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Analysis of Disability Exclusion from Health care services of Bangladesh during Covid-19

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ABSTRACT

Disability is an emerging issue in public health services, however comparatively unrecognized population in terms of their accessibility. Bangladesh's fragile public and highly commercial private health care service ensured their disparate community status more eloquent. Along with that, long-lasting traditional understanding also reinforces the circumstances, which set the spotlight on the deep crack in the COVID-19 pandemic-generated policy in Bangladesh. During the COVID-19, the Bangladesh government adopted policies, that ignored persons with disabilities (PWD) who experienced heightened vulnerability. Based on reviewing existing literature, policy papers, and documents this article tried to identify the country's societal understanding of the community, psychosocial interpretation of existing medical interventions for them the rationing of emergency responses during COVID-19, and the failure of telemedicine services abruptly. Therefore, this article has significance because it presents the policy failure of the government and hints at adopting inclusive policies for the disabled population and setting significance for others.

Introduction:

Bangladesh, one of the growing economies of the world is trying to adopt an inclusive approach to facilitate its citizens as key contributors of development. Therefore, its 2.8% population with various disabilities is under prime consideration in developing initiatives. In 2020 Bangladesh faced COVID-19 and adapted various policies to tackle the crisis. As a result, it is expected to consider

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people with disabilities (PWD) to maintain such an inclusive approach in a global humanitarian crisis. However, there are various loopholes and shortcomings in existing and undertaking policies to incorporate these vulnerable people. Persons with various disabilities (PWD) are highly vulnerable during the global pandemic of COVID-19 due to their limited access to healthcare services in Bangladesh. Inadequate medical and social safety services in developing countries turned into a catastrophe fueled by the economic shutdown and restricted physical mobility. As a result, an important question arises why did the policy-making process fail to ensure appropriate inclusion of persons with disbailitie due to the existing literature review for the study? Bangladesh is facing various consecutive issues of COVID-19 due to the thoughtlessness of the government. Consequently, current research aims to identify the causes and consequences of inaccessible healthcare services for this marginalized population, having necessary policies required for the country.

Research Objectives:

This article aims to understand how Bangladesh's policy understands access to health care services for persons with various disabilities. Specific Objectives are:

a) Explain the health care services existing in the country and their understanding of the prevailing socio-economic situation.

b) Describing psychological and cultural issues in health services and persons with disabilities' encounter with those factors.

c) Explaining technological access during the COVID-19 pandemic and policy-generated exclusion.

Review of the existing literature:

Bangladesh in Health Care Access of PWD: Exclusion of disability in traditional society is longer Empirical studies show that person with disabilities faces inequality in essential healthcare services due to physical, and behavioral differences, and monetary insufficiency (Brennan, 2020). International Disability Alliances indicate that 52% of their participants experience inaccessibility of the physician (P-41). Governmental failure and indifference to developed and developing are evident in such disruption. However, South Asia is the exception because of its population and geopolitical causes (Gudlavalleti, 2018). Historically, it has experienced poor medical services in terms of unequal social, gender-based, and economic status (McClintock et al., 2018). Framing and defining disability are also unique in this subcontinent.

People with various disabilities demands continuous caregiving from family members or skilled teams to survive, which requires physical involvement with the therapeutic and assistive device using knowledge (Francis, 2020). However, during COVID-19 professional people are found resigning from their caregiving services for fear of infection without providing any substitute. Globally, PWD, who live in an institutional setup, also encounter food scarcity, insufficient medical facilities, dehydration, less toilet assistance, and a lack of personal protective measures due to a caregiving workforce shortage. 44% of residential schools for disabled students reported no government support for personal protection, 34% got few, and 18% sufficiently received their allocation (Brennan, 2020 P-23).

Telemedicine can address remote healthcare services through telephone, email, and video consultation to access unreachable patients (Waller & Stotler, 2018). Disabled people may not follow the social distancing measures uninterruptedly, increasing the chances of getting infected (Douglas et al. 2020). As a result, doctors passively use government-led isolation to cut them down from the patient list, consequently, depriving them of their life-saving medical demands (UNHRC, 2020). Medical practitioners prefer a utilitarian approach for allocating limited resources considering survival chances rather than human rights consideration (Chen & MacNamara, 2020). However, these highly controversial processes may sidestep with technological support, for example, telemedicine. Planned and regular telemedicine services were found beneficial for independent living with intellectual disabilities (Zaagsma et al. 2020 P-755). Although telemedicine services are applicable for generalized and specialized treatment, they save patients' time and money and schedule mismanagement (Scott Kruse et al., 2018). Moreover, the country's health sector is struggling due to its mediocre infrastructure and more significant population tally (Mostafa et al., 2010), while tech-based facilities can ensure equity, quality, and budget-friendly services (Alam, 2018 P-113). In addition, such facilities can address immediate actions in diagnosis, prescribing, referring, or counseling toward necessary medical attention.

Bangladesh addresses equal health services for PWD in several policies. According to Alam et al., 2020, 50% of neurodevelopmental patients failed to access medical facilities during COVID-19 due to mobility crises, financial limitations, severe appointment delays due to excessive workload of doctors, and ignorance. Their pre-existing physical condition increases infection, and death prevalence found less elaborated at the national guideline of clinical management of COVID-19 indicates policy negligence towards them. Moreover, precautionary messages are also inappropriate for genetic and acquired disabilities due to their literacy rate and human communication restrictions (Thelwall and Levitt, 2020). Besides, they are deprived of testing facilities due to metropolitan area-based services; in contrast, 80% of Bangladesh's disability demographics live in rural areas (World Bank, 2020). Moreover, their financial crisis restricts them from accessing essential medical support and pushes them toward life-threatening situations. The country's only child death due to COVID-19 is six years old physically challenged with Cerebral Palsy (the Business Standard, 2020).

Inadequacy of impairment need-based knowledge among Bangladesh's policymakers causes disparities among disabled and non-disabled citizens, reinforcing stigma with depression. However, policy-led stigma indicates traditional cultural influence where impairment is a matter of curse and shame and also provokes physical, institutional, and communication barriers to their regular living experiences (Kalyanwala et al., 2019). Disability generates an unsupportive community reaction which yields marginalization and hampers social equilibrium (Corrigan, 2014). In low- and middle-income countries, disability organizations found traumatic behavior from PWD families, influenced by colonial discriminatory gaze towards them (Bond, 2017). Moreover, misconceptions about modern medicine led to disability and also sidestep handicapped communities from health care services (Stone & Butera, 2012), correlated with poverty, illiteracy, and disadvantaged identity.

Nonetheless, the health sector receives the lowest allocation for a longer time. By 2017 Bangladesh can ensure approximately 0.4% of GDP (Osmani, 2020 P- 9), turning 23.44% in the 2020-21 fiscal year revised budget (The Business Standard, 2020). During this more prolonged deprivation, health services lessen their capacity to face any emergency like COVID-19. Moreover, the person with disabilities encounters individualistic non-clinical understanding and poor patient-provider relationships (Gudlavalleti, 2018), worsening the situation during COVID-19.

Research Questions

As indicated earlier, the main goal of this paper is to explore the potential causes of persons with disabilities exclusion from health service during the COVID-19 pandemic, considering a serious humanitarian crisis of the century. The identifiable factors of this process are mostly socio-economic situation, mental understanding of the community through cultural lenses, and technological limitations to reinforce the exclusion. Considering the research problem two questions arise for the research. They are:

1. What socio-economic determinants are influencing PWDs' access to health services?
2. How do mental understanding and policies contribute to ensuring this exclusion?

Methods

Most of the investigation resources come from secondary sources. Some data and information are gathered from primary sources, such as domestic legislation, budget papers, local legal instruments, law reports, and global organization resolutions. Secondary sources consulted include books, journal articles, newspaper reports, online journals, e-books, and organization-published reports. All the selected documents were collected from Internet sources.

Basically, the literature is collected through a keyword searching process from various academic online platforms. Later they are synthesized and summarized to clarify the understanding of research objectives.

Precisely, literature was selected to answer research questions considering below below-mentioned criteria. Scholarly articles related to healthcare services of COVID-19 in Bangladesh are scattered and inaccessible. Therefore, Open-access journal articles for instance, Global Health Journal, British Medical Journal, Journal of Intellectual Disability Research, Disability and Health Journal, Disability, and Rehabilitation, International Journal of Environmental Research and Public Health, etc., digitally and manually available policy papers and financial documents, national and international newspaper articles are considered to analyze for answering the questions.

Inclusion Criteria	Exclusion Criteria
1. Economic condition-related literature 2. Cultural Understanding Related journal 3. Technological uses related articles 4. COVID-19 and disability-related policies	1. Global North Perspective related articles on COVID health services. Only Bangladesh, Asia, and developing countries-related pieces of literature have been included.

Social Exclusion Stages for PWD

Analyzing literature, this article finds some key issues of the exclusion stages for disability. There are very limited number of literature where the disabled community is found at the focal point, however, the situation is correlated through scholarly articles along with various newspaper reports and experience-sharing blogs to understand the segregation process.

Withdrawn assistance

Bangladesh's disabled people reported seeking 14 times more healthcare support than non-disabled people (Hossain & Chatterjee, 1998), however infrastructural barriers and patient-provider relations remain unaddressed. As a result, infection of COVID-19 and its social distancing precautions hit these areas for an extreme attack towards PWD. Intellectual and neurodevelopmental disabled people are the worst sufferers due to the pandemic, though their mortality rate is higher than other people around 3:18 in the ratio (Glover et al., 2017).

Bangladesh has 103 integrated disability centers with free rehabilitation services; however, UNICEF (2014) reported incompetency and capacity lacking in the services. Lack of inter-ministerial coordination, inefficient constituent committees, and redirecting the implementation of the Social Welfare Ministry were found as reasons behind such circumstances. Exceptional schools, therapeutic centers, disability welfare activities of religious institutions (Missionaries of Charity, ISKON), and community organizations (Amra Samaj Gori, Blooms, Nijera Kori) encounter donation and human resources scarcity during the pandemic. The government instructed a multisectoral strategic plan to address PWD for all emergency support without proper implementation.

Economic struggle

Disability and poverty have a deep correlation though their lifestyle demands extra expenses for regular medical and therapeutic services, assistive technical support, caregiver expenses, and infrastructural and conveyance costs (Mitra et al., 2017). However, various studies indicate low educational attainment, poor job security, and inadequate wages create susceptibility to manage lifesaving treatments (Mizunoya & Yamasaki, 2018, Mactagart et al., 2018). During the current pandemic, the labor market encounters severe disruption in job security, unemployment, wage reduction, and economic inoperativeness. According to a survey of 5000 households in Bangladesh, 63% mentioned the financial crisis from the beginning of lockdown (Rahman et al., 2021). Economic degradation of families with disabled member(s) consequently suspends their medical support at first though it takes extra cost, which may help to survive their non-disabled members. Female informal workers with disabilities encounter additional vulnerability (Mizunoya & Mitra, 2013). Along with that mixed public-private healthcare systems in various low- and middle-income countries explored catastrophic redistribution during the crisis which is an outcome of a market market-generated healthcare system (Williams et. al. 2021). Even some countries reported refusing to admit COVID-19 patients and encountered license seizures and legal actions (Amani, 2020). Bangladesh also encounters similar incidences however; the precisely disabled population was found defocused from the whole scenario. Moreover, market strategy in the private health sector mostly depends on seed financing and policies of the International Financial Corporation (IFC), which encourages general people to take private health care facilities including rapid, professional, and other easy-to-access supplementary services (diagnosis, pharmaceuticals, emergency, etc.); grind down public medical facilities massively over the decades (Sparke, 2020). During COVID 19 primarily they failed to attend to patients causing a dreadful situation, however, they started to survive after claiming extra charges for personal protection facilities (PPE, Mask, sanitizer, etc.) from patients becoming too costly for patients to bear (Orissa Post, 2020). As a result, it reflects in sixth Bangladesh National Health Account indicates a 69% hike in medical expenditure in 2020 (TBS, 2023). According to the sustainable development goals (SDG) monitoring framework, 10-25% of out-of-pocket expenditures for medical purposes are considered disastrous, which is happening in the country. Along with that health insurance facilities are less popular in Bangladesh, still 10 insurance companies pay 70% of their claims and most people bear expenses from personal savings ultimately leading to a liquidity crisis at the personal and state level (TBS, 2024).

Sociopsychological and cultural influence

Health care services are dominated by biological understanding; consider socio-cultural knowledge in a limited sphere, especially for cultural minorities (Torsch & Ma, 2000). However, ethnic minorities, disabled people, and homosexual identities encounter an argumentative situation with medical science to some extent.

The gap between government and disabled citizens is enrooted in cultural understanding. Starting from the definition of ableism, which exhibits a contributory relationship with the order of life, produces privilege, segregation, and differentiation and creates a hierarchy (Campbell, 2017, P- 287-88). The continuation of such divide and rule idea signifies a biological human body into a standardizing identity in political understanding and legal framework (Foucault, 1977), which continues an argument in social perception between able and disabled notions. Gradually, human bodies have become a government matter. Constitutionally, people need to classify some codes, which create their identity as a part of the nation or state. Disabled citizens receive left-out status by this time without any further examination. At this stage, disabled bodies face a certain amount of conversion or hybridization, such as an implant or using devices to alter them towards gaining a bit of ableism. Moreover, the system induces fear in disabled citizens framing their bodies as uncontrolled (Latour, 1993). However, such ‘re-defined identity from scientific thoughtfulness cannot facilitate them in the long run. Their hybridization demands more medical attention compared to their natural condition. Medical science produces a conservative idea that fits their existing knowledge to conceal the shortcomings, which provokes exclusion in the long run. Though the health research budget is either fixed or inadequate in low- and middle-income countries; a study found obstruction cases for some longer prevailing diseases for instance Malaria, Tuberculosis, or nutritional aspects (Haslam et al. 2020).

On the other hand, culture and environment develop interpretation and thoughtfulness for a social being (Kleinman, 1978). The global south, which adopted an outdated version of disability notion from the global north with an uneven mixture of traditional cultural understanding, resembles the deficient medical model (Titchkosky and Aubrecht 2016). An in-depth finding from Ghai, 2018; a study on Indian Bengali culture exhibits that disability conceptualization relies on family policy, origin, and valuation of disabled members and represents them towards others, considering a family as the basic unit of society. Gradually, family acknowledgment and cultural consideration reflect the national perspective linearly or diversely.

Global South adopted a eugenic understanding of development follows an ideology to conceal related forces to shape a population's identity and the democratic state apparatus exhibits a mode of equity, however, institutional resistance to manipulate public verdict also prevails (Garland-Thomson, 2019, P-28). Moreover, social identity theory explains that people think and feel optimistic about the group they belong to, enhance their self-image, and consequently, divide other group members into "us" and "them" (Baron et al., 2012, P- 195). Historically, the classification goes on, and capitalistic welfare policy encounters the old wine in a new bottle.

Telemedicine service failure

The World Health Organization defined telemedicine services as provisional health services during pandemics. Patients may exchange their medical information with the doctor for diagnosis and treatment by staying far away (WHO, 2016). However, Bangladesh faces multidimensional issues in accessing telemedicine. The government data shows 101.186 million internet subscribers and 162.920 million cellular phone users, which is high compared to its demographics (BTRC, 2020). The mobile ownership rate of 74% in Bangladesh found disproportionate network availability in urban and rural areas (After Access, 2018). Internet connections are not acting as the number indicates. The absence of IT literacy, health consciousness, dissatisfaction, and lack of digital security are significant barriers to telemedicine services in Bangladesh (Chowdhury et al., 2020, P-3-5). Consistently, their financial capacity is lacking due to self-employment, low-wage occupation, and high health maintenance costs (Sarwar and Imran, 2020, P-8). Working from home does not fit with their professions; as a result, their withdrawal from services occurs, which impacts their food consumption, accommodation, and overall living standard—moreover, these interconnected causes generate more impoverished health conditions for PWD.

In Bangladesh, there are some different initiatives required for telemedicine. Doctors get their charges through electronic funds transfer apps such as Bkash (only operated in Bangladesh) or bank transfers. But for a rural dweller, arranging the appropriate device, and an internet connection and understanding the procedure found troublesome and expensive, will cause extra degradation in persons with disabilities' economic status compared with face-to-face medical service. In addition, language and telecommunication skills are also essential to work the service. Moreover, for senior citizens with acquired disorders such as Aphasia, Dementia or Parkinson's disease, diagnosis and medication with a therapeutic process might be critical in some cases. Message distortion and privacy violations are suspected to occur by unsecured connections and unencrypted devices (Petersen & DeMuro, 2015). Still, cellular phone-based services may overcome the country's delicate medical setup. In January 2021, 171.854 million mobile phone subscribers were found in Bangladesh, which means approximately 99% population is under connectivity (BTRC, 2021); however, existing network infrastructure is not strong enough to provide uninterrupted connectivity. Therefore, a community-integrated remote health service might be more operative for persons with disabilities and their caregivers in Bangladesh.

Policy interaction in exclusion

Bangladesh's middle-income status compelled the government to filter a few extremely needy portions for the disabled community to access government monetary support. The project titled Allowances for financially insolvent disabled started in 2006 and is considered the primary initiative by the Social Welfare Ministry to support the marginalized community. However, the service can be explained as a strategic cash-generating process, not as a quality and skill development initiative required for their mainstreaming in society. Their identity crisis is under a "contributor or consumer" dilemma that impacts their civil rights, duties, and collective thinking (Reisman, 2001, P-31). As a result, the "welfare" process of making them economically empowered generates more stigma and consequently exclusion.

Bangladesh encountered a paradigm shift in disability welfare by 'The Protection for the Person with neurodevelopmental disability trust act-2013', eased the medical model generated understanding precisely, for Autism Spectrum Disorder and other communication disabilities. Additionally, the state imposed additional medical taxes for hospitals and clinics in the 2018-19 fiscal year if they failed to attend disabled patients (Dio, 2018). However, from the one-stop service review, the concerned ministry is going through the limitation of access to mainstream medical services. For instance, they cannot refer any patient to mainstream healthcare services (Gov. Uk, 2019), which compels a person with a disability to rely straight on the hospitals and medical practitioners, to understand disability in a narrowed-down way.

Though the social welfare ministry is entitled to deal with disability policy and implementation, there is a severe lack of expertise among the officials to deal with the sensitive matter. For example, in 2013, the ministry exhibited only 1% of demographics with disabilities; however, improper statistical methodology was used to do the survey (GOV.UK, 2019). It indicates contradictory, severe incompetency, and violation of human rights in its international stance.

A state is always a rational actor which must ensure full employment, proper redistribution of resources to maintain cohesion in social class along with systematic and predictable risk management encountered by its citizens in terms of labour market, welfare or some other criteria to exhibit its inclusion or exclusionary behavior to target population (Edwards and Golver, 2001, P-3). In terms of that, Social Welfare Ministry's limitations start from its budget allocation. The 2019-20 budget estimates only 0.15 million USD for disability detection surveys, and disability allowances grow grossly, they got 191,094,135.66 USD in the 2020-21 budget in total (MoF, 2020). However, in 2024-25 budget allocated 150,692,745.28

USD for disability allowance budget: merged as disability allowance and education stipend program with an allocation of 186,159,476 USD (MoF, 2025). Therefore, inclusionary behavior is unbalanced for around 2.8% population as the target beneficiary of this allocation. In addition, mismanagement prevails in the implementation and distribution as well. In 2017 Transparency International Bangladesh reported that 48% of households with disabilities encounter anomalies and bribery in the recruitment process (Rahman et al., 2020).

Administrative failure continues at both national and international platforms; for instance, being a signatory of the Committee on the Rights of People with Disability in 2007, Bangladesh postponed its initial report publication until 2018. In this report, the National Human Rights Commission is mentioned as a designated body to ensure civil rights for poor communities, however, only three complaints were noted in the NHRC's annual report (NHRC, 2018, P- 22). So, the commission may not be considered a reliable body to ensure the community's rights. Moreover, the CRPD alternative report shows less clarity, an absence of holistic ideas, and zero monitoring from the Rights and Protection of Persons with Disability 2013 Act (Thompson, 2020 P-11).

To be precise, social welfare emerged as a political agenda and was profoundly associated with the market. Doctors stay away from their philosophical understanding of helping the sick in the capitalist system, somewhat more interested in accusing financial benefits from their earned knowledge (Reisman, 2001, P- 206). Medical services are not a commodity to sell; however, the current practice indicates the reverse. Bangladesh's rising number of private medical colleges, diagnostic centers, and hospitals is considered an innovative business that fulfills its owners' socio-political intentions with monetary benefits. As a result, the COVID-19 crisis unmasked them. From the beginning of the pandemic, they avoided COVID-19-infected patients and denied attending emergency patients without advance PCR test reports, whereas 77.3% of patients prefer private healthcare services in Bangladesh (Julquarnine, 2020). Therefore, endless public suffering happened during the pandemic.

The patient-provider relationship also changed with neoliberal health care services. Lower standards of professionalism, patients' hopelessness, and consequent frustration prevail in this circumstance. Bangladesh is not an exception. Out-of-the-pocket expenditure, less interaction with doctors, few post-treatment cares and follow-ups, and reluctant nursing services make the situation worse. However, people rely on the existing services to survive. Therapeutic facilities such as speech therapy, occupational therapy, physiotherapy, surgery, and prescribing appropriate medication considering their immune system are not available in every government and private hospital. As a result, their caregivers need to search for good clinics with fewer movements. During COVID-19, when private clinics announced closure, the disabled community faced their official exclusion from health care, which seemed equal to killing them. Doctors calculate their time, the scope of a patient's survival, and resource allocation to attend to a disabled patient, generating dilemmas and distress among doctors and patients' families (Pulrang, 2020). Even government policies, especially in Bangladesh, did not have any specifications or details about disabled patients providing services. Moreover, COVID-19 vaccination policies also prioritized the elite class, senior citizens with acute health problems, and the young generation in the priority, without any specific mention of impaired community.

Figure 1.: An Overview of the exclusion process of people with disabilities during COVID-19 in Bangladesh

Possible ways to overcome:

Addressing disabled people in emergency health services is their right, not a privilege. However, Bangladesh's COVID-19-related laws and orders consistently ignore the vulnerable community, whereas innovative recovery options are there.

1. Required to adopt new policy making model for instance agenda building model to replace traditional approaches for implementation.
2. Mass media, community media services, and social media can provide information on disability care information in convenient ways for various impairments during COVID-19 elaborately and in a simplified way. It will spread out rapidly.

3. Voluntary interaction services with essential precautions may provide physical and mental relief, paid, or rewarded by the government or non-government organizations such as family planning initiatives taken in Bangladesh in the 90s. Even dedicated community clinics may work.
4. Telephonic attainment may perform better during emergency services. Speech and language therapy services for development and intellectual disabilities by efficient students with wages may work in some cases.
5. Motivation and counseling services for parents and caregivers may develop psychological deadlock.
6. Vaccinating by rationing acute disabled people also keeps the hope alive for their survival.

Conclusion:

The study exhibited various socio-psychological, economic and cultural factors whereas all these factors can be controlled through appropriate policy making mechanisms. Therefore, Agneda building model of health policy making can reduce these disparities for people with various disabilities in philosophy of ensuring their citizenship rights practically. A country's health system reflects its financing and regulatory mechanism (Osman, 2008), and monetary management, administrative and behavioral exposure are known as "control knobs" in such mechanism. Along with that healthcare systems inherited political legacy to work out. As a result, resource allocation, ensuring access and related policy implementation are mostly dominant political philosophy oriented (Friebel & Wallenburg, 2024). Considering the situation, Bangladesh can adapt Agenda Building model for health policy making, because access and allocation of health services demands further transparency and accountability for PWD as well as ensured by all political determinants. Another important point is, policy process is outlined and defined by larger political context of a country, because multiple problems are free-floating, bumping, colliding and competing to get attention of policy making (Kreidler & Michele, 2021). Political actors can put policy problems in public mind through their appealing narrative and exclusive persuasion capacity to make a bridge among public demand (Maarse, 2023). Moreover, the model can extend its stakeholders considering the need accordingly. For instance, calling of a more inclusive health service will require, consent of focus demographics, national and international agencies for health care support, media for setting the agenda in heterogenous public concern etc. Bangladesh's inaccessible health care services are widely prevailed and fading the countries achievements in this sector (Osman,2008). However, the whole discussion of current study indicates a major change in policy making model to reducing the other discriminatory factors for PWD. Agenda setting model can be a possible solution for it.

The Covid-19 pandemic tested human rights to its fullest. A developing nation's reality exhibited far worse than expected. Bangladesh's mass transmission by the

Delta variant of COVID-19 exhibited the loopholes of health services through an unregulated testing system, unethical elite preferences in vaccine distribution to ventilation allocation. Under this circumstance, vulnerability parameters for disability were less considerate, though a consistent violation of existing disability policies and unaccountable market-oriented emergency services will overlay them with appropriate defenses. The catastrophe sustained in post post-pandemic era though it is not getting enough time and economic support to recover. Moreover, showing the lower number of affected patients through such testing facilities kept the nation and policymakers unaware of the actual crisis of the health services. According to a national news agency in Bangladesh, only 1001 people died from March 2020 to May 2020. (UNB, 2020). Such activities indicate potential discrepancies in this process. Unfortunately, the disability-related data crisis justified top-down negligence in policymaking during such a global health emergency. From the argument given here, it is also evident that cultural understanding of isolation prolonged mismanagement along with other structural difficulties, for instance, technological resource allocation mismanagement. Bangladesh requires a logically segmented and compact disability policy including prospected health emergencies to establish an inclusive and humanitarian society for the future.

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