to us. At the moment, they also dismiss our health difficulties if they aren't severe or related to COVID. Their rationale is that minor issues aren't as critical as they once were because they now have much more important [Covid] cases to deal with." – Ameena (patient)

3.2 Literacy, Language, and Hospital Setting as Barriers

The huge rush of patients, fast medical check-up procedure, language barrier, unclear communication between non-Miya care-givers or staff and 'Miya' care-seekers, as well as low level of education among the 'Miyas' acted as major barriers against them in times of the pandemic.

The majority of 'Miyas' have always found it difficult to properly explain their health and illness conditions in detail, correctly understand the diagnosis report and medicine prescription, and ask for additional information or advice from health professionals.

This has gotten worse in the pandemic situation because they were not allowed to take more than the required time; the practice of physical distancing and wearing masks has further hampered doctor-patient communication due to muffling of voices and unclear verbal instructions; and due to the increasing number of patients and workload, hospital pharmaceuticals and other staff were even less willing to guide or offer help, leaving the 'Miyas' to rely on their slightly educated attendees or on own self-instinct.

"I've always struggled to explain my problems to doctors and make sense of the diagnoses or prescribed medications. I try to bring my son-in-law with me whenever possible, but due to his hectic work schedule, I sometimes have to visit the hospital by myself. The current situation has been doubly intimidating for me because I'm having trouble keeping up with the doctor's hurried check-up and adhering to other protocols. If we try to take up more of the doctor's time or ask more questions, we are either chastised or completely ignored." – Ali (patient)

3.3 Protocols, Conflicts, and Dilemmas in COVID-19

With the onset of the COVID-19 pandemic, the hospital implemented stringent protocols and guidelines such as limiting the number of attendants to one or two (given the severity of the patient's condition), restricting 24/7 entry inside the hospital premises except at specified times during the day, prohibiting frequent visits, banning outside food and other items, mandating double vaccination certificates, and creating a separate sitting and waiting area outside the hospital.

These rules, however, have caused conflicting experiences and dilemmas for 'Miya' health seekers and their attendants, as well as exacerbated the prevalent discriminatory responses by non-Miya hospital staff towards them.

"I am struggling greatly because my husband is not permitted to visit me frequently due to strict rules and restrictions, so I must rely on a nurse for even minor assistance. The nurses are unfriendly, and whenever I complain about pain or discomfort while nursing my baby, they scold me, saying that we ['Miya' women] surely throw a lot of tantrums despite giving birth frequently. If the accompanying pain or discomfort of childbirth and breastfeeding is unbearable, we should refrain from becoming pregnant, as it would reduce our own and medical staff's burdens while also slowing our growing population." – Nazma (patient)

3.3 Internal Connections and Class Privileges

During the pandemic, the privileged and well-off individuals benefited from their internal connections with professional caregivers or hospital staff in terms of accessing better medical treatment, services, health appointments, and other facilities, as opposed to the marginalised 'Miyas'.

"While we are prohibited from entering the hospital premises at any time, even during an emergency, well-off individuals are permitted to entry for treatment or to visitations at any time during a day. When these people see entry restrictions or long lines, they immediately make a call, and after a while, someone from inside comes and takes them along. While they benefit from inside connections with staff or doctors, we are forced to follow the rules, wait in ques, and fight for entry." – Salma (attendant)

The 'Miyas' have suffered due to their inability to form connections with non-Miya medical staff, dearth of employees from their own community or connections with those few involved in low-paying jobs such as cleaning or gatekeeping, and lack of economic and socio-cultural capital or resources.

"I've noticed many fellows from our community questioning the person in authority as to why we and other poor people are always obligated to strictly follow the guidelines, to which they either denied or suggested us to make such connections rather than complaining. This is difficult, however, because non-Miya medical staff are unapproachable and partial, favouring only a selective few." – Mustafizur (attendant)

While COVID guidelines were strictly enforced against the 'Miyas', they were easily

overruled and broken without repercussions by the non-Miyas. As a result, the pandemic has revealed the hospital's corrupted and classist nature, which favours and champions the privileged sections.

3.5 Carriers of Virus – Interplay of Body Politics, Social Distancing and Social Exclusion

Because of their low socioeconomic and literary status as well as poor living and occupational standards, vulnerable 'Miya' bodies have always been politicised as unclean, unhygienic, and polluted. During the pandemic, such hegemonic medical gaze and biased practices intensified and legitimised, resulting in 'Miyas' being viewed with suspicion and deemed as easy 'carriers' of the virus.

Physical distance was vigorously maintained from the 'Miya' community by non-Miya privileged health-seekers, care-givers and medical staff in the name of safety and preserving one's health. As a result, their voices have been silenced, problems ignored, and access to fair treatment and quality healthcare facilities denied.

"During one of my hospital visits, I was waiting outside the doctor's chamber for my turn when the lady calling out patients' names told me to stand on the side to maintain distance rather than sit on the bench with others [non-Miyas] and I It felt ai If I was filthy and infected. The incident made me realise that I need to present myself properly, especially during pandemic times." – Salim (attendant)

Therefore, the 'Miya' community has witnessed and experienced intense social distance and exclusion, and ultimately in dehumanisation in the healthcare context.

Conclusion

On a daily basis, the 'Miya' patients and their attendants face, deal with, and bargain with multiple problems beyond their biological health issues in the realm of healthcare. Despite the fact that every individual, particularly the poor and vulnerable, is subjected to unfair treatment and biased responses, being a 'Miya' adds to their disadvantages.

The COVID-19 pandemic intensified their existing hardships by amplifying deep-seated prejudices, unhealthy medical practices, discriminatory treatment, and lack of empathy towards them by non-Miya medical staff, thus widening the physical, emotional, and social divide between the two groups. It has also boosted an unjust and exploitative medical environment that factored unhealthy, unsatisfactory, stressful, and disrespectful healthcare experiences.

However, the 'Miya' community is not completely unaware of the discrimination they face, nor are they voiceless victims of an unjust system. Regardless of the fact that they have little means or resources, they continue to fight, negotiate, and bargain in their own unique ways, like shouting or causing chaos to attract necessary attention.

They may face both prolonged and new healthcare challenges in the upcoming pandemic waves and post-pandemic situation. As Sikali (2020) noted that the impact of 'social distancing' on an individual's mental and emotional health can be devastating, and it may persist even after the pandemic. Similarly, the research findings suggest that the COVID-19-induced disparities in norms, situations, and practices may continue to harm the 'Miya' community for a longer time.

Acknowledgment

Conflicts of Interest

The author declares no conflict of interest.

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