Trust in the Bangladeshi Health System During the COVID-19 Pandemic: A Mixed-Methods Exploration

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Abstract

Background

Lack of trust in public health institutions hinders care-seeking and limits community support for contact tracing, information and communication uptake, and multi-sectoral or multi-stakeholder engagement. In light of these understandings, our aim was to determine levels of impersonal and interpersonal trust in the context of COVID-19 pandemic response in Bangladesh.

Methods

As this mixed-methods research was conducted during the pandemic, data was gathered via an online survey involving 508 respondents, along with seven online focus group discussions in which 50 purposively selected male and female clinicians and non-clinicians took part. Quantitative data was subjected to descriptive and comparative analysis, whereas content analysis was applied to the qualitative data.

Results

Survey respondents have less trust in the health system (a mean score of 3.77/10) than in the service providers (4.95/10). In the context of impersonal trust, the lowest level of trust is observed in the Fairness domain (3.12/10), followed by the Confidence domain (3.38/10). In the context of interpersonal trust, the lowest level of trust is observed in the Fairness domain (3.81/10), followed by the Communication domain (4.83/10). While some non-clinical participants blamed doctors for shying away from caregiving during the early days of the pandemic, most praised them for providing care, risking their life due to the shortage of PPE, and even sacrificing their life in the process. Several participants also cited lack of fairness in pandemic management, such as imposing lockdown in periphery areas of the country without arranging transport for those requiring medical help to the centrally located modern health facilities, and visible attempts by the political decision-makers to protect the business interests without consideration for the safety of the poor. However, both clinicians and non-clinicians concurred on the need for the service providers to improve communication related to COVID-19 management.

Conclusions

Health sector stewards in Bangladesh should learn the lessons from other countries, ensure multi-sectoral engagement involving the community and political forces, and empower public health experts to organize and consolidate a concerted health system effort in gaining trust in the short term while striving to build a resilient and responsive health system in the long term.

Background

The term ‘trust’ implies an implicit understanding between two or more parties that neither will exploit the interests of others to his/her benefit [1-4]. In the context of the COVID-19 pandemic, this implies that the

health system is expected to protect the people, and that those in charge will refrain from exploiting the vulnerability of others. Different levels of trust can be established, depending on whether a person, a system, or an institution is the trusted party [2]. For example, in their study focusing on the maternity care in Kenya, Sripad et al. defined interpersonal (trust between the service provider and the service seeker) and impersonal (trust in a social system, such as the healthcare system) trust [5]. In this article, we use the term ‘impersonal trust’ to refer to the trust of the Bangladeshi people in the national health system during the COVID-19 pandemic. On the other hand, we define ‘interpersonal trust’ as the trust of the general public in health service providers, such as the doctors. To evaluate their trust levels, we have adopted the eight domains of trust proposed by S Ozawa and P Sripad [6], as outlined in Table 1.

Table 1. Definition of the Eight Domains of Trust

Trust Domain	Definition
Fidelity	Perception that health systems/service providers would prioritize service to the people above self-interest
Honesty	Perceived level of integrity and openness of health systems/service providers
Systems Trust	Perception that institutions in health system/service providers would provide service according to appropriate processes and policies
Communication	Perception that the institutions in health systems/service providers would provide quality and correct information
Confidentiality	Perception that health systems actors/service providers would maintain privacy of patient information
Confidence	Perception that one could confidently rely on the health systems/service providers
Fairness	Perception that health systems/service providers are treating the disadvantaged and vulnerable groups appropriately
Competence	Perceived ability, qualification and reputation of the health systems/service providers to provide appropriate services

Health systems are comprised of institutions in which individuals perform various activities with the aim of improving people’s health [7]. In Bangladesh, Ministry of Health and Family Welfare (MoHFW) is responsible for policy, planning, and overall governance of the health sector, which is entrusted to different directorate generals that are responsible for policy implementation. The pandemic response is guided by the Infectious Diseases (Prevention, Control, and Elimination) Act 2018, according to which the Directorate General of Health Services (DGHS) is the central coordinating and responsible body for COVID-19 response. Under this directive, the Institution of Epidemiology, Disease Control, and Research (IEDCR) is the main scientific body to provide technical guidance and support for screening at the point of entry, while also being responsible for quarantine imposition and management, contact tracing, initial testing (which is later contracted out to other government and a few private laboratories), forecasting, surveillance, and outbreak response [8]. In the urban areas, however, the Ministry of Local Government,

Rural Development and Cooperatives is responsible for primary-level healthcare, while secondary and tertiary care is bestowed upon an unregulated (or poorly regulated) private sector [9, 10]. As of July 7th, 2020, Bangladesh ranked 17th in the world due to 168,645 COVID-19 cases and 215 deaths [11], while also taking the 3rd place in terms of the number of new cases (3,027) per day. The country's test rate (5,321 per million inhabitants) is among the lowest in the world and is the second-lowest (after Afghanistan) among its South Asian neighbors [12].

Trust in health systems is important, as it fosters cooperation among diverse stakeholders and contributes to health production [2], which is imperative when responding to a pandemic in the short term while allowing development of a resilient health system in the longer term. It plays a critical role in garnering social order within the population [2, 6] and ensuring good governance [13, 14]. Trust also improves communication flows, which is essential for reducing the risk of infection in a pandemic [15, 16] and for ensuring timely technical and managerial decision-making by experts and managers [2, 17]. Gathering and sharing information on newly infected individuals and their contacts (as a part of contact tracing activities) is a cornerstone of pandemic response, but can only be executed if the public trusts in the health system and the state governance [2, 15, 17]. Lack of trust in these institutions may invoke widespread stigma regarding infectious diseases, which severely obstructs case detection, isolation, quarantine, and case management activities [18, 19]. In contrast, when the population trusts in the health system, access, utilization, adherence, and continuity of care are improved, which in turn enhances public health and satisfaction [6, 17, 19]. Moreover, COVID-19 response requires adaptive leadership, i.e., individuals capable of making bold decisions and passing timely regulations based on most recent scientific evidence, which is impossible without trust between decision-makers and all pertinent stakeholders, including general public [20].

However, while it is undisputed that trust is important in COVID-19 response and developing a resilient health system in the long run, the meaning and the effects of trust (or its absence) in the context of COVID-19 pandemic response remains unexplored. Indeed, a comprehensive literature review conducted as a part of this investigation uncovered only one systematic review focusing on trust measures and their content areas [6], and a few articles exploring trust in the context of healthcare [2, 3, 5, 21, 22]. Moreover, as most of these studies have been conducted in the Western countries [14], research on the role of trust in pandemic preparedness and response globally is scarce [17] and such research is absent in Bangladesh. The present study was motivated by this gap in the literature, and our aim was quantitatively measuring impersonal and interpersonal trust, and explaining these findings qualitatively in the context of COVID-19 pandemic response in Bangladesh.

Methods

Study design

Quantitative data for this explanatory mixed-methods study [23] was gathered via an online survey probing into the respondents' impersonal and interpersonal trust in the context of COVID-19 pandemic,

while their responses were examined further during focus group discussions (FGDs), providing a qualitative dimension to the survey findings. By triangulating the quantitative and qualitative data, the goal was to obtain a deeper understanding of the construct of trust in the Bangladeshi health system.

Quantitative component

The survey adopted in the present study was designed specifically for this purpose, while drawing upon the eight domains of trust described in Table 1 [6]. The questionnaire was circulated via the social media platforms used in Bangladesh as well as through the email databases using a Google Forms link. The survey probed into the respondents' demographic information (age, sex, education, occupation, monthly expenditure, and personal COVID-19 status or that of a household member), and their degree of trust in terms of the eight domains outlined in Table 3. As age and monthly expenditure were continuous variables, to facilitate analysis, these were categorized into < 30 years, 30–50 years, and > 50 years, and 0–5,000 BDT, 5,000–20,000 BDT, 20,000–50,000 BDT, BDT 50,000–100,000 BDT, and >100,000 BDT (Bangladeshi Taka), respectively. Sex (with 'male' and 'female' as the only options) was a dichotomous variable, while education was a categorical variable with illiterate, primary, secondary, higher secondary, and university as the available responses. Occupation was also a categorical variable, allowing the respondents to select among student, unemployed, public job, private job, and business owner or self-employed. Finally, COVID-19 status was a dichotomous variable with 'positive' and 'negative' as the response options. The responses related to the impersonal and interpersonal trust domains were elicited through a Likert scale, where 0 denoted a fully negative perception and 10 a fully positive one. The participants' responses were later categorized as Low Trust (0–3), Moderate Trust (4–6), and High Trust (7–10). Two additional variables reflecting the scaled value of impersonal and interpersonal trust scores, respectively, were produced for each respondent by averaging the total obtained scores related to trust.

Data collection, which commenced on June 10th, 2020 and ended on June 12th, 2020, resulted in 517 voluntary responses. After removing faulty entries (those in which >50% of the questions were not answered, or multiple surveys completed by the same respondent), and imputing the missing values (using averages for continuous variables and Hot-Deck imputation method [24] for the Likert scale values), 508 datapoints remained and were analyzed using Stata version 16 to obtain the relevant descriptive statistics (mean, standard deviation, frequency) depending on the variable type. Domain-wise comparison between impersonal and interpersonal trust was also performed.

Qualitative component

We conducted seven FGDs between June 15th and June 17th 2020 with individuals who showed interest in the study, which was promoted via a Google Forms link circulated across social media and email databases. Each mixed-gender FGD was conducted and recorded through the video conferencing software Google Meet and involved 6–10 participants that were purposively selected from the Google

Forms list. For the purposes of subsequent analyses, FGD participants were broadly classified into clinicians (graduate students with medical or dental background pursuing degrees in public health at a private university; renowned public health experts with a medical background; and clinicians practicing medicine or dentistry) and non-clinicians (undergraduate students pursuing non-medical degrees such as management, marketing, botany, business, and pharmacy, etc. at a public university; undergraduate students pursuing public health degrees at a public university; undergraduate students pursuing degrees in food and nutrition at a public university; and different professionals such as executives, trainers, managers, and coordinators of public and private organizations).

The FGDs were moderated by the first author, who is a health policy and systems researcher with experience and expertise in qualitative research methods. The second author, trained in economics and experienced in qualitative research, assisted in note-taking. Each FGD lasted 60–105 minutes and was conducted in Bengali, the native language of the respondents and the researchers.

All FGDs were transcribed by the authors before being subjected to content analysis [25], which was deemed the most appropriate method given the paucity of research on the phenomenon being studied, as it avoids the risk of establishing preconceived themes. We developed the inductive categories through the following steps: data familiarization, coding schema or framework development, data coding, grouping, and data interpretation. In order to increase the validity of the findings yielded, the first and the second author independently coded the dataset, while seeking input from the third author, who is an experienced medical anthropologist, if additional deliberations were needed to reach a consensus.

Results

Quantitative component

Background characteristics of the respondents

The sample comprised of 318 (62.60%) males and 190 (37.40%) females. Majority of the participants (64.76%) were below 30 years of age, and had a university degree (91.93%). However, a significant variation in monthly expenditure was noted, with the mean (M) of 36,705 BDT and standard deviation (SD) of 44,881 BDT. Moreover, around 9% of the respondents reported having at least one family member diagnosed with COVID-19, as shown in Table 2.

Table 2. Background Characteristics of the Sample

Variable	Category	Number	Percentage	Mean	Standard Deviation
Gender	Male	318	62.60		
	Female	190	37.40		
Age	Mean (Standard Deviation)			29.67	8.18
	< 30 Years	329	64.76		
	30–50 Years	165	32.48		
	> 50 Years	14	2.76		
Education	Illiterate	0	0		
	Primary	2	0.39		
	Secondary	7	1.38		
	Higher Secondary	32	6.30		
	University	467	91.93		
Occupation	Student	163	32.09		
	Unemployed	64	12.60		
	Public Job	47	9.25		
	Private Job	185	36.42		
	Business/Self Employed	49	9.65		
Monthly Expenditure	Mean (SD)			36704.54	44881.43
	0–5,000 BDT	40	7.87		
	5,000–20,000 BDT	229	45.08		
	20,000–50,000 BDT	120	23.62		
	50,000–100,000 BDT	96	18.90		
	> 100,000 BDT	23	4.93		
COVID-19 Status	Positive	45	8.86		
	Negative	463	91.14		

Mean scores across different trust domains

As can be seen from Table 3, the mean score for impersonal and interpersonal trust is 3.77 and 4.95, respectively. The lowest level of trust on both scales is observed in the Fairness domain (3.12 and 3.81, respectively), followed by the Confidence domain (3.38) on the impersonal trust scale, and Communication domain (4.83) on the interpersonal trust scale. The highest level of trust is observed in the Confidentiality domain, with 4.83 obtained for impersonal and 5.53 for interpersonal trust. It is also noteworthy that 45% of respondents reported low levels of impersonal trust, while 53% indicated moderate degree of interpersonal trust.

Table 3. Comparison of Mean Values and Impersonal and Interpersonal Trust Levels

Variable		Impersonal Trust				Interpersonal Trust			
		Mean	SD	n	%	Mean	SD	n	%
Average Score Across all Domains		3.77	2.60			4.95	2.48		
Domain 1: Fidelity		3.66	3.04			5.10	2.94		
Domain 2: Honesty		3.92	2.94			5.32	2.90		
Domain 3: Systems Trust		3.85	2.86			5.19	2.92		
Domain 4: Communication		3.67	2.92			4.83	2.91		
Domain 5: Confidentiality		4.83	2.93			5.53	2.94		
Domain 6: Confidence		3.38	2.97			4.93	3.00		
Domain 7: Fairness		3.12	2.85			3.81	2.99		
Domain 8: Competence		3.71	2.97			4.92	2.82		
Trust (Categorical)	Low Trust			231	45.47			122	24.02
	Moderate Trust			179	35.24			269	52.95
	High Trust			98	19.29			117	23.03

n = number of responses, SD = standard deviation

The radar graph shown in Figure 1 depicting the mean scores in each domain indicates that the respondents have less trust in the health system than in the health service providers.

Qualitative component

In this section, the main findings from the quantitative survey are examined qualitatively. Focus is given to (1) lower trust in the health system than in the health service providers, (2) low Fairness scores, (3) low impersonal trust in terms of Confidence, and (4) low interpersonal trust in terms of Communication.

Background characteristics of the focus group participants

As noted previously, 50 individuals (28 males and 22 females, aged 19–75 years) took part in seven FGDs (Table 4). Four of these FGDs were held with individuals with a non-clinical background (n = 28) and the remaining three focused on the views of clinicians (n = 22). Nearly 50% of the respondents had training in public health.

Table 4.Characteristics of the FGD participants

FGD Number	Group characteristics	Number of respondents	Age range in years	Male/female	Clinical or non-clinical background
FGD-1	Undergraduate students pursuing degrees in management, marketing, botany, business, and pharmacy at a public university	6	19–21	5/1	Non-clinical
FGD-2	Graduate students with medicine or dentistry as their undergraduate background pursuing public health degrees at a private university	6	25–34	0/6	Clinical
FGD-3	Undergraduate students pursuing public health degrees at a public university	9	21–26	4/5	Non-clinical
FGD-4	Undergraduate students pursuing food and nutrition degrees at a public university	6	22–25	0/6	Non-clinical
FGD-5	Different professionals such as executives, trainers, managers, and coordinators of public and private organizations	7	24–28	6/1	Non-clinical
FGD-6	Renowned public health experts with medical background	7	45–75	5/ 2	Clinical
FGD-7	Practicing clinicians with either medical or dentistry background	9	28–67	8/1	Clinical

Less trust in the health system than in the health service providers

FGD participants offered diverse views regarding their trust in the health system versus the health service providers. While some non-clinicians blamed doctors for shying away from caregiving during the early days of the pandemic (this finding emerged in two of the four FGDs in which individuals with non-clinical background took part), most praised them for providing care, risking their life despite PPE shortages, and even sacrificing their life in the process (this view was shared in all FGDs in which individuals with non-clinical background took part). One participant observed:

So far, we have been blaming only the doctors for not giving services. Now, we can see how important service management is in coordination with other health actors. Health system cannot be managed by the doctors alone. [FGD-5, service holders of different professions, non-clinical background]

However, in all three FGDs held with the clinicians, there was a prevalent view that people consider doctors or service providers as the sole representatives of the health system, while the doctors are also the victims of the system, as some are even attacked by the members of public. Commenting on the recent murder of a doctor by the aggravated relative of a deceased patient, one doctor said:

Patients don't believe us when we say that oxygen cylinders are not available. They become violent. They attack us. They don't understand that access to resources is not in the hands of the doctors. They only know the doctors as the representatives of the health system. [FGD-7, practicing clinicians, clinical background]

Lowest trust in terms of Fairness

Qualitative findings on this topic supported the quantitative results. FGD participants mentioned several instances in which lack of fairness in pandemic management was evident, such as imposing lockdown in periphery areas of the country without arranging transport for the patients to the centrally located modern health facilities and visible attempts by the political decision-makers to protect the business interests at the expense of the safety of the poor. These allegations were compounded by the rumors that private hospitals were not discharging cured patients in order to generate more profit, charging astronomical amounts of money for scarce services such as intensive care unit (ICU) or oxygen, and taking patients hostage for money, as explained by one of the participants:

My relative was kept in a private hospital for extra three days after she was found COVID negative. She was even given oxygen. When asked why, they said, it is for extra patient safety. [FGD-3, undergraduate students pursuing a public health degree at a public university, non-clinical background]

During the discussions, some participants commented on circulating stories of high profile people booking the whole hospital for their family members, some business tycoons leaving the country by air ambulances or chartered flights, and the alleged designation of a public hospital only for the so-called VIPs. As one participant observed:

Wealthy and the political elites of the ruling party are getting one type of treatment, while the members of general public are getting something different. Some managed to get out of the country via chartered flights, some ministers booked ICUs even before requiring one. Hearing such news, as a middle- or lower-middle-class member of the society, I can't help losing trust in the health system. All facilities are there to protect the upper layer of the society. [FGD-4, undergraduate students pursuing food and nutrition degrees at a public university, non-clinical background]

Low impersonal trust in terms of Confidence

FGD participants also expressed low confidence in the health system due to the pre-existing inadequacies, which were compounded by the mistakes made by those in charge of managing the health system during the pandemic. Several participants observed mismatches between what has been said and done. The health sector reportedly failed to place the right persons in the right positions for optimal pandemic response, as expressed by a professor of public health:

An epidemic is a public health emergency; it is neither clinical nor an administrative issue. So, we must see this problem through the public health lens. ... We the public health professionals should be given the flexibility to do whatever is needed for the country, not something that just pleases the political leadership. [FGD-6, renowned public health experts, clinical background]

Reportedly, lack of preparation was also evident, as exemplified by imposing home quarantine instead of an institutional one at the beginning of the pandemic, despite knowing that intimate Bangladeshi culture is clearly not conducive to home quarantine. Insufficient testing, delays in providing test results, high cost of diagnosis and treatment in the private sector, and insufficient equipment in the health centers also indicate a lack of forethought among the health system actors, leading to erosion of public confidence, as explained by one participant:

We are not getting the test results in time. My friend's father got his test report after ten days by which time he was already dead. [FGD-3, undergraduate students pursuing a public health degree at a public university, non-clinical background]

Low interpersonal trust in terms of Communication

Both clinicians and non-clinicians concurred that the service providers involved in COVID-19 management needed to improve their communication with the public to avoid further erosion of trust. Many doctors were alleged not to be responsive enough while caring for the COVID-19 patients, as one public university student explained:

In hospitals, especially the government hospitals, doctors don't care about the patients. Doctors should not only provide clinical care, but also explain the disease, talk to the patients with respect, and dedicate more time to each case. [FGD-1, undergraduate students pursuing different degrees at a public university, non-clinical background]

Some doctors allegedly shared information on social and regular media, most of which was later proven to be false. In a 'viral' video posted on the social media, a doctor confidently claimed that coronavirus would go away in the summer, while a respected senior doctor openly advertised use of unproven medicines. A student pursuing a public health degree at a private university, who is also a dental surgeon, commented on this issue:

I found many of my doctor friends posting about different treatments for COVID-19. I think that this may confuse and mislead people, as different doctors are saying different things. [FGD-2, graduate students pursuing a public health degree at a private university, clinical background]

Discussion

The findings yielded by this mixed-methods study indicate that Bangladeshi people do not trust the health system in general, and the management of the COVID-19 pandemic in particular. Most of the participants cited lack of fairness as the most important source of mistrust, which is further compounded by inadequate communication by the service providers. These findings can be used for reorganizing and restructuring the country's response to the COVID-19 pandemic in the short term and developing a resilient health system in the long term.

Our survey also revealed that nearly half of the respondents had low level of trust towards the health system, while nearly quarter of the respondents were mistrustful of the service providers, and these findings were supported by the qualitative evidence. In their qualitative study, Shorey and colleagues found that, even in a relatively well-managed country like Singapore, 35% of the readers' comments in online local media outlets conveyed fear and concern due to the pandemic. People were panic buying and hoarding goods, as they were worried about their future [26]. Elgar and colleagues conducted a time-series analysis of social capital, income inequality and COVID-19 deaths in 84 countries, which revealed that mortality was negatively related to confidence in state institutions [27]. Drawing upon examples from the past epidemics, Bollyky et al. argued that fighting a pandemic requires public trust which governments have to earn [28]. A recent 23-country study conducted by Han et al., currently under peer review, similarly indicates that in countries with higher trust in government people are more inclined to follow rules imposed to stop the spread of the virus, such as washing their hands, avoiding crowded places, and making personal sacrifices [29].

Lack of fairness (i.e., the perception that health system is not treating the disadvantaged and vulnerable groups appropriately) emerged as the major source of low trust in the Bangladeshi health system during the COVID-19 pandemic. The same sentiment was shared during the FGDs, as many participants commented on discriminatory care for the wealthy and the urban people, and exploitation of the patients by the unregulated for-profit private hospitals. Due to the COVID-19 pandemic, already existing structural inequalities, discrimination, and abuse further exacerbate the mistreatment of persons with disabilities, older persons, children (especially poorer and marginalized children), youth, informal workers, migrants, refugees and internally displaced persons, racial and ethnic minorities, indigenous peoples, LGBTIQ people, and prisoners [30]. The time-series analysis conducted by Elgar et al. showed that mortality due to COVID-19 is positively related to income inequality [27].

Since doctors are often seen as the face of a health system, people blame them for health system inadequacies, despite considerable sacrifices most doctors have made throughout the pandemic. So far, around 3,000 doctors in Bangladesh contracted the virus and more than 100 died due to COVID-19 [31].

Allegations of lack of responsiveness and good communication skills have been reported in Bangladeshi media [32] as well as in academic publications [10, 33, 34]. Instances of violence against doctors are also reported in studies from Bangladesh [35] and countries with a similar socioeconomic context [36], and these incidents are not restricted to the COVID-19 pandemic, as they also occur in other times.

Policy recommendations

When managing any health crisis, a science-based professional response by engaging the relevant experts is essential. Experts may include, but are not limited to public health professionals, including infectious disease epidemiologists, health policy and systems experts, medical anthropologists, health economists, and health communication experts; laboratory scientists, including virologists, microbiologists, biochemists, and lab technicians; and relevant clinicians, including physicians, nurses, and paramedics. In the long run, however, a separate public health track, which is currently absent in the Bangladeshi health sector, must be implemented [37]. To foster a trusting relationship with the public, those in charge of the health system should ensure transparency and accountability in every aspect of its functions.

To address discrimination or lack of fairness, it is important to regulate the private sector with respect to cost and service quality, and ensure that no service provider can deny care to any patient based on his/her social, economic, political, religious, gender, or any other form of identity. Politicians in power should engage with other social, cultural, and religious entities, as well as members of other political parties, in order to respond to the COVID-19 crisis more effectively, with a view of fostering an inclusive multi-sectoral collaboration and community engagement [38-40].

Finally, to address the growing mistrust in the service providers, contextually aligned treatment guidelines exploiting telemedicine technology [41, 42] should be developed. Service providers should be trained and directed to provide services equitably and professionally [43, 44], while those in charge should address their legitimate demands, especially those pertaining to workplace security.

Research implications

Since this study focused solely on the perspectives of individuals at the demand-side of the health sector, it would be beneficial to conduct further investigations into health system governance to obtain the supply-side perspectives, including those of the government actors. Patients' views on the responsiveness of the service providers and service providers' perspectives on their own safety and experiences during the COVID-19 pandemic are also fruitful research avenues.

Limitations

The main limitation of this study stems from the use of online survey and focus groups, which resulted in a sample that did not reflect the demographics of the Bangladeshi population (mean age of 30 years and higher level of education). Consequently, the findings reported here cannot be generalized to other social strata or other countries. Second, it is worth noting that the first author was a COVID-19 patient at the time this study was conducted, which could potentially bias the qualitative analysis. However, every effort was made to reduce this risk through data triangulation [45], and by engaging multiple research team members in data coding and interpretation.

Conclusions

Pandemics have been known to humans since the beginning of the recorded history [46, 47]. Thus, while COVID-19 may be the first documented coronavirus pandemic [48], it is unlikely to be the last. Bangladesh experienced several local disease outbreaks over the past several years [49-52] as well as a dengue epidemic in 2019 [53]. However, due to their lower magnitude compared to the COVID-19 pandemic, the need for a comprehensive overhauling of the health systems has not been felt so deeply until now. Low- and middle-income countries like Bangladesh are particularly vulnerable to pandemics due to their weak governance and limited health system preparedness [39]. Therefore, to ensure better pandemic management in the future, they have to instate resilient health systems, which demands public trust [15].

This view is confirmed in the present study, as the Bangladeshi people expressed mistrust in the health system and, albeit to a lesser extent, in the health service providers. Lack of fairness in dealing with the COVID-19 pandemic and weak communication skills of the service providers contributed to the mistrust. Based on these findings, we recommend that our health system leaders learn from their mistakes in order to prevent even greater loss of life and economic downturn going forward. We also believe that our health sector stewards should take advantage of the lessons from other countries, ensure multi-sectoral engagement involving the community and political forces, and empower the public health experts to organize and consolidate a concerted effort in gaining public trust in the short term, while working toward building a resilient and responsive health system in the long term.

Abbreviations

DGHS Directorate General of Health Services

FGD Focus Group Discussion

ICU Intensive Care Unit

IEDCR Institution of Epidemiology, Disease Control, and Research

MoHFW Ministry of Health and Family Welfare

PPE Personal Protective Equipment

Declarations

Ethics approval and consent to participate

All the respondents provided verbal informed consent. All ethical principles were adhered to. The research was reviewed and approved by the Ethical Review Committee of the Public Health Foundation, Bangladesh (Reference number: 02/2020).

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

TJ conceptualized and designed the study; helped in data acquisition, analysis and interpretation; drafted the manuscript; revised per the feedback of the co-authors; ensured administrative, technical, and material support; and provided supervision and leadership. MNBK conceptualized and designed the study; helped in data acquisition, analysis, and interpretation; drafted the manuscript; and ensured administrative, technical, and material support. SZ helped in data analysis and interpretation; reviewed critically and provided feedback; provided technical guidance; and offered supervision. All authors read and approved the final manuscript.

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Figures

Figure 1

Radar Graph Comparing Domains of Interpersonal and Impersonal Trust