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What we see, what we endure: representation of physical diseases in Bangladeshi cinema

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Independent University, Bangladesh

**What We See, What We Endure: Representation of Physical Diseases in
Bangladeshi Cinema**

An undergraduate thesis submitted by

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for the partial fulfillment of the requirements for the degree of

BACHELOR OF SOCIAL SCIENCE

in

SOCIOLOGY

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What We See, What We Endure: Representation of Physical Diseases in Bangladeshi Cinema

by

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A Thesis submitted in conformity with the requirements for the

**Bachelor of Social Science in Sociology
School of Liberal Arts and Social Sciences
Independent University, Bangladesh**

Supervised by

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DECLARATION

It is hereby declared that:

1. The thesis submitted is my own original work while completing a degree at Independent University, Bangladesh. The thesis does not contain material previously published or written by a third party, except where this is appropriately cited through full and accurate referencing.
2. The thesis does not contain material which has been accepted, or submitted, for any other degree or diploma at a university or other institution.
3. I have acknowledged all main sources of help.

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Date: 27 September 2026

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The Author
Autumn 2026
Dhaka, Bangladesh

ABSTRACT

This thesis explores if representations of physical disease relate to real-world disease prevalence, or to the demands of storytelling, through some selected Bangladeshi films. It has found that cinematic representations of disease do not simply reflect medical reality. In fact, diseases are represented through stigma, secrecy, urgency, and moral conflict, and are also shaped by class, gender, and historical period.

While disability and mental illness have been the subject of significant research in Bangladeshi cinema, physical disease, however, has scope for further research. This study aims to contribute to this area by examining four aspects: disease burden and cinematic representation; urban and rural settings; gender differences in family and social responses to illness; and the role of affluence, social class, and religion in access to care, treatment, and survival.

The study uses qualitative, interpretive content and thematic analysis of eight purposively selected films, and paired across four disease categories: HIV/AIDS, cancer, COVID-19, and fever. Two films represent each category and were released in different years. Adapted from Domaradzki's (2022) coding framework, with the support of conceptual framework, this design allowed for a comparison across diseases, their settings, and diachronic comparison within each disease category.

The findings indicate that HIV/AIDS and COVID-19 receive significant attention due to their potential for stigma, drama, and social conflict, while major causes of death such as cardiovascular disease receive little attention in the selected sample. Urban, specialist-based healthcare appears more frequently than rural healthcare. Female patients are more likely to face social judgment than male patients, whose illness is more likely to bring families together around their role as providers. Affluence and social class emerge as key factors in access to care and survival, while religious identity carries little contribution across the sample. Overall, the findings indicate that the chosen Bangladeshi cinema represents physical disease across changing social, cultural, and historical contexts, thus not simply reflecting medical reality.

Keywords: Bangladeshi cinema; disease representation; stigma; illness narratives; structural violence; medical sociology; Dhallywood; gender and illness

ETHICAL STATEMENT

This thesis explores the representation of physical disease from a purposive sample of eight Bangladeshi films. It does not involve primary research with any participant.

No individuals were interviewed, surveyed, or observed by the researcher, and no identifiable information about the participants was gathered. The patients, doctors, and families mentioned in this thesis are fictional and dramatised characters in publicly released and commercially distributed films. The portrayal of these characters and their experiences is discussed in this thesis, but they are not presented as examples of actual clinical conditions.

Most of the films viewed as part of this research contain depictions of suffering, medical drama, and related themes. They are described and examined in detail for their sociological relevance and academic interest. This thesis aims to understand the representation of diseases in culture. Hence, it does not resort to describing or dramatising torments of patients. If any copyrighted material (dialogue, images, or descriptions of scenes) is used, it is quoted or mentioned only when required for the analysis and commentary. All films are cited by their directors and years of release.

This research follows all ethical guidelines of Independent University, Bangladesh, and was reviewed and has been approved accordingly.

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LIST OF ABBREVIATIONS

AIDS	— Acquired Immunodeficiency Syndrome
ARV	— Antiretroviral (therapy)
COVID-19	— Coronavirus Disease 2019
GBD	— Global Burden of Disease
HIV	— Human Immunodeficiency Virus

Chapter 1: Introduction

Anu: “Rokon, after death, where does a person go? What happens?”

Rokon: “[I] think, he comes as a bird.”



— *Matir Moyna* (2002), (Timestamp: 52:17-52:26)

This conversation between two children about death presents how individuals make sense of illness and death through everyday beliefs, family experiences, and ideas shared within their communities. While the excerpt from *Matir Moyna* has little to do with disease and suffering, it raises an important concern for this thesis: people develop their idea of disease through many ways besides doctors and hospitals: Through family, society, media, and popular culture.

Thus, cinema can be an important way of perceiving the world, and has a lot to convey about diseases and their cultural narratives. Prior to learning about diseases (such as cancer, HIV/AIDS, or viral infections) from educational institutions, people may encounter them through films in which these diseases are portrayed in a certain way. This portrayal uses stories, emotions, characters, images, and cultural ideas to convey ideas about a disease, its

effects, and its consequences. Hence, the ways in which film depicts a sick body, and the aspects it leaves out, can influence a person's perceptions on it.

The purpose of this thesis is to examine the ways in which Bangladeshi cinema chooses to show about physical disease, how these diseases are represented, and what remains less visible.

1.1 Background of the Study

Bangladesh is currently undergoing what public health researchers describe as an epidemiological transition. Infectious and communicable diseases, such as tuberculosis, dengue, and diarrhoeal illnesses, remain prevalent, and poverty, population density, and unequal access to sanitation and healthcare continue to contribute to these diseases. At the same time, non-communicable diseases such as stroke, cardiovascular disease, and cancer have seen a rise as life expectancy has increased and lifestyles have changed. The Global Burden of Disease Study describes this situation in Bangladesh as a “double burden” which impacts the population and healthcare system (GBD 2019 Bangladesh Burden of Disease Collaborators, 2023); a “double burden” is one where both communicable and non-communicable diseases exert pressure. Additionally, diseases are not spread evenly. A person's location, gender, class, and access to healthcare can affect how they experience and survive disease.

Cinema in Bangladesh, commonly known as Dhallywood, has represented diverse forms of sick characters in different ways. Disease sometimes appears as a background, or subplot, and sometimes is the central issue of a film. Some films use disease for sympathy or melodrama, while some build the story around the experience of diagnosis, treatment, suffering, and death.

The literature on Bangladeshi cinema obtained by this thesis has concentrated on disability (Dawn, 2014; Ferdous, 2024; Sayed, 2020) and mental illness (Pathak & Biswal, 2021; Karmakar et al., 2025; Arafat & Hossain, 2026). These studies provide important ways of understanding the representation of illness and the sick body on screen. This thesis builds on this work, in a different direction: examining physical diseases, including cancer, HIV/AIDS, COVID-19, and fever, in terms of their diagnosis, presentation, and treatment in Bangladeshi films.

Studying physical disease in this way is important for several reasons.

First, it is worth examining what diseases Bangladeshi cinema depicts and what it does not, as the prevalence of one disease over another, or a lack thereof, may indicate information about its selection and representation in the industry. Studies of other national cinemas have also found discrepancies between diseases that receive attention on screen and diseases that cause greater harm in real life (Perciaccante et al., 2019; Safran, 1998). This thesis explores whether a similar pattern can be found in Bangladeshi cinema.

Second, films can influence perceptions of doctors and healthcare institutions. They can present doctors as caring and competent, or as distant, dismissive, or unable to help. Trust in medical professionals is formed not only by experiences but also by cultural beliefs and social beliefs. Therefore, cinematic portrayals of the two are important parts of analysing disease.

Third, disease is not represented separately or in a socially neutral way. A wealthy individual in a Dhallywood film has a far different experience than a poor individual who has to rely on local informal treatment, and perhaps misdiagnosis. Gender can also play a role in the way someone expresses suffering, how they seek treatment, and how they control their healthcare. Similarly, whether a story occurs in Dhaka or in a village can dictate the healthcare options available to its characters. Class, gender, and geography therefore influence how disease is experienced and represented.

A growing body of literature has begun studying Bangladeshi cinema as a distinctly national industry worthy of study in its own right, rather than primarily as a part of the wider Bengali-language cinema of West Bengal. Ferdous (2024), for example, examines disability in Bangladeshi cinema, while Uddin (2023) examines gender. Karmakar et al. (2025) also call for comparative research between the two Bengali film industries. This thesis follows this direction by focusing specifically on Bangladeshi cinema and by shifting attention from disability and mental illness to physical, biomedical disease.

1.2 Statement of the Problem

Bangladeshi cinema's engagement with physical disease opens up several linked problems, each of which this thesis traces through the analysis. This thesis considers four major areas: disease visibility, setting, gender, and social position.

1.2.1 Disease Visibility and Framing

The first problem concerns which physical diseases are made visible in Bangladeshi cinema. It is worth noting whether the cinematic attention reflects the actual prevalence and burden of diseases in Bangladesh, how consistently particular diseases are represented, and commercial or promotional factors that may influence their visibility.

A preliminary glance at the selected films suggests that diseases such as cancer and COVID-19 receive considerable attention, while others, such as cardiovascular disease, are much less represented. Previous research, as examined by this thesis, has found a relationship between disease burden and cinematic representation, as well as issues such as causes, prevention, commercial performance, and promotional framing of disease on the screen. This thesis extends these questions to Bangladeshi cinema.

It therefore examines whether the frequency of diseases in the selected films reflects their real-world prevalence, why some diseases appear repeatedly while others receive little attention, whether commercial performance is related to the diseases chosen for the films, and how promotional materials such as film titles, posters, and trailers make disease visible or less visible compared with its importance within the story.

1.2.2 Setting

The second problem concerns setting. The social and geographical environment in which a film places its characters can affect the portrayal of disease and healthcare.

For example, an urban household might have better access to specialists and hospitals, while a rural household might have lesser healthcare options. The selected films show the differences between urban and rural settings, and this thesis looks into how the location relates to healthcare access, treatment, and experiences of illness and suffering.

1.2.3 Gender

The third problem concerns gender. Research into healthcare in Bangladesh has suggested that women can face greater barriers to healthcare access, disclosure, and decision-

making. Illness among women can also be connected with social judgment and stigma within the wider patriarchal structures.

This thesis examines whether Bangladeshi cinema reflects these social patterns. It considers how diseases affect male and female characters, how their symptoms and suffering are presented and represented, how families and society respond to them, and whether male and female characters are given similar levels of agency within the story.

1.2.4 Class, Affluence, and Religion

The fourth problem concerns affluence, class, and religion. Representation is determined not only by the disease itself but also by who experiences it.

This thesis examines how a character's socioeconomic position, class, and religious identity is connected to their access to doctors, hospitals, medication, and other forms of treatment.

Together, these four areas: Disease visibility and framing, setting, gender, and social position, comprise sections of analysis in this thesis.

1.3 Rationale of the Study

This study has both academic and social significance.

Academically, it builds upon the research on Bangladeshi cinema from disability and mental illness to physical disease. This allows us to examine whether patterns identified in previous studies also appear in the representation of physical disease. These patterns include using illness as a plot, connecting suffering with punishment or moral consequences, and giving different levels of agency to male and female characters. The study also considers whether physical disease is represented differently from disability and mental illness.

Socially, it is based on the hypothesis that cinema is one of the informal ways through which people encounter ideas about disease. It exists alongside formal health communication and other sources of information, such as newspapers and community knowledge. Research on health media and rural health beliefs in Bangladesh has suggested that people's understandings of illness are formed by poverty, work, social conditions, and community beliefs, and not by biomedical categories alone (Khasru et al., 2021; Jamil & Dutta, 2012).

Cinema's representation of setting, class, and access to healthcare are therefore important. Films may reflect these social realities, but they may also simplify them for narrative purposes.

Stigma is another reason for studying representation. Research in Bangladesh has documented stigma related to infectious diseases and mental illness (Miah et al., 2022; Shohel et al., 2022; Roy & Chowdhury, 2024). If films reproduce, exaggerate, or challenge such stigma, they contribute to wider cultural ideas about how sick people must be treated by families and communities. Studying these representations, therefore, contributes to broader discussions about disease-related stigma in Bangladesh.

Finally, this study is timely as its sample consists of films released between 2001 and 2024. This period includes significant changes in Bangladesh's disease burden and healthcare environment, as well as the COVID-19 pandemic, which changed the way illness had been discussed and represented around the world. Studying films from this period allows us to look into both older and more recent patterns of disease representation.

1.4 Research Questions

This thesis explores the main research question, through the five following sub-questions:

Main Research Question: How is physical disease represented in Bangladeshi cinema, and what does the presence, absence, and framing of different diseases tell us about how Bangladeshi cinema and culture understands the sick body?

Sub-Questions:

1. Which physical diseases are most commonly portrayed in Bangladeshi cinema, and to what extent is this representative of the actual disease burden and prevalence in Bangladesh, including how consistently the films engage with causes and prevention?
2. How does the representation of disease differ across urban and rural settings, particularly in terms of access to healthcare, treatment options, and the patient's experience of suffering?

3. How do families and society in films respond differently to female and male patients, in terms of care, stigma, and social judgment?
4. How does a character's socioeconomic class affect their access to doctors, hospitals, medication, and other forms of treatment?
5. How does the representation of disease, physician-patient relationships, and the patient's experience change over time?

1.5 Research Objectives

Each objective below is planned to gather evidence needed to answer the respective research question:

Objective-1: To classify the physical diseases represented within the selected Bangladeshi films, to explore their frequency and distribution within the sample, and to compare this to Bangladesh's disease burden, as well as the film's engagement with the causes and prevention.

Objective-2: To examine the demographic characteristics of patient and physician characters within selected films, interactions between them, treatment experiences of the patient, and differences in these representations across urban and rural settings,

Objective-3: To examine how physician-patient interactions and patients' experiences of diagnosis, treatment, and care differ according to a character's gender and socioeconomic class, including reactions to it from their family and society.

Objective-4: To examine whether the representation of disease, physician-patient relationships, and patient experience changes over time, by comparing the two films within each disease category across their release dates.

Together, these four objectives, and the five sub-questions they address, provide the insights needed to address the main research question: by combining what the sample shows about setting, gender, class, compared with disease prevalence and change over time. In this way, this thesis will explore how Bangladeshi cinema and culture understand the sick body as a whole.

1.6 Scope and Limitations

This thesis focuses on eight Bangladeshi films selected for their explicit representation of physical, biomedically defined diseases:

- *Meghla Akash* (2001)
- *Megher Koley Rod* (2008)
- *Matir Moyna* (2002)
- *Bad Son* (2005)
- *Corona Bole Kichu Nei* (2020)
- *Unoponchash Batash* (2020)
- *Rickshaw Girl* (2021)
- *Ahare Jibon* (2024)

It uses a qualitative and thematic approach, examining the films closely at the scene level to analyse how disease, patients, doctors, and treatment settings are represented.

Additionally, this study has a number of boundaries.

First, it focuses on physical, biomedical disease rather than disability or mental illness. Both disability and mental illness already have a developing body of research in the Bangladeshi context. When these categories overlap within a film, for example, when a physical illness is accompanied by paralysis, the analysis considers them in relation to the physical condition being studied.

Second, the sample was purposively selected for these films as these are relevant to the research questions. This selection allows for the detailed analysis of eight films, rather than a complete survey of disease representation throughout the history of Dhallywood. The findings therefore apply most directly to this selected sample.

Third, information about the commercial performance of some older or independently released films is limited. Where box-office data are available, the thesis uses these. Where reliable information is not publicly available, this thesis acknowledges this limitation. This also leaves room for future research on the relationship between commercial performance and disease representation.

Fourth, the study examines textual representation, meaning what is shown within the films. It does not look into how Bangladeshi audiences personally interpret or respond to these representations. Audience research is therefore an important area for future study.

Finally, the analysis involves interpretation of scenes, symptoms, and social contexts. To make this process consistent, the thesis uses a structured coding framework across all films, making the interpretive process clear and traceable.

1.7 Operational Definitions

The following terms are used throughout the thesis:

Disease, Illness, and Sickness. Medical anthropology distinguishes between disease, illness, and sickness (Nichter & van der Geest, 2025). Disease refers to the biomedical view of a health problem, from a doctor-centred view: a condition defined by abnormalities in the structure or function of the body's organs and systems, identified and named according to medical evidence and authority (Helman, 1981). Illness refers to the patient's own subjective experience of feeling unwell, including how the person and those around them interpret what is happening, how it affects behaviour and relationships, and how they respond to it (Helman, 1981). Sickness refers then to the social role and social recognition attached to being unwell, including how family members, communities, and institutions respond to someone who is identified as sick. Helman (1981, p. 548), drawing on Cassell (1976), summarises the difference between the first two terms directly: Disease is something an organ has, while illness is something a person has.

This thesis is concerned mainly with disease in this technical sense: how physical conditions are named, classified, diagnosed, and treated within the selected films. However, illness and sickness are also considered within this thesis, as a film cannot represent disease without also representing the people who suffer it and the society that responds to them.

Physical Disease. For this thesis, physical disease refers to biomedically defined conditions affecting the body that are diagnosed and treated by medical professionals through established clinical methods. Examples include cancer, HIV/AIDS, COVID-19, cardiovascular disease, paralysis, fever, and appendicitis. This definition is distinguished, following the World Health Organisation's classification of functioning, disability, and health

(WHO, 2001), from disability, which refers to a longer-term physical or sensory impairment, and mental illness, which refers mainly to conditions affecting cognition, mood, or behaviour. However, these categories can overlap within individual films.

Representation. refers to how a film uses narrative, dialogue, visual choices, and characterisation to create meaning around disease. It does not imply that a film is expected to provide a medically accurate or documentary account of disease. Following the constructionist approach to representation (Hall, 1997), representation is considered as a constructed, and selective process, influenced by genre convention, commercial factors, and cultural values, not as a neutral mirror of medical fact.

Dhallywood. refers to the mainstream Bangla-language commercial film industry based in Dhaka, Bangladesh (Hoek, 2014). In this thesis, the term is used interchangeably with “Bangladeshi cinema” to refer to the national film industry being studied.

Disease Burden. refers to the impact of a disease on a population, typically measured through indicators such as prevalence and mortality (Murray & Lopez, 1996).

Stigma. Stigma in this thesis refers to negative social attitudes and treatment directed at a person because of their illness. It is understood through the four-part classification, including, self-stigma, public stigma, professional stigma and institutional (or structural) stigma (Corrigan, Druss, & Perlick, 2014), a framework further adapted to the Bangladeshi context by Roy and Chowdhury (2024).

1.8 Researcher Positionality

No visual text, whether moving or still, has only one fixed meaning. Sarah Pink (2013), in her work on visual ethnography, argues that reflexivity is an important part of visual analysis. The researcher's position, experiences, and interpretive choices influence how visual material is understood. Therefore, visual analysis cannot be completely separated from the person conducting it.

In this study, the researcher's position as a Bangladeshi sociology student is relevant to the analysis because the films are part of their own cultural and linguistic environment. Familiarity with Bangla language, expressions, gestures, and common representations of patients and doctors in Bangladeshi cinema can influence how particular scenes are

understood. The researcher's own assumptions about illness, care, stigma, and medical treatment can also shape the interpretations. Acknowledging these influences does not eliminate them; instead, it makes the researcher position clear and allows the reader to consider how it may have influenced the analysis.

Pink's (2013) concept of multivocality further explains why visual material can have different meanings for different people. A filmmaker, character, audience member, and researcher may each understand the same scene in different ways. For example, a scene intended by the filmmaker to represent dignified suffering may be understood by one viewer as reinforcing stigma, while another viewer may see it as giving visibility to an illness that is rarely represented in cinema. Different readings can emerge from the same scene.

This is particularly relevant to the coding and interpretation used in this thesis. The analysis of disease, doctor, and patient representation is done, based on the researcher's reading of the selected films, according to the research questions and coding framework. Therefore, it is presented as one careful interpretation, not the only possible meaning of the scenes. As a beginner working with this film sample and coding framework for the first time, the interpretations are shaped by the researcher's social position, familiarity with the films and their cultural context, and the specific focus of this research. A researcher or viewer with a different background or research focus could interpret the same scenes differently.

To make the basis of the interpretations clear, the analysis first describes what appears on the screen as accurately as possible before explaining its meaning. This allows readers to see the evidence behind each interpretation and consider it for themselves. The interpretations in this thesis are therefore not claims of absolute meaning, but are interpretive judgments. In Pink's (2013) terms, they are one voice in conversation with the visual material.

With these terms and this researcher position established, the following chapters proceed to:

- Review literature on disability, mental illness, and disease representation in South Asian and Bengali cinema (Chapter 2)
- Explain the methodology used to select and analyse the film sample (Chapter 3)
- Present the findings organised around disease burden, causation, commercial performance, promotional framing, and the intersections of location, gender, class, and religion (Chapter 4)

- Discuss what these findings suggest about how the selected Bangladeshi cinema constructs the sick body (Chapter 5)
- Present the references followed throughout the thesis (Chapter 6)

Chapter 2: Literature Review & Conceptual Framework

2.1 Introduction

This chapter provides a review of existing research on illness, disability, and disease in cinema, and an overview of the concepts used to analyse the selected films. It has two main purposes. One is to demonstrate the place of this study in obtained research on illness, disability, and disease in cinema. The second is to provide an explanation of the ideas that guide the analysis of the films in Chapter 4.

Cinema is one way by which the public learns about disease beyond their personal experiences. Films do not merely present medical facts (Ferdous, 2024; Perciaccante et al., 2019). They select which diseases to show, how symptoms and suffering appear on screen, and the roles played by doctors, patients, and families. These selections are influenced not only by medical realities but also by culture, commercial interests, and social values. Thus, research on disease representation draws from a number of areas, including medical sociology, medical anthropology, disability studies, film studies, and health communication. This chapter synthesises this body of research, and focuses on the themes which are most relevant to this study.

The chapter is organised as follows. Section 2.2 provides a thematic review of the literature it studied. It first summarises research on whether the diseases depicted in films are similar to the diseases that cause the most harm in real life. It then reviews research on disability and mental illness in South Asian and Bengali cinema, followed by an overview of research on disease as a metaphor, including tuberculosis and HIV/AIDS, and of research on outbreak films and health information. Research on cancer pain and the representation of healthcare providers is then reviewed, ending in research on gender in Bangladeshi cinema and on the social and cultural factors related to stigma, healthcare access, and health communication in Bangladesh. Section 2.3 identifies the research gap that emerges from this literature. Section 2.4 presents the conceptual framework. It combines the distinction between disease, illness, and sickness with Hall's work on representation, encoding, and decoding, Fiske's account of popular culture and audience pleasure, Kleinman's explanatory models of illness, Frank's illness narratives, Goffman's concept of stigma, Farmer's concept of

structural violence, and Pink's approach to reflexivity in visual research. Section 2.5 provides a summary of the chapter.

Two main features of the collected literature shape this thesis. Firstly, much of the research on Bangladeshi and nearby Bengali cinema has been focused on disability and mental illness. Secondly, much of the research on specific diseases and disease outbreaks comes from outside Bangladesh. As a result, physical, biomedical disease in Bangladeshi cinema has received little study. This chapter provides the basis for addressing this gap by identifying the findings, categories, and concepts from earlier studies which can be applied to the analysis of the eight selected Bangladeshi films.

2.2 Literature Review

2.2.1 Disease Visibility and Real-World Disease Burden

A common finding in the literature is that the diseases most frequently depicted on screen are not always those which cause the greatest harm in real life. Perciaccante et al. (2019) reviewed all 554 films nominated for the Academy Award for Best Picture since 1929. They found medicine-related content in 105 films (18.9%), rising to 21.9% among films that actually won the award. Psychiatric disorders were the most prevalent category, appearing in 21.9% of films that featured medical content. They were followed by neurological diseases, alcohol addiction, and infectious diseases, each appearing in 13.3% of these films. In comparison, cancer and cardiac disease, which are two of the main causes of death in real life, appeared respectively in only 8.5% and 2.8% of the films respectively. The study also found that some disease representations followed historical disease patterns. For example, infectious disease stories were concentrated in films set during the 1930s and 1940s, whereas HIV/AIDS stories were more common in films set during the 1980s.

Safran (1998), reviewing several decades of quantitative research on disability representation in American cinema, found a similar pattern from a disability studies perspective. Psychiatric disabilities consistently took up the largest share of disability roles, ranging from 42% to 43.5% across different periods. They are followed by sensory impairments, drug addiction, and neuromuscular disorders. Blindness alone accounted for about 13% of all disability roles (Byrd & Elliott, 1988, as cited in Safran, 1998), which was

far greater than its actual prevalence in the general population. This pattern has been explained by its compatibility of psychiatric and sensory disabilities with genres such as suspense, horror, and melodrama (Byrd & Elliott, 1985; Fleming & Manvell, 1985, as cited in Safran, 1998).

This finding is relevant to this thesis's preliminary observation discovery that cancer and COVID-19 dominate the selected Bangladeshi film sample, while cardiovascular disease appears only once in *Saba* (2024). In combination with Perciaccante et al. (2019), these findings suggest that the difference between the real-world burden of disease and on-screen visibility found in Western cinema may also exist in Bangladeshi cinema. This thesis is therefore positioned to study this possibility directly in Dhallywood.

2.2.2 Disability Representation in South Asian Cinema

Research on disability in South Asian cinema is considerably more advanced for India than for Bangladesh. This literature provides a useful comparison for this study.

Dawn (2014) conducted a systematic review of 26 Hindi films from the 1960s to 2010 and six English-language films. The study traces a shift from films based largely on charity and sympathy, such as *Dosti* (1964), *Koshish* (1972), and *Sparsh* (1984), towards films which focused on specific conditions, including dyslexia in *Taare Zameen Par* (2007), autism in *My Name Is Khan* (2010), and progeria in *Paa* (2009). However, Dawn (2014) also finds that Hindi cinema tends to represent disabled characters into simple plot roles, such as the Curio, the Super Cripple, the Object of Ridicule, or the Burden. The *Golmaal* film series is given as an example of this trend.

Using the concept of the gaze by Foucault, and the objectifying stare by Sartre, as a "constituent power" that fixes a person's identity, Dawn (2014) describes this pattern as a "psychiatric gaze." Through this gaze, non-disabled society defines and stigmatizes disabled people. Dawn also identifies a gender difference in these representations. Disabled men are more likely to be portrayed in romantic roles, whereas disabled women are more likely to be desexualized, treated as children, or confined to caring roles rather than being portrayed as spouses or economically independent people. This finding is similar to the pattern later identified in Bangladeshi cinema by Ferdous (2024).

2.2.3 Disability Representation in Bangladeshi Cinema

Research specifically on Bangladeshi cinema is more recent. Ferdous (2024) offers one of the closest existing studies to this thesis. Using Roland Barthes' concept of myth, and the social model of disability, Ferdouse (2024) analyses three Bangladeshi films from different decades: *Shuva* (2006), *Ostitto* (2016), and *Raat Jaga Phool* (2021).

Ferdous (2024) finds that disability is repeatedly used as a plot device, a form of punishment, or means to achieve passive heroism and comic relief. Female disabled characters are particularly associated with dependency, pity, and shame within patriarchal family structures. The study also finds that treatment and recovery are often portrayed in romanticised, rather than realistic ways. Ferdous describes the study as an early detailed qualitative examination of disability representation in Bangladeshi cinema, and places it within the wider international literature on disability in Hollywood, Bollywood, Iranian, and Japanese cinema.

Sayed (2020), in a shorter non-peer-reviewed essay, comes to a similar conclusion but through a different approach. By applying Paul Hunt's classic classification of disability stereotypes, Sayed identifies three recurrent character types in recent Bangladeshi films. These are the Victim, represented by the disabled beggar-father in *GohineShobdo* (2010); the Superhero or "supercrip," represented by the blind vendor with unusually developed senses in *Alpha* (2019); and the Villain, represented by a psychotic antagonist in *Dhaka Attack* (2017), who directly links mental illness with criminality. Sayed argues that even the seemingly positive image of the "supercrip" is limiting, as it implies that a disabled person's worth is dependent on overcoming or compensating for disability instead of allowing disability to be only one part of a complete character.

2.2.4 Mental Illness in South Asian and Bengali Cinema

Mental illness has been the subject of considerable academic interest in South Asian cinema, with many studies identifying similar patterns.

Pathak and Biswal (2021) examine representations of mental illness in Hindi cinema across two periods, before and after what they call "media convergence." In the earlier period, people with mental illness are often portrayed as naive, violent, or destructive. Psychiatrists

are also frequently represented as uncaring and unscientific figures, described by the authors as "shamans in white aprons." Treatments such as electroconvulsive therapy and lobotomy are shown as forms of punishment rather than treatment, as seen in *Kyon Ki*.

In the later period, Pathak and Biswal identified a movement towards more empathetic and medically accurate portrayals in films such as *Taare Zameen Par*, *My Name Is Khan*, and *Dear Zindagi*. However, problems remain. For example, *Judgementall Hai Kya* contains an inaccurate diagnosis despite its more positive intentions. The authors also note that even newer and more sensitive representations mainly focus on urban and middle class patients, whereas rural and poorer individuals with mental illness appear far less frequently. This observation is relevant to this thesis's interest in the differences between urban and rural representations.

Karmakar et al. (2025) provide one of the studies most similar to this thesis in terms of method and scope. Their systematic review of mental health representation in Bengali-language cinema from 1950 to 2024 moves from the psychologically complex, but medically ambiguous representations of Satyajit Ray and Ritwik Ghatak, in films such as *Charulata*, *Meghe Dhaka Tara*, and *Devi*, to Rituparno Ghosh's more psychologically developed, but still undiagnosed stories in the 1990s. It then examines the more explicit depiction of dementia in *Mayurakshi*, gender dysphoria in *Nagarkirtan*, and psychological stress due to the pandemic in *Kalkokkho* and *Bed No. 3*.

Across this period, Karmakar et al. (2025) find that mental health professionals remain marginal, stereotyped, or absent as characters. The study also finds that mental illness is still sometimes linked with supernatural possession, even in recent films such as *Bhoot Chaturdashi* and *Debi*. The review is focused on Bengali cinema produced in West Bengal. But it also identifies a number of Bangladeshi films, including *Matir Moina* (2002), *Third Person Singular Number* (2009), *Television* (2012), *Shuva* (2006), *Ostitto* (2016), *Doob* (2017), *Debi* (2018), and *Raat Jaga Phool* (2021), which are discussed as important examples of changing representations. The authors specifically encourage future comparative research between the two Bengali film industries. This thesis follows that this direction, but shifts the focus from mental illness to physical disease.

2.2.5 Mental Health and Popular Media in Bangladesh

Arafat and Hossain (2026) provide another Bangladeshi example, although their study looks at television drama rather than cinema. Through qualitative content analysis of a popular Bangla drama which looks at psychological distress in a newly married woman, they identify five recurring narrative patterns:

1. Conflict between a new bride and her in-laws.
2. Stigmatisation of mental illness within the family.
3. The use of self-harm as a way to exert pressure in family conflict.
4. Family oppression leading to psychological distress.
5. Detailed and explicit media-style narration of the act itself.

The authors situate these findings within Bangladesh's wider social stigma around mental illness and suicide. They build on their earlier research on suicide representation in Bangladeshi news media, extending this discussion to entertainment media.

Although this thesis is focused on physical rather than mental disease, Arafat and Hossain (2026) are important methodologically. Their study is one of the clearest examples of structured content analysis applied to Bangladeshi popular narrative media in relation to health. Their five themes: Family conflict, stigma, the use of illness within relationships, family pressure, and the level of narrative detail, could also provide useful categories for examining psychosocial aspects of physical illness representation in films.

2.2.6 Disease as Metaphor: Tuberculosis and HIV/AIDS

Another group of studies explores ways in which diseases are used as symbols or metaphors rather than simply as medical conditions within a story.

Gupta (2021) investigates why Ritwik Ghatak chose tuberculosis as the illness affecting Nita, the protagonist of *Meghe Dhaka Tara* (1960). The study argues that tuberculosis is "semiotically proximate" to other meanings associated with Nita, including the idyllic, the mythic, and the idea of a lost and undivided Bengal. Using Sontag's *Illness as Metaphor*, Gupta traces the historical association of tuberculosis with sensitivity, repression, and romantic self-sacrifice. The study argues that Nita's journey to a sanitarium functions as a form of exile and reflects the trauma of Partition.

Avcı (2024) also explores tuberculosis from a different angle. The study analyses three mid-twentieth-century sanatorium films from Italy, Czechoslovakia, and Turkey: *Una Breve Vacanza*, *UčitelTance*, and *Kelebeğin Rüyası*. Avcı argues that tuberculosis has been attractive to filmmakers for three main reasons. First, its symptoms are visible without causing severe physical disfigurement, and fairly straightforward for actors to portray. Second, its historical association with youth, beauty, and tragic love supports romantic narratives. Third, the sanatorium offers a visually attractive environment that can resemble a peaceful or vacation-like environment.

Together, Gupta (2021) and Avcı (2024) suggest that the cinematic appeal of tuberculosis in both Bengali and European cinema, is at least partially due to its dual usefulness both as a medical condition and as an aesthetic and symbolic device. This is relevant to the present thesis, it explores whether tuberculosis or other serious physical diseases are selected for similar symbolic or aesthetic reasons in Bangladeshi cinema.

Zhang (2024) applies a similar approach to HIV/AIDS in Chinese cinema. The study examines Chinese AIDS films from 1988 to 2023 through the lens of conceptual metaphor theory and a Foucauldian power-knowledge framework. Zhang identifies three stages in the representation of people living with HIV. The first is an "abjection politics" phase, in which people with HIV are portrayed as dangerous or morally deviant. The second is a "compassionate politics" phase, in which they are shown as vulnerable people deserving of sympathy. The third is a "touching politics" phase, in which they are presented as inspirational heroes.

Zhang argues that these shifts reflect broader changes in China's modernisation and state power relations and are not mere artistic choices. This three-stage model is useful for comparison with the two HIV/AIDS films in the Bangladeshi sample, *Meghla Akash* (2001) and *Megher Koley Rod* (2008), both directed by Nargis Akter about a decade apart. It raises the question of whether Bangladeshi cinema has shifted from representations based on fear or moral judgment toward compassion, or whether HIV/AIDS is portrayed differently due to Bangladesh's own religious and social context.

2.2.7 Infectious Diseases, Outbreak Films, and Health Information

Another group of studies explore whether commercial films actually provide useful health information during outbreaks of infectious diseases. This is particularly relevant to the COVID-19 and fever-related films in this thesis.

Kendal (2021) applies Protection Motivation Theory to this issue. The theory suggests that people's behavior during an epidemic is influenced by their perception of the disease's seriousness, their perception of vulnerability, and their confidence in the effectiveness of protective measures. Popular media can influence these perceptions even when the information it provides is not scientifically accurate.

Kendal reviews 20 English-language films about viral outbreaks, released between 1995 and 2015, including *Outbreak*, *Contagion*, and *World War Z*. Epidemiologists or virologists appear as major characters in only four out of the 20 reviewed films. Kendal argues that this presents a missed opportunity since films could capitalise on their ability to educate audiences about the real response mechanisms of health professionals during outbreaks.

The study highlights repeated racial and gender-based scapegoating: The first person to die from infection is more often a woman or a member of an ethnic minority, and "patient zero" is frequently presented as belonging to a marginalised group. In *Contagion*, *Cabin Fever*, and *Planet Terror*, female sexuality is specifically blamed for the spread of disease.

Kendal (2021) also discusses a Bangladeshi example: During the Nipah virus outbreak in 2004, a lack of transparency around the disease led some families to believe that hospital workers were giving patients lethal injections. As a result, some families chose to avoid hospitals and refused treatment (Parveen et al., 2016, as cited in Kendal, 2021). This example directly relates to this thesis's interest in institutional trust and treatment-seeking behavior in Bangladeshi films.

Paul (2020) offers a regional comparison by analysing the Hollywood film *Contagion* (2011) and the Malayalam film *Virus* (2019), based on the real Nipah outbreak in Kerala in 2018. Paul finds that *Contagion* does include some accurate health information, including an

explanation of the reproduction number (R-naught) and fomite transmission; however, it contains an error regarding intranasal vaccine administration. Overall, the media is shown as an obstacle rather than a source of public understanding.

Virus addresses a real cultural and religious conflict between a Muslim family's wishes to bury their son according to religious customs and public health authorities' recommendations to cremate infectious remains. The film also accurately presents Nipah as a zoonotic disease and acknowledges its status as a WHO-priority disease.

Nevertheless, Paul concludes that both films provide only limited and sustained health information, and being made regionally and based on a real local outbreak is not, by itself, sufficient to ensure greater health awareness. This finding is relevant to the three COVID-19 films in the Bangladeshi sample, *Oxygen*, *Corona Bole Kichu Nei*, and *Ahare Jibon*, as it reflects the challenge of combining dramatic storytelling with accurate public health information.

2.2.8 Representation of a Specific Symptom: Cancer Pain

Most of the literature discussed above examines diseases as a whole. Mukhida et al. (2022) take a specific focus, investigating the portrayal of cancer pain and its treatment in Hollywood cinema.

The researchers initially considered 1,094 films and selected four that fit their inclusion criteria: *Wit*, *Terms of Endearment*, *Shadowlands*, and *The Barbarian Invasions*. They identify four major themes.

First, cancer patients are generally shown with genuine sympathy, especially in terms of how the pain affects their quality of life and relationships. Second, doctors are often shown as inattentive or emotionally distant towards patients' pain, whereas nurses are frequently depicted as caring advocates, although sometimes overworked. Third, pain treatment is seen to rely mainly on opioids, introduced only as a final option. Finally, hospitals are frequently shown as overcrowded or underresourced environments that make it harder to provide humane care.

Mukhida et al. (2022) argue that, although their sample size is small and the demographic makeup is fairly similar across the four films, this could be a useful teaching

tool for healthcare professionals seeking to understand the expectations of patient-centered pain care better. For the present thesis, this distinction between how doctors and nurses' responses offers a useful category for examining healthcare providers in the Bangladeshi films, particularly the cancer films *Unoponchash Batash*, and *Bad Son*.

2.2.9 Gender and the Representation of Disease

Gender is a theme that recurs throughout much of the literature reviewed here. The study most directly relevant to this thesis is Uddin's (2023) content analysis of 13 popular Dhallywood films covering the period from the 1970s to the 2010s.

Uddin (2023) argues that Bangladeshi cinema contributes to the normalisation of the subordination of women. Women are repeatedly portrayed as either as devi figures who are endlessly patient and goddess-like, or as greedy and harmful characters. They are frequently given secondary roles that revolve around male protagonists. Particularly in post-1990 films, women are also objectified through their clothing, dance, and camera framing.

Using Berger's perspective of "men act, women appear" and Nussbaum's theory of commodification, Uddin examines how dialogue, plot roles, and the amount of speech women are allowed work together to normalise patriarchal ideas. The study builds upon earlier research on gender in Bengali cinema, including *Viridi* (2003), *Sarkar* (2009), *Gooptu* (2011), and *Mukherjee* (2016), which looked at Indian Bengali cinema in West Bengal. Uddin positions the study as an early study of gender representation in Bangladeshi cinema specifically.

This approach is similar to the positioning of Ferdous (2024) on disability and this thesis on physical disease. Together, these studies suggest a growing recognition of the need to examine Bangladeshi cinema as a distinct national film industry, rather than an underdifferentiated extension of Bengali-language cinema.

Uddin's (2023) findings that women in Bangladeshi cinema have limited narrative agency raise the question, for this thesis, of whether female patients in female-centered illness narratives such as *Meghla Akash* and *Megher Koley Rod*, have a voice and agency in their own stories, or are primarily portrayed as objects of observation and suffering. The gender-related issue addressed by this thesis therefore builds partly upon Uddin's findings.

2.2.10 Sociocultural Context of Health Communication in Bangladesh

The final group of studies do not involve cinema at all. Instead, they provide information on stigma, healthcare access, and health communication in Bangladesh, and thus offer a real-world context for interpreting fictional representations of disease.

Khasru et al. (2021) conducted a pilot content analysis of 461 health-related newspaper articles published in three major Bangladeshi newspapers over a five-month period. They find that only 44% of the articles report positively on health services. 27.1% report malpractice or treatment errors, and 49.9% report questionable medical information. The questionable information mostly involved unregistered practitioners referred to as "doctors." The researchers also found that 78.3% of Bangladeshi health journalists have no formal training in health reporting.

These findings suggest that inaccurate health information and distrust of medical institutions are already present in Bangladesh's factual health media, rather solely in fictional cinema. This provides a useful context for interpreting similar patterns in the films discussed in this thesis.

Jamil and Dutta (2012) offer a more qualitative perspective. Using a culture-centered approach, they examine how a rural Bangladeshi community understands and discusses health, illness, and healing. They find that people's understanding of health cannot be separated from poverty, work, and social marginalisation. In other words, people do not understand illness only through the lens of biomedical categories.

This is directly relevant to the focus of this thesis on the representation of urban and rural areas. It offers a concrete basis for comparing whether the film sample presents disease differently depending on whether the story is located in an urban or rural setting.

Several other studies investigate the social stigma surrounding illness in Bangladesh. Miah et al. (2022) interviewed people in three Bangladeshi cities during the COVID-19 pandemic and found that stigma around symptoms, quarantine, and health services was responsible for some people choosing to hide their symptoms and avoid treatment. This can

contribute to increased disease transmission and is comparable to the institutional distrust discussed by Kendal (2021) in outbreak films.

Shohel et al. (2022) and Roy and Chowdhury (2024) also document continuing stigma towards people with mental illness in Bangladesh. Roy and Chowdhury (2024) develops a four-part classification of stigma: self-stigma, public stigma, professional stigma, and institutional stigma. Their classification is developed through interviews with patients, healthcare professionals, and members of the public.

These studies suggest that stigma is a well-documented and multi-layered social reality in Bangladesh, and so may reasonably be treated as an analytical category when it appears in physical disease narratives in the films discussed by this thesis.

2.3 Research Gap

Pulling the threads of this review together, three main observations stand out, and each one helps position the present thesis, from both within, and against, the existing literature.

First, the literature consistently shows that disease visibility on screen does not reliably reflect the actual disease burden. Perciaccante et al. (2019) demonstrate this clearly for Oscar-nominated cinema, and Safran (1998) demonstrates a structurally similar pattern for disability representation in American film. The preliminary review of the Bangladeshi film sample undertaken for this thesis suggests a comparable pattern: cancer and COVID-19 dominate the collected sample of Bangladeshi disease films, while cardiovascular disease, a genuine major cause of death in Bangladesh, appears in only a single film. This thesis is designed to examine this potential mismatch in a systematic way, rather than relying on a preliminary impression.

Second, a growing, but still relatively small, body of recent research, most notably on disability (Ferdous, 2024), gender, (Uddin, 2023), and mental health (Karmakar et al., 2025), has begun to treat Bangladeshi cinema as a distinct national film industry that deserves its own study, rather than as an undifferentiated extension of Bengali-language cinema made in West Bengal. This is a necessary corrective, since Bangladeshi and West Bengali cinema have developed under different political, economic, and religious conditions since 1947 and

especially since 1971, and collapsing these into a single analytical category risks obscuring the kind of locally specific patterns this thesis is interested in discovering. Karmakar et al. (2025) explicitly call for more comparative research between the two industries, and this thesis contributes to that call in a specific direction: It moves the object of study from mental illness, which has already received comparative attention, to physical, biomedical disease, which has not.

Finally, and most directly relevant to the empirical chapters that follow, studies focusing on specific diseases and on outbreak narratives, including Gupta (2021), Avci (2024), Zhang (2024), Kendal (2021), Paul (2020), and Mukhida et al. (2022), collectively offer a rich set of analytical tools: Disease as cultural metaphor, institutional trust and its collapse, gendered scapegoating, health information both accurate and inaccurate, and differentiated representation of physicians versus nurses. However, nearly all of these frameworks were developed entirely outside Bangladesh, using film samples drawn from Hollywood, China, Turkey, Italy, Czechoslovakia, and India. This thesis's core contribution is to apply these previously separate analytical tools to Bangladeshi commercial cinema, in a specifically and systematically way that explores the representation of physical illness, a subject on which, within the literature surveyed here, there is still no dedicated, sustained, empirical study.

Thus, the gap this thesis addresses, then, is not simply an absence of research on Bangladeshi cinema in general, since Ferdous (2024), Uddin (2023), and Karmakar et al. (2025) show that such research is beginning to emerge. However, it is the absence, specifically, of research that examines the broad and varied category of physical, biomedical disease, instead of disability or mental illness, using a structured, comparative, content-analytic method, within that emerging body of Bangladesh-specific film literature. This thesis positions itself as an initial, deliberately systematic attempt to address that specific gap.

2.4 Conceptual Framework

Addressing the research gap identified in Section 2.3 requires analytical concepts that are employable across all eight films. The studies reviewed above offer specific findings and categories, such as disease as a metaphor, trust in healthcare institutions, and the portrayal of doctors and nurses. The concepts discussed below provide the broader framework for interpreting and applying these categories across the selected films.

This is a conceptual thesis. That is, it draws on a set of theoretical concepts from medical sociology, medical anthropology, cultural studies, and visual research. These concepts act as analytical tools in the qualitative content analysis of the eight selected films. They help to describe what is shown on screen, and to explain why it may be shown that way. The concepts are introduced below, in the order in which they are used in the analysis, from the representation of disease as a whole, to the experiences of patients and families, to the social structures that shape illness, and finally to the position of the researcher.

Disease, Illness, and Sickness As An Orienting Distinction. The framework rests on the distinction between disease, illness, and sickness introduced in Chapter 1. Disease refers to the biomedical, doctor-centred view of a health problem, illness to the patient's own experience of feeling unwell, and sickness to the social role and recognition attached to being unwell (Helman, 1981). The thesis is primarily concerned with disease, meaning how physical conditions are named, classified, and managed from a medical point of view in the films. The concepts below mostly serve to explain the illness and sickness dimensions that inform this focus.

Representation, Encoding, and Decoding (Stuart Hall). Hall's work on representation (Hall, 1997) and on encoding and decoding (Hall, 1980) provides the starting point for treating films as constructed texts rather than records of medical fact. Media texts "encode" meaning through production choices such as casting, framing, dialogue, and the selection of subject matter. Audiences then "decode" these meanings, and they do not always do so in the way the producers intended. Hall also draws attention to how repeated representational choices accumulate over time into stereotypes. In this thesis, the concept guides the analysis of which diseases are chosen, how patients and doctors are characterised, and how the films present disease in their titles, posters, and other promotional material. It also supports the comparison between the two films in each disease category, since changes across release dates may reveal patterns that accumulate or shift over time.

Popular Culture and Audience Pleasure (John Fiske). Fiske's work (Fiske, 1989, 2010) explains popularity through audience pleasure and relevance, not informational value: audiences actively find meaning and pleasure in texts that feel relevant to their own lives, rather than simply absorbing what producers intend. This helps interpret why films might prefer symptoms, suffering, and emotional drama over causes and prevention, and why

commercial success may reward emotionally relevant disease stories over medically instructive ones.

Explanatory Models of Illness (Arthur Kleinman). Kleinman (1980) argues that patients, families, and healers each hold their own explanatory model of what an illness is, why it occurred, and how it is to be treated. These models often conflict with biomedical explanations. In the film analysis, the concept is used to read how characters explain a disease to each other. It helps in examining scenes where doctors give an opinion and where patients and families respond to it, including cases where blame, religious belief, or non-biomedical treatment such as homeopathy is presented as an alternative to a medical account. It is particularly relevant to the scene types concerned with the doctor's opinion and the patient's response, and to the analysis of urban and rural representation.

Illness Narratives (Arthur Frank). Frank (1995/2013) identifies three broad ways in which people narrate sickness. In the restitution narrative, a person is sick, receives treatment, and becomes well again. In the chaos narrative, illness is formless, meaningless suffering with no resolution. In the quest narrative, illness becomes a transformative journey from which meaning is gained. Although Frank's typology was developed for the stories people tell about their own illness, it is used here as a lens for reading the overall shape of a patient's storyline in a film. It is applied to the scene types that follow the patient's condition from the first symptoms through progression to survival or death, and it helps to show whether films tend to promise recovery, present suffering without resolution, or give illness a redemptive meaning.

Stigma (Erving Goffman). Goffman's (1963) framework distinguishes between visible, discrediting marks of difference and those that can be concealed, and it describes how individuals and the people around them manage a "spoiled identity" in social interaction. This concept guides the analysis of psychosocial issues such as stigmatisation, isolation, and discrimination. It is particularly useful for diseases whose symptoms may be hidden or revealed, and examining how families and communities react once a patient's condition is known. It also ties to the gender-based analysis, since it allows the thesis to ask whether male and female patients are treated differently once they are marked as sick.

Structural violence (Paul Farmer). Farmer's concept of structural violence describes how social structures such as poverty, unequal access to healthcare, and political and economic

systems cause harm indirectly, through everyday conditions that make illness, suffering, and death more likely for some groups than for others (Farmer, 2004). In Farmer's framing, when a poor person dies of a treatable disease because they cannot afford care, the death is not simply bad luck or an individual failure. It is the result of an unequal system working as it is structured to work. In this thesis, the concept is used to analyse how class, location, and cost shape access to doctors, hospitals, and medicine, and to interpret films in which treatment is delayed, unaffordable, or unavailable.

Reflexivity and the Multivocality Of Images. The final two concepts concern how the films themselves are read. Reflexivity holds that the researcher's presence, standpoint, and interpretive choices actively shape what an image or visual text is taken to mean (Pink, 2013). There is no neutral reading of visual material, so the analyst's position must be accounted for as part of the analysis. This is addressed through the researcher positionality section in Chapter 1 and the reflexive discussion in Chapter 3.

The multivocality of images adds that a single image or scene can carry multiple and sometimes contradictory meanings, depending on whether it is seen by the filmmaker, the character, the audience, or the researcher (Pink, 2013). Visual material should therefore not be treated as having one fixed or correct interpretation. Together, these concepts mean that the findings of this thesis are presented as one possible reading of the films. Other viewers, including filmmakers and Bangladeshi audiences, may understand the same scenes differently.

2.5 Chapter Summary

This chapter reviewed existing research on the representation of illness, disability, and disease in cinema, and introduced the theoretical concepts that guide the analysis of the eight selected films.

The literature review was organised thematically. Research on Western cinema repeatedly demonstrates that the diseases shown on screen are rarely those that have the greatest harm on real-world public health. Films appear to select diseases and illnesses that offer the most scope for dramatic, visual, or symbolic storytelling. Research on South Asian and Bengali cinema has focused predominantly on disability and mental illness. A number of recurring issues were identified by this body of literature: Stereotypical portrayals of disabled

people; absence of mental health professionals or their restriction to a marginal role; and gender tropes of dependency and pity.

Studies of particular diseases and outbreaks (tuberculosis, HIV/AIDS, and viral outbreaks), show that cinematic portrayals draw on disease as cultural metaphor, and can present both accurate and misleading representations of health information simultaneously. The blame for disease is sometimes shifted onto women and other socially marginalised groups. Research on the representation of cancer pain shows differing tropes regarding the role doctors and nurses are portrayed. Research into gendered representations of illness in Bangladeshi cinema raises questions around the agency and voice of female patients. And the findings in health-related media and communication in Bangladesh reveal themes of stigma, mistrust of medical institutions, and alternative beliefs about illness that exist outside biomedical medicine.

Taken together, this body of literature shows the research gap that this thesis seeks to fill. Although research on Bangladeshi cinema is growing, and particular diseases and outbreaks have been studied within other national cinemas. However, the representation of physical and biomedical diseases in Bangladeshi cinema offers another important area for further study. This thesis contributes to this through a structured and comparative content analysis of eight Bangladeshi films.

The conceptual framework provides the tools for this analysis. It begins with the differentiation between disease, illness, and sickness, with a focus on the former two. Stuart Hall's work on representation and encoding/decoding helps explain how films construct meaning and how they can be understood as texts. John Fiske's work on popular culture offers an explanation for cross-cultural similarities in the kinds of diseases and tropes that are presented.

Arthur Kleinman's concept of explanatory models helps analyse illness narratives, how a patient's illness story develops throughout a film. Erving Goffman's concept of stigma helps analyse how patients are treated and judged because of their illness. Paul Farmer's concept of structural violence highlights the ways in which social and economic conditions, including class, location, and treatment costs, can restrict access to healthcare.

Finally, the concepts of reflexivity and the multivocality of the images in cinematic texts ensure that this thesis does not claim to offer a singular correct reading of the films. The

researcher's own gaze is acknowledged as a factor that influences how scenes or characters are understood here.

The literature review and conceptual framework provide the categories and questions that will guide the analysis that forms the basis of this thesis's contribution. The next chapter discusses the research methods used to apply these concepts discussed.

Chapter 3: Research Methodology

3.1 Introduction

This chapter explains the methods and procedures adopted to study the representations of physical, biomedical disease in Bangladeshi cinema. It describes the rationale in selecting this research approach and research design, the strategies for selecting the eight films in this thesis for analysis, the procedures for collecting and recording data from the films, and the processes for analysing and interpreting this data. The chapter also discusses the ethical issues associated with this study and the limitations of the methods adopted for readers to take into account in evaluating the results.

As described in Chapter 1, this thesis focuses primarily on disease as a biomedical category. This means that this study looks at representations of naming, classifying, diagnosing, and treating physical conditions found in the selected films. At the same time, it uses related concepts of illness and sickness (Helman, 1981; Nichter & van der Geest, 2025). These concepts allow exploring the ways in which patients experience and express suffering and the ways in which families and communities respond to disease. As such, the methodology adopted considers all three dimensions as they appear on screen, with the movie as the main unit of analysis, rather than the audiences and industries involved.

3.2 Research Approach

This study primarily uses a qualitative research approach. A qualitative one is suitable given that this study is mainly concerned with meaning and representation rather than measurement. Films communicate ideas about disease, treatment, and the sick body through their narratives, dialogue, cinematography, casting choices, and tone. Hence, these all require an examination and interpretation rather than simply measurement. While quantitative content analysis can indicate how often a disease or symptom appears, it cannot itself explain what that disease represents within the story and cultural context of the film.

However, this thesis also incorporates quantitative description, from the coding framework adopted from Domaradzki's (2022), to give the qualitative work a numerical presentation. Here, basic frequency counts as a descriptive basis. For example, it counts how many films depict a particular symptom or how many patients in the sample receive hospital-

based care. These support the wider qualitative and concept-based analysis. For the coding template, this thesis follows the design used by Domaradzki (2022) in his study of rare disease representation in popular cinema (see Section 3.5). The frequency data answers the question, “What is shown and how often?” while the qualitative and concept-based analysis then asks, “What does this representation mean, and for whom?”

The approach is also interpretive and reflexive. Pink (2013) argues that there is no completely neutral way to read or interpret visual material. A researcher’s own position and interpretive choices influence how a scene or image is understood. Therefore, the position of the researcher, as a beginner, is part of the analytical process. This has direct importance for the analysis presented in Chapter 4.

3.3 Research Design

The research utilises qualitative content and thematic analysis of narrative feature films. In this study, a film is considered a cultural text, a constructed cultural product, which may be systematically ‘read’ to decode the meanings it presents regarding disease, medicine, and the body. This approach is related to Hall’s (1980) encoding/decoding model.

The study is also conceptual in nature. It does not seek to generate or test one entirely new theory. Instead, the existing concepts from medical anthropology, sociology, and film theory are employed, including Kleinman’s explanatory models, Frank’s illness narratives, Goffman’s concept of stigma, Hall’s encoding/decoding framework, and Farmer’s concept of structural violence.

The application of these concepts to the chosen Bangladeshi films in order to explain and understand content is, therefore, the main contribution of this thesis to the fields, to Bangladeshi cinema and its representation of physical disease.

The research design has a two-step process of analysis, which accounts for the distinction between manifest and latent content in qualitative content analysis.

1. Descriptive content analysis: The first step identifies and records clear and observable features of each film. These include:

- the disease shown;

- the symptoms shown;
- the treatment approach;
- the demographic characteristics of patients and physicians;
- the healthcare setting;
- the outcome, including survival or death; and
- where relevant, the type and location of death.

This stage, then, produces the six coding tables (Tables 1-6), utilised in Chapter 4, which are adapted from Domaradzki's (2022) coding framework for the study of rare disease in film.

2. Thematic analysis

The second step interprets the scenes identified in the first step, using the conceptual framework presented in Chapter 2. The purpose is to understand how disease is constructed through the story, images, and symbols of the films. This includes examining illness narratives through Frank (1995/2013), explanations of disease and illness articulated by characters through Kleinman (1980), and the use of stigma through Goffman (1963).

The thesis also follows a comparative design, where the eight films are not treated as a single group. Instead, they are divided into four categories of disease: HIV/AIDS, COVID-19, cancer, and fever. Each category contains two films respectively, which were released in different years. For example, *Meghla Akash* (2001) and its sequel *Megher Koley Rod* (2008) are both concerned with HIV/AIDS. Similarly, *Corona Bole Kichu Nei* (2020) and *Ahare Jibon* (2024) are both concerned with COVID-19, being released four years apart.

This pairing allows this thesis to examine the representation of the same disease at different points in time and to explore whether representation changes over the years. This directly relates to Objective 5 in Chapter 1: Examines whether disease representation, physician-patient relationships, and patient experiences change over time within each disease category.

The main unit of analysis is the individual scenes depicting disease, illness, or any related medical encounter. By focusing on individual scenes, the research can go beyond a

general statement of how a film represents a disease. For instance, instead of making only a general statement about how a film represents cancer, the analysis can examine how the diagnosis scene is presented differently to a scene showing the patient's final stage of disease, or how a doctor's behaviour changes depending on the healthcare settings, such as a private clinic and a public hospital ward within the same film.

3.4 Sampling Technique

This study uses purposive (criterion-based) sampling, a non-probability sampling method in which films are selected deliberately on the basis of what they offer in terms of information for the research questions, not randomly for statistical representation. Below is a list of the movies this thesis was able to collect, which had physical disease as main plots:

Table 3.1: List of Collected Movies (13 Movies)

SL	Movie Title	Type of Disease	Year	Genre	Country	Director	Box office
1	Meghla Akash	HIV/AIDS	2001	Family, Drama	Bangladesh	Nargis Akter	Moderate-to-commercial box office success
2	Megher Koley Rod	(No one was sick but topic was on HIV/AIDS)	2008	Family, Drama	Bangladesh	Nargis Akter	Unpublished
3	Oxygen	COVID-19	2020	Drama / Thespian Short Film	Bangladesh	Raihan Rafi	No data because it was published on YouTube
4	Corona Bole Kichu Nei	COVID-19	2020	Drama Short Film	Bangladesh	Shihab Shaheen	No data because it was published on YouTube
5	Bad Son	Cancer	2005	Action,	Bangladesh	Monowar	Unpublished

				Family Melodrama, and Romance	hi	Khokon	ed
6	Saba	Heart disease + paralysis	2024	Drama	Bangladeshi	Maksud Hossain	Unpublished
7	Opekkha	Cancer	2018	Drama	Bangladeshi	Partho Paulinews Folia	No data because it was published independently
8	Ahare Jibon	COVID-19	2024	Drama	Bangladeshi	Chotku Ahmed	Unpublished
9	Unoponchash Batash	Cancer	2020	Romantic Drama	Bangladeshi	Masud Hasan Ujjal	Worldwide box office: \$8,368 (approx.)
10	Alatchakra	Cancer	2021	Bengali war-drama	Bangladeshi	Habibur Rahman	No data
11	Rickshaw Girl	Fever	2021	Family Drama	USA-Bangladeshi joint venture	Amitabh Reza Chowdhury	\$1,973 USD worldwide (approx.)
12	Matir Moyna	Fever	2002	Bengali war-drama	Bangladeshi	Tareque Masud	US\$46,852 to US\$48,752 worldwide (approx.)
13	Shikari	Appendicitis	2001	Action, drama, and romance	Bangladeshi	M.N. Ispahani and Arif Jahan	Unpublished

Table 3.2: The Sampling Procedure

Stage	Number of Films	Reason for Exclusion
Initial Identification	30	–
Preliminary screening	20	Disease is not central to the plot film / Not a physical biomedical disease
Full viewing	13	After full watch, found movies that did not meet initial criteria
Final sample	8	Following final criteria

Initial identification of the sampling frame. An initial search for Bangladeshi films representing physical disease was conducted using Google and IMDb. From this search, 30 possible films were collected. Each film was then independently assessed, and after reviewing plot summaries on IMDb and Wikipedia, the list was reduced to 20 films. Only those films that dealt substantially with a physical, biomedical disease were retained.

The 20 films were then reduced to 13 through complete viewing of each film, by confirming that the disease played an important role in their narratives, for detailed content coding.

These 13 films belonged to six categories of disease:

- HIV/AIDS - 2 films
- COVID-19 - 3 films
- Cancer - 4 films
- Fever - 2 films
- Heart disease - 1 film
- Appendicitis - 1 film

In addition to full-length feature films, several Bangladeshi short films made specifically in response to the COVID-19 pandemic were included.

Inclusion criteria. Eight films were finally selected from the group of 13 for full analysis using the following criteria:

- The film must be a Bangladeshi production, and in case of joint production, the director of the film has to be Bangladeshi. This follows the aim of the thesis to treat Bangladeshi cinema as a distinct national film tradition, following Ferdous (2024), Uddin (2023), and Karmakar et al. (2025).
- The film must present a physical, biomedical disease as an important component of the story, not as an incidental or minor plot element. Films mainly focused on psychiatric or intellectual disability were outside the scope of this thesis, as discussed in Chapter 2.
- In the sample, the disease must be represented in at least one other film, with the two films released in different years. This allows the opportunity for diachronic comparison, therefore achieving Objective 5.
- The films must be available online for repeat viewing.

Exclusion. Five films from the group of 13 were excluded from the final analysis. It occurred when they did not have a suitable paired film within the same disease category in the sample, making the scope of diachronic comparison impossible. Therefore, films which involved heart disease and paralysis in one case, and appendicitis in another. And the final four-category structure was finally obtained: HIV/AIDS, COVID-19, cancer, and fever.

The exclusion of these films is acknowledged as a methodological limitation; it does not indicate that these diseases are any less socially important.

Final sample. The final sample consists of eight films, arranged in four pairs of disease-category:

Table 3.3: Final Sample of Films by Disease Category

Disease Category	Earlier Film	Later Film
HIV/AIDS	<i>Meghla Akash</i> (2001)	<i>Megher Koley Rod</i> (2008)
Fever	<i>Matir Moyna</i> (2002)	<i>Rickshaw Girl</i> (2021)
Cancer	<i>Bad Son</i> (2005)	<i>Unoponchash Batash</i> (2020)
COVID-19	<i>Corona Bole Kichu Nei</i> (2020)	<i>Ahare Jibon</i> (2024)

This sample size is suitable for qualitative textual analysis. In this type of research, detailed in-depth analysis of each case is more important than analysing a very large number of films. However, the small and purposefully selected sample also limits how far the findings can be generalised. This issue is discussed directly in Section 3.8.

3.5 Data Collection Methods

The data is collected through repeated, close viewing of each film, supported by a structured method of taking scene-level notes, where the film itself is the main source of data rather than survey participants or interview respondents.

Viewing Procedure: Every film in the final sample was watched in full at least twice. The first viewing was used to understand the complete story, the overall narrative, and the role of disease in the film. The second viewing was more detailed. Every scene involving disease, illness, symptoms, diagnosis, treatment, and the psychosocial effects of illness was identified and recorded. When a scene was unclear or contained important symbolic meaning, it was watched a few more times.

Scene Identification and Transcription: Each identified scene was recorded with its exact timestamp. For example: “00:39:49-00:41:23”. A detailed description of what happened in each scene was also noted down. This included:

- who was present;
- what was said;
- how the disease or symptom was shown;
- how the characters reacted; and
- what happened during the medical encounter.

Most of the films are in Bangla. Therefore, the important lines of dialogue from Bangla to English were translated in a way that preserves as much meaning as possible that might be otherwise lost through translation. For example, the exact words a doctor uses to give a diagnosis may be important information. Similarly, the specific language used by family members to express blame, denial, or support can carry important social meaning.

This process resulted in a scene-by-scene qualitative log for each film. This log became the main raw data used for creating the coding tables and conducting the thematic analysis in Chapter 4.

Coding Instrument. After creating the scene-level logs, each film was coded using a structured coding instrument. This instrument was adapted from the six-table framework developed by Domaradzki (2022) for studying rare disease representation in popular cinema.

The instrument records the following information:

Table 3.1: Film Characteristics: This table records: Film title; disease type; year of release; genre; country of production; director; and box office performance, where data was available.

Several Bangladeshi films, especially short films independently released on YouTube, do not have published box office figures.

Table 4.1: Disease Characteristics: This table records: Whether the disease is named on screen; whether the disease is described; whether its cause or etiology is explained; symptoms shown; treatment approach; and; whether medication is shown being taken.

Table 4.2: Physician Characteristics: This table records: Sex of the physician; age; ethnicity as represented; professional position; place of work; and; attitude toward the patient.

Table 4.3: Patient Characteristics: This table records: Sex of the patient; age category; religious or ethnic identity as represented on screen; type of care received; prognosis; survival or death; type and location of death where relevant; emotional and psychological response to diagnosis; practical and systemic obstacles faced by the patient; and; family reaction to the diagnosis.

Table 4.4: Setting and Healthcare Access: This table records: Whether the film is set in an urban or rural context; the type of healthcare facility shown; the type of physician available, such as general physician, specialist, or no physician; and; whether travel to receive healthcare is shown.

Table 4.5: Psychosocial Issues: This table records whether the film shows: Stigmatisation; isolation or social exclusion; discrimination; and; reduced life opportunities connected to illness.

The coding instrument had two main purposes.

First, it ensured that the research remained focused on the research goals and collected the same kind of information from every film. This made structured comparison possible across the eight films and the four disease-category pairs.

Second, every coded entry in the tables can be connected to a specific timestamped scene in the qualitative log. This means that the numerical counts in Chapter 4 are not separate from the qualitative analysis. Each count can be linked back to the particular scenes that produced them.

The coding instrument therefore connects the descriptive analysis with the interpretive and thematic analysis discussed in Section 3.6.

Supplementary Sources. In addition to the main data collected from the films, a limited amount of secondary information was collected to support parts of the analysis. This included box office figures, where publicly available, to analyse commercial performance in Chapter 4, and promotional posters for each film, which were examined to analyse promotional materials in Chapter 4.

Secondary sources were not collected systematically beyond these two categories. For example, director filmographies, trailers, press coverage, and other promotional or related materials were not collected or analysed. This limited use of secondary data is recognised as a limitation of the study and is discussed in Section 3.8.

3.6 Data Analysis Procedure

This thesis uses two related methods of analysis across three sequential stages: Qualitative content analysis and thematic analysis. Content analysis, as discussed by Krippendorff (2004), can be applied at both qualitative and quantitative levels.

Qualitative content analysis examines what is shown by systematically identifying and classifying the manifest, or directly visible, content of scenes. This process produced the coding categories in Tables 1-6 and follows Hsieh and Shannon's (2005) conventional approach, where categories are derived from the data rather than imposed by pre-existing theory. A quantitative descriptive level within this process provides simple frequency counts

of the coded categories, such as how often a symptom appears or how many patients receive hospital-based care.

Thematic analysis, following Braun and Clarke's (2006) six-phase model, examines what the findings mean, by interpreting latent content, patterns, and recurring themes through the conceptual framework introduced in Chapter 2, including Kleinman, Frank, Goffman, Hall, and Farmer.

The two methods are integrated across the three stages, with each stage building on the coded findings of the previous one. The analysis progresses from description, to comparison, and finally to interpretation.

Stage 1: Within-Film Description (Qualitative Content Analysis, with Quantitative Description). For each film, the coded information from Tables 1-6 was brought together to create a descriptive profile. This involved qualitative content analysis, where the manifest content of each scene was placed into coding categories such as disease, symptoms, treatment, setting, outcome, and so on, following Hsieh and Shannon's (2005) approach to manifest-content coding. The analysis also involved counting how often each category appeared within each film. Together, these processes produced a profile that answered questions such as: What disease is shown? What symptoms appear? What treatments are shown? Who are the patients and physicians? What happens to them?

At this stage, the analysis remains focused on manifest content, meaning what is directly shown on screen.

Stage 2: Cross-Case and Diachronic Comparison (Qualitative Content Analysis). Next, the descriptive profiles produced in Stage 1 were compared across the sample. This extended the same qualitative content analysis from individual films to the full set of films. The comparison was carried out in two ways:

Cross-disease comparison: This examined differences between the HIV/AIDS, COVID-19, cancer, and fever categories. For example, it considered whether some diseases were more strongly associated with stigma and isolation in Table 4.5 than others, or whether some diseases received more explanation of their causes and treatments in Table 4.1.

Within-category, diachronic comparison: This compared the two films within each disease category to examine whether representation changed between the earlier and later films. For example, it examined whether *Ahare Jibon* (2024) represents stigma, medical authority, or family reactions differently from *Corona Bole Kichu Nei* (2020).

The frequency information in Tables 1-6 provides evidence for both types of comparison. At this stage, the analysis remains focused on identifying and classifying patterns and differences in the manifest content across the films. It does not yet interpret why these patterns exist. That interpretive step is carried out in Stage 3.

Stage 3: Thematic and Conceptual Interpretation (Thematic Analysis). The final stage moves from manifest content to latent content, or the deeper meanings within the material. Following Braun and Clarke (2006), the coded findings from Stages 1 and 2 were interpreted using the theoretical concepts introduced in Chapter 2. This stage examines why the identified patterns appear and what they suggest about how Bangladeshi cinema constructs and presents the sick body. It produced the main thematic arguments presented in Chapter 4.

Therefore, the three stages move from qualitative content analysis of manifest content, supported by quantitative description in Stages 1 and 2, to thematic analysis of latent content in Stage 3. This sequence ensures that the interpretive claims made in Chapter 4 can be traced back to specific, coded, and countable evidence in Tables 1-6, rather than relying on interpretation alone.

3.7 Ethical Considerations

This study analyses publicly released and commercially distributed feature films and short films. It does not collect information directly from human research participants.

Therefore, the study does not involve the usual ethical risks associated with primary research involving human subjects. Interviews, surveys, or observations of living people were not conducted. Hence, personal or identifying information about real individuals were also not collected.

The “patients,” “doctors,” and “family members” discussed in this thesis are fictional or dramatised characters. The analysis therefore focuses on their representation in the films, and does not treat them as real medical patients or clinical cases.

However, several ethical issues were still considered during the research.

- **Use of Copyrighted Material.** The films analysed in this study are copyrighted creative works. Any dialogue, images, or extended descriptions included in the thesis are limited to what is required for academic analysis and commentary. This follows the principles of fair use/fair dealing in academic research. Each film is also properly attributed to its director and year of release.
- **Sensitivity When Discussing Suffering and Death.** Several films contain scenes of severe disease, medical crisis, and death. These include deaths connected to COVID-19 and cancer. These scenes are analysed and described for their sociological and analytical importance, to understand cultural representation, neither for dramatic or sensational effect, nor to reproduce or cause distress.
- **Institutional Approval.** This research was conducted in accordance with the ethical review requirements of the researcher's home institution, Independent University, Bangladesh. The ethical statement is provided at the front of the thesis.

3.8 Limitations of the Methodology

Several methodological limitations should be considered when interpreting the findings presented in Chapter 4.

Sample Size and Generalisability. The final sample contains eight films, which is appropriate for intensive, scene-level qualitative analysis within the scope of this thesis. However, eight films represent only a small portion of the broader body of Bangladeshi cinema that has represented illness over the years. Therefore, the findings should be regarded as a detailed account of how disease is represented in these films. They should not be treated as a statistically representative or comprehensive picture of all Bangladeshi cinema.

Purposive Sampling and Selection Bias. The sample was formed by first identifying 13 Bangladeshi films through an online search, in each of which disease or illness formed an active part of the plot. This list of 13 was then narrowed down to the final 8 films selected for analysis, on the basis of whether a film could be paired with another film in the same disease category for diachronic comparison (Section 3.4). Due to this narrowing, the study necessarily excludes films depicting other significant diseases (including cardiovascular

disease and appendicitis, each represented by only one film in the initial sample of thirteen), and may therefore under-represent certain forms of illness experience present in Bangladeshi cinema more broadly.

Single-Researcher Coding. All scene identification, transcription, and coding was conducted by the researcher. Therefore, in this qualitative research, the coding decisions reflect the interpretation of one researcher. This is particularly relevant for more interpretive categories such as: A physician's "attitude toward patient"; and a family's emotional response.

Availability and Quality Of Source Material. Several short films in the sample, especially films about COVID-19, were released directly on YouTube rather than through conventional cinema distribution. Box office data was also unpublished or unavailable for several films, including some earlier titles. This limited the depth of analysis possible for the box office and commercial-performance part of the study, especially under Problem Statement 1c.

Translation and Language. The main language of the films is Bangla. Therefore, dialogue-level analysis involved translation and interpretation by the researcher. However, some details of tone, language level, and culturally specific meaning may not be fully captured by the English presentation of the analysis, although an effort was made to preserve these where possible.

Limited Use of Secondary Sources. The study used only limited secondary sources, mainly publicly available box office figures and promotional posters. Other materials, such as director filmographies, trailers, and press coverage, were not systematically collected or analysed. This limits the scope of the secondary-source analysis.

Textual Analysis Without Audience Reception Data. This thesis studies textual representation, meaning what is represented and encoded in the films themselves. It does not study how Bangladeshi audiences understand or respond to these representations. Following Hall's encoding/decoding model, the meanings identified through the analysis are not necessarily the same meanings intended by the filmmakers. They may also differ from the meanings audiences from different walks of life take from the films. Therefore, this thesis makes claims about disease representation as constructed within the films. It does not make claims about the intentions of filmmakers; or the effects of the films on audiences.

Studying these issues would require different research methods, such as interviews with filmmakers, or audience surveys and focus groups. These methods are outside the scope of this study.

3.9 Chapter Summary

This chapter explained the methodology used for studying the representation of physical, biomedical disease in Bangladeshi cinema. As a qualitative exploration, the study includes descriptive quantitative elements such as frequency counts to illustrate the qualitative analyses. The study is interpretive and reflexive, acknowledging the researcher's position can influence the interpretation of film scenes.

The qualitative method is content and thematic analysis. Existing theoretical concepts from medical anthropology, sociology, and film theory are applied to the films, including Kleinman's explanatory models, Frank's illness narratives, Goffman's stigma, Hall's encoding/decoding framework, and Farmer's structural violence. The eight films were thematically grouped based on the four physical, biomedical categories of disease: HIV/AIDS (2 films), fever (2 films), cancer (2 films), and COVID-19 (2 films), with two films in each category from different years. This allows comparison between diseases and comparison of their representation over time.

A criterion-based purposive sampling was followed to obtain these four categories. First, 13 Bangladeshi films were collected that dealt with physical disease or illness, and finally selected eight for analysis. The films were required to meet four inclusion criteria: 1) Bangladeshi productions or directed by Bangladesh's filmmakers. 2) The film's plot must revolve around physical biomedical diseases, 3) The film category must include one or more films to evaluate the representation of disease over time. 4) Availability of films for repeat viewing.

The eight shortlisted films were viewed systematically multiple times, and created a table with six units of analysis following Domaradzki's (2022) film analysis tables (film characteristics, disease characteristics, patient characteristics, physicians and scientists, psychosocial issues, and healthcare setting and access.). Relevant scenes were extracted with timestamps and described the scene's verbal and nonverbal content, including the symptoms,

diagnostic procedures, and the patients' reactions and behaviour. Publicly available box office figures and promotional posters were also used for specific parts of the analysis.

The analysis followed a three-stage iterative process of describing, comparing and interpreting. In addition, the chapter also discusses ethical considerations, including copyright, sensitivity of the topics of disease and death in the film, researcher positionality, and institutional approval.

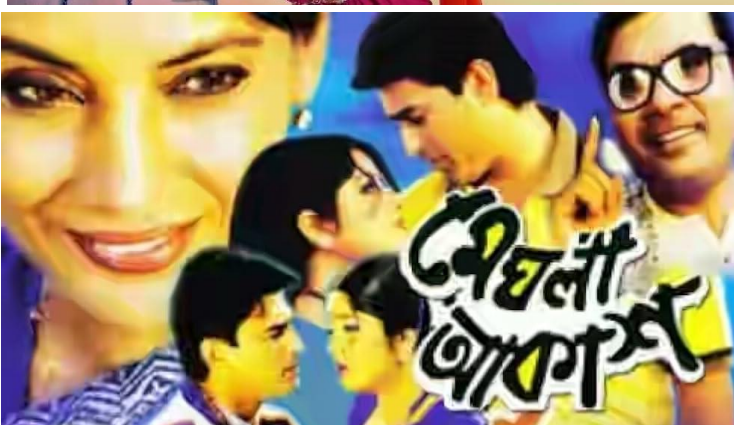
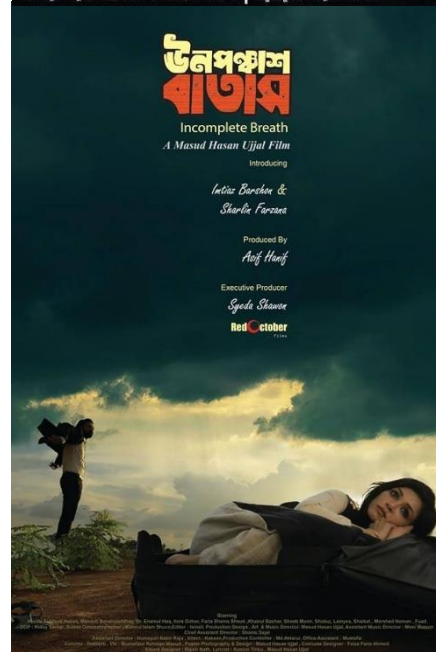
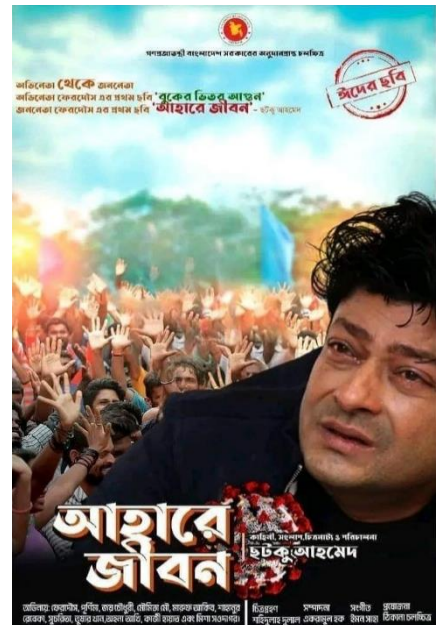
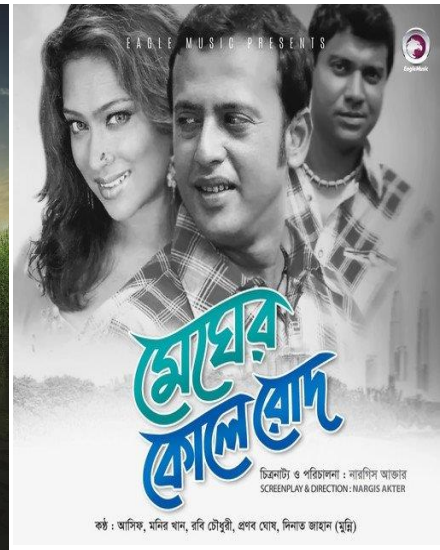
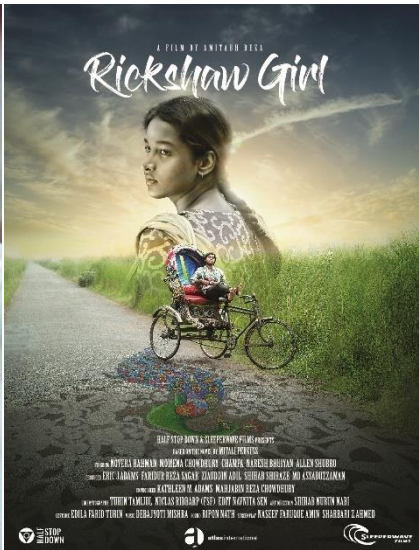
Finally, this chapter covered the methodological limitations of the study: Small sample, single-researcher coding, limited secondary data, probable translation issues, and the absence of audience reviews.

Chapter 4: Findings and Discussion

4.1 Introduction

This chapter presents the findings and analysis of the eight selected Bangladeshi films: *Meghla Akash* (2001), *Megher Koley Rod* (2008), *Matir Moyna* (2002), *Bad Son* (2005), *Corona Bole Kichu Nei* (2020), *Unoponchash Batash* (2020), *Rickshaw Girl* (2021), and *Ahare Jibon* (2024).

Below are the posters of the movies to provide a visual introduction to them:



The chapter is divided into two parts: Findings and Analysis.

The first part, on Findings (Section 4.2), describes how each film represents and constructs disease, through seven recurring types of scenes:

1. the beginning of the illness and the symptoms expressed by the patient;
2. the doctor's opinion and advice after the patient's first visit;
3. the patient's condition and response after receiving the doctor's opinion;
4. the doctor's final opinion and prognosis;
5. the progression of the patient's condition;
6. the patient's survival or death; and
7. the reactions of the patient's family and community.

The seven types of scenes were identified based on recurring patterns in the selected films. Using these scene types allow a clear and consistent way to describe how disease develops and is presented on screen across the sample.

The second part on Analysis (Sections 4.3–4.7), moves from describing what happens in the films to interpreting what these representations mean. It returns to the four problem statements discussed in Chapter 1 and examines what the findings show about disease burden and cinematic visibility, urban-rural differences, gender-based differences, and the role of affluence, class, and religion in shaping disease representation.

Each problem statement is analysed using the specific theoretical concepts identified as relevant to that problem in Chapter 2 and Chapter 3. The chapter therefore does not use one single conceptual framework for all of the findings. Instead, it uses different concepts for different problems according to their relevance to the issue under examination. Finally, the chapter concludes with a chapter summary.

4.2 Findings:

Across the eight films in the comparative sample, this section utilises seven recurring types of scenes to explore how physical biomedical disease is represented on screen. These seven scene types were selected as they appear, in different forms and in different orders, in almost all of the films in the sample. They provide a common ground for comparing the representation of disease across films that otherwise have very different stories, characters, and settings. They are used here as an analytical lens, the films are actually not limited to these seven types of scenes.

This approach is valuable as it allows the same questions to be asked of all eight films. Rather than asking only what disease appears in a film, this section explores how a film represents the beginning of a disease, how medical diagnosis is portrayed, how the patient reacts to medical information, how disease progresses, how its outcome is depicted, and others react to the patient's condition. Individually, these may appear to be generic aspects of a film's storyline, but in combination across eight Bangladeshi films, they reveal recurring ways of representing physical biomedical disease and its impact in social relationships.

It is worth noting that the seven scene types do not appear with the same level of detail in all films, and their order also differs. *Ahare Jibon*, *Unoponchash Batash*, and *Rickshaw Girl* present a relatively clear progression from the appearance of symptoms to the eventual outcome. *Megher Koley Rod*, on the other hand, reverses the expected sequence as the "sickness" here is a false accusation rather than a confirmed diagnosis. The sequence proceeds from the family's claim that she is sick, towards the doctor's medical finding that she is not. *Meghla Akash* and *Bad Son* also include multiple patients' disease-related scenes within the same storyline. These differences are important and are noted in the relevant sections below as the way a film follows or deviates from the expected sequence is itself part of the findings.

4.2.1 Physical Symptoms and the Patient's Response

One recurring pattern across the eight films is that the body always shows signs of disease before a character openly accepts or acknowledges what is happening. The films portray physical indications of illness such as coughing, fever, weakness, or collapse to the audience, as the patient describes the symptoms as temporary, ordinary, or not serious. There

is a difference between what the audience can see happening to the body and what the character is willing to acknowledge.

Table 4:1: Characteristics of Disease in the 8 Movies

Type of disease shown in the movies	N
HIV/AIDS	2 (<i>Meghla Akash, Megher Koley Rod</i>)
COVID-19	2 (<i>Ahare Jibon, Corona Bole Kichu Nei</i>)
Cancer	2 (<i>Unoponchash Batash, Bad Son</i>)
Fever	2 (<i>Matir Moyna, Rickshaw Girl</i>)
Does the movie mention/describe the disease?	
Yes	8 (<i>Matir Moyna, Rickshaw Girl, Unoponchash Batash, Ahare Jibon, Bad Son, Corona Bole Kichu Nei, Meghla Akash, Megher Koley Rod</i>)
No	
Does the movie describe the etiology (cause) of the disease?	
Yes	5 (<i>Unoponchash Batash, Ahare Jibon, Corona Bole Kichu Nei, Meghla Akash, Megher Koley Rod</i>)
No	3 (<i>Matir Moyna, Rickshaw Girl, Bad Son</i>)
Does the movie describe/explain the symptoms the disease produces?	
Yes	5 (<i>Matir Moyna, Rickshaw Girl, Unoponchash Batash, Ahare Jibon, Meghla Akash</i>)
No	3 (<i>Bad Son, Corona Bole Kichu Nei, Megher Koley Rod</i>)
Symptoms shown in movies	

Problems with movement	3 (<i>Ahare Jibon, Unoponchash Batash, Matir Moyna</i>)
Breathing difficulties	4 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Rickshaw Girl</i>)
Lung problems	1 (<i>Unoponchash Batash</i>)
Pain	7 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Bad Son, Meghla Akash</i>)

Caught (from contagious)	4 (<i>Corona Bole Kichu Nei, Ahare Jibon, Meghla Akash</i>)
Fatigue/tiredness	6 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Meghla Akash</i>)
Weight loss	1 (<i>Ahare Jibon</i>)
Hair loss	1 (<i>Unoponchash Batash</i>)
Speech loss	1 (<i>Unoponchash Batash</i>)
Depression	2 (<i>Ahare Jibon, Unoponchash Batash</i>)
Cough	6 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Meghla Akash</i>)
Fever	6 (<i>Ahare Jibon, Unoponchash Batash, Matir Moyna, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Loose Motion	1 (<i>Meghla Akash</i>)
Senseless	2 (<i>Ahare Jibon, Unoponchash Batash</i>)
No symptoms	1 (<i>Megher Koley Rod</i>)
What kind of treatment approach do the movies show?	
Medications	3 (<i>Ahare Jibon, Unoponchash Batash, Rickshaw Girl</i>)
Operation	1 (<i>Unoponchash Batash</i>)
Inhalations	2 (<i>Ahare Jibon, Unoponchash Batash</i>)
Homeopathy Treatment	1 (<i>Matir Moyna</i>)
Was sent to a foreign country	1 (<i>Bad Son</i>)
Does not mention	1 (<i>Corona Bole Kichu Nei</i>)
No treatment	
Are the medications being taken by the patients?	
Yes	4 (<i>Ahare Jibon, Unoponchash Batash, Matir Moyna, Meghla Akash</i>)
No	3 (<i>Rickshaw Girl, Bad Son, Meghla Akash</i>)
Does not mention	1 (<i>Corona Bole Kichu Nei</i>)
Does the movie show the patient suffering from the disease?	
Yes	8 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Matir Moyna, Rickshaw Girl, Bad Son, Meghla</i>)

	Akash)
No	
Is the character shown receiving hospital-based or palliative/end-of-life care?	
Yes	9 (<i>Corona Bole Kichu Nei</i> , <i>Megher Koley Rod</i> , <i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Matir Moyna</i> , <i>Rickshaw Girl</i> , <i>Bad Son</i> , <i>Meghla Akash</i>)
No	
Does the disease lead to the patient's death within the movie?	
Yes	7 (<i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Matir Moyna</i> , <i>Rickshaw Girl</i> , <i>Bad Son</i> , <i>Megher Koley Rod</i>)
No	2 (<i>Corona Bole Kichu Nei</i> , <i>Megher Koley Rod</i>)

This pattern is especially clear when the disease first presents itself through a physical collapse. In *Rickshaw Girl*, Selim's condition becomes visible when he falls while riding his rickshaw, and a crowd gathers around him. Naima, his daughter, runs toward him, but even though he is too weak to stand properly, he tells her, "It was just the sun. Go home, I'm coming," His coughing and heavy breathing continue while people help him return home, but he describes the event as something temporary.

A similar but quieter event occurs in *Bad Son*. Babu experiences severe head pain and briefly loses consciousness while sharing good news with his adoptive father. After getting stable, he immediately says that "nothing has happened." The physical collapse is less dramatic than Selim's, but the same pattern follows: a visible physical problem is followed by an immediate attempt to minimise its seriousness.

In other films, the physical symptoms develop over a longer period rather than presenting themselves through a sudden collapse. When this happens, the characters often give more detailed explanations for believing the symptoms are not serious.

In *Unoponchash Batash*, Nira finds Ayon lying in a dark room. His body is described as "burning" with fever, but Ayon explains that this happens every evening. He says that he takes paracetamol and then, the fever goes away after he sweats. He therefore describes the

condition as an ordinary "seasonal fever." At the same time, at the doctor's chamber, he mentions that his dry cough has continued for "about a month." This cough later becomes an important early symptom of cancer that eventually leads to his death. His familiarity with the recurring fever seems to make the symptom seem ordinary to him.

Meghla Akash presents a similar pattern through two characters. Meghla has been experiencing evening fever, sweating, and diarrhoea for three to four months, before seeing the doctor for a different reason. Even then, she describes the condition as "nothing." Javed also describes his own rapid cough to the same doctor as something that occasionally "relapses" and is "nothing serious." In both cases, recurring symptoms become familiar to the characters. Because the symptoms were familiar to the characters, they seem to treat their condition as nothing to worry about.

Corona Bole Kichu Nei takes this pattern further. The father does not attempt to simply minimise his physical symptoms. He repeatedly denies that he could have COVID-19. Over four masks and repeated temperature checks, he continues to believe that the disease cannot happen to him because of his religious faith. However, when he begins coughing heavily and has difficulty breathing, he locks himself in his room because his physical condition has made him afraid that he might affect his family too. In this case, denial and the visible development of physical symptoms seem to be within the same sequence.

Matir Moyna presents the simplest form of disease onset in the sample. Since Asma is a child, her fever is introduced mainly through the adults around her. The adults treat the fever as a recurring problem that must be managed. Asma herself is not given the opportunity to explain or minimise her physical condition. The representation of disease therefore comes mainly through her body and through the adults' responses to it.

Megher Koley Rod is different from all the other films in this respect. Rodela is not shown experiencing any physical symptom of a biomedical disease. There is no physical sign for her to minimise or deny. Instead, her alleged disease begins with a claim made by other people on her wedding night. Her in-laws believe that she has HIV because her deceased parents had AIDS. Therefore, unlike the other seven films, the disease narrative in this film begins with an accusation of a disease rather than with the physical body showing signs of a confirmed disease.

Taken all together, these scenes show that the representation of disease often begins with a visible change in the body. However, the films also give importance to what immediately surrounds the physical change. In several cases, the patient tries to explain the symptom as ordinary or temporary. In *Megher Koley Rod*, by contrast, the alleged sickness exists first without any actual physical signs. This difference is important when considering how the films connect biomedical disease with social responses.

4.2.2 The Doctor's First Opinion and Advice after the Patient's First Visit

If the first group of scenes represent disease mainly through physical symptoms, the first medical consultation changes the way the condition is represented. The doctor is the person who examines the physical condition, interprets symptoms, orders tests, or provides a medical explanation. However, the films differ considerably in what doctors tell patients and families, how much explanation they give, and how easily the characters are able to access medical care.

These differences are important because they show that the representation of biomedical disease is not limited to the physical condition itself. The films also show how medical knowledge is communicated and how access to that knowledge can depend on social relationships and economic circumstances.

Table 4:2: Characteristics of Physicians

Sex	N
Male	8 (<i>Megher Koley Rod</i> , <i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Matir Moyna</i> , <i>Bad Son</i>)
Female	4 (<i>Megher Koley Rod</i> , <i>Rickshaw Girl</i> , <i>Meghla Akash</i>)
Physicians were not in the movie	1 (<i>Corona Bole Kichu Nei</i>)
Unidentified	3 (<i>Ahare Jibon</i>)
Age	
Young	1 (<i>Meghla Akash</i>)
Middle age	3 (<i>Rickshaw Girl</i> , <i>Bad Son</i> , <i>Meghla Akash</i>)

Older	7 (<i>Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Matir Moyna</i>)
Not shown	4 (<i>Ahare Jibon, Matir Moyna</i>)
Ethnicity	
Muslim	7 (<i>Megher Koley Rod, Unoponchash Batash, Matir Moyna, Meghla Akash</i>)
Hindu	
No mention	8 (<i>Ahare Jibon, Unoponchash Batash, Matir Moyna, Rickshaw Girl, Bad Son</i>)
Others	
Position	
Physician	6 (<i>Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Matir Moyna, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Assistant	1 (<i>Meghla Akash</i>)
Surgeon	3 (<i>Ahare Jibon</i>)
No mention	
Place of work	
Hospital/clinic	7 (<i>Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Private chamber	2 (<i>Unoponchash Batash, Matir Moyna</i>)
Quarantine centre	1 (<i>Ahare Jibon</i>)
Attitude toward patient	
Care/support	7 (<i>Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Matir Moyna, Bad Son, Meghla Akash</i>)
Disinterest or insensitive behaviour	1 (<i>Rickshaw Girl</i>)

Unoponchash Batash gives the most detailed treatment in the sample. Nira's father, who is himself a doctor, examines Ayon informally in his chamber. The examination includes a thermometer and stethoscope, as well as a series of questions such as "When does your fever come?", "Does convulsion happen?", "(Do you have) cough?" He initially mentions tuberculosis as a possible concern, but he reassures Nira that there is no indication of

anything serious. Before he can make a full medical decision, he prescribes a cough test, blood test, and chest X-ray.

The scene also contains an important social detail concerning access to medical care. Ayon becomes nervous about meeting Nira's father as a patient. Nira reassures him by describing her father as the kind of doctor who listens to Rabindra Sangeet in his chamber while seeing patients and therefore is not someone to fear. The doctor is presented as approachable.

At the same time, the scene shows a difference in access to healthcare. Generally, patients may have to wait or face difficulties when trying to get an appointment with a busy doctor. Ayon, however, is able to see Nira's father on the same evening because Nira already has a personal connection with him. In this way, the film shows how a personal relationship can make access to medical care easier.

The visual presentation adds another layer to the scene. Ayon's room is shown in dark, almost black tones, while the doctor's chamber is brightly lit in white. This contrast can be read as representing a movement from the uncertainty surrounding his physical condition to medical attention and hope.

Picture: How Lighting Changes As Despair and Hope



[Source: Movie: Unoponchash Batash (2020).

Timestamp On the Left: 01:12:37; On the Right: 01:14:51]

The first consultation is later connected to another medical scene. After Ayon's test results become available, the same doctor studies the X-ray and appears concerned. He then refers Ayon to a chest specialist, Professor Rajjak, without immediately alarming his daughter.

Meghla Akash also presents a detailed medical consultation, but the situation is different because the doctor already suspects HIV based on Meghla's symptoms. The doctor orders a "thorough medical checkup," and when Meghla asks about the cost of testing, she is told that testing at the public hospital is free. The film, therefore, directly addresses the patient's concern about whether she can afford medical testing.

Later, the same doctor explains the results to Javed after obtaining Meghla's permission. The doctor explains the possible route of transmission by asking about Javed's sexual history, blood donation, and use of condoms. The information is presented step by step in this film. Therefore, medical information is not limited to announcing a diagnosis; the doctor also explains how the infection could have been transmitted.

The two films present different forms of access to medical care. In *Unoponchash Batash*, a personal relationship with a doctor makes immediate consultation easier. In *Meghla Akash*, the availability of free testing at a public hospital addresses the financial barrier to medical care. Both examples show that access to medical knowledge is connected to social and institutional conditions.

Bad Son presents a more limited form of medical consultation, and even within the same film the consultations differ. Nazma's tumour is communicated in a direct and transactional way. The district hospital doctor gives the diagnosis and immediately mentions a cost of approximately 40,000–50,000 taka. Hospital admission is arranged on the same day. The doctor in the film does explain the treatment procedure, i.e., an operation is needed, since without timely surgery the growth will turn into cancer. But neither how she developed it nor how it might have been prevented is addressed.

Babu's diagnosis involves a different type of formality. Before telling him the diagnosis, the doctor asks whether a blood relative is present to receive the information. The doctor continues only after Babu explains that he has no one else. The scene focuses not only on Babu receiving the diagnosis, but also on the doctor's decision to ask whether a family member should be present when the diagnosis is given. It shows that the delivery of serious medical information is presented as a process involving both the patient and their family.

Rickshaw Girl presents the shortest and most limited medical consultation in the sample. In that scene, the doctor examines Selim's eyes and writes a prescription:

Doctor: Give the prescription to the compounder. He will tell you where to buy it from.

Selim's Wife: How long must he take it?

Doctor: Foreveeeeer.

Selim's Wife: How much do you think it will cost?

Doctor: I'm not sure. But I think you need a good amount of money. Please go out. He (the compounder) will tell you where to go.

— *Rickshaw Girl* (2021), (Timestamp: 00:18:49-00:19:29)

Then, the doctor moves on to the next patient. The family is never given a specific named diagnosis on the screen.

The film also visually communicates the family's financial hardship. Earlier, a wide and shaky-camera shot shows Naima pulling the rickshaw while her father, sitting in the passenger's seat, coughs behind her. It is a shot composed specifically, it would seem, to convey the family's inability to afford even "a simple hobby (for Naima) or a simple recovery from a minor setback (for Selim)."

Megher Koley Rod reverses the pattern seen in the other films. Here, Rodela herself seeks medical assistance because she wants to know whether the claim made by her in-laws is medically true. She visits an AIDS specialist to verify the allegation that she has HIV. The doctor reacts with some surprise and says, "No one comes to test for AIDS by themselves, especially girls." He asks her a series of questions about possible risk factors before agreeing to test her blood. The scene, therefore, presents a woman independently seeking medical confirmation on a disease as sensitive as AIDS, as something unusual within the film's social setting.

When these consultations are considered together, they show considerable differences in the representation of access to medical knowledge. *Unoponchash Batash* and *Meghla Akash* provide comparatively detailed medical explanations, while *Bad Son* and *Rickshaw Girl* present medical consultation in a shorter and more transactional manner. *Megher Koley*

Rod adds another variation: the patient herself must take the initiative to seek medical confirmation.

The films also show that the name of the disease is not always immediately provided. When the medical information is incomplete, delayed, or withheld, the patient or a family member often has to ask what the condition actually is before a clear explanation is provided.

4.2.3 The Patient's Condition & Response after Receiving the Doctor's Opinion

After a medical opinion or diagnosis is given, the films present different ways in which patients respond to information about their physical disease. In this sample, a recurring difference is observed between the male and female characters confronting serious disease. The male characters tend to withdraw from people close to them, whereas the women remain more directly involved in seeking or continuing medical information and care.

In *Bad Son*, Babu reacts to his cancer diagnosis by asking the doctor not to tell anyone. He then withdraws and uses alcohol as a means of dealing with his distress. He tells a child he has befriended that the bottle is "medicine to help you forget sorrows." He hides his diagnosis from his adoptive father for some time, and then informs him. Later, when he tells Kajol, his romantic love interest, he first asks her to promise that she will keep the information secret.

Babu explains that he does not want to burden Nazma, his adoptive mother. He had previously promised her biological son, Joy, that he would not hurt her. His response to the diagnosis therefore includes secrecy, withdrawal, and an attempt to protect people close to him by keeping the disease hidden.

Ayon in *Unoponchash Batash* reacts similarly to the seriousness, cost, and prognosis of his disease. Rather than accepting treatment paid for by Nira's family, he flees the hospital. He leaves Nira a message explaining that treatments might extend his life by only a few months to a year, but he does not want to "play the lottery" with the time remaining in his life. He also does not want Nira to spend money that she would have to obtain from her family.

Selim in *Rickshaw Girl* reacts more quietly. He does not flee or openly conceal his condition in the same way as Babu and Ayon do. Instead, he continues trying to work while coping with coughing and physical exhaustion. His disease becomes a part of the family's existing economic difficulties, and he does not object when his wife sells her own bangles to pay for his medication.

The film pays particular visual attention to this sacrifice. Naima secretly hears her mother deciding to give up her bangles. The scene is followed by a slow series of close-up still shots: first the mother, then the father with his younger daughter beside him, then the grandmother, then the bangles, and finally Naima. The sequence pauses on each family member and on bangles, the material object being sacrificed. Instead of advancing the story, the scene emphasises the costs of the father's disease for his family.

Picture: A Close-up Scene of the Sacrifice of Bangles



[Source: Movie: Rickshaw Girl (2021). Timestamp: 31:00]

In the three male characters, the disease is therefore represented as something that is carried privately or silently. Babu hides his diagnosis, Ayon flees the treatment because of the expected costs but unguaranteed life extension, and Selim continues to try to work while the family absorbs the economic consequences.

The two women in the sample who face serious situations like HIV-related, respond differently.

In *Meghla Akash*, Meghla's response to her actual HIV diagnosis is quieter. She had already experienced untreated physical symptoms for several months. After the diagnosis, she remains involved in the medical process instead of quitting it. Javed, rather than Meghla, displays much of the immediate shock and disbelief when he receives the information. Rodela, in *Megher Koley Rod*, responds differently after receiving the doctor's initial opinion. Instead of focusing on the waiting for her blood-test result, she begins preparing to challenge the accusation against her through legal action against Nijhum. She treats the situation not simply as a personal medical problem, but as an accusation that she must fight through the legal system.

This is an important part of her response, even though it is not a medical response. Babu and Ayon respond to their diagnoses mainly by hiding their conditions and withdrawing from other people. Rodela responds in the opposite way. She confronts the accusation and seeks a formal legal solution.

The scenes therefore present different ways of representing patient responses to medical information. The three male characters with serious disease tend to respond through secrecy, withdrawal, or quiet endurance, whereas Rodela and Meghla remain connected to the medical process. This recurring difference is part of the gendered pattern present in the selected films.

4.2.4 The Doctor's Final Opinion, Prognosis, and Further Consultation

The final medical opinion and prognosis is represented differently from the initial medical opinion. In several films, the patient does not directly receive the full information about the likely outcome of the disease; rather, the information is first given to a family member or other intermediary. This creates a pattern in which the medical prognosis is communicated indirectly to the person whose body is affected.

Unoponchash Batash presents this most clearly. Nira's father contacts the specialist, Professor Rajjak, by telephone to ask about Ayon's prognosis. Professor Rajjak explains that Ayon's mesothelioma has reached the fourth stage and that his liver is already affected. He says that "life extension is near to impossible." When Nira's father asks whether treatment

abroad might help, Rajjak says that he does not think it would. He estimates that Ayon might have "maybe three months, six months [left], or anytime [the death may happen]."

Ayon does not receive this complete prognosis directly from Professor Rajjak. Instead, he only learns a version of this information through his own research, never through a direct conversation with the specialist who determined it; Nira also learns the same term by reading a definition of mesothelioma in the car after leaving the hospital, so even this indirect route to understanding the diagnosis is something each of them arrive at alone, instead of together.

Ahare Jibon presents an even more indirect final medical opinion. There is no spoken prognosis. After repeated attempts to resuscitate Rabbi, the surgeons exchange looks and stop using electric shocks. The audience understands that the medical team has concluded that further resuscitation will not work, even though no doctor verbally states that conclusion.

In both *Unoponchash Batash* and *Ahare Jibon*, therefore, the final medical outcome is not presented through a simple doctor-patient conversation.

Bad Son does not provide a complete final-prognosis scene for Babu. Once his illness is known, his affluent family turns their attention towards finding treatment abroad. The narrative therefore replaces a scene in which a doctor declares that nothing more can be done, with a decision by the family to take action and seek further treatment.

Rickshaw Girl and *Matir Moyna* do not contain a separate final medical consultation. In *Rickshaw Girl*, Selim's physical condition continues to deteriorate outside the clinical setting until his death. In *Matir Moyna*, Asma's fever and physical condition remain part of the household's daily routines without the narrative going to a doctor for a medical checkup.

Megher Koley Rod provides the clearest exception to the otherwise serious or terminal nature of final medical opinions in the sample. Rodela's first HIV-screening test is already negative, so the doctor informs her that a second confirmatory test is not needed. He tells her directly that she is "HIV free." The medical opinion therefore clears her from rather than confirming a disease.

A second medical opinion appears later in the courtroom. Obstetrics specialist, Dr. Selina, explains that HIV-positive mothers can give birth to HIV-negative children when they

receive antiretroviral treatment. This medical testimony directly challenges the assumption that caused Rodela's in-laws to reject her. In this film, medical knowledge therefore changes the meaning of the original accusation. It provides evidence against the social judgment made about her.

4.2.5 Progression of the Patient's Physical Condition Throughout the Film

Following the initial medical consultation and prognosis, the films differ widely in how much of the physical progression of disease is presented on the screen. Some films repeatedly show the body becoming weaker and the physical symptoms becoming more serious; others show only selected symptoms or move away from the patient's body and reveal the outcome later.

This difference is important because it determines the extent to which the audience is asked to observe the physical effects of biomedical disease. A film can make bodily deterioration highly visible, or it can leave parts of the progression outside the frame and communicate them through dialogue or later events.

Ahare Jibon uses the first approach clearly. Rabbi's physical condition changes through a series of increasingly serious symptoms. At first, he had a mild cough while in quarantine. Later, in his apartment, he is visibly struggling to walk, panting and coughing. When his son finds him, Rabbi's skin has become visibly darker, his eyes are swollen and red, and his lips are red. He then faints and is eventually admitted to hospital. In the hospital he requires an oxygen mask and an IV infusion. The medical team finally attempts to resuscitate him using electric shocks.

The physical changes are repeatedly visible on Rabbi's body before they are explained through dialogue. The audience therefore observes the progression of the disease through changes in appearance, breathing, movement, and medical intervention.

Unoponchash Batash follows similarly with Ayon. His early symptoms include nightly fever and dry cough. Later, the doctors identify his cancer as already "matured." The specialist then describes the disease to him as fourth-stage cancer. Near the end, Ayon wakes with severe chest pain and difficulty breathing. His condition becomes so serious that he can

no longer speak clearly. In the ambulance, he manages to say only Nira's name before the monitor flatlines.

In both *Ahare Jibon* and *Unoponchash Batash*, breathing becomes an important physical indicator of disease progression. The worsening ability to breathe allows the audience to see that the patient's physical condition is becoming more serious.

Bad Son presents a different approach. Babu's disease is represented through recurring headaches and one collapse, but the film spends more time on the family's cries on not wanting to lose Babu (aka, Bijoy, their lost son) and their eventual reconciliation, than on showing a gradual physical deterioration. In the final scenes, Babu is shown being sent abroad for treatment. The medical outcome is presented in short rather than represented through a detailed sequence of worsening physical symptoms.

Rickshaw Girl withholds even more of the physical progression. Selim continues coughing and appears weak in several scenes, but the film eventually moves away from him. His death is revealed later through a conversation between Naima and a friend rather than through a final scene showing his physical condition.

Meghla Akash moves in the opposite direction. After Meghla's HIV diagnosis, the film does not show her physical condition becoming progressively worse. Instead, once she receives treatment and support, her story moves towards stabilisation and eventually marriage. The narrative therefore represents improvement rather than physical deterioration.

Corona Bole Kichu Nei presents a shorter progression. The father's sequence begins with denial and self-isolation, it moves to heavy coughing and difficulty breathing, and finally, he is persuaded to seek hospital care. The film does not develop this into a long-term progression of disease beyond that point.

Considered altogether, *Ahare Jibon* and *Unoponchash Batash* provide the most detailed visual representation of physical deterioration, and both end with the death of the patient. *Bad Son* gives less visual attention to physical decline, *Meghla Akash* moves toward stabilisation and *Rickshaw Girl* moves away from the patient's body before revealing his death. The amount of physical deterioration shown on screen therefore varies considerably across the sample.

4.2.6 Survival or Death of the Patient

In these films, death or survival is rarely shown as something that happens only to the patient. Other people are usually involved in the moment. They may be present, try to help, receive the news, or be kept away from the patient. Therefore, the films show whether the patient survives or dies, and they also show who stays with the patient, who is kept away, and how other people react to the outcome. This response is connected with the social environment of the person who has the disease.

Rabbi's death in *Ahare Jibon* takes place in an ICU. His son Shuvo is finally allowed to enter the room, after a sympathetic police officer forced his way past hospital security, taking Shuvo with him. Shuvo is then able to embrace his father. At that exact moment, the heart-rate monitor gives its final sound, marking Rabbi's death. The rest of the family, after getting permission for entry, were only able to watch through a window. They remain outside of the ICU wearing masks, because of the same hospital restrictions that had almost stopped Shuvo from reaching his father. The scene therefore connects Rabbi's death with the physical reunion between father and son, while the rest of the family remains separated from him.

Ayon's death in *Unoponchash Batash* also focuses on the people around the patient. He dies in an ambulance shortly after his hospital-wedding to Nira. Nira stays beside him, tries to comfort him, and requests the driver to drive faster, while he struggles to breathe and speak. Immediately after his death, the film brings attention to his earlier decision to become an organ donor. His death is therefore shown as something that can continue to have an effect on other people even after his own life has ended.

Selim's death in *Rickshaw Girl* is different from the other deaths in the sample. It is the only death that happens completely off screen. Naima learns about her father's death from a friend on a railway overbridge. The friend tells her, "Your father died yesterday. He is no more." Instead of showing Selim's death, the film shows Naima's disbelief and emotional breakdown after hearing the news. The audience is therefore told about his death rather than shown the moment itself.

The films that show survival also connect the patient's outcome with other people.

In *Bad Son*, Babu collapses again after a confrontation with the enemies. However, he is eventually sent abroad for treatment. The final scenes show him alive, happy, dressed

formally, and returned home to his mother. His survival is therefore presented through his return and reunion with his mother.

In *Meghla Akash*, Meghla survives her HIV diagnosis and moves towards marriage and a stable future with Javed. Her survival is connected with a larger story of social acceptance. However, the doctor tells Javed in the same film that he and Meghla will not be able to have children.

This point is later changed in *Megher Koley Rod*, which works as a continuation of the story. In the courtroom scene, an obstetrics specialist explains that Javed and Meghla had actually come to her because they wanted to have a child. The doctor says that she gave Meghla a full course of antiretroviral treatment to make the pregnancy safer. Meghla then gave birth to their daughter, Rodela, who tested HIV-free.

However, Meghla herself does not survive the childbirth. The cause of her death is presented as the caesarean delivery itself, rather than HIV. Her death therefore falls outside the disease narrative that *Meghla Akash* had developed around her HIV diagnosis. Her HIV is not presented as the direct cause of her death during childbirth.

Rodela's outcome in *Megher Koley Rod* is different because she was never actually infected with HIV. She is cleared of the accusation through both a blood-screening test and later courtroom testimony. Her outcome can therefore be understood as vindication rather than recovery from disease.

Corona Bole Kichu Nei leaves the outcome of the father's hospital visit unstated on screen, so it remains unclear whether he recovered or passed away. The film ends when Afrin convinces him to unlock his room's door, where he was panicking about being infected with COVID, and go to the hospital. Therefore, since the audience does not actually see his survival, his survival could be assumed because he is not presented as one of the characters who passes away. His case is therefore the only one in the sample where the patient's final outcome is completely left outside the film.

The film places this incomplete outcome next to another COVID-19 death that the audience learns about through a news article. Shortly before the father's own symptoms appear, Afrin reads the article on her phone. It reports the death of a COVID-19 patient named Pobon Das. He was taken to a rural health complex in Noakhali. However, the doctor

on duty did not have access to a proper medical facility, so he had to treat Pobon Das outside, on the stairs. The doctor could not save him, and after the patient's death, the doctor sits beside his body and gives up, while Pobon Das's wife cries beside him.

Picture: A News Article from the Movie



[Source: Movie: Corona Bole Kichu Nei (2020). Timestamp: 15:16]

Unlike the other deaths in the sample, Pobon Das is not a character whom the audience has previously met. His death is not shown as part of his own story, but the audience learns of it through the news article that Afrin reads on her phone. The placement of this information is important within the film as it appears just before the father's own illness begins. The death of a stranger therefore shows what the father could potentially face, and it served awareness for the daughter to be more careful for her family.

At the same time, the film presents a different outcome for the father. Pobon Das is treated in a rural health facility where the doctor lacks proper resources, while Afrin's father has the opportunity to receive treatment in a better-resourced urban hospital. The contrast between the two cases shows two different outcomes of COVID-19 within different

healthcare settings: one patient dies when adequate facilities are unavailable, while the father has the option to seek a proper hospital treatment.

Overall, the films show survival and death in different ways. Some deaths are shown directly through the patient's final physical moments, as in *Ahare Jibon* and *Unoponchash Batash*. Some are communicated to the audience through another person's words, as in *Rickshaw Girl*. One death is presented only through a news report, as in the case of Pobon Das in *Corona Bole Kichu Nei*. Survival is also connected to family reunion, social acceptance, medical treatment, or, in Rodela's case, proof that she was never infected. Different forms of representation show that the outcome of a physical biomedical disease is presented not only through the patient's body, but also through the people, medical systems, and social circumstances surrounding the patient.

4.2.7 Reactions and Views of the Patient's Family and Surrounding Community

The reactions of family members and other people around the patient is another recurring element of the representation of biomedical disease across the films. Different characters respond in different ways. Some move closer to the patient and attempt to provide care or protection, while others distance themselves either because they fear the disease, worry about the social consequences of association, or are concerned about financial or personal costs.

Table 4:3: Characteristics of Patients & Reactions of their Families

Sex	N
Male	6 (<i>Corona Bole Kichu Nei</i> , <i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Rickshaw Girl</i> , <i>Bad Son</i> , <i>Meghla Akash</i>)
Female	3 (<i>Megher Koley Rod</i> , <i>Matir Moyna</i> , <i>Meghla Akash</i>)
Age	
Child	1 (<i>Matir Moyna</i>)
Adolescent	
Adult	6 (<i>Megher Koley Rod</i> , <i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Bad Son</i> , <i>Meghla Akash</i>)

Elderly	2 (<i>Corona Bole Kichu Nei, Rickshaw Girl</i>)
Ethnicity	
Muslim	9 (<i>Corona Bole Kichu Nei, Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Matir Moyna, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Hindu	
Others	
Type of care they received in the movie	
Homecare	2 (<i>Matir Moyna, Rickshaw Girl</i>)
Hospital care	4 (<i>Corona Bole Kichu Nei, Megher Koley Rod, Ahare Jibon, Bad Son</i>)
Home and hospital care	3 (<i>Unoponchash Batash, Meghla Akash</i>)
Quarantine care	1 (<i>Ahare Jibon</i>)
No care	
Prognosis	
Survives	1 (<i>Bad Son</i>)
Dies	
At home	1 (<i>Matir Moyna</i>)
In the hospital	1 (<i>Ahare Jibon</i>)
On the way to the hospital	1 (<i>Unoponchash Batash</i>)
Doesn't mention location	1 (<i>Rickshaw Girl</i>)
Didn't show	3 (<i>Corona Bole Kichu Nei, Meghla Akash</i>)
Type of death they went through	
Lack of treatment	1 (<i>Rickshaw Girl</i>)
Lack of proper treatment	
Lack of allopathy treatment	1 (<i>Matir Moyna</i>)
Death from Disease	4 (<i>Ahare Jibon, Unoponchash Batash, Megher Koley Rod</i>)
Patient's emotional/psychological response to their diagnosis or condition	
Denial	4 (<i>Corona Bole Kichu Nei, Ahare Jibon, Meghla Akash</i>)

Anger	1 (<i>Ahare Jibon</i>)
Depression	7 (<i>Corona Bole Kichu Nei, Megher Koley Rod, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Acceptance	5 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Meghla Akash</i>)
No reaction	1 (<i>Matir Moyna</i>)
The practical/systemic obstacles the patient faces in relation to their illness	
Lack of access to correct diagnosis	2 (<i>Unoponchash Batash, Matir Moyna</i>)
Lack of information	4 (<i>Ahare Jibon, Matir Moyna, Meghla Akash</i>)
Lack of scientific knowledge	1 (<i>Meghla Akash</i>)
Lack of appropriate quality healthcare	
Lack of treatment	2 (<i>Unoponchash Batash, Rickshaw Girl</i>)
High cost of drugs and care	2 (<i>Unoponchash Batash, Rickshaw Girl</i>)
Inequalities in availability of treatment and care	
Disturbance in family dynamics	5 (<i>Ahare Jibon, Matir Moyna, Rickshaw Girl, Bad Son, Meghla Akash</i>)
How did the family react to the patient's diagnosis?	
Care/support	7 (<i>Corona Bole Kichu Nei, Ahare Jibon, Unoponchash Batash, Rickshaw Girl, Bad Son, Meghla Akash</i>)
Feeling of blame	2 (<i>Megher Koley Rod, Ahare Jibon</i>)
Disinterest/indifference	
Lack of understanding	1 (<i>Megher Koley Rod</i>)
Denial	4 (<i>Megher Koley Rod, Ahare Jibon, Meghla Akash</i>)

These reactions are important for this thesis because they show how the representation of biomedical disease is connected to the social environment surrounding the affected body. The disease itself is a biomedical condition, but the films also represent the ways in which it

affects the patient's relationships, family position, finances, and social status after it is discovered.

Ahare Jibon presents this division within a family. Rabbi's family, including his wife Dola, his son Shuvo, repeatedly try to reach him despite quarantine and hospital restrictions. Shuvo, in particular, even leaves his own home to find his father.

The extended family is more divided, mainly because of differences between relatives connected by marriage. When Rabbi's brother plans to visit him in the hospital, his father-in-law asks if they really are going to see "a corona patient." But Rabbi's brother defends him, saying that he is not just a "corona patient" but his younger brother. His father-in-law argues that a corona patient should be avoided "no matter if he's a dad or a son" because they pose a risk spreading the virus.

Rabbi's sister's husband therefore offers to visit, saying since he is not related to Rabbi by blood, he says he has "no problem" if he gets infected. Rabbi's brother still goes to the hospital, despite the brother-in-law's offer to take the risk, which the father-in-law was unwilling to do.

Megher Koley Rod displays a stronger form of social rejection (Table 4.5). Rodela's in-laws accept the claim that she has HIV despite having no medical evidence. The fact that her deceased parents had AIDS becomes a basis for the accusation. Her in-laws threaten divorce, prevent their son from seeing her, and make him swear on his mother's life that he will not visit her.

Rodela's uncle and aunt do not believe the accusation, but they are unable to protect her from the threats of the more powerful family, the husband's family. The film, therefore, demonstrates that sympathy from some family members does not necessarily provide power enough to protect one from rejection by others.

Meghla Akash responds to this form of stigma more directly. The doctor advises her medical students not to distance themselves from a person with AIDS. She explains that the disease is not transmissible. And in the end of the film in case of Meghla and Javed's marriage, when Rimi (one of the students of the doctor and Javed's sister) was hesitant about Javed marrying Meghla, the doctor convinced her that Meghla's "first identity" is "a human."

Through this intervention, the doctor encourages Rimi to accept Meghla rather than reject her.

The same idea appears in *Megher Koley Rod*. In the courtroom, the obstetrics specialist Dr. Selina not only provides medical evidence to clear Rodela but also explains that women living with HIV often face violations of their rights. They need love more than anything else, and she becomes emotional while speaking. Like the doctor in *Meghla Akash*, she goes beyond her medical role to defend the dignity of patients facing stigma.

Bad Son presents family reaction through misunderstanding rather than direct stigma towards the disease. Babu refuses to donate blood to Joy, who is injured and in need of blood for a successful treatment, but is hiding his cancer. Nazma, Joya, Joy's girlfriend, and Kajol interpret his refusal as selfishness and even as an attempt to kill Joy. Babu is called "a bad son" and is ordered to leave permanently.

The family's interpretation changes when Babu's illness becomes known, and their anger turns into guilt, and the family begins working towards reconciliation and funding his treatment. The hostility in this film is therefore mostly tied to the concealment of the disease. Once the disease is discovered, then the family's response becomes more protective.

Rickshaw Girl represents a different kind of response. Rather than direct emotional stigma, the film focuses on economic and gendered disrespect (Table 4.5). Mamun bhai, the owner of the rickshaw, shows little concern about Selim's physical condition. He threatens to take the rickshaw back due to unpaid rent. At the same time, Naima's mother loses her domestic job and is accused of stealing. This makes it even more difficult for the family to pay for Selim's treatment.

When Naima yells at Mamun that her father "is not doing well," Mamun threatens to slap her rather than responding to her concern. Naima talks back to him. Later, she also says that she will "beat the shit out of" the woman who wrongly accused her mother of theft. These moments can be read as representations of a young woman's resistance to economic and gendered disrespect.

However, the film does also show that this sense of empowerment is contested. Naima's mother tells her that she does not have the "capability" to do anything and has "zero

faith" in Naima's painting as a possible source of income. Thus, her ability to stand up for herself is also questioned by her own family.

Eventually, Mamun's men take the rickshaw away while his group chants his name. The scene is a visible display of economic and social power. It is also connected to the treatment of the family to the wider economic conditions surrounding Selim's disease.

Unoponchash Batash presents a family response that is initially more concerned about class differences than by Ayon's disease. Nira's father was initially concerned about Ayon's occupation as a medical sales representative. Nira's mother also mocks the social mismatch between a daughter of a "foreign-degree" doctor and an MPO son-in-law (Medical Promotion Officer).

When Ayon's disease becomes serious, however, the family's attention changes. Their concern becomes focused on his survival. Nira's language also changes from "you" to "we," towards him, suggesting that she now sees his treatment as a shared responsibility. In this film, the serious disease is shaping a family relationship to sympathy, which had previously been impacted by class differences.

Corona Bole Kichu Nei and *Matir Moyna* keep their reactions mainly within the household.

In *Corona Bole Kichu Nei*, Afrin is the primary person who persuades her father to stop denying his physical condition and seek hospital treatment. The film does not show a broader community response in the same way as *Ahare Jibon* or *Megher Koley Rod*.

In *Matir Moyna*, the disagreement mostly takes place between Asma's parents. Her father prefers religious faith and homeopathic treatment, while her mother wants to consult a doctor. An uncle, Asma's father's brother, becomes a third participant by secretly providing allopathic medicine despite the father's preference, but that medicine never reaches for Asma.

Picture: The Mother's Emotional Distress Portrayed through Camerawork



[Source: Movie: Matir Moyna (2002).

Timestamp On the Left: 01:02:45; On the Right: 01:03:03]

Another scene between Asma's parents shows the mother's emotional distress without letting her husband see it openly. Her face and feelings are partially hidden behind her sari's veil. The scene uses an extreme close-up at eye level, with warm but desaturated colours, and ends by showing her reflection in a mirror rather than her face directly. The visual framing connects her hidden feelings and her limited ability to express it openly within the marriage.

Across the eight films, therefore, the reactions of other people are rarely determined by the biomedical disease in itself. People also respond based on what they perceive the disease will cost them. The perceived cost may involve social reputation, money, family relationships, marriage, employment, or personal safety. The films repeatedly show that these social and material concerns influence whether people move toward the patient or away from them.

4.3 Analysis:

4.3.1 Representation of Physical Disease in Selected Bangladeshi Cinema

4.3.1.1 Disease Burden versus Cinematic Visibility

The first dimension of this problem statement on representation of physical disease in Bangladeshi cinema, and Research Sub-question 1 that follows from it, asks a simple question: do the diseases shown most often in the Bangladeshi cinema sample match the

diseases that actually affect the Bangladeshi population most heavily, or does cinema choose diseases for other reasons? Table 3.1 and Table 4.1 show the cinematic side of this comparison. In the wider thirteen-film sample from which the final sample was selected, cancer appears in four films, COVID-19 in three, HIV/AIDS and fever in two each, while heart disease-with-paralysis and appendicitis appear only once. Therefore, four conditions make up most of the disease representation in the films. The epidemiological comparison below examines whether this reflects the actual disease burden in the population or whether other factors influence which diseases are chosen for films.

The actual disease burden in Bangladesh looks quite different when measured through health data rather than films. The most comprehensive available estimate, the Global Burden of Disease Study's Bangladesh analysis, found that non-communicable diseases made up fourteen of the twenty leading causes of death in the country by 2019. Stroke, ischaemic heart disease, and chronic obstructive pulmonary disease (COPD) were the top three causes of death. Neonatal disorders, stroke, and ischaemic heart disease also caused the largest share of years of life lost (Islam et al., 2023). None of these major causes, stroke, ischaemic heart disease, COPD, or neonatal disorders, is the main subject of a film in the wider sample. The closest example is *Saba* (2024), the only film in the sample dealing with heart disease and paralysis. It therefore represents a whole category of disease that, following the health data, could have a much larger presence in the sample but appears only once.

Cancer is the main exception among these non-communicable diseases. It receives a level of attention in the films that is closer to its actual disease burden. Bangladesh recorded an estimated 167,256 new cancer cases and 116,598 cancer deaths in 2022 (Hossain et al., 2026). Cancer is therefore a major cause of death in the country. Its four appearances in the wider film sample make it one of the most visible diseases in the sample. In this case, cinematic visibility and actual disease burden are more closely connected.

HIV/AIDS presents its own pattern of representation in the films examined as well. In *Meghla Akash* and *Megher Koley Rod*, the focus is not mainly on the medical effects of the disease but on the social responses surrounding it, particularly stigma, fear, secrecy, family rejection, and misunderstanding. The conflicts in both films develop largely from how HIV/AIDS is perceived and how people respond to the possibility or presence of the disease. This suggests that, in these films, HIV/AIDS functions not only as a medical condition but also as a source of social and moral conflict.

COVID-19 had become a major cause of death for a period of time. Bangladesh recorded close to 29,500 cumulative confirmed COVID-19 deaths by the point when the World Health Organization's dashboard data stabilised (World Health Organization, 2024). This was a substantial number of deaths, although it was still smaller than the annual number of deaths caused by stroke, ischaemic heart disease, or cancer alone. COVID-19 was also concentrated within roughly a two-year emergency period, rather than being a long-term and continuous disease burden. Even so, COVID-19 produced three films in the wider sample within a few years of the outbreak. Two of these were short films released directly online rather than through cinemas.

Taken together, these comparisons show a clear pattern. The diseases represented in this sample of Bangladeshi cinema are generally not the diseases that kill the largest number of Bangladeshis. Instead, the films often focus on diseases that create strong fear, secrecy, or immediate social problems. HIV/AIDS is represented through its stigma and moral associations. COVID-19 is connected to its sudden and highly visible public crisis. Cancer is different because its cinematic presence is closer to its actual disease burden, while also having a strong dramatic role because of its serious and often fatal nature and its long history as a dramatic subject in world cinema. In contrast, cardiovascular diseases, respiratory diseases, and neonatal disorders receive very little or no attention in the sample, even though health data identifies them as major causes of death in Bangladesh.

Fever, the fourth recurring category in the sample, does not fit this pattern completely. Fever is not itself a specific disease. It is a symptom that can be caused by different illnesses. In both *Matir Moyna* and *Rickshaw Girl*, fever represents an illness that is not clearly diagnosed or given a specific medical name. This means that at least one-quarter of the films in the cinematic sample are not really representing a specific disease burden. Instead, they represent the broader experience of being ill without receiving a clear diagnosis. This can also be understood as an indirect comment on limited access to rural healthcare, which Section 4.6 examines in more detail.

In addition, the sample was compiled based on criteria which will suit the research focus, instead of randomly selecting from the full population of Bangladeshi films. Therefore, the difference between cinematic visibility and actual disease burden is considered in relation to the specific sample selected.

Although what the comparison does show is limited, but it is still meaningful. Within this sample, the diseases chosen by Bangladeshi cinema appear to be influenced less by how common a disease is in the population and more by what the disease can do within a film's story. Diseases that can create stigma, urgency, fear, secrecy, or moral conflict receive more attention. Cancer is an important exception because both its disease burden and cinematic presence are high. Overall, this pattern supports the thesis's broader argument that cinematic visibility is a selective form of representation rather than a direct reflection of public health data.

4.3.1.2 Uneven Distribution, Causes, and Prevention

The second dimension of the problem statement on representation, asks whether films that do take up disease actually engage with its causes and prevention, or whether they focus overwhelmingly on symptoms and suffering once the illness has already arrived. In Table 4.1, five of the eight films, *Unoponchash Batash*, *Ahare Jibon*, *Corona Bole Kichu Nei*, *Meghla Akash*, and *Megher Koley Rod*, describe the etiology of the disease in some form, while the remaining three (*Matir Moyna*, *Rickshaw Girl*, *Bad Son*) do not. At first glance, the four conditions may seem to be represented equally. However, the films deal with the causes and development of HIV/AIDS and COVID-19 very differently from how they deal with fever and cancer.

For HIV/AIDS and COVID-19, cause is almost unavoidable as a plot element, because both diseases are transmissible, and transmissibility is precisely what generates the stigma, fear, and social consequences that make these films dramatically interesting in the first place. *Meghla Akash* openly talks about how the HIV is contracted, with proper information to encourage the students in the film and the viewers of this film, not to generate accusations, suspicions, and secrecy. The same is true of *Corona Bole Kichu Nei* and *Ahare Jibon*, where the very premise of contagion, someone might "catch" the disease from someone else, drives the isolation, blame, and quarantine measures depicted in Table 4.5. But they also did talk about how to prevent oneself from a contagious disease like COVID-19, especially in *Corona Bole Kichu Nei*, where Afrin tried to convince her dad to stay home, isolated from strangers, and to wear a mask even if he goes outside.

Cancer and fever behave differently. *Unoponchash Batash* does discuss etiology, but *Bad Son* does not, and neither *Matir Moyna* nor *Rickshaw Girl* addresses the cause of the

fever their protagonists suffer from. This is telling: unlike HIV/AIDS and COVID-19, cancer and fever in this sample are not diseases whose *origin* drives the plot. They are diseases whose *consequences*: Suffering, cost, death; drive the plot. The films are far more interested in what the disease does to a family than in why the disease occurred at all. This difference supports Kleinman's concept of explanatory models. In these films, the focus is less on explaining the biomedical cause or prevention of the disease and more on showing the disease as something that simply happens, often to people who are already vulnerable. The stories mainly focus on what happens after the disease appears.

Symptom representation follows a related but distinct pattern (Table 4.1). Five films visually or narratively depict symptoms in some detail, *Matir Moyna*, *Rickshaw Girl*, *Unoponchash Batash*, *Ahare Jibon*, *Corona Bole Kichu Nei* and *Meghla Akash*, and *Bad Son*, while only *Megher Koley Rod* do not. The films mainly show two symptoms: pain, which appears in six and fatigue, which appears in five. Both appear in six of the eight films. Cough and fever are also common symptoms. However, a low number of films in this sample gave attention to disease prevention.

This has a clear implication for Research Sub-question 1. Bangladeshi cinema, in this sample, treats disease overwhelmingly as something to be endured rather than something to be prevented. The emotional and drama in these films is showed almost entirely through suffering, sacrifice, and family response, which is consistent with Frank's chaos and restitution narrative types: Most of these films gravitate toward restitution narratives when the patient survives and chaos narratives when they do not, but very few of them adopt anything resembling a public-health or quest narrative in which illness becomes an occasion for structural or preventive reflection. This matters for the thesis's broader argument: if Bangladeshi commercial cinema is one of the few mass-cultural spaces where ordinary audiences encounter representations of serious illness, its near-total silence on prevention represents a missed opportunity for public health messaging, a point this thesis returns to in Chapter Five.

4.3.1.3 Box Office Performance

The third dimension of the problem statement on representation, asks whether commercial performance affects which illnesses receive cinematic representation, and whether films about different diseases perform differently at the box office. Table 3.1

provides the available figures. However, the limited box office data is itself an important finding. Four of the eight core films: *Megher Koley Rod*, *Corona Bole Kichu Nei*, *Ahare Jibon*, and *Bad Son*, are either recorded as unpublished or have no available box office data. This situation is also connected to wider problems with box office records in Bangladeshi cinema. Box office reporting has been affected by piracy and the lack of a centralised digital ticketing system across the country's cinema halls. One industry estimate reported that more than 900 cinema halls had closed across the country since 2000, leaving only a few hundred halls operating (Chowdhury, 2016). In this situation, even when a film is released in cinemas, reliable information about its earnings may not be available. Chowdhury (2016) also describes situations where a hall owner may not even know that unauthorised copies of a film are already being circulated in nearby tea stalls on the day of its release. Therefore, the absence of a published box office figure tells us both about a film's reception but also about the condition of the country's cinema exhibition and reporting system.

Among the films with available figures, *Matir Moyna* has the highest reported box office performance. Its worldwide gross is reported to be between US\$46,852 and US\$48,752. It has the strongest commercial performance among the films in the sample. The film is also one of the oldest films in the group, released in 2002. *Unoponchash Batash* (2020) has a reported worldwide gross of approximately US\$8,368, while *Rickshaw Girl* (2021) has a reported worldwide gross of approximately US\$1,973. *Meghla Akash* (2001) is described as having achieved "moderate-to-commercial box office success," but no specific figure is available.

If we look only at these figures, it may appear that fever, which is shown in *Matir Moyna*, was more commercially successful than cancer or COVID-19. However, other factors provide a stronger explanation. *Matir Moyna* is the only Bangladeshi film to win an official prize at the Cannes Film Festival. It received the FIPRESCI (International Critics') award in the Directors' Fortnight section in 2002. The award recognised its "authentic, moving, and delicate portrayal of a country struggling for its democratic rights" (Raisha, 2019). This international recognition helped the film reach audiences outside Bangladesh through international distribution, screenings, and continued circulation for more than two decades. The film was also shown through broadcasts and festival screenings after its original release. These opportunities gave *Matir Moyna* more chances to earn money over time than a locally released illness film without a similar festival profile. Therefore, its stronger box office

performance may be better understood in relation to its international recognition and long-term circulation rather than the presence of fever in the story.

Unoponchash Batash also needs to be considered in relation to the circumstances of its release. At the time of its production, contemporary reports described it as one of the "big-budget and much-anticipated" Bangladeshi films. It was mentioned alongside major commercial films such as *Bidrohi* and *Mission Extreme*. However, its theatrical release was delayed when cinemas across Bangladesh were closed from 18 March 2020 as part of COVID-19 control measures (UNB, 2020). Therefore, the film's relative box office figure cannot be understood only in relation to its cancer story. Its commercial release was affected by the closure of cinemas during the pandemic. The disruption was caused by the wider COVID-19 situation, not by the film's subject matter. Therefore, the box office figure is not the only evidence of how audiences responded to cancer as a cinematic subject.

The COVID-19 films in the wider sample show another type of commercial situation. *Oxygen* and *Corona Bole Kichu Nei*, both released in 2020, were published directly on YouTube rather than being released through cinemas. As a result, they do not have traditional cinema box office figures. This decision was also connected to the closure of cinemas during the pandemic. With the cinema sector closed for much of 2020 (UNB, 2020), a short film about the pandemic could reach audiences more easily through direct online release while the crisis was still happening. Therefore, the lack of box office data for these two films does not necessarily mean that they were commercially unsuccessful. Instead, it shows that cinema box office was not the main measure of success for films that were released directly to online audiences during the crisis.

Another possible pattern can be seen in the available data, although the evidence is limited. *Matir Moyna*, the strongest commercial performer in the sample, is also the film in which disease is least central to the main story. Fever is part of a much larger story about a rural family during the Bangladesh Liberation War. This supports Domaradzki's (2022) observation, using the comparable coding framework adapted by this thesis, that popular cinema often places serious illness within a larger story instead of making the illness the only focus.

It is therefore possible that disease may work more successfully at the box office when it is part of a larger story, such as a war story, family drama, or romance. The relatively

modest or unavailable box office figures for films in which illness is a central subject, such as *Unoponchash Batash*, and *Rickshaw Girl*, are consistent with this possibility. However, several other factors also affect these figures, including festival recognition, cinema closures during the pandemic, and wider problems with box office reporting in Bangladesh (Chowdhury, 2016). Because the sample is small, the available data cannot establish this pattern with confidence.

What can be said more clearly is that the available data does not show a simple pattern in which films about disease are either rewarded or punished at the box office. In this sample, commercial performance appears to be connected to several factors beyond the disease shown in the film. These include the historical setting, combination of different genres, festival recognition, and the timing of release in relation to a national health crisis. In at least one case, *Unoponchash Batash*, these outside factors may have had a greater effect on commercial performance than the disease represented in the film.

4.3.1.4 Promotional Materials

The fourth dimension of the problem statement on representation, looks at how disease is shown, hidden, or presented differently in the promotional materials of these films. These materials include film titles, posters, and marketing language. This helps show how audiences are expected to understand a film before they even enter the cinema.

The film titles provide the clearest starting point. They show that most of the films avoid directly naming the disease. Among the eight core films, only *Corona Bole Kichu Nei* ("There is No Such Thing as Corona") directly names a disease in its title. However, the title raises the question of whether the disease is real before the film even begins. This also prepares the audience for the denial shown in the patient emotional-response data in Table 4.3.

The other titles use metaphor, mood, or the main story instead of medical terms. *Meghla Akash* ("Cloudy Sky") and *Megher Koley Rod* ("Sunlight on the Lap of Clouds") use images of weather to create an emotional mood instead of naming HIV/AIDS. *Unoponchash Batash* ("The Forty-Ninth Wind") and *Ahare Jibon* ("Oh, Life") refer indirectly to ideas such as fate, breathing, and death without naming cancer or COVID-19. *Matir Moyna* ("The Clay

Bird") and *Rickshaw Girl* focus on a character or an object rather than disease. *Bad Son* presents its cancer story through a family relationship instead of directly naming the disease.

The visual layer of the promotional material, however, does not conceal the disease in the same way the titles do. The YouTube thumbnail for *Corona Bole Kichu Nei* places two recognisable symbols directly around the two main characters: several spike-covered spherical icons that had become globally standardised as a visual shorthand for the coronavirus by the time of the film's 2020 release, scattered across the background, and a surgical face mask held in Afrin, the daughter's hand, towards her father. The poster for *Ahare Jibon* does something similar in a single, more compact image: a red spiked-virus icon is layered over the lead actor's chest, positioned as though it is entering or his body.

Also, before the latter film was released, press coverage openly described its subject. Announcement reports described the main character as a migrant worker returning from Italy who "travels back to Bangladesh during the Covid-19 pandemic but faces complications upon his return." The reports also described the film as being based on "a real incident" from the pandemic (The Business Standard, 2022).

Picture: *Corona Bole Kichu Nei* (2020) *Ahare Jibon* (2024) Movie Poster | Source: IMDb



Therefore, the disease was not hidden from people who followed news about the two films. The information was available in industry reports and other coverage. However, the disease was not mentioned in the title, which is the main piece of information every potential viewer sees. This suggests that the promotional approach gave more specific information

about the disease to people who were already interested enough to read further, while giving other audiences a softer and more emotional message through the title.

This finding can also be understood through Hall's (1980) encoding/decoding framework. If the films presented disease directly in their marketing, audiences would enter the cinema already thinking of them mainly as "disease films." This could make the films more attractive to people specifically interested in that subject, but it could also reduce their wider appeal. It could also create stigma-related reactions before the audience even watches the film. These are the same types of stigma-avoidance responses discussed later in this chapter.

Instead, the films often present disease indirectly in their promotional materials. They use images of weather, breathing, fate, family, and relationships instead of directly naming the disease. The disease becomes clear once the audience watches the film, but it is often softened or hidden before the audience decides to watch it.

Picture: *Unoponchash Batash* (2020) and *Rickshaw Girl* (2021) Movie Poster
Source: IMDb



This suggests a two-stage approach. First, the film attracts audiences through familiar and less stigmatising ideas such as family, emotion, weather, or relationships. Then, after the audience becomes interested in the characters, the film presents the specific disease and its effects. Fiske's (1989) discussion of popular culture helps explain why this approach may

work commercially. Audiences may be more attracted to familiar emotional subjects, such as a cloudy sky, a family, or a sister, than to the direct idea of watching a film "about HIV" or "about cancer," even when the film eventually deals seriously with those diseases.

4.3.2 Urban versus Rural Representation

The second problem statement, or research sub-question 2, asks how disease is represented differently in urban and rural settings, especially in terms of healthcare access, treatment options, and experiences of suffering. Six of the eight films in Table 4.4, *Meghla Akash*, *Megher Koley Rod*, *Corona Bole Kichu Nei*, *Bad Son*, *Ahare Jibon*, and *Unoponchash Batash*, are set in urban areas. Only *Rickshaw Girl* and *Matir Moyna* are set in rural areas.

Table 4.4: Setting and Healthcare Access

Movie Title	Setting (Urban/Rural)	Type of Healthcare Facility Shown	Type of Physician Available (General/Specialist/None)	Travel to Receive Care Shown? (Yes/No)
<i>Meghla Akash</i>	Urban	Hospital	Specialist	Yes
<i>Megher Koley Rod</i>	Urban	Hospital	Specialist	No
<i>Corona Bole Kichu Nei</i>	Urban	None Shown	None Shown	No
<i>Bad Son</i>	Urban	Hospital (home and abroad)	Specialist	Yes
<i>Ahare Jibon</i>	Urban	Quarantine Centre and Hospital	General	Yes
<i>Unoponchash Batash</i>	Urban	Private Chamber and Hospital	Specialist	Yes

<i>Rickshaw Girl</i>	Rural	Hospital	General	No
<i>Matir Moyna</i>	Rural	Home	Homeopathy	Not applicable

The two rural films show very different forms of care. In *Matir Moyna*, Asma's fever is treated completely at home. Her father, who is a homeopathic physician, gives her a homeopathic remedy, and no medical facility is shown. In *Rickshaw Girl*, a hospital and a doctor are shown, but the doctor is a general physician. The doctor does not identify Selim's disease or refer him to another doctor. In contrast, the six urban films regularly show hospitals, private doctors' chambers, and even a quarantine centre. Four of these films, *Meghla Akash*, *Megher Koley Rod*, *Bad Son*, and *Unoponchash Batash*, show named specialists. *Bad Son* shows the highest level of access because the patient is sent abroad for treatment.

This difference is not only a choice made by the films. It also reflects a well-documented difference in Bangladesh's healthcare system. Workforce data show a stark rural-urban gap in doctor density: approximately 182 doctors per 100,000 people in urban areas, compared with only 11 per 100,000 in rural areas (Ahmed et al., 2013, as cited in Uddin, 2025). This means the number of doctors per person was more than sixteen times higher in urban areas. The same survey found a similar difference in the number of registered nurses: 0.8 per 10,000 people in rural areas compared with 5.8 per 10,000 in urban areas.

The nationally representative survey also found a different pattern for informal and non-allopathic providers. Traditional healers, including kabiraj and faith healers, were available at a rate of 82.6 per 10,000 people in rural areas, compared with 8.6 per 10,000 in urban areas (Ahmed et al., 2011). Qualified homeopaths did not show the same strong rural pattern. In fact, the survey found slightly more qualified homeopaths in urban areas. Therefore, in *Matir Moyna*, Asma's father has a strong belief in homeopathic treatment and chooses to use it instead of the allopathic medicine that her uncle secretly brings for her. The father describes the allopathic medicine as a threat to the "virtue" of his own remedy. His decision to use homeopathy is therefore based on his strong belief in it, not simply because other treatment is unavailable.

The national data supports the healthcare setting shown in the film. A rural household facing illness is more likely to receive care first from a non-allopathic or informal provider, such as a homeopath, kabiraj, or faith healer, than from a specialist like those shown in *Meghla Akash* or *Unoponchash Batash*.

The difference can also be seen in the distribution of qualified doctors. A 2019 discussion on the distribution of doctors reported that Dhaka division had 4,749 posted physicians for only 783 posts, creating a 42.2% surplus. At the same time, more than half of the posts were vacant across Barisal, Rangpur, Khulna, Sylhet, Rajshahi, Chattogram, and Mymensingh divisions combined (The Financial Express, 2019). The same report referred to a World Health Organization estimate that 35% of Bangladesh's doctors and 30% of its nurses serve only the 15% of the population living in Dhaka, Chattogram, Rajshahi, and Khulna. In contrast, fewer than 20% of health workers serve the more than 70% of Bangladeshis living in rural areas (The Financial Express, 2019).

This information helps explain *Rickshaw Girl*, regarding the distribution of healthcare workers in Bangladesh. The hospital shown in the film is overcrowded, and the doctor appears to move quickly from one patient to another, spending only a short time on diagnosis so that the queue can continue moving. This is consistent with a healthcare system where specialist and general care are provided with too few hands compared with the number of people who need care. Although it eradicates the problem of doctor's absence, it can result in long waits and short consultations.

A similar concern appears in *Unoponchash Batash*. When Nira offers him to go see a doctor with her, for his fever, Ayon is not worried that there is no doctor available. Instead, he worries if getting a doctor's appointment instantly is possible, since seeing a doctor and receiving proper attention may take a long time, possibly even several days. Taken together, the two films show a broader sociological pattern: access to healthcare in Bangladesh depends not only on whether a healthcare provider is available, but also on the time, cost, and waiting involved in getting care. These factors can affect how much time a patient receives and how thoroughly the patient can be examined and treated.

The "travel to receive care" column in Table 4.4 adds another part to this picture. Several urban films, *Meghla Akash*, *Bad Son*, *Ahare Jibon*, and *Unoponchash Batash*, show patients travelling for treatment. At first, this may seem to weaken the difference between

urban and rural settings. However, the type of travel is important. In these films, patients travel within the city or travel to other countries. They are not shown making the longer journey from rural areas to cities, which can be a major barrier to healthcare in Bangladesh. For example, patients may travel between a private doctor's chamber and a hospital, while Babu in *Bad Son* is sent abroad for treatment.

Neither *Rickshaw Girl* nor *Matir Moyna* shows this type of travel, but the reasons are different. In *Rickshaw Girl*, the family's main problem is paying for Selim's medicine. Therefore, travelling to a city-based specialist is not shown as an urgent option for the family. In *Matir Moyna*, however, the lack of travel is not related to cost or distance. The family has the ability to afford allopathic treatment, and Asma's uncle actually brings one to Asma's mother. However, Asma's father insists on homeopathy instead. Therefore, the lack of specialist care in this film reflects a personal belief rather than a structural barrier to healthcare access.

The two rural films therefore support the wider argument in different ways. *Rickshaw Girl* is consistent with the idea that structural factors, such as cost, can limit a rural family's use of specialist healthcare even when a hospital is nearby. This is the kind of constraint described by Farmer's (2004) concept of structural violence. In this concept, harm can result not from an individual's choice but from social and economic conditions that limit the choices available to people.

Matir Moyna, however, makes this picture more complex. The film shows that limited access to healthcare is not always the reason for seeking non-allopathic treatment. Workforce data helps explain why traditional and homeopathic providers are generally more available in rural areas, but this film shows that even when a family has other healthcare options, belief in a particular treatment can still determine the outcome.

Together, the two films suggest that the urban-rural difference in this sample cannot be explained by one factor alone. Structural barriers explain some of what is shown, but they do not explain everything. Cost and access can shape healthcare choices, while personal beliefs can also influence the type of treatment a family chooses.

Another important point is the rural focus of the sample. Bangladesh remains a majority-rural country, with more than 70% of the population living outside the major cities

(The Financial Express, 2019). However, only two of the eight core films are set in rural areas.

This finding connects with the result discussed in Section 4.3.1.1. That section shows that the diseases represented in the sample do not closely follow the country's main causes of death. Instead, the sample gives more attention to diseases associated with stigma or sudden public concern. The same pattern can be seen geographically. The diseases represented in the sample do not fully reflect the country's actual disease burden, and the settings shown in these films also give less attention to rural Bangladesh, where most Bangladeshis live and experience illness.

Overall, the urban-rural difference in this sample is important not only because of where the stories take place, but also because of the different healthcare experiences shown in these settings. Urban films make hospitals, specialists, diagnosis, and treatment options more visible. Rural films make limited access, home-based care, and the absence of specialist treatment more visible.

4.3.3 Gender-Based Differences in Disease Representation

The third problem statement looks at gender differences in the way disease is represented. Research Sub-question 3 asks more specifically: how do family and society in films respond differently to female and male patients, especially in terms of care, stigma, and social judgment?

Table 4.3 shows that there are more male than female patients in the eight-film sample. However, this should not be understood as a general pattern in Bangladeshi cinema. In the larger thirteen-film sample, from which the eight-film sample was selected, the difference is much smaller: there are fifteen patients in total, including eight males and seven females. Therefore, the unequal number of male and female patients in the main sample is partly the result of how the sample was selected. This is important because the differences in how illness is treated cannot simply be explained by women appearing less often as patients.

This distribution can be understood through Berger's (1972) argument that in visual culture, "men act and women appear" (p. 47). In simple terms, women are often shown as people who are looked at and judged, rather than as active characters whose own experiences

control the story. Mulvey (1975) later applied this idea to cinema. She argued that mainstream films often divide looking into an active/male role and a passive/female role.

Research on Bangladeshi cinema has found a similar pattern in commercial films. Rahman and Zannat (2021) found that mainstream Bangladeshi films often give women a limited set of roles, such as the submissive and self-sacrificing wife or mother, or as objects of male desire. Women are less often given independent control over the story.

The gender distribution becomes relevant when we look at how male and female patients are treated in the films. Female patients are often shown as people who are judged, protected, or rejected by others. They usually have less control over how their illness is understood and managed. The following discussion therefore focuses on individual patients and on how other people respond to their illnesses.

Table 4.5: Psychosocial Issues Related to the Diseases

	N
Stigmatisation	2 (<i>Megher Koley Rod</i> , <i>Ahare Jibon</i>)
Isolation/social exclusion	4 (<i>Megher Koley Rod</i> , <i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Matir Moyna</i>)
Discrimination	1 (<i>Rickshaw Girl</i>)
Reduced life opportunities	3 (<i>Ahare Jibon</i> , <i>Unoponchash Batash</i> , <i>Rickshaw Girl</i>)
No issues faced by the patient(s)	

The clearest example of this pattern being challenged is also the most revealing. *Megher Koley Rod* is the only film in the sample where the whole story is organised around a suspected female patient. The film shows something that does not happen in the same way in the films with male patients. An illness accusation made against Rodela on her wedding night is treated by her husband's family, not mainly as a medical problem that needs to be tested and treated, but as a threat to the marriage itself.

Rodela's in-laws do not ask how she can be tested, treated, or cared for. Instead, they threaten divorce and stop Nijhum from contacting her. Her body is presented as a possible source of infection and a danger to the future of the family, rather than as the body of a

person who may simply have a medical condition. No male patient in this sample faces a similar situation.

Rabbi's COVID-19 diagnosis in *Ahare Jibon* causes disgust and social distancing from his brother's father-in-law, and the stigma also reaches one of his sisters, Mira. When her boyfriend, Pavel wanted to introduce her to his mother, this was the conversation between the mother and son:

Pavel's Mother: Didn't you say the other day that her brother has arrived from Italy? He'd been placed in isolation being suspected of [carrying] Corona [virus]?

Pavel: Yes, Ma. Mira's brother is still in quarantine.

Pavel's Mother: You shouldn't have brought her here before getting the results of her brother's test. What if he tests positive?

Pavel: What are you saying?

Pavel's Mother: I'm saying the right thing. Now it's not right to bond with a girl from Corona-house.

— *Ahare Jibon* (2024), (Timestamp: 1:03:01-1:03:30)

Therefore, Pavel's mother refuses to meet her until Rabbi's test result comes out, telling her son he does not need to bond with a girl from a "Corona-house." Rabbi's own marriage, however, is never threatened. Similarly, Ayon's cancer in *Unoponchash Batash* does not prevent Nira's family from eventually accepting their relationship. They even marry in the hospital before Ayon dies.

Across this sample, illness in a man is something around which the family comes together, while illness, or even the suspicion of illness, in a woman can become a reason for the family to remove her. This difference can be understood through the wider structure of gender and stigma. A woman's illness can carry an additional social meaning because it is connected to her value as a wife, while a man's illness is more closely connected to his role as a provider.

Meghla's story in *Meghla Akash* makes this picture more complex. Her delay in seeking medical care can be compared with a well-documented problem involving women's access to healthcare in Bangladesh.

A national research shows that women's healthcare decisions in Bangladesh are often controlled by other people. A study of married women in rural Cox's Bazar found that only 12% of women had the power to make their own decisions about seeking healthcare for themselves (Mainuddin et al., 2015). Similarly, qualitative research on obstetric emergencies in rural Bangladesh found that decisions about when to seek medical care were usually made by husbands or other male relatives rather than by the women experiencing the health crisis themselves (Sikder et al., 2011).

Meghla's experience, however, does not directly follow this pattern. The film does not show a man or another person making the decision for her. She also does not ask Javed or her boss at the brothel for help, even though she could have approached either of them. The film does not explain why she is reluctant to seek care. We see that she treats the recurring fever as something normal ("nothing to be serious about"), and when tests are suggested, she says that she cannot afford them. Whether her situation in the brothel influenced her delay is left for the viewers to decide. One possible interpretation is she did not want to become a burden on others. Javed was already supporting her, and her boss would probably have contacted him anyway. From a sociological point of view, this could reflect the expectation that a woman who depends on a man's support should avoid adding to his financial burden.

However, once her treatment begins, Meghla receives support from the people around her. Javed listens to the doctor when the doctor tells him to get himself tested, even before he learns what went wrong. After Meghla's diagnosis, he remains fully committed to both his own treatment and hers. Also, when Rimi, Javed's sister, poses a question on Javed marrying Meghla, the doctor (who is Rimi's professor as well) convinces her that Meghla's "first identity" is "a human." Rimi then apologises to Javed and accepts Meghla as a new member of the family.

This support does not completely separate *Meghla Akash* from its sequel *Megher Koley Rod*, because Rodela also has people who refuse to judge her immediately. Her aunt and uncle, who raised her after her parents died, stay with her throughout the situation. When Nijhum's parents ask them to take her away, her uncle tells her to come back home. He still

considers their house to be her home. Uday, a friend of both Rodela and Nijhum and now her lawyer, also supports her. He brings Meghla's obstetric doctor, Dr. Selina, to court, where she explains that a mother with HIV can give birth to a child who is free from HIV.

The difference is in who responds first and where the support comes from. Meghla receives support from her partner and her doctor as soon as treatment begins. But Rodela's first responders, her husband's family, judged her immediately. Her support instead comes from her own family and from people outside the marriage: her aunt and uncle, and later Uday and Dr. Selina. In both films, therefore, the woman's illness is largely named and decided by other people. What protects her is whether someone is willing to listen before judging her.

Matir Moyna gives the clearest example in the sample of gendered authority over a sick body when the person making the decision is not even the patient. Asma's treatment becomes a disagreement between her parents, and the father's decision wins. He insists on using his own homeopathic treatment and secretly takes away the allopathic medicine brought by the mother's uncle. He presents the allopathic medicine as a threat to the "virtue" of his own treatment, and to keep faith in Allah.

The mother's wish to consult a doctor is directly rejected instead of being discussed or negotiated. This is not simply limited to a disagreement between religion and secular medicine. It also shows a pattern found in the rural Bangladeshi obstetric research mentioned earlier. In that research, decisions about seeking or withholding medical care for a family member were often controlled by the male authority in the household rather than by the person who was closest to the patient's everyday condition (Sikder et al., 2011). Asma has no voice in this disagreement because she is a child. Therefore, the conflict is entirely between two adults who claim authority over her body, and the film resolves the disagreement in favour of the father.

Not every female character is passive. Naima in *Rickshaw Girl*, who is not herself a patient, speaks up for her sick father. However, her agency is used to help him rather than herself. A daughter's ability to help a sick father is accepted by characters within the story, while a wife's attempt to defend herself against a suspected illness, as in *Megher Koley Rod*, is not treated in the same way.

This contrast points to a broader pattern that can be seen beyond these individual scenes. Section 4.2.3 discussed how patients respond to diagnosis. Male patients who hide their illness or withdraw from others, such as Babu and Ayon, were understood as trying to protect their social position, especially their role as providers, from the burden their illness might place on others. Female patients such as Meghla and Rodela, in contrast, remain actively involved. Meghla continues to take part in her treatment, while Rodela faces the stigmatised situation and tries to find a solution.

However, when viewed from a gender perspective, this should not necessarily be understood as complete or independent freedom. Their actions are still connected to the need to be accepted and judged positively by other people. Rodela seeks testing partly to restore her position in her husband's family's eyes. Meghla's continued involvement in treatment also develops alongside, and partly because of, her relationship with Javed.

The men's withdrawal and the women's involvement can therefore be understood as two different responses to the same basic pressure: their bodies have become subject to other people's judgment. For men, this pressure is connected to the expectation that a provider should not become a burden. For women, it is connected to the expectation that a wife or future wife should not become a liability.

Taken together, these patterns suggest that, at least within this sample, Bangladeshi cinema shows family and society responding differently to female and male patients in ways that reflect patriarchal structures. However, the films do not simply make women passive. Instead, they give women's illness, whether real, suspected, or completely fabricated, different and often harsher social consequences than men's illness. The films also often place the people around the woman, rather than the woman herself, in the position of deciding how her illness should be named, treated, or judged.

The small sample means that this pattern cannot confidently be generalised to Bangladeshi cinema as a whole, since only four patients across the eight core films are women: Meghla, Rodela, Asma, and Nazma in *Bad Son*. One point worth mentioning is, Nazma's tumour diagnosis is resolved quickly and receives little further attention after Babu's concealed cancer becomes the main focus of the film. These four female patients are compared with six male patients, giving a ratio that is similar to the eight-to-seven distribution found in the wider group of thirteen films.

Therefore, the gender difference in the number of patients is not large enough by itself to explain the stronger differences in how illness is treated. Those differences lie in how family and society respond: a woman's illness, whether real or only suspected, becomes a question of her place in the family and marriage, and her acceptance or rejection depends on the people around her, while a man's illness is more often met with care.

4.3.4 Affluence, Class, and Religion in Disease Representation

Disease in these eight films is consistently presented as part of the patient's social environment. Every patient belongs to a household with a particular income, lives in a particular part of the country, and has a religious identity. Among these factors, income and location are documented factors that affect unequal access to healthcare in Bangladesh. They influence the type of care a patient receives and who diagnoses them. In this sample, as discussed below, the role of a religious identity is more connected to how a patient's suffering is presented and understood.

Paul Farmer's idea of structural violence is useful for understanding this pattern. Farmer argues that suffering and early death are not randomly distributed. Instead, they are connected to a person's position in an unequal society. When someone dies from a treatable condition because they could not reach or afford proper care, that death can be understood as the result of societal structures rather than only as an individual misfortune (Farmer, 2004). From this perspective, the data in Tables 3, 4, and 6 do more than show who is rich or poor and who is Muslim or not. They also show how the films distribute the “chance of survival” among different patients.

Affluence and Social Class: Who Gets Diagnosed, Treated, and Saved

Table 4.4 shows differences in the type of healthcare facility and doctor available to patients across the eight films. *Bad Son* and *Meghla Akash* place their patients in hospitals with specialist doctors. In both films, the patient's loved ones commute with them for treatment. In *Bad Son*, the patient is sent abroad. In contrast, *Rickshaw Girl* and *Matir Moyna* are set in rural areas. Their patients receive care only from a general doctor or, in the case of *Matir Moyna*, receive homeopathic treatment at home without an allopathic doctor being involved.

This urban-rural difference is not simply a choice made for the story. It reflects a difference between rural and urban healthcare in Bangladesh. Data on doctor density, cited in Uddin's (2025) study of primary healthcare in Bangladesh, show about 182 doctors per 100,000 people in urban areas compared with only 11 doctors per 100,000 people in rural areas (Ahmed et al., 2013, as cited in Uddin, 2025). National data on household healthcare spending also show that rural households have higher rates of catastrophic health expenditure (CHE) than urban households. This gap became larger between 2005 and 2016. The difference is mainly linked to the lower economic status of rural households, lower educational levels among household heads, and the higher rate of chronic illness, rather than simply the distance from healthcare facilities (Rahman et al., 2024).

Rickshaw Girl fits this pattern directly: The family does reach a doctor, who examines the father and gives them a prescription. What follows is the cost of the medication. The mother sells her bangles to afford it, and Naima moves to Dhaka to provide for her father's treatment, but she fails to provide the fund in time before her father dies. This is a closer match to what Rahman et al. actually identify as the primary cause of the rural-urban CHE gap, household economic status, rather than a story about the unavailability of medical care.

Matir Moyna is a more complicated case. The family is not completely cut off from allopathic medicine because of distance or cost. Asma's uncle brings allopathic medicine into the home, but her father, who practises homeopathy himself, refuses to allow it to be used. He believes that it would weaken the value of his own treatment. Therefore, this is not a story about a family having no treatment options. Instead, it is a story about one family member having enough authority to decide which understanding of illness and treatment will control the household, even when another option is physically available.

This fits Kleinman's model of competing explanations of illness more closely than a simple explanation based only on healthcare access. Patients, families, and healers may have various explanations for disease than biomedical doctors. When these different understandings conflict, biomedical medicine does not always win. In this case, the father's authority within the home and his professional authority as a homeopath override the other treatment option that was available to the family (Kleinman, 1980).

When *Matir Moyna* is compared with *Rickshaw Girl*, this creates a useful contrast. One film shows a structural deprivation, while the other shows a disagreement over medical authority inside a rural setting.

Bad Son appears at the opposite end of this pattern. The patient is "sent to a foreign country" for cancer treatment. At first, this may seem like a simple way for the film to solve the story. However, it also reflects a well-documented practice of medical tourism among wealthier Bangladeshi families. Industry estimates suggest that around 800,000 Bangladeshis travel abroad each year for medical treatment and spend billions of dollars in total. Heart disease, cancer, and kidney disease are among the common reasons for this travel. Experts connect this movement to gaps in specialist healthcare in Bangladesh and a lack of public trust on domestic hospitals.

Seen in this context, *Bad Son* is not only a story about one family's love and sacrifice. It also shows a clear class difference: wealthy families can seek treatment abroad, which may give patients a better chance of survival. In Stuart Hall's terms, the film *encodes* a shared cultural idea: going abroad can mean living, while staying can mean dying. Bangladeshi audiences may recognise this idea because many people know someone who has travelled abroad for treatment or have seen this practice reported in the media.

But on the other hand, *Unoponchash Batash* makes this picture more complex. The family of the heart-transplant recipient, who appear only in the final scene after Ayon's death, for their son's heart surgery, are presented as wealthy. After his death, a doctor comes to Nira to give her a donation form for heart-transplant to sign on, as Ayon's wife; the patient's family is waiting for it. When Nira asks the doctor that Ayon wanted his organs to be donated to families who cannot afford it, the mother of the patient comes to her and explains their situation, that why her son needs the heart, and that they are indeed wealthy enough to "rent an entire airplane." But she also tells Nira that they should not have to suffer the loss of their son simply because they are affluent.

This case differs from *Bad Son*. In *Bad Son*, money buys a purchasable good: a doctor abroad, and a treatment slot. In *Unoponchash Batash*, the recipient family's son needs a compatible donor heart, and no amount of wealth can manufacture one, since a heart can be given, not bought. Wealth reaches its limit here not because the family lacks money, like in *Rickshaw Girl*, but because the thing they need is not for sale at any price. Read this way,

structural violence, in Farmer's sense, is not the claim that money guarantees survival; it is the claim that survival chances are unevenly distributed by social position. A family that cannot purchase a heart directly can still purchase everything that surrounds the transplant: standing in the room to make the case, and the chance to explain themselves directly to the person deciding whether to sign the donation form. Although Ayon explicitly wanted his organs to go to families who could not afford care, yet the heart is instead directed toward a wealthy family. Ayon's wish to redirect that resource toward the poor is not shown to succeed; the recipients remain privileged along the same axis he was trying to interrupt. Therefore, their wealth does have an influence on how the scene plays out.

Besides that, in the film, Ayon is not shown as wealthy himself. He introduces himself as a medical sales representative (MPO) and says that he previously worked at a ship-breaking yard. After he is told to be admitted immediately for treatment, he leaves the hospital instead of allowing Nira's family to pay for the emergency treatment Professor Rajjak recommends. He describes the treatment as a "lottery" that he cannot afford to play. The specialist care Ayon receives is also not because of his own financial resources. He gets an appointment with a named specialist without waiting, and later receives a hospital room where the staff bend administrative rules for him. However, this access comes through Nira and Nira's father, a doctor who personally helps them.

Seen this way, *Unoponchash Batash* supports Farmer's argument about structural violence. Ayon receives specialist and dignified care only because another person's social connections give him access that his own resources could not provide. When it comes to treatment that could actually extend his life, the lack of money, especially his own money, determines the outcome.

The film therefore shows a difference between the quality of the dying process and the fact of death. Social connections can improve the way Ayon is treated and allow him to experience dignity, but his death is still connected to treatment that he could not personally afford.

Ahare Jibon provides a partial exception. Rabbi is shown as an economically successful migrant worker. He is wealthy enough to work in Italy and support his family from abroad, and he lives in an urban area. However, he is first treated in a state quarantine centre and later in a public hospital. This happens because COVID-19 was treated as a public health

emergency. It required a standard response involving quarantine, testing, and isolation. In principle, these measures applied to returning travellers regardless of their income. In this way, the pandemic temporarily reduced some of the class differences seen in the other films. Rabbi cannot use his wealth to avoid quarantine. His COVID-positive status determines how the state treats him, not his economic position.

However, the film shows that social class still matters in relation to stigma. Rabbi's brother's father-in-law refuses to visit him and treats a "corona patient" as someone who should be avoided "no matter if he's a dad or a son." In contrast, his sister's husband volunteers to visit him because he is not related by blood and therefore has "no problem" taking the risk of infection.

This suggests that formal healthcare access and informal social exclusion work differently in the film. Medical treatment is shaped by the state's public health system in times of emergencies, while social exclusion is shaped by family relationships and fear of infection.

Religion: Statistical Uniformity and Its Narrative Function

While wealth and social class create clear differences across the sample, religion creates very little visible difference. Every patient across all eight films is Muslim; no Hindu patient, and none from any other religious identity, appears anywhere in the sample (Table 4.3). The pattern is similar for doctors: in the few cases where ethnicity is identified, they are Muslim as well, while the remaining cases are unspecified (Table 4.2).

At one level, this uniformity reflects Bangladesh's population. Muslims make up about 90% of the country's population. Islamic religious leaders are also widely documented as an early point of contact for many Bangladeshis dealing with illness, especially mental or unexplained conditions (Arafat et al., 2025).

However, this pattern can be connected to Hall's concept of encoding. Repeated choices in on-screen representation can make one religious identity appear to be the normal or default identity through which national illness and suffering are presented, while other identities become less visible simply because they are absent from the screen (Hall, 1980). A point to be noted is that, this is an interpretation based on the statistical pattern in this sample,

not a claim that has been independently proven for Bangladeshi cinema as a whole. A larger group of films would be needed to test whether this pattern continues.

The hospital wedding scene in *Unoponchash Batash* presents religion in a different and more formally accepted way. A Kaji comes to the hospital room to perform Nira and Ayon's nikah. The hospital staff actively allow the ceremony to take place, to the point of allowing flowers in the premise. When Nira's friends begin the nikah arrangements in the room, Ayon asks one of them "What's going on? These weren't supposed to be allowed at a hospital." The nurse, checking on him during that time, tells him, "There is no law for you here, sir. Even the doctors know [about] this," showing that the hospital is willing to make an exception for him.

This connects with Kleinman's argument that patients, families, and healthcare providers can have different but coexisting understandings of what illness requires. In this scene, biomedical treatment and religious (marital) practice work together. The hospital does not simply tolerate the wedding; its staff actively help make it possible. This suggests that, in the film, religious ritual is not treated as a response to an already-accepted death. Nira arranges the nikah in the hope that it will give Ayon hope, help him "recover", or at least live longer, and the hospital staff do not contradict this belief; they support it by making the ceremony possible.

More broadly, the disease stories in the sample are strongly medicalised. They give doctors almost complete authority to explain and diagnose illness, even though Bangladesh has a cultural setting where medical and religious explanations exist together rather than one replacing the other. This makes the films' representation narrower than the different ways of understanding illness described by Kleinman. The films mainly focus on medical explanations and treatment, while religious beliefs and practices are only presented as something which may help people understand or cope with illness, such as praying to Allah for one's own or someone's recovery, as shown in *Ahare Jibon* and *Bad Son*.

Religion can also be used to cope with the fear and uncertainty surrounding an unknown disease, sometimes through beliefs that may contribute to stigma, as shown in *Corona Bole Kichu Nei*, when the protagonist Afrin shows her dad a viral video of him circulating on social media, where, when asked, he states his reasons on why he chose not to wear a mask during the COVID-19 pandemic:

Interviewer: This is a contagious disease!

Afrin's Father: I am a Muslim. I pray five times a day. I won't get those Corona-torona. Do you know who gets those? Those who are atheist, those who don't believe in Islam... Them!

— *Corona Bole Kichu Nei* (2020), (Timestamp: 16:58)

It is also important to note that recent Bangladeshi cinema has begun to show religion in more specific and sometimes more complex ways. As journalist Jannatul Naym Pieal observed in a 2026 Daily Star feature, newer films are willing to present real disagreements about religion on screen. Therefore, the limited religious representation found in this eight-film sample is not a feature of Bangladeshi cinema as a whole.

Class and Religion as Different Factors of Structural Violence

Taken together, these findings show that class, location, and household resources are clear structural factors that shape disease outcomes and how disease is represented in this sample. The role of religion cannot be compared in the same way because all patients in the eight films share the same broad religious identity. As a result, there is no variation in the sample that would allow us to test whether religion has a direct effect on disease outcomes. This religious uniformity is itself an important finding about representation because it suggests that the films present illness through a largely similar religious perspective. However, it should not be understood as evidence that religion is less important than class. A sample that includes patients from different religious backgrounds would be needed to make such a comparison.

When religion appears in the films, it works less as a source of visible inequality between characters and more as a private way of coping with extreme suffering. It can also appear as a religious ritual that the medical institution allows or supports, but it is rarely shown as being in conflict with medical care.

This is an important finding. Across the eight films, differences in social class, location, and access to healthcare are more clearly visible than differences related to religion.

The films particularly show differences between urban and rural settings, specialist and general care, and access to treatment within Bangladesh or abroad.

Farmer's argument that structural violence works through ordinary social arrangements rather than through single, clearly visible acts can be seen in the way these class differences appear in the films. The affluent characters in *Bad Son* or *Unoponchash Batash* are not shown rethinking their decision regarding if they should see a specialist or travel abroad. For their social class, these options are simply accepted as the normal course of action. In the same way, homeopathy is presented as the normal and accepted course of action in *Matir Moyna*.

The fact that these decisions seem normal and unquestioned helps reveal how disease representation in these films is shaped by social structures rather than only by individual choices.

4.4 Change Over Time Within Disease Categories: A Diachronic Comparison

The comparative sample was built around four disease categories: HIV/AIDS, cancer, COVID-19, and fever. Each category is represented by two films released in different years (Section 3.4). This design makes it possible to ask a question, whether these representations change over time within the same disease category. This section examines each pair and then identifies a broader pattern across all four categories.

4.4.1 HIV/AIDS: *Meghla Akash* (2001) and *Megher Koley Rod* (2008)

In *Meghla Akash*, HIV is a confirmed medical diagnosis, and the film deals with its stigma mainly through the medical encounter. The specialist doctor challenges the stigma by touching an HIV-positive patient in front of her students. She explains the couple's diagnosis to Javed in her office and later arranges his and Meghla's marriage by convincing Rimi (her student and Javed's sister). The doctor therefore acts not only as a clinician, but also as a moral authority, who uses her personal and professional position to remove the stigma surrounding HIV. But she did warn Javed that he cannot have children anymore.

Megher Koley Rod, released seven years later, presents the situation differently. Rodela is not actually infected. She is assumed to have HIV only because it was assumed her late parents died from it, and her husband's family makes this accusation on her wedding night. The stigma is no longer dealt with only inside a doctor's office, it had to be resolved twice: first through a private HIV test that proved she is negative, and then through expert evidence in court. A second doctor, Dr. Selina had to explain to a doubtful lawyer and judge that it is possible for an HIV-positive mother to give birth to a HIV-negative child and how. The struggle for acceptance has therefore moved from the clinic to the courtroom.

Using Hall's (1980) idea of encoding and the way meaning builds through repeated representations, this change shows a shift in how HIV is presented: by 2008, the story no longer focuses on whether a person with HIV can be accepted, but on the consequences of wrongly associating HIV with a person's family history.

The dramatic question in the second film is therefore no longer "can a person with HIV be forgiven or accepted?" The first film had already addressed that question. Instead, *Megher Koley Rod* asks what happens when a family's fear of HIV becomes strong enough to overcome marriage, medical evidence, and personal loyalty, even when that fear is based on a false accusation.

This is broadly similar to the pattern Zhang (2024) identifies in Chinese cinema, where HIV/AIDS stories gradually move from presenting infected people as morally suspicious toward presenting them as wronged or vulnerable people whose suffering is caused by the prejudice of others. The Bangladeshi films show a locally specific version of this change. The second film does not simply reduce the judgment placed on the patient; it removes her responsibility completely by making the illness itself fictional. As a result, the main conflict becomes the family's willingness to believe an accusation rather than the patient's own past behaviour.

4.4.2 Cancer: *Bad Son* (2005) and *Unoponchash Batash* (2020)

The fifteen-year gap between these films shows the increase in medical detail in the sample. In *Bad Son*, Babu's cancer is revealed in one short statement: "he has cancer." The film gives no information about the type or stage of the disease or about its treatment. Cancer mainly serves to create drama around secrecy, family reconciliation, and inheritance. The

story is finally resolved off-screen when the reunited and newly wealthy family sends Babu abroad for treatment.

In *Unoponchash Batash*, Ayon's cancer is presented through a much clearer medical process. A chest x-ray shows "pulmonary metastasis." A specialist identifies the disease as the fourth stage of mesothelioma. The doctor discusses the stage of the disease, liver condition, and an estimated survival period of three to six months, and recommends Ayon to get emergency treatment. Later, another doctor suggests an experimental chemotherapy treatment and explains its risks directly to Ayon. Ayon and Nira also search for information about the disease online, something that does not appear in the 2005 film.

This increase in medical detail is consistent with Fiske's (1989) observation that popular media adapts to what audiences already know and expect. By 2020, Bangladeshi audiences had much greater exposure to medical terms through global medical dramas, health journalism, and eventually the COVID-19 pandemic than audiences had in 2005. The two films also have very different endings. *Bad Son* ends with a restorative, almost fairy-tale-like recovery after the family's wealth returns. This is consistent with what Frank (1995/2013) calls a restitution narrative. *Unoponchash Batash*, however, ends with Ayon's death even though he has access to a specialist, which is closer to Frank's chaos narrative, where suffering cannot ultimately be solved by medicine. Taken together, the sampled films suggest that as these became more willing to present specific medical details, they also became more willing to show a disease ending in death.

4.4.3 COVID-19: *Corona Bole Kichu Nei* (2020) and *Ahare Jibon* (2024)

This is the only pair in the sample separated by only four years, but the two films take very different approaches to the pandemic. *Corona Bole Kichu Nei*, a short film released on YouTube during the first year of the outbreak, stays almost completely inside one household. A father denies that the disease exists and sees it as a punishment for people who are not religious. His daughter eventually convinces him to seek medical care. No doctor, hospital, or state institution appears on screen. The crisis is handled entirely within the family.

Ahare Jibon, made four years later after the main emergency had passed, presents a much more detailed institutional setting. It includes a government quarantine centre, an

airport police unit enforcing isolation, and a hospital ICU where workers wear PPE. It also shows a series of bureaucratic barriers that a police officer must personally overcome so that a dying man's son can say goodbye to him. Stigma also extends beyond the patient, affecting his sister's chances of marriage.

Wade's (2022) study of films about outbreaks before the pandemic found that such films often focus on whether social institutions can be trusted to manage a disease threat. Wald (2008) similarly describes the "outbreak narrative" as focusing on the tension between individual bodies and the larger institutions responsible for controlling infection. The chosen Bangladeshi films fit this research in a locally specific way. The film was made about a time when the crisis was still new to the country. Hence, it focuses on the private experience of disbelief and fear because the pandemic's institutional systems, such as quarantine centres and hospital triage, were also new and not yet fully familiar to ordinary people. The later film utilised this wonder and presented a fuller picture of how these institutions worked, including both their moments of harshness and compassion. This suggests that films made during a live health crisis and films made later about the same crisis may differ not only in tone but also in scope, moving from private questions of belief and fear toward public issues of bureaucracy and enforcement.

4.4.4 Fever: *Matir Moyna* (2002) and *Rickshaw Girl* (2021)

In *Matir Moyna*, which is closer to the beginning of the sample, Asma's fever is treated completely at home, and no biomedical doctor appears in connection with her illness. Her father's authority as a practising homeopath, together with his religious suspicion on allopathic medicine, prevents Asma from receiving the allopathic treatment her uncle has already brought to the house. The main barrier to her care is therefore ideological and familial.

In *Rickshaw Girl*, released almost two decades later, a doctor and hospital are present. Selim is examined and given medicine, but his family cannot afford the medication. The problem is therefore not a refusal to seek biomedical treatment but the inability to pay for it, which ultimately contributes to his death.

Both films end with an unexplained fever becoming fatal. In this respect, little has changed in nineteen years: cinema still uses an undiagnosed fever to represent illness. What

changes is the obstacle that causes the failure of care. *Matir Moyna* places the problem within the family's belief system. This fits Kleinman's (1980) discussion of competing explanatory models of illness, where a family's or healer's understanding of disease can override biomedical advice even when that advice is available.

Rickshaw Girl, by contrast, places the problem in the cost of treatment. This is closer to Farmer's (2004) idea of structural violence, where poverty, rather than a person's beliefs or choices, determines whether a treatable illness becomes fatal. The shift from a father's religious authority to the price of medicine as the main barrier may reflect a broader change in how the selected Bangladeshi cinema explains suffering. Earlier films in the sample are more likely to place the cause of harm in personal or religious beliefs, while the later film places it more directly in economic inequality. This is also consistent with Section 4.3.4, which found that class and treatment costs, more than any other single factor, shape who survives in this sample.

4.4.5 A Cross-Category Pattern

Three tentative patterns appear across all four pairs, although the sample contains only two films per category, so these patterns should be treated as suggestive rather than established.

First, medical information becomes more specific over time. The earlier films in the cancer and fever pairs, as well as the short COVID-19 film, provide little or simplified clinical information. The later films in these three pairs, along with *Megher Koley Rod's* courtroom discussion of ARV treatment, provide more detailed information about diagnosis and medical procedures. This supports the chapter's earlier finding (Section 4.3.1.2) that the sample gives little focus on prevention. At the same time, it suggests that the films engage more deeply with diagnosis and treatment as the sample moves toward the present.

Second, the discussion of disease is moving from private settings to wider social institutions. It begins with the private clinic in *Meghla Akash*, moves to the courtroom in *Megher Koley Rod*, and reaches the quarantine centre, hospital, and police checkpoint in *Ahare Jibon*. Earlier films tend to resolve the meaning of disease through the authority of one doctor. Later films spread that authority across several institutions.

Third, the outcomes become less likely to provide resolution. In three of the four pairs, cancer, COVID-19, and fever, the later film ends with the patient's death. In contrast, two of the earlier films, *Bad Son* and, arguably, *Corona Bole Kichu Nei*, which ends before a final outcome is shown, move toward or suggest recovery. The HIV/AIDS pair appears to be an exception because Rodela in *Megher Koley Rod* was never actually ill. However, if the film is seen as a story about the fear of illness rather than illness itself, the conflict is resolved only after medical and/or legal intervention. In Frank's (1995/2013) terms, the sample shows a small shift from restitution narratives to chaos narratives as the release dates become more recent. However, it is yet to determine whether this reflects a wider historical change in Bangladeshi cinema, a general movement from melodrama toward realism, or simply the small and purposively selected nature of this eight-film sample.

Taken together, these findings provide a preliminary answer to Objective 6. The representation of disease, as well as the institutions and relationships surrounding it, does appear to change across the release dates represented in this sample. The main changes are greater clinical detail, a wider and more contested group of institutions, and a greater willingness to allow illness to end in death rather than recovery. However, determining whether this is a broader historical pattern in Bangladeshi cinema would require a larger diachronic sample than the present thesis was designed to provide.

4.5 Chapter Summary

This chapter has examined how eight Bangladeshi films represent physical and medically defined diseases, using seven recurring types of scenes as a common analytical lens and then connects the findings to the thesis's four problem statements.

The Findings section (4.2) showed that disease in these films usually begins with a visible change in the body that the patient first minimises or denies. The patient then seeks medical advice, but the depth and availability of medical care vary greatly depending on their social circumstances. The illness then develops through prognosis and physical changes and finally leads to an outcome, either survival or death. However, these outcomes are rarely shown as belonging only to the patient. Family and community reactions regularly influence how the illness is understood. These reactions depend less on the medical condition itself and more on what people believe the illness will cost them socially, financially, or in their relationships. *Megher Koley Rod* was an important exception throughout this section. Its

central "illness" is based on a false accusation rather than a confirmed medical diagnosis. Because of this, the film often changes or challenges the patterns found in the other seven films.

The Analysis section (4.3) then connected these findings to the thesis's four problem statements. First, the diseases that receive the most attention in this sample, HIV/AIDS, COVID-19, and cancer, do not closely match the main causes of death in Bangladesh. Instead, the films appear to give more attention to diseases that can create stigma, urgency, or moral conflict. Cancer is a partial exception because it has both strong dramatic importance and significant health importance. The films also give limited attention to disease prevention. Their box-office performance is mixed and is influenced by factors beyond disease representation. In marketing, disease is often named indirectly or not named at all. This can be understood through Goffman's discussion of stigma management, as avoiding or controlling information about a stigmatized disease can reduce the risk of social judgment, while Hall's idea of encoding helps explain how these meanings are presented to audiences.

Second, the urban-rural difference found in the films reflects a real and well-documented difference in Bangladesh's healthcare workforce and its distribution. However, *Matir Moyna* shows that access alone does not always explain treatment choices. Even when another form of treatment is physically available, personal beliefs and authority within the family can determine which treatment is used. This fits more closely with Kleinman's model of competing ways of understanding illness.

Third, clear gender differences appear in the sample. Male patients often hide their illness or withdraw from others in order to protect their role as providers. Female patients, whether they are actually diagnosed or only suspected of having a disease, are more often affected by how other people interpret and judge their illness. Suspicion or diagnosis also brings comparatively more serious social consequences for female patients, as shown in *Megher Koley Rod*.

Fourth, affluence and social class appear to be the main structural factors shaping who receives a diagnosis, who gets treatment, and who survives. This pattern is understood through Farmer's concept of structural violence. In contrast, religious identity is very similar across the sample. It therefore does not create much visible difference between the patients. Instead, religion mainly appears as a private way of coping with suffering. One notable

exception is the hospital scene where medical staff actively allow and support a religious/marital ritual within the medical setting.

Taken together, these findings support the thesis's main argument: Bangladeshi cinema presents disease in a selective and socially shaped way rather than simply reflecting the country's public health reality. The diseases selected, the places where the stories take place, and the ways patients and their families respond are influenced by class, gender, and dramatic storytelling as well as by medical facts.

Chapter 5: Conclusion

5.1 Introduction

This thesis was built around one main question behind its four problem statements and five objectives: Does a sample of Bangladeshi cinema represent physical disease according to its real-world burden and harm, or does it select and present diseases based on what helps tell the story? Using a purposively selected sample of eight Bangladeshi films across four disease categories, the thesis found that the visibility of disease in cinema does not match its actual burden. Instead, diseases are selected and represented based on their ability to create stigma, secrecy, urgency, and moral conflict. This selection is also shaped by class, gender, and historical period rather than by medical facts alone.

This thesis examined what its Bangladeshi cinema sample chooses to show about biomedical, physical disease, how these diseases are represented, and what remains less visible. Using a purposively selected sample of eight Bangladeshi films, *Meghla Akash* (2001), *Megher Koley Rod* (2008), *Matir Moyna* (2002), *Bad Son* (2005), *Corona Bole Kichu Nei* (2020), *Unoponchash Batash* (2020), *Rickshaw Girl* (2021), and *Ahare Jibon* (2024), the study analysed how disease is introduced, diagnosed, experienced, and resolved on screen. It also examined how these representations relate to disease burden, setting, gender, and social position, and whether they changed over the more than two decades covered by the sample.

This concluding chapter brings together the findings from Chapter 4. It revisits the thesis's four problem statements and four research objectives based on the evidence presented there. It also considers the study's academic and social contribution, discusses its limitations, and suggests directions for future research. The chapter ends with brief remarks on what this thesis suggests about the relationship between Bangladeshi cinema in this sample and public understanding of disease.

5.2 Summary of Key Findings

5.2.1 Disease Visibility and Framing

The findings show a clear difference between which diseases receive attention in films and which diseases cause the most deaths in Bangladesh. Non-communicable diseases such as stroke, ischaemic heart disease, and chronic obstructive pulmonary disease account for the largest share of deaths in Bangladesh. However, none of these is the main subject of a film in the sample. Cardiovascular disease appears only once, in *Saba*, within the wider thirteen-film pool. In contrast, HIV/AIDS appears in two films despite its relatively small national disease burden, while COVID-19 produced three films within a few years of the outbreak. Cancer is the clearest exception because its frequency in the sample is more closely related to its significant real-world burden. At least in this sample, Bangladeshi cinema seems to select diseases less because of how common they are and more because they can create stigma, secrecy, urgency, or moral conflict.

The films also deal unevenly with the causes and prevention of disease. HIV/AIDS and COVID-19 narratives make transmission important because contagion creates the fear and blame that drive the stories. Cancer and fever narratives, however, rarely explain where the disease comes from. Instead, they focus on what the illness does to the family. Prevention receives almost no attention across the sample. Box-office performance also shows no simple relationship with disease type. Where box-office data is available, factors such as festival recognition, genre, and cinema closures during the pandemic explain the outcomes more clearly than the disease represented. Promotional materials also usually avoid naming the disease directly. Instead, they use metaphor and mood, first attracting audiences through familiar emotional themes and revealing the illness on screen later.

5.2.2 Setting

The sample is mainly made up of urban stories. Only *Matir Moyna* and *Rickshaw Girl* are set in rural Bangladesh, even though much of the national population lives outside major cities. In these two rural films, the barriers to healthcare are different. *Rickshaw Girl* shows a family struggling with the cost of medicine, which is consistent with Farmer's (2004) concept of structural violence. *Matir Moyna*, on the other hand, shows a family that has access to

allopathic medicine but does not use it because of the father's authority and beliefs. This is better explained through Kleinman's (1980) model of competing explanatory models. The six urban films, by comparison, regularly show named specialists and private medical chambers. This fictional pattern is similar to well-documented differences in the distribution of healthcare workers in Bangladesh. The difference between the rural and urban films cannot therefore be explained by one factor alone. Cost and distance, as well as personal beliefs and family authority, all affect access to care.

5.2.3 Gender

Illness in male characters often brings the family together around the patient's role as a provider. Illness, or even the suspicion of illness, in female characters can instead cause the family to distance itself from her. This difference is especially clear in *Megher Koley Rod*, where an unproven HIV accusation is treated by the in-laws as a threat to the marriage rather than as a medical issue. However, the sample does not support a simple generalisation. Meghla in *Meghla Akash* receives continued support after her diagnosis becomes known, while Rodela receives support from her aunt, uncle, and lawyer even though her husband's family rejects her. The important factor seems to be not gender alone, but who is the first person to judge the patient and whether that person listens before condemning her.

5.2.4 Class, Affluence, and Religion

Wealth and social class appear to be the clearest structural factors affecting outcomes. *Bad Son* shows a wealthy family paying for treatment abroad, while *Unoponchash Batash* shows that even wealth cannot provide a compatible donor organ, although it can provide the social position needed to argue for one. Through Farmer's (2004) concept of structural violence, the sample shows that chances of survival are not equally distributed across social positions, whether or not the inequality involves a direct financial payment.

Religion shows very little variation in the sample. Every patient and identified doctor is Muslim, so the sample does not provide enough variation to examine whether religious identity itself affects outcomes. When religion appears, such as in the hospital wedding in *Unoponchash Batash*, it works mainly as a private way of coping that the medical institution allows rather than challenges.

5.2.5 Change Over Time

Comparing the two films within each of the four disease categories allowed the study to examine whether disease representation changes over time. Three tentative patterns appeared.

First, medical information becomes more specific in the later film of most pairs. The representation moves from an unnamed condition toward a named diagnosis, staging, and prognosis. This is especially clear when comparing *Bad Son* (2005) with *Unoponchash Batash* (2020).

Second, the setting in which the meaning or legitimacy of disease is challenged becomes wider over time. It moves from the private clinic in *Meghla Akash*, to the courtroom in *Megher Koley Rod*, and then to the quarantine centre, hospital, and police checkpoint in *Ahare Jibon*.

Finally, the endings move away from resolution. In three of the four pairs, the later film ends with the patient's death, while the earlier films more often move toward recovery or vindication. This change is consistent with Frank's (1995/2013) movement from restitution toward chaos narratives. Since each disease category contains only two films, these patterns are treated as suggestive rather than established. However, they provide a preliminary answer to Objective 6 that could not be provided by the rest of the chapter, which was organised around the four problem statements.

5.2.6 Overall Pattern

Across all the findings, one main argument emerges: at least within this sample, Bangladeshi cinema represents physical disease selectively and in ways shaped by social structures rather than simply reflecting public health reality. This selectivity also changes over the period covered by the sample. The diseases selected, the settings in which the stories take place, the responses of family and community, and the institutions involved in resolving or failing to resolve illness are influenced by class, gender, dramatic conventions, and historical period as well as by medical facts.

5.3 Contribution of the Study

Academically, this thesis expands the study of illness in Bangladeshi cinema beyond disability and mental illness to the less-studied area of physical, biomedically defined disease. It brings together concepts including Hall's (1980) encoding and decoding, Fiske's (1989) popular culture, Kleinman's (1980) explanatory models, Frank's (1995/2013) illness narratives, Goffman's (1963) stigma, and Farmer's (2004) structural violence. These concepts are applied systematically and across different time periods to a Bangladeshi film sample.

Socially, the study supports the idea that cinema can act as an informal way through which people encounter and understand disease. The almost complete absence of prevention-focused stories, the repeated gender difference in how patients are judged, and the clear role of class in access to healthcare suggest that commercial cinema has the power to either discourage or promote forms of stigma and inequality, which also exist more broadly in Bangladeshi society.

5.4 Limitations of the Study

Several limitations should be considered when interpreting the findings:

- **Sample Size and Selection:** The final sample contains eight films selected from an initial pool of thirteen to allow comparison across four disease categories. It is therefore not statistically representative of Bangladeshi cinema. Diseases that could not be paired, including cardiovascular disease and appendicitis, were excluded, and due to the method of sampling process, rural settings received low representation in the sample.
- **Promotional Materials and Directors:** Film titles and some promotional framing were discussed, but posters, trailers, and press coverage were not systematically analysed. Similarly, possible patterns in individual directors' approaches to disease were not examined, due to time constraints.
- **Incomplete Film Population:** The initial pool of thirteen films was identified through an online search and excluded Bangladesh-India co-productions and other international joint productions directed by non-Bangladeshi directors. The search may also have missed older, undigitised, independently released, or less widely reviewed

films. Therefore, the true population of Bangladeshi films representing physical disease remains unknown.

- **Small Diachronic Sample:** The comparison of change over time is based on only two films per disease category. It can show differences between the selected pairs but cannot establish a wider historical trend in Bangladeshi cinema.
- **Single-Researcher Coding:** All scene identification, transcription, and coding were carried out by one researcher. Interpretive findings therefore reflect a single reading of the films.
- **Limited Source Data:** Box-office and promotional information, especially for older and independently released films, was often unavailable. This limited the commercial-performance analysis.
- **Translation:** The films are in Bangla, so the analysis relied on the researcher's own translation. Some culturally specific meanings, tones, and language details may therefore not be fully captured in English.
- **No Audience Reception Data:** The thesis examines how disease is encoded within the films using Hall's (1980) framework. But it does not examine how Bangladeshi audiences actually decode or interpret these representations. The findings therefore represent one reading.

5.5 Recommendations for Future Research

The limitations above suggest several specific areas for future research:

- **Larger and More Diverse Sample:** Include more films, if available, particularly those dealing with cardiovascular disease, respiratory illness, and other major causes of death, to test whether the gap between disease burden and cinematic visibility continues beyond this sample.
- **Systematic Visual Analysis:** Conduct a shot-level analysis of framing, colour, lighting, and camera movement to examine visual representation more systematically.
- **Expanded Diachronic Comparison:** Compare more than two films within each disease category, or add disease categories with enough films for comparison, to

determine whether the shift toward greater clinical detail and less narrative resolution represents a wider historical pattern.

- **Audience Reception:** Use interviews or focus groups with Bangladeshi viewers to examine the decoding side of Hall's (1980) framework.
- **Promotional and Directorial Analysis:** Study posters, trailers and press coverage across a larger sample. Examining directors' complete filmographies could also show whether their approaches to representing disease remain consistent or change across films.
- **More Complete Film Identification:** The researcher could also use film archives, Bangladesh Film Censor Board records, industry databases, and consultation with film scholars and archivists to identify films that an online search may miss, including Bangladesh-India joint productions and older or less documented Dhallywood films.

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