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# Awareness of Rickshaw Pullers About COVID-19 Prevention in Dhaka City

Fabia Hannan Mone<sup>1,2</sup>, Mohsina Ahmed Keya<sup>1</sup>, Al Modina Akter<sup>1</sup>, Tamanna Sultana Tania<sup>1</sup>, Mst. Parvin Akhter<sup>1</sup>, Subodh Chandra Barman<sup>1</sup>, Lipika Sarker<sup>1</sup>, Ponkoj Roy<sup>1</sup>, Shahana Nasrin<sup>1</sup>

<sup>1</sup> Institute of Social Welfare and Research (ISWR), University of Dhaka, Bangladesh

<sup>2</sup> School of Life Sciences, University of Westminster, UK

Correspondence: Fabia Hannan Mone, Institute of Social Welfare and Research (ISWR), University of Dhaka, Bangladesh. E-mail: [fabiamone@gmail.com](mailto:fabiamone@gmail.com)

ORCID ID: <https://orcid.org/0000-0003-2633-9507>

## Abstract

This study examines the level of knowledge and awareness of COVID-19 among rickshaw pullers in Dhaka, Bangladesh. Employing a qualitative research design, data were collected through in-depth interviews with 30 Male rickshaw pullers aged 20 to 65 years. The study investigated participants' understanding of the disease, their day-to-day practices, and the broader impact of the pandemic on their livelihoods. The findings reveal a strikingly low level of COVID-19 awareness, accompanied by widespread misconceptions. Notably, none of the participants initially recognized the term "COVID-19"; recognition only occurred when the disease was referred to as "coronavirus." Rather than perceiving COVID-19 primarily as a public health threat, participants held divergent beliefs-some attributed it to divine punishment, while others associated it with political agendas or state-imposed control through lockdown measures. Approximately 95% of respondents demonstrated little to no understanding of transmission routes or disease severity. Economic anxieties-particularly concerning loss of income and food insecurity-consistently took precedence over fear of infection, which in turn contributed to limited adherence to and comprehension of recommended preventive measures. These findings underscore the urgent need for context-sensitive health communication strategies tailored to the realities of economically vulnerable occupational groups such as rickshaw pullers. Community-based awareness initiatives are recommended as a practical and effective means of improving health literacy and strengthening protective behaviors within such populations.

**Keywords:** Awareness, Covid-19, Dhaka, Public Health, Rickshaw Pullers, Socio-Economic Impact

## 1. Introduction

### 1.1 The Research Problem

The emerging disease COVID-19 spread rapidly and led to thousands of deaths in many countries (Zhu et al., 2020). To avoid the tragedy where the surge of too many patients overwhelmed medical systems (World Health Organization, 2021), a simple and effective approach to slow the spread of the virus was emergently desired worldwide. Handwashing and mask-wearing are critical components to slow the transmission of SARS-CoV-2

(Choi & Ki, 2020). However, within low-resource environments, executing these preventative strategies poses severe logistical conflicts.

Bangladesh is a lower-middle-income country in South Asia with a population estimated at approximately 160 million. The country has been facing rapid urbanization over the past few decades, with more than one-third of the population currently residing in dense urban centers. A study shows that there are more than 1.1 million rickshaws running in Dhaka City alone, representing a massive informal transport sector (Asian Development Bank, 2012). Many of these operators live in localized slum areas where basic amenities cannot be fulfilled easily. During the peak waves of the pandemic, Bangladesh emerged as one of the most heavily affected countries in South Asia (BRAC, 2020; IEDCR, 2021; Sayeed, 2021).

### *1.2 Importance of the Problem*

To prevent the possible spread of this virus pandemic, the World Health Organization (WHO) recommended universal compliance with specific containment measures, including rigorous handwashing, sanitized operations, mask utilization, physical distancing, and home quarantine. However, preventing the spread of this pandemic presented steep, unfeasible barriers among rickshaw pullers of Dhaka City because of structural systemic challenges such as poor sanitation facilities, absolute poverty, and a critical lack of formal public health awareness.

This problem deserves dedicated qualitative research because blanket, top-down public health regulations are often modeled around citizens with stable incomes and private infrastructure. For informal day-laborers like rickshaw pullers, compliance with preventative health dictates directly threatens immediate daily economic survival. Understanding the unique cognitive, socio-economic, and structural barriers experienced by this highly mobile occupational group is crucial to designing effective public health communication models and crisis safety nets. Therefore, the formal purpose of this study is to qualitatively map awareness, perceptions, and lived compliance challenges regarding COVID-19 safety measures among active rickshaw pullers in Dhaka City.

### *1.3 Relevant Scholarship*

Current scholarship examining pandemic responses in developing countries frequently highlights a strong intersection between poverty and health literacy deficits. Studies across lower-middle-income contexts confirm that while basic awareness of a pandemic may exist broadly in urban sectors, the depth of medical understanding regarding transmission pathways and severe clinical outcomes remains significantly low among marginalized, low-wage laborers (Anwar et al., 2020; Islam et al., 2020; Lau et al., 2020). Furthermore, regional data from Bangladesh indicates that low-income urban and rural residents display highly divergent health behaviors due to conflicting economic anxieties and localized structural limitations (Sarwer et al., 2020; Siddikur Rahman et al., 2021).

By focusing specifically on the highly mobile, informal transport sector of rickshaw pullers, this study directly addresses a critical gap in the existing literature. It provides empirical, contextual data demonstrating the direct conflict between state-mandated safety directives and the immediate economic survival needs of urban informal workers.

### *1.4 Research Questions and Correspondence to Design*

To evaluate the specific problem, this empirical study is driven by three primary qualitative research questions:

- How do urban rickshaw pullers interpret and conceptualize the nature and terminology of the COVID-19 virus?
- What are the specific behavioral and environmental barriers that prevent regular compliance with standardized mask utilization and hand hygiene protocols?
- How do immediate socio-economic pressures and daily livelihood requirements influence or override infection anxieties?

Because these questions aim to explore internal cognitive perspectives, behavioral realities, and lived structural barriers, this study uses a qualitative phenomenological research design (Finlay, 2009). Individual face-to-face in-depth interviews were selected as the primary data collection tool. This qualitative approach allows researchers to look past rigid statistical parameters, capturing the direct narratives, linguistic nuances, and contextual realities necessary to explain the complex relationship between low health literacy, economic vulnerability, and preventative behavioral gaps.

## **2. Method**

### *2.1 Research Design*

This study employed a qualitative research design using an in-depth interview approach to explore the lived experiences, perceptions, and awareness levels of the participants regarding the COVID-19 pandemic. A qualitative framework was selected to gain an in-depth understanding of how social realities are constructed and interpreted by individuals within their specific occupational contexts.

### *2.2 Participant Characteristics and Selection Criteria*

The target population for this study consisted of active male rickshaw pullers operating within Dhaka city, Bangladesh. To be eligible for inclusion, participants had to be actively engaged in rickshaw pulling during the pandemic period and aged between 20 and 65 years. Female rickshaw pullers and individuals outside this age bracket were excluded from the study criteria. However, no female rickshaw pullers were found during data collection. This is likely because, due to cultural and social norms, female rickshaw pullers are very rare across Bangladesh.

### *2.3 Sampling Procedures and Sampling Size*

A purposive, convenience sampling strategy was utilized to select participants from various key commercial and residential areas across Dhaka city. A total sample size of 30 active male rickshaw pullers was achieved. Data collection was restricted to the geographical boundaries of Dhaka city due to practical constraints and accessibility considerations during state-imposed lockdown periods. All participation was voluntary, and written informed consent was obtained from each respondent prior to individual sessions.

### *2.4 Data Collection and Measurement Approaches*

Data were collected through semi-structured, face-to-face in-depth interviews conducted in the native language (Bengali). A pre-designed interview guide consisting of open-ended questions was used to examine three primary domains: general knowledge and recognition of COVID-19, day-to-day preventive practices (such as mask-wearing and hand hygiene), and the socio-economic impacts of pandemic restrictions on livelihoods. Quality and reliability were maintained by ensuring a uniform interview style across sessions.

## **3. Results**

### *3.1 Recruitment and Participant Demographics*

Field recruitment and data collection were carried out over a specified period from July to October 2021 across multiple high-traffic commercial and residential locations in Dhaka City, Bangladesh. A total of 30 active male rickshaw pullers were enrolled in the study. The demographic profile of the sample indicates that all respondents were male, with ages ranging between 20 and 65 years. All 30 participants successfully completed the individual face-to-face in-depth interview sessions, resulting in a 100% completion rate for primary data analysis.

### *3.2 Qualitative Data Analysis and Core Themes*

The collected interview text was analyzed to identify primary thematic trends related to COVID-19 awareness, daily safety practices, and socio-economic outcomes. The findings reveal critical trends across three primary dimensions:

### 3.2.1 Knowledge and Disease Recognition

A primary and uniform finding was that initial recognition of the term "COVID-19" was non-existent among the respondents. Participants only recognized or identified the disease when the term was colloquially substituted with "coronavirus." Furthermore, instead of seeing the virus as a biological public health threat, participants expressed divergent, non-medical perspectives.

*"I have never heard of anything called COVID-19. We only know it when people say Coronavirus. To us, it feels like a punishment from God or some political play to keep us inside."* (Participant 12, 42 years old)

The pandemic was frequently interpreted through either a fatalistic viewpoint (attributing the virus to divine punishment) or socio-political viewpoints (interpreting the virus as a tool for government control or political agendas executed via lockdowns).

### 3.2.2 Transmission Awareness and Severity Perceptions

Approximately 95% of the interviewed rickshaw pullers demonstrated an absolute deficit in understanding how the virus spreads (transmission pathways) or its clinical severity. Due to this low level of medical understanding, standard public health guidelines—such as regular hand hygiene, physical distancing, and proper mask utilization—were either poorly understood or ignored in day-to-day operations.

### 3.2.3 Economic Impact vs. Infection Anxieties

The data consistently revealed that economic survival and immediate daily livelihoods took absolute precedence over the fear of contracting the virus. Participants voiced severe anxieties regarding food insecurity and the loss of daily wages due to state-enforced lockdown measures.

*"If I do not pull my rickshaw today, my family does not eat tonight. The virus might kill me later, but hunger will kill my children tomorrow. That is why the lockdowns hurt us more than the disease."* (Participant 5, 29 years old)

This acute financial strain acted as a direct barrier to protective health behaviors, as securing a daily income was perceived as an immediate necessity that overrode compliance with preventive isolation or physical distancing protocols.

## 4. Discussion

### 4.1 Interpretation of Key Findings

The findings of this study confirm that awareness regarding COVID-19 is profoundly low among rickshaw pullers in Dhaka City, heavily influenced by non-medical beliefs and immediate socio-economic survival pressures. Unlike general urban populations who recognized standardized medical terms via mainstream public health channels, this group experienced a total disconnect, demonstrating zero recognition of the term "COVID-19" until it was colloquially named "coronavirus." This distinction highlights a critical breakdown in formal health communication. Rather than interpreting the pandemic as a biological crisis, the widespread perception of the virus as either a divine curse or political propaganda aligns with a pattern where marginalized occupational groups rationalize macro-crises through familiar fatalistic or state-distrust lenses when accessible, transparent medical data is lacking.

### 4.2 Contextualization with Existing Literature

These findings strongly mirror similar qualitative trends observed globally and regionally during the pandemic. For example, the severe lack of transmission knowledge and low practice of safety measures among the accessed informal workers corroborate observations made by Lau et al. (2020) regarding income-poor households in the Philippines, where structural vulnerabilities compromised compliance with health protocols. Furthermore, the explicit prioritization of economic survival over virus mitigation seen in 95% of our respondents directly mirrors the findings of Anwar et al. (2020) and Rahman et al. (2021), who documented how economic anxieties, food insecurity, and immediate threats to daily livelihoods consistently overrode the fear of infection in lower-middle-income occupational settings.

#### *4.3 Study Limitations and Generalizability*

Several explicit limitations must be acknowledged when evaluating the generalizability and operational context of these insights. First, because the accessed sample was selected through convenience sampling within the urban center of Dhaka City, these insights cannot be systematically generalized to represent all informal sector workers or rural transport operators throughout Bangladesh. Second, data collection was entirely restricted to male participants, meaning the distinct socio-economic vulnerabilities and pandemic awareness profiles of female informal workers remain uncaptured. Third, relying on face-to-face qualitative interviews introduces potential social desirability bias, where respondents might underreport non-compliance with state-mandated lockdown protocols.

Finally, administrative and structural constraints introduce a significant temporal gap between initial field execution and final dissemination. The primary data were gathered between July and October 2021 as a partial requirement for an institutional specialization curriculum, with an initial report compiled in May 2022. Due to extended academic graduation timelines and subsequent overseas academic relocations of key co-authors, formal publication tracking was delayed. Although the analytical findings were structurally vetted and peer-reviewed via oral presentation at an international congress in June 2024, readers should evaluate these qualitative realities as an empirical reflection of the mid-pandemic landscape.

#### *4.4 Theoretical and Practical Significance*

Despite these boundaries, the practical and public health significance of this study remains critical. The outcomes offer a clear, empirical explanation of why blanket, top-down health policies (such as digital tracking or commercial lockdowns) fail to protect marginalized communities if they are not accompanied by localized, transparent economic safety nets and tailored, context-sensitive public health education. For future pandemic preparedness, applications must center on community-led communication strategies that deploy health literacy programs in accessible languages directly at informal transport hubs.

#### *4.5 Recommendations*

Based on the lived experiences and critical gaps identified among the participants, the following actions are recommended to support marginalized community networks during public health crises:

**Tailored Health Communication:** Public health entities and mass media agencies must abandon generic, top-down medical terminology and deploy localized, community-specific terminology (e.g., substituting standardized terminology with colloquial phrasing) to optimize actual risk recognition.

**Targeted Economic Safety Nets:** Since immediate economic survival completely overrode infection anxieties for 95% of the respondents, future state-enforced lockdown protocols must be strictly integrated with targeted financial relief, food security provisions, and direct livelihood subsidies designed explicitly for informal transport laborers.

Grassroots Intervention Hubs: Decentralized health literacy campaigns and preventative resource distribution setups (such as masks and hand hygiene stations) should be actively integrated directly into structural informal hubs, including local rickshaw garages and terminal gathering zones.

Inclusive Macro Policy: Government agencies, public health professionals, and policy architects must structurally incorporate vulnerable, low-income informal sector layers into national pandemic response strategies to build resilient, equity-driven urban crisis frameworks.

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**Informed Consent Statement/Ethics approval:** All subjects gave their informed consent for inclusion before they participated in the study. The study was conducted in accordance with the Declaration of Helsinki, and the protocol was reviewed and overseen by the academic research supervisor at the Institute of Social Welfare and Research (ISWR), University of Dhaka. Participants were fully informed regarding the purpose of the research, the absolute anonymity of their responses, how their data would be utilized for academic reporting, and that no physical or social risks were associated with their participation.

**Data Availability Statement:** The qualitative interview data generated and analyzed during the current study are not publicly available due to ethical restrictions and the need to maintain absolute participant confidentiality and anonymity as agreed upon under the informed consent protocol. Excerpts of the analytical thematic text are included within the manuscript's results section.

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**Declaration of Generative AI and AI-assisted Technologies:** This study has not used any generative AI tools or technologies in the preparation of this manuscript.

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## Appendix A

The Semi-Structured Interview Schedule for Assessing COVID-19 Awareness and Prevention Barriers Among Urban Rickshaw Pullers. The following guide outlines the core qualitative thematic tracks and question frameworks utilized during the individual face-to-face in-depth interviews (N=30) conducted across Dhaka City, Bangladesh.

| Theme Track                                         | Core Inquiry Focus & Colloquial Prompts                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Track 1: Basic Disease Conceptualization            | <ul style="list-style-type: none"> <li>• What do you understand by the term "Coronavirus" or "COVID-19"?</li> <li>• Where or from whom did you first hear about this disease?</li> <li>• What are the main symptoms of this sickness as far as you know?</li> </ul>                                                                                                                       |
| Track 2: Prevention Awareness & Source Literacy     | <ul style="list-style-type: none"> <li>• What specific actions has the government or doctor recommended to stay safe?</li> <li>• How effective do you believe handwashing and wearing masks are against the virus?</li> <li>• What kinds of masks do you use, and how often do you clean or replace them?</li> </ul>                                                                      |
| Track 3: Livelihood Conflicts & Structural Barriers | <ul style="list-style-type: none"> <li>• How did the state-enforced lockdown affect your daily income and family food security?</li> <li>• When pulling a rickshaw, what makes it difficult to maintain a physical distance or wash hands frequently?</li> <li>• If you feel sick or experience a fever, what steps do you take, and why might you choose to continue working?</li> </ul> |

## Appendix B

Picture 1: Glimpse of COVID-19 and Rickshaw Pullers



### COVID-19

Coronaviruses are a family of viruses that infect mammals and birds and cause sickness. Coronaviruses cause infections of the respiratory tract in humans that can vary from moderate to fatal.

Infection with the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus strain causes COVID-19.

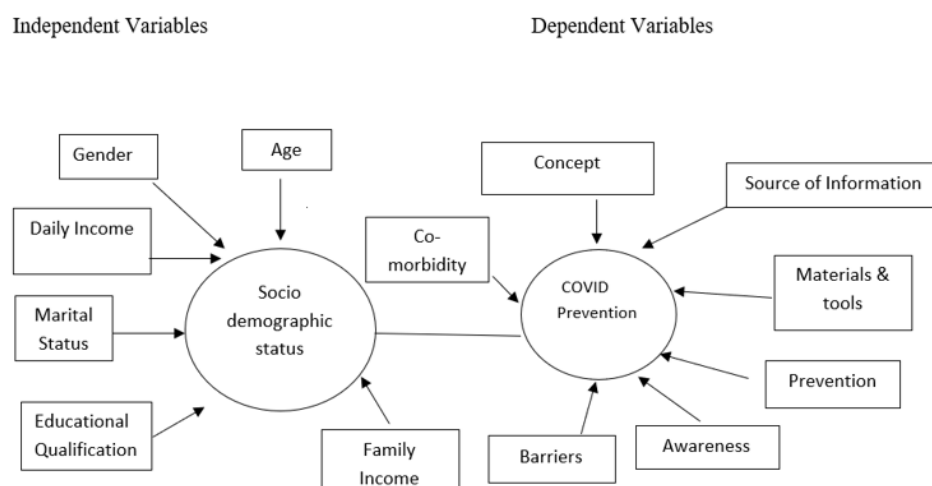
In Wuhan, China, the first SARS-CoV-2 illnesses were detected. The source of viral transmission to humans, as well as whether the virus became harmful before or after the spillover event, remained unexplained.

### Rickshaw Pullers

Rickshaw pullers are automated rickshaws, and pedal-powered cycle rickshaws, or pedicabs, are utilized for short-distance passenger transportation in many large and medium-sized cities. They go to work every day mostly to meet their families' daily subsistence needs. According to the Bangladesh Institute of Labor Studies (BILS) 2019 Survey, there are roughly 1.5 million rickshaw pullers in Dhaka.

### Awareness

The ability to directly know and perceive, feel, or be attentive to events is known as awareness. It is, more broadly, the state of being aware of something. Our discussion will be confined to COVID-19 in this study.



Picture 2: Variables of COVID-19 and Rickshaw Pullers Awareness

## Independent Variables

## Dependent Variables

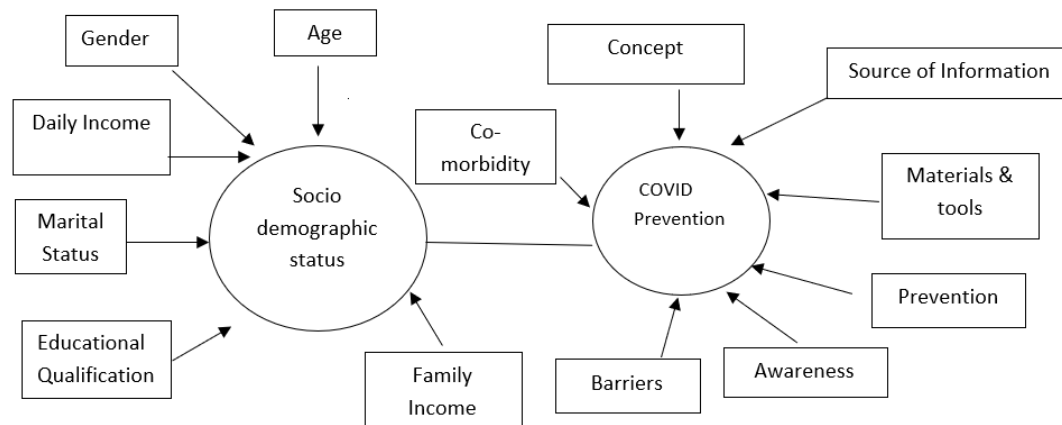


Table 1: Characteristics of Participants

| SL | Participa<br>nts | Age | Marital<br>Status | Educational<br>Qualificatio<br>ns | Reside<br>nce   | Income Per<br>Day Before<br>COVID-19<br>(BDT) | Income Per<br>Day After<br>COVID-<br>19 (BDT) | Type<br>Family | of |
|----|------------------|-----|-------------------|-----------------------------------|-----------------|-----------------------------------------------|-----------------------------------------------|----------------|----|
| 1  | A1               | 27  | Married           | SSC                               | Slum            | 1000                                          | 500                                           | Single         |    |
| 2  | A2               | 33  | Married           | Class-2                           | Slum            | 900                                           | 400                                           | Joint          |    |
| 3  | A3               | 27  | Married           | SSC                               | Slum            | 800                                           | 400                                           | Single         |    |
| 4  | A4               | 27  | Married           | SSC                               | Slum            | 1000                                          | 500                                           | Joint          |    |
| 5  | A5               | 38  | Married           | Class-5                           | Slum            | 1000                                          | 500                                           | Single         |    |
| 6  | A6               | 21  | Unmarried         | SSC                               | Rented<br>House | 900                                           | 500                                           | Single         |    |
| 7  | A7               | 35  | Married           | Class-2                           | Slum            | 850                                           | 400                                           | Single         |    |
| 8  | A8               | 38  | Married           | Illiterate                        | Rented<br>House | 850                                           | 400                                           | Joint          |    |
| 9  | A9               | 35  | Married           | Class-5                           | Rented<br>House | 900                                           | 500                                           | Joint          |    |
| 10 | A10              | 27  | Married           | Class-5                           | Slum            | 1000                                          | 500                                           | Single         |    |
| 11 | A11              | 28  | Married           | SSC                               | Slum            | 1000                                          | 400                                           | Single         |    |
| 12 | A12              | 40  | Married           | Class-2                           | Slum            | 1000                                          | 500                                           | Single         |    |
| 13 | A13              | 61  | Married           | Class-5                           | Rented<br>House | 900                                           | 400                                           | Joint          |    |
| 14 | A14              | 28  | Unmarried         | Class-5                           | Rented<br>House | 850                                           | 400                                           | Joint          |    |
| 15 | A15              | 25  | Married           | SSC                               | Slum            | 900                                           | 400                                           | Joint          |    |
| 16 | A16              | 36  | Married           | SSC                               | Slum            | 1000                                          | 500                                           | Single         |    |
| 17 | A17              | 27  | Married           | Class-5                           | Slum            | 800                                           | 400                                           | Single         |    |
| 18 | A18              | 35  | Married           | Class-5                           | Rented<br>House | 800                                           | 400                                           | Single         |    |
| 19 | A19              | 62  | Married           | Illiterate                        | Rented<br>House | 900                                           | 400                                           | Single         |    |

|    |     |    |           |            |              |      |     |        |
|----|-----|----|-----------|------------|--------------|------|-----|--------|
| 20 | A20 | 30 | Married   | Class-5    | Rented House | 1000 | 500 | Single |
| 21 | A21 | 28 | Unmarried | Class-5    | Slum         | 1000 | 500 | Joint  |
| 22 | A22 | 45 | Married   | Class-2    | Rented House | 900  | 400 | Joint  |
| 23 | A23 | 65 | Married   | Illiterate | Slum         | 800  | 400 | Joint  |
| 24 | A24 | 22 | Married   | SSC        | Rented House | 1000 | 500 | Joint  |
| 25 | A25 | 35 | Married   | Class-5    | Slum         | 1000 | 500 | Single |
| 26 | A26 | 40 | Married   | Class-2    | Rented House | 1000 | 500 | Single |
| 27 | A27 | 20 | Unmarried | SSC        | Slum         | 900  | 400 | Single |
| 28 | A28 | 56 | Married   | Illiterate | Rented House | 800  | 500 | Single |
| 29 | A29 | 35 | Married   | Class-2    | Slum         | 1000 | 400 | Single |
| 30 | A30 | 32 | Married   | Illiterate | Rented House | 1000 | 500 | Single |

Table 2: Participants' Knowledge about COVID-19 Symptoms

**Symptoms of COVID-19****# of respondents' awareness**

Fever

These are the most common symptoms, but 1/3<sup>rd</sup> of respondents are aware of this fact.

Dry cough

Tiredness

Body aches and pains

Sore throat

These are fewer common symptoms and 3/4<sup>th</sup> of the respondents never heard of these symptoms before. Their knowledge about the symptoms is less and they are informed of these through the mass education program initiated by the health department.

Diarrhoea

Conjunctivitis

Headache

Loss of taste &amp; smell

Rash on skin

Discoloration of fingers or toes

Breathing difficulty

These are serious symptoms of COVID-19 that only 6 of the respondents are aware of these

Chest pain

Loss of speech or movement

Table 3: Participants' Knowledge about Precautions of COVID-19

| <b>Impacts of COVID-19</b>                     | <b>Rickshaw puller's level of awareness</b>                                                                                                                                   |
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Wearing Mask                                   | 85% of the rickshaw puller do not wear a facemask when serving their passenger.<br>70% of them wear masks only when they see traffic police on the roadside.                  |
| Maintaining at least 1-meter physical distance | Maintaining physical distance outside for the rickshaw puller is almost impossible.<br>90% of the respondents do not aware of this physical distance as a protective measure. |
| Keep hands clean & cover cough and sneeze      | 98% of respondents do not use hand sanitizer and 82% of them do not do hand wash during their work. 37% of them use soap at home to clean their hand.                         |
| Open windows and doors for ventilation         | Ventilation facilities are not sufficient enough for 70% of respondents' residences and they have no idea about this as a precaution.                                         |
| Avoid crowd                                    | 86% of respondents do not know about the crowd to be avoided during this pandemic and they are unable to escape from the crowd due to the nature of the job.                  |
| Limit time in enclosed spaces                  | 91% of the respondents are not aware of this precaution and they often spend time in congested spaces like home.                                                              |