Journal of Population and Development
Volume 2, December 2020, pp. 97-116

Socio-Cultural Causes of Slum Dwelling Women's Health Vulnerability: A Qualitative Study in the Korail Slum of Dhaka City

Rahnuma Ayesha Siddiqua[1]; Farid Uddin[2]

Abstract

In search of better livelihood opportunities, many rural poor migrate to city centers and often work as an active force behind urban slums. Due to the unhealthy and unfavorable living conditions of the slums, the health status of both men and women is at risk. However, in terms of health status, the situation of women is more vulnerable due to poor sanitation, lack of pure drinking water, lack of cleanliness in the area, contaminated foods, poor housing infrastructure, improper drainage system, lack of awareness, lack of access in availing basic human needs and many others. In this context, to understand the health vulnerabilities of slum-dwelling women, the study was carried out in the Korail slum of Dhaka city, Bangladesh. The key informant of the study was selected on a purposive basis, and the snowball sampling method was used to select the rest of the study participants. In addition, observations, discussions with the key informant, and semi-structured yet informal interview methods were used for collecting data. The research found that some participants work outside to support their economically challenged families apart from performing acute household responsibilities. The women of the Korail slum are economically subordinate, backward, and socially neglected due to the socio-cultural values of Bangladesh. They belong to the 'muted group' to access their fundamental health rights and achieve personal well-being. The study findings suggested that along with the absence of basic human needs, the patriarchal norms and prejudices are also responsible for the health vulnerabilities of the women residing in the Korail slum.

Keywords: Slum, Unhealthy environment, Women's health, Patriarchal norms, Subordination, Dhaka City

Introduction

The slum-dwelling women are the poor since their works are not considered productive (Helal et al., 2017). They have inadequate sanitation facilities, cooking places, water, and electricity, leading them to live in unhealthy and unhygienic environments (Helal et al., 2017). The poor living conditions of slum-dwelling

[1] Lecturer, Department of Criminology, University of Dhaka. Email: rahnuma.siddiqua@gmail.com
[2] Lecturer, Department of Anthropology, Comilla University. Email: fariduddin3054@gmail.com

women ultimately result in economic loss due to reduced working hours and job insecurity due to sickness (Jankowska et al., 2011). Human beings' health conditions and sickness are highly influenced by environmental factors, lifestyle, and dietary patterns (Lindberg, 2010). However, in the case of women, the health condition worsens because of their low education level resulting in unscientific health beliefs and their apathetic attitude towards personal healthcare and societal negligence (Goswami, 2014). Thus, the health of slum-dwelling women is more vulnerable than men. It is important to mention that the women of lower socio-economic class often come to the city to make livelihood opportunities for their families (Goswami, 2014).

However, in Bangladesh, people from different parts of the country often migrate to Dhaka to search for jobs, better opportunities, and live a better life, which eventually contributes to the growth of the capital. Dhaka is identified as the most densely populated city of Bangladesh and identified as one of the populous cities of the world (Swapan et al., 2017). Dhaka is the melting pot of people of diverse backgrounds and different regions of the country. The poor migrants who come to Dhaka to live a minimum life but often reside in slum areas of the city and contribute to urban slums. According to the Census of Slum Areas and Floating Population 2014, the number of slums was 13,935, whereas in the slum census 1997, it was only 2991 (BBS, 2015). Around 64.9 percent of slum dwellers live in rented houses, 27.3 percent in their own houses, 7.0 percent in rent-free houses (BBS, 2015). According to Slum Census 2014, in Dhaka, there are 3,394 slums. The latest census reported that about 1.06 million people live in slums in Dhaka city, whereas 2.23 million across the country (BBS, 2015).The report entitled "State of The World's Cities 2006/7", defined a slum household as many individuals living in the same house in a city that lacks one or more of the following: a. durable housing, b. sufficient living, c. quick access to improved water, d. access to sanitation, e. secure tenure (UN-Habitat, 2006). In the context of Bangladesh, slums are 'areas of concentrated vulnerability', which includes poor housing, high population density, impoverished environment, and high frequency of people below the poverty line (Mberu et al., 2016). Thus, urban slums can be described as overcrowded places characterized by lack of suitable housing, pure drinking water, healthy environment, proper hygiene, sanitary system, basic health care, education facilities, etc. Jankowska et al. (2011) mentioned that these 'common characteristics' of slums are associated with the health and well-being vulnerabilities of the slum dwellers. Mohapatra (2012) mentioned that people migrated to urban centers to make their livelihood in developing countries and contributed to unplanned hyper-urbanization, which resulted in detrimental health consequences to the urban poor. Gowsami (2014) mentioned that health vulnerability is linked with the unhealthy environment of slums and the poor economic conditions of slum dwellers. He also mentioned that most slum women are marginalized because of their poor socio-economic

conditions. Lack of skill and educational opportunities ultimately creates a barrier to living a decent life (Gowsami, 2014).

Latif et al. (2016) pointed out that the slum dwellers are deprived of basic needs such as food and housing problems, poor sanitation conditions, poor quality or no sewerage and drainage, inadequate educational facilities, lack of utility services like gas facilities, electricity connection, and piped water supply. All these conditions ultimately lead to an unhygienic environment for the families living in the slum areas. Banerjee (2012) opined that normally in slum areas, the health status of both men and women is below the standard level. Banerjee (2012) also mentioned that women's health conditions worsen as they are treated as the most insignificant part of society. WHO report (2010) mentioned that 'health inequalities' occurred in society because of the enduring context in which someone grows up and spends their lives and access to the health system. It can be said that the men and women segment of society experiences health consequences differently because they encounter the socio-economic context of the society inversely. Nevertheless, societal negligence regarding women's health comes through socialization in different societies, where the perception of the woman's body is culturally constructed. Scheper-Hughes and Lock (1987) showed the evidence of cultural construction of the body from Brazilian and Japanese cultures (Inhorn, 2006).

In this context, this study aimed at exploring the underlying socio-cultural causes of women's health vulnerability in the Korail slum of Dhaka, as it is one of the largest slums of the capital city. The slum borders Gulshan and Banani, which are identified as two of Dhaka's most affluent neighborhoods. Despite being located at the center of Dhaka city, most of its population lives under the poverty line. According to BBS (2015), about 36,719 people lived in this slum.

Conceptual framework: Vulnerability, women, and health

Vulnerability and health

In general, vulnerability means danger, fragility, endangered, resistless, and possibly being attacked or harmed physically or emotionally. Different scholars defined vulnerability from different perspectives. In Cutter's (1996) view, vulnerability is related to the possibility of damage or loss while encountering a hazard that is broadly connected with environmental context. Turner et al. (2003) defined vulnerability as the likelihood of experiencing damage or harm due to hazards. However, vulnerability is identified with a negative connotation as it indicates the probability of damage. In addition to this, vulnerability and poverty are intricately linked (Jankowska et al., 2011). Vulnerability is related to lack of access to basic human needs and equal rights in accessing healthcare. 'Lack of access' puts a human being at 'potential risk' or 'likelihood of experiencing damage' regarding health and well-being. Besides, vulnerability is also deeply gendered (Roger, 1997). Thus, health vulnerability should be understood

through the complex connection between an individual's actions, capabilities, and basic features of society. In the case of the health vulnerability of slum-dwelling women, gender inequality is a crucial element for understanding the real-life health scenario.

Socio-cultural construction of gender

In a patriarchal society, slum-dwelling women belong to more inferior social strata than men because of their gendered identity. Ortner (1974) identified women's subordination and inferiority through 'gender symbolism' (Moore, 1990). That means women are not only economically subordinate but also socially inferior. Furthermore, Ortner (1974) mentioned that society symbolically identified women as 'close to nature' considering women's body (physiology) functions, which includes women's reproductive health. Women's physiology also confines her with specific social roles because of her natural association with her children, which further relates her to a specific domestic life cycle (social) (Ortner, 1974). However, Ortner (1974) also elaborated that women's physiology and traditional social roles sequentially give her a different psychological (psychic structure) understanding of the 'feminine' world as women are nurtured through different socialization procedures.

On the other hand, Ortner (1974) found that society treated men as 'culture' and viewed 'culture' as a way of 'transcending natural existence', which includes 'control' and 'domination over the natural world. From this perspective, culture is superior to nature, which further elaborated that man is considered superior to women in different societies (Ortner, 1974; Moore, 1990). However, in different societies, the difference between men and women are associated with the culturally constructed set of oppositions where men are associated with 'up', 'right', 'purity', 'strength', 'dominant' etc. and women are related to 'down', 'left', 'pollution', 'weakness', 'submissive' etc. which are bolstered and diffused through the processes of socialization (Ortner, 1974; Moore, 1990). Ortner (1974) also mentioned that in socialization, both men and women perceive society as demonstrating gendered social roles and practice it in their day-to-day life. The socialization process also shapes women's perception of health and illness and confines them to a boundary that defines what should be exposed. Edwin Ardener (1975) proposed a theory named 'muted group' where he argued that dominant groups in the society generate and control the mode of expression of both the genders. In Ardener's (1975) point of view, muted groups are silenced by the structures of dominance. If they wish to express themselves, they are compelled to do so through the dominant ideologies (Ardener, 1975). Thus, in a patriarchal society where women are treated as a subdominant group, they must have structured their world view and perception according to dominant ideology (Moore, 1990). Therefore, women's mode of expression in our society is molded by the men-dominated culture that hinders women from expressing

themselves and becomes more relevant during illness through tolerance.

The social body and women's health

The body is an essential factor that is not biological rather social alongside the mode of expression. Marry Douglas (1970), and Nancy Scheper-Hughes and Margaret Lock (1987) suggested that the concept of the social body is a metaphorical and symbolic representation of the human body. The human body is perceived as different socio-cultural aspects, values, and events (Scheper-Hughes & Lock, 1987). However, the body in health refers to 'the model of organic wholeness' (Scheper-Hughes & Lock, 1987). The body of sickness has been perceived as the result of social disharmony, conflict, and disintegration (Scheper-Hughes & Lock, 1987). Therefore, the body is not only biological but also gendered and socially constructed. Needham (1973) showed some associations between right and left-handedness where men are right and superior, and women are left and inferior. Scheper-Hughes and Lock (1987) drew attention to such uses of the body as a convenient means of justifying particular social values and social arrangements, indicating the natural dominance of men over women. In the discussion of the social construction of gender from Ortner's perspective, Moore (1990) analyzed,

> "…these associations are not inherent in the biological and social nature of sexes, but cultural constructs which are powerfully reinforced by the social activities which both define and are defined by them." (Moore, 1990, p. 15)

However, these symbolic equations lead to the dominance of men over women and make women inferior, which also includes women's health and well-being. Therefore, data were analyzed in the context of this conceptual framework to identify the socio-cultural causes of the Korail slum-dwelling women's health vulnerability.

Objectives and research questions of the study

The broad objective of this study was to identify the socio-cultural causes of health vulnerability of slum-dwelling women of the Korail slum of Dhaka city of Bangladesh. For exploring the topic, the study's main objective was further divided into two specific objectives: a) to understand the accessibility of basic human needs by the slum-dwelling women; b) to explore the socio-cultural norms and practices of the Korail slum for identifying the health vulnerabilities of women. Thus, to explore the research objectives, the study further developed the research questions: (1) What is the situation of Korail slum's women in accessing basic human needs? Does the access to basic human needs affect the health condition of the Korail slum-dwelling women? (2) What are the existing socio-cultural norms and practices of the Korail slum? Do the norms and

practices affect women's position in the slum area? Is there any relation between slum-dwelling women's health vulnerability and socio-cultural norms and practices?

Materials and methods

Selection of the study area

The research was conducted among the population of the Korail slum in order to collect the primary data. Considering the size of the Korail slum, the study covered only a specific part of the slum. For the study, the data were collected from the Mosharraf Bazaar, the north-east side of the Korail slum.

Fieldwork and observation

Data were collected using an ethnographic way based on fieldwork of seven days. The fieldwork was conducted in April 2018. At the initial stage, wide observation, informal conversation, rapport building, and selecting key informant techniques were carried out to understand the socio-cultural situation and physical environment of Korail slum and get access to collect data.

Rapport building and identifying key informant

In order to conduct the research, few hours were spent at the local tea stall by the researchers for meeting local people and having an informal conversation with different people residing in the Korail. Through informal discussion, a friendly relation was established with some of the slum residents. A 20-year-old young enthusiast named Yeasin Ahmed (pseudo name) was selected as the key informant of the research following the purposive sampling method. Yeasin's family's long history of living in the Korail slum and his spontaneous nature to help were reasons behind the selection. Yeasin's family has lived in the Korail slum for 22 years. They own a grocery shop and a rickshaw garage where rickshaws are rented by many rickshaw-pullers daily.

Sampling

For primary data collection, 16 participants were selected from the residents of the Mosharraf Bazaar of the Korail slum. The first participant of the study was selected with the help of the key informant. After that, the snowball sampling method was used to select the rest of the participants above 25 years old. Age was taken into consideration, so that the participants can have at least more than five years of living experience in the Korail slum area as adults. However, among the participants, 12 were women, and 4 were men. Though the study focused on women's health vulnerabilities, the masculine perspectives were also important for understanding the mentioned objectives. Hence, four men participants were selected for conducting the interviews. Finally, the participants were selected for semi-structured interviews to understand the socio-cultural norms associated with the women's health vulnerability of the Korail slum.

Semi-structured informal interview

A semi-structured questionnaire was developed focusing on the study's objectives, and interviews of the participants were carried out. The interviews were primarily based on a semi-structured questionnaire, but the interviews were not rigid to that structured pattern. The pattern of the questionnaire was a bit flexible and informal during the time of the interviews. The informal and flexible nature of the interviews gave space to the participants for opening themselves. The semi-structured nature of the interview gave the space for providing important data specific to the research context.

Ethical consideration

Interviews were taken in a quiet place like home or shop and according to participants' voluntary will and consent. The participants understood that the data they would share would be used for research purposes. No objections were raised by the participants about the publication of the data. Moreover, considering the ethical issue of social research, participants' identities were anonymized, and the names used in this paper are not real.

Data organization and analysis

Field notes were transcribed, translated and organized thematically based on the objectives of the study. Finally, field data were read several times by the researchers to obtain a general sense from all the interviews and understand the perspectives of different interviewees. After that, the data were analyzed concerning some relevant literature and conceptual framework.

Results

Socio-demographic profile of the participants

The participants' of this study came to the Korail slum of Dhaka in search of better livelihood opportunities for combating poverty. Only one participant said that he came to the Korail slum by becoming a victim of river erosion. Table 1 depicts some basic socio-economic and demographic information about the participants of this research.

From table 1, it is visible that six of the participants were homemakers among the woman participants, four of them were housekeepers, and only two of them were garment workers. All the men participants were working as rickshaw pullers and earned more than BDT7000 per month. The four participants working as housekeepers earned approximately BDT2000 to BDT3000 per month, whereas the two garment workers earned BDT9000 and BDT6000 per month. Most of the participants did not get the chance to get in touch with the formal education system and remained illiterate. The overall living condition of the participants was very poor and unhygienic.

Table 1. Socio-economic and demographic profile of the participants

Name*	Gender	Age (Years)	Level of Formal Education	Occupation	Monthly Income (BDT)	Reason for Coming to Dhaka
Habibul	Male	42	No education	Rickshaw-Puller	7000	Poverty
Shimuli	Female	35	Class 4	Garments Worker	9000	Searching work
Khatun	Female	40	No education	Homemaker	Nil	Poverty
Bulofa	Female	30	No education	Housekeeper	2500	Poverty
Laizu	Female	30	Higher Secondary	Homemaker	Nil	Poverty
Shampa	Female	28	No education	Homemaker	Nil	Poverty
Surma	Female	27	No education	Homemaker	Nil	Poverty
Rozina	Female	26	Class 5	Housekeeper	3000	Poverty
Rina	Female	39	No education	Housekeeper	2000	Poverty
Shamsunnahar	Female	37	Class 5	Garments Worker	6000	Looking for job
Sharifa	Female	45	No education	Homemaker	Nil	Poverty
Suman	Male	40	No education	Rickshaw-Puller	7500	Homelessness
Hakim	Male	55	No education	Rickshaw-Puller	8000	Poverty
Halim	Male	33	No education	Rickshaw-Puller	7500	Poverty
Moyna	Female	35	No education	Housekeeper	3000	Poverty
Nurzahan	Female	48	No education	Homemaker	Nil	Poverty

* Pseudo name, Source: Fieldwork, April 2018

Women's access to basic human needs

It is known that food, shelter, clothing, education, and healthcare are basic human needs for living a minimum life. However, the slum people cannot meet their basic needs adequately, and Korail slum is no different. The interviews found that eight participants were eating rice, smashed items, and pulses/lentils as their breakfast, and the other eight participants preferred bread and egg in breakfast. Fourteen participants said that they had rice and fish curry as their main meal. Only two said that they consumed meat with rice in lunch and dinner at least four days a month, and both of them were men. Variation was rare in their food habit. Besides, for drinking and cooking, they used the water that came through three supply lines. Supply water was not pure, and sometimes the supply water was contaminated because of the leakage in the line. They rarely boiled water before drinking; thus, they suffered from diseases like cholera, diarrhea, and dysentery.

For sound health and life, a clean living environment is required. However, at the Korail slum, households were tin-shaded, exceedingly small, unclean, and stuffy.

There were no trees around. As a result, during the summer season, there was extreme heat everywhere. Even it was hotter inside the room since the tin shades become heated by the sunlight. Slum-dwelling people suffered from fever, jaundice, dysentery, and several skin problems from such excessive heat. Their sanitation systems were also miserable. Toilets were dirty, unhygienic, and shared. All the women participants said that sharing a standard public toilet was quite tricky for them. Only six participants said that they washed their hands with soap after using the toilet. Moreover, during rainy days the drains often overflowed, and the courtyards were flooded with unclean sluggish water and became the reason for many waterborne diseases.

Apart from that, all the participants said that they usually had two dresses for regular use. Because of insufficient clean water, they could not wash and clean their clothes properly. They also suffered a lot during the winter season as they were poor and could not afford sufficient warm clothes. As a result, they suffered from the cold, cough, and fever, and so on. Besides, education has a profound effect on health, and the formal education rate of the participants was extremely poor. There was only a kindergarten school situated in the area, which was insufficient to provide primary education to all the inhabitants of the study area.

Moreover, access to healthcare services is one of the vital factors of living a healthy life. According to the participants, there was no hospital or clinic in the slum. The people of the Korail slum suffered more from various illnesses all year round because of the absence of hospitals and formal healthcare systems in the study area. Participants identified the names and causes of summer and winter diseases based on their sufferings.

Table 2. Summer and winter diseases at Korail slum

Name of Season	Name of Diseases	Causes of Diseases
Summer	Fever, cold	Excessive heat, season change, mosquito bite
	Jaundice	Unclean water, extreme heat, not wearing shoes regularly
	Skin problems (allergy and others)	Being unclean, excessive heat
	Dysentery	Impure water, contaminated food, excessive heat and so on
	Fever, cold, and cough	Cold, lack of sufficient warm clothes, sleeping on the floor
Winter	Fever	Hot and cold both
	Dental problem	Being unaware, irregularity in cleaning teeth
	Different ache/ pain (headache, back pain, and so on)	Work pressure, tension, sleeping problem/disorder

Source: Fieldwork, April 2018

From table 2, it can be said that the common diseases of the Korail slum were fever, cold, jaundice, pain, dysentery, dental problems, and several skin problems. Irrespective of gender, all the participants suffered from the mentioned diseases. However, lack of access and an unhealthy environment increased the risk of all the inhabitants of the Korail slum. Though all the people of the slum often lack proper access to basic human needs, the women were facing many problems in accessing basic human needs because of their gendered position. The study found that women often preserved the better portion of the meal for the household head or the men members of the family. Rozina, who was working as a housekeeper, said,

> "I usually take my meal after serving and feeding meals to all the members of the family. However, sometimes it happens that after serving food to all the family members, the food pots become empty, and during those days I often suffer from hunger."

This recognized and practiced cultural norms of food-taking behavior affected women members' health and suffered from malnutrition as there is a strong correlation between food habits and diseases.

Double work yet economic subordination

The slum-dwelling people often came here from different parts of the country to improve their economic condition. Thus, the women members also get engaged in different types of work to support their families. The participants mentioned that in the Korail slum, women worked outside their homes to earn some money for their family and responsible for doing their household chores. This double responsibility created much pressure on their health as they rarely got time to rest and often worked continuously. In housekeeper Bulofa's words,

> "I have to get up early in the morning. Then, after finishing my household responsibilities, I go to my workplace. Then, after returning from the workplace again, I must do my own household chores like cooking, washing, rearing children, and other works that pressure me. As a result, I often feel fragile".

Besides, the women participants working as garment workers also said they must complete their household chores before going to the garments and returning from them. Though the women of the Korail slum worked hard to complete their household chores, their traditional household works did not get any economic recognition. As a result, they were subordinate to their men counterparts and could not decide in the family matters. A garments worker Shimuli said,

> "Though I earn BDT9000 per month. But I cannot spend the money by myself. So I give the money to my husband, and he usually gives me a tiny amount of money to spend on everyday household needs."

Though they worked both inside and outside the household, their works were unrecognized. Consequently, their sufferings became unnoticed. However, all these ignorances put them in a subordinate position where they could not spend their earned money according to their will.

Negligence of sickness and doing work with sickness

The women participants said that even when they were sick, they had to do the household work, which was considered their main duty. In such situations, they neglected their illness and continued to work as it was rooted in the social learning they received from their family and society. Khatun, a homemaker, explained,

> "Recently, , my right leg was fractured, and then I went to a doctor. The doctor bandaged the leg and advised me to take some rest for one month. However, after one week, I removed the bandage and did not visit the doctor, although the doctor told me to have a visit after one week. I have three sons and a five-year-old daughter. As a result, I have to do all the household chores by myself. If I sit idly doing nothing, then my home will turn into a big dustbin! Even I have to go to the local market to buy our daily products/essentials."

In the context of the Korail slum, women were expected to behave in a 'feminine' way that did not prioritize their health and personal well-being even if they became sick. Sharifa, who was a 45-year-old homemaker, shared her experience as,

> "I suffered from a kidney problem that cost me a great deal of money. After the kidney problem, I am suffering from waist pain. According to the doctor's suggestion, I bought a waist belt, but after using it for some days, I have stopped using it because it is difficult to work while wearing the belt. The doctor also suggested that I should work by sitting on a comparatively high bench. But I have to cook for the workers in the shop too. So, I give up wearing the belt although I am still suffering from chronic pain."

One of the men participants, Halim, who was a father of two small children, shared,

> "Even if my wife suffers from an illness, she has to perform the household chores as we do not have any relatives or helping hands for sharing her workload. I am busy with my work as my family depends on my income. Thus, I cannot afford to leave my work behind to take care of her… Well, this kind of situation sometimes makes her health more vulnerable… but she somehow manages to do all her household chores."

It is clear from the participants' experiences stated above that even when women became sick; they had to perform their regular household duties and responsibilities such as cooking, washing, and cleaning, which increased their sickness level and made their health condition more vulnerable. It was observed that women of the Korail slum neglected their illness and bodily comfort to perform their social responsibilities. In addition to that, from the men participants' point of view, it was also visible that they were not attentive to the sickness of their women counterparts.

Social responsibility of women as caregiver

It was found that when any members of the family became sick, usually the women members took care of them. In the context of traditional patriarchal Bangladesh society, women are the family's caregivers, and the Korail slum situation is also traditional. Women could not even risk/isolate themselves even when anyone in the family suffered from contagious diseases. Rozina, a housekeeper, shared.

> "When someone in my family becomes sick, I have to ensure proper care of the sick person. For example, I have a daughter and a son. A few days back, my son was affected by chickenpox; though it is a contagious disease, I had to look after him all the time. He was sick for five days, and after five days, I was infected by this disease, and I had to continue the regular household chores as I have no helping hand to share my work at home."

On the other hand, the women of the Korail slum often thought that regardless of context, caregiving is their social responsibility. From the early days of childhood, they were taught and had seen that caregiving was the responsibility of the women members of the family. Laizu, a homemaker, said,

> "When my husband gets sick, I try my best to take care of him since he is the only earner of the family. However, on the other hand, he is all to me. During the marriage, my mother told me that from now on, my husband should be all to me, and I should take care of him even if I suffer."

This narrative is the best illustration of how socio-cultural values and responsibilities were constructing women's perceptions. Through diverse social interactions, people usually learn society's anticipated norms and regulations in different phases of human social lives and gradually behave and respond similarly. Suman was asked when someone from his family became sick, and the sick person was being taken care of. He replied,

> "My wife takes care of the children when they are sick because it is one of her duties. Being a man, I have many works outside the family.

> I have to ensure my daily income because you know how challenging it is to live life in Dhaka."

However, from the women participant's point of view, the husband rarely takes responsibility as a family caregiver. Moreover, even from the men's point of view, the men members were unwilling to take care of the sick persons of the family, considering caregiving as a women's domain. Besides, although women were wholeheartedly engaged in taking care of sick family members, they were discriminated against and deprived of care when they became sick.

Lack of health awareness

The major issue of being unaware of the health problems and vulnerabilities was slum-dwelling women's lack of proper knowledge, education, and slum culture. During fieldwork, Rina, who was a housekeeper, said.

> "…at first, I had a cough, and it continued for a long time. I thought it was a normal cough and took medicine from the nearest dispensary, but it did not work. At last, when there was blood with the cough regularly, I got scared and went to the doctor. The doctor gave some tests and said that I had TB and it was in worse condition and told me if I had gone earlier, it would not be so serious."

The women neglected the illness symptoms as they learned to overlook illness symptoms through socialization. On the other hand, sometimes, they continued to be unaware of the symptoms because of their illiteracy or low educational level. They did not care about any sickness unless it became severe. Khatun said, "People do not get serious until they cannot deal with the illness suffering". Most women participants did not want to talk about menstrual hygiene management and treated it as a disease not discussed with others due to long-standing patriarchal taboos. Only two women said they used a piece of cloth as a material for managing the menstrual period. One of them said that she took baths; the other participant said she preferred to stay at home and did not take a bath during the menstrual period. However, sufficient information could not be gathered to analyze the real scenario as it was a matter of shame. Besides, whenever the researchers started talking about sexually transmitted diseases, they said they were unaware of such issues and somehow hesitated to talk more about any other issue. Half of the women had more than two children. Frequent pregnancies indicated that either woman did not control their reproductive health or lacked proper knowledge about reproductive health.

Decision making and healthcare seeking behaviour of women

Economic independence and recognition of works are major sources of decision-making capacity. Nevertheless, the study found that women lacked decision-making power in the family even after earning money because of the

men-dominated socio-cultural norms and practices that devalued women's works. In the Korail slum, women were dependent on their men counterparts about visiting doctors and taking medicines during their illness. During the interview, one of the men named Habibul, who was a 42-year-old rickshaw-puller, mentioned.

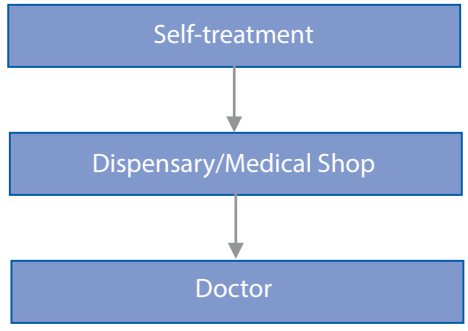
> "When any of my family members become sick, I make decisions when and where to take them for treatment. Besides, my wife is not well-acquainted with the hospital environment and management. Thus, she will not be able to handle the treatment issue alone… along with all these facts, I have to think about how much money or other resources I could spend on their treatment, and only then can I decide where to take them for seeking healthcare".

Moreover, when the issue is getting treatments, the situation seems static from the perception of women. Being an income-generating household member, Shamsunnahar, a 37-year-old woman, was not allowed to visit the doctor or hospital alone. She could not even think of her income as her own and could not spend it for her treatment by herself despite earning money. In her words,

> "I cannot do whatever I wish to do about the management of the treatment of my illness. I have to seek permission from my husband to visit a doctor… Besides, he is the decision-maker regarding treatment or healthcare-seeking behavior as he will provide the cost".

The treatment of women and other family members is depended on the wish and decision of the male household head. Women were not economically independent in the context of the Korail slum, regardless of earning money by themselves. Thus, they could not decide for themselves while being sick even if they felt the need for it. The same was applicable when a family member became sick. Besides, the sickness of women of the Korail slum was neglected by them. If they fell sick, their sickness did not even get proper attention from the male head of the family. From the women's point of view, it was noticeable that by growing up in a men-dominated culture, the women of the Korail slum learned to hide their illness and preferred self-treatment. From the perspectives of the women of the study, the healthcare-seeking behavior of the women of Korail slum could be listed as:

Diagram 1. Process of healthcare seeking behaviour among Korail slum dwelling women



However, because of the socio-cultural pattern, the Korail slum-dwelling women preferred self-treatment. If necessary, they went to the dispensary or the medicine shop to seek advice and take medicines. When the sickness became unmanageable in the mentioned way, they went to the doctors for proper treatment, which depended on their male counterparts' decisions or permission. Considering the financial issue, they mostly went to doctors of the Government hospitals and sometimes also visited private clinics in such a situation.

Discussion

The people of the Korail slum did not have proper access to basic human needs because of their poor socio-economic conditions. Women of the Korail slum had less access to basic human needs and resources because of their subordinate position in society. They could not have a proper meal as they had to preserve the better portion of the meal for the male members of the household. Thus, the women of the Korail slum were more vulnerable to malnutrition and other diseases. Lack of access to resources ultimately puts them into the likelihood of experiencing higher risk than the community's male members. According to Jankowska and colleagues,

> "Those who are most vulnerable to hazards and stressors are likely to be people who have poor access to health resources and facilities, which may then lead to lower-than-average health outcomes." (Jankowska et al., 2011, p. 223)

Women in the Korail slum area were particularly vulnerable, mainly because of the stigma attached to women's bodies and sexuality, a lower social status due to gender inequality, and greater patriarchal control over their bodies. Nevertheless, the health of the slum dwellers had been inevitably affected by the physical-environmental condition of the slum (Banerjee, 2012). Along with that, the patriarchal labeling as 'inferior' or 'subordinate' and 'stigmas' attached to the

'female body' made the health situations of Korail slum-dwelling women more vulnerable than men. However, a person's health had been extensively related to their capability to arrange their basic needs, which depend on the access and control someone had over the material and non-material resources to promote life satisfaction (Bear et al., 2003). Apart from that, public health authorities might not have all the relevant information for providing healthcare support to the poor city dwellers (WHO, 2010). In the context of Dhaka, the situation is more vulnerable because of the unplanned urbanization process. However, the overall vulnerable situation of the urban slum put the women of the slum in a more threatened healthcare and well-being situation.

Anderson (1987), in a study on migrated women's health, showed that women after migration had to perform double duties at a time- household chores and paid work. In the Korail slum, the study found that most of the women of this research were doing work both at households and outside to combat poverty and ensure their family's livelihoods. This kind of job practice created a burden on them. They needed to complete their household chores even if they worked outside for the family's financial benefit. Even after working outside and earning to support their families, their work and contribution remained unrecognized because of the socio-cultural construction of gender where they were not the owner of their earnings. They either learned to give the earned money willingly to the male household head or were forced to do so.

Furthermore, women's household activities had not been recognized as productive by society (Helal et al., 2017), which remains similar for the women of the Korail slum. The society created division between men's and women's workwear, and responsibilities were low in economic value and esteem (Lorber, 1994). Women residing in the Korail slum were still socially and economically subordinate regardless of performing double duties. Hence, it can be said that the slum women were the most suppressed, oppressed, and exploited section of the society (Annandale et al., 1990). Despite being overloaded with work pressure, the slum-dwelling women of the Korail had less or no time for themselves, which again resulted in loneliness, mental stress, physical weakness, and depression. In the context of the Korail slum, following the findings of the study, both physical and mental health situations of the women were neglected. During the study, they were not concerned about the potential health vulnerability associated with their working pattern and were reluctant to take care of themselves properly. However, the practice of women's subordination and voicelessness is deeply rooted in the patriarchal culture of Bangladesh.

As women's work inside and outside the home remains unrecognized by society, society pretends to be ignorant of their sufferings and women become the victims of patriarchal manifestation of subordination. According to the patriarchal norms, women are 'close to nature' (Ortner, 1974) who are supposed to be 'soft-hearted', 'loving', and 'caring'. In a patriarchal society, women learned to

behave in a 'feminine' way, including nurturing, caring, devotion, obedience, duty, responsibility, etc. (Sultana, 2010). However, the study reflected such patriarchal practices much intensely where women's health vulnerabilities were strongly associated with the patriarchal norms and values of Bangladesh society. In the Korail slum, male domination often controlled and confined the female members of the slum. The Korail slum-dwelling women needed to take care of their family members when anyone became sick.

Nevertheless, when they became sick, they did not get proper care and nursing because of society's negligence and patriarchal domination, making their health condition more vulnerable. In a patriarchal society like Bangladesh, women's health is nothing, and their situation is like they are 'born to suffer', which can be linked to the 'social body' concept of Scheper-Hughes and Lock (1987) where the body had been considered in the context of culture, nature, and society. Here, it is essential to mention that by performing all the traditional responsibilities, sick women of the Korail slum did not attract society's attention; instead, they focused on women's social responsibilities like household chores, doers, and caregivers.

The population's health is influenced by the demographic characteristics and the socio-economic status of that community, nature of the accessible health care services, quality and types of the health care providers, medical technology, and available health and well-being knowledge (Kaplan et al., 2005). It is noticeable that when the women of the Korail slum needed help for their health and sickness management, they depended on the decision of their male counterparts. This kind of cultural practice is deeply rooted in the patriarchal norms of Bangladesh, where dominant male ideology subsided women's perspectives and needs. In this process, 'free expression of women' became muted and unheard. From Ardener's (1975) perspective, the muteness did not reflect that women are a silent group; instead, it reflected the suppressive relation between the dominant and subordinate groups. However, because of the time and scope of the research, the health vulnerabilities of all age group women of the Korail slum could not be included in the study. Besides, the study was unable to incorporate an equal number of men participants. Nevertheless, it is evident that in the context of the women of Korail slum, muteness and subordination was a culturally produced and practiced phenomenon that also affected slum-dwelling women's health, well-being, and healthcare-seeking behavior.

Conclusions

The poorest people live in the slum. They cannot meet all the basic needs. This condition is more acute for the women than for the men of the Korail slum. The study has found that the gendered identity and the patriarchal norms of Bangladesh society are responsible for the health vulnerabilities of the women residing in the Korail slum. The patriarchal and male-prioritized culture has been

dominating its female members. Females have been socialized to internalize and preserve patriarchal values and gender inequalities without conscious of patriarchal subordination. Women have learned about their duties and responsibilities from early childhood through socialization. As a result, they have learned to normalize the discriminative attitudes against themselves, have preserved them, and bear those values throughout their lives. The study has found that even in health, sickness, and health-seeking behaviors, women of the Korail slum have been the sufferers of the patriarchal norms and values. So, it is the patriarchal culture that is responsible for the Korail slum women's health vulnerabilities. In Bangladesh, social and cultural values are responsible for the health vulnerability of women, and the situation of the Korail slum is no exception.

Though the women of the Korail slum work inside and outside the home, their works have not been recognized as work or job. They often give their earned wages to their husbands; thus, they remain economically subordinate. Patriarchal social value-based constructions of gender have influenced their subordination. Therefore, women's health vulnerability is deeply rooted in the socio-cultural practices of the patriarchal society of Bangladesh. The women of the Korail slum have not been aware of health issues, have neglected their sickness, and have considered the regular household chores as their prime responsibility. Moreover, caregiving is also considered solely as the responsibility of women. Women cannot even choose their health-seeking behavior because of the patriarchal norms, regulations, and economic subordination; rather, the male household head has socially subjugated them. From this study, it can be said that men-dominated socio-cultural behavior and practices have significant implications on slum-dwelling women's lives, which directly affect their health and lead to health vulnerabilities.

Acknowledgments: We are grateful to all our research participants of the Korail slum who have helped us by giving their precious time and sharing their experiences with us.

References

Anderson, J. M. (1987). Migration and health: Perspectives on immigrant women. *Sociology of Health and Illness,* 9(4), 410-438.

Annandale, E., & Hunt, K. (1990). Masculinity, femininity and sex: An exploration of their relative contribution to explaining gender differences in health. *Sociology of Health and Illness,* 12(1), 24-46.

Ardener, E. (1975). The problem revisited. In S. Ardener (Ed.), *Perceiving women* (pp.19-27). Dent.

Banerjee, A. (2012). Status of health among slum dwelling women- a case study on Dankuni municipality, Hooghly. *International Journal of Current Research,* 4(11): 049-053.

Baer, A. H., Singer, M., & Susser, I. (2003). *Medical anthropology and the world system.* Bergin and Garvey.

Bangladesh Bureau of Statistics (BBS). (2015). *Census of slum areas and floating population 2014*. Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning, Government of the People's Republic of Bangladesh.

Cutter, S. (1996). Vulnerability to environmental hazards. *Progress in Human Geography,* 20(4), 529-539.

Douglas, M. (1970). *Natural symbols: Exploration in cosmology.* Vintage.

Goswami, S. (2014). A study on women's healthcare practice in urban slums: Indian scenario. *Evidence Based Women's Health Journal,* 4, 201-207.

Helal, Md. A. A., Islam, S., & Rahman, Md. M. (2017). Slum women and their socio-economic characteristics: A study in Dhaka city. *Journal of Social Sciences and Humanities,* 12(3), 175-189.

Inhorn, M. C. (2006). Defining women's health: A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly,* 20(3), 345-375. https://www.jstor.org/stable/3840533

Jankowska, M. M., Weeks, J. R., & Engstrom, R. (2011). Do the most vulnerable people live in the worst slums? A spatial analysis of Accra, Ghana. *Annals of GIS,* 17(4), 221-235. https://doi.org/10.1080/19475683.2011.625976

Kaplan, G. A., Siefert, K., Ranjit, N., Raghunathan, T. E., Young, E. A., Tran, D., Danziger, S., Hudson, S., Lynch, J. W., & Tolman, R. (2005). The health of poor women under welfare reform. *American Journal of Public Health,* 95(7), 1252–1258. https://doi.org/10.2105/AJPH.2004.037804

Latif, M.B., Irin, A., & Ferdaus, J. (2016). Socio-economic and health status of slum dwellers of the Kalyanpur slum in Dhaka city. Bangladesh *Journal of Scientific Research,* 29(1), 73-83. DOI: https://doi.org/10.3329 /bjsr.v29i1.29760

Lindberg, S. (2010). *Food and western disease: Health and nutrition from an evolutionary perspective.* Wiley-Blackwell. Lorber, J. (1994). Paradoxes of gender. Yale University Press.

Mberu, B. U., Haregu, T. N., Kyobutungi, C., & Ezeh, A. C. (2016). Health and health-related indicators in slum, rural, and urban communities: A comparative analysis. *Global Health Action,* 9(1), 33163.

Mohapatra, S. (2012). Assessing differential health vulnerability of the slum in Chandigarh, India. *Internationales Asien Forum,* 43(1-2), 81-89.

Moore, H. L. (1990). Feminism and anthropology. University of Minnesota Press.

Needham, R. (Ed.). (1973). *Right and left: Essay on dual symbolic classification.* University of Chicago Press.

Ortner, S. B. (1974). Is female to male as nature is to culture? In M. Z. Rosaldo and

L. Lamphere (Eds.), *Woman, culture, and society* (pp. 68-87). Stanford University Press.

Rogers, A. C. (1997). Vulnerability, health and health care. *Journal of Advanced Nursing,* 27, 65-72.

Scheper-Hughes, N., & Lock, M. M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly,* 1(1), 6-41.

Sultana, A. (2010). Patriarchy and women's subordination: A theoretical analysis. *The Arts Faculty Journal,* July 2010-June 2011.

Swapan, M. S. H., Zaman, A. U., Ahsan, T., & Ahmed, F. (2017). Transforming urban dichotomies and challenges of South Asian megacities: Rethinking sustainable growth of Dhaka, Bangladesh. *Urban Science,* 1(4), 31. http://dx.doi.org/10.3390/urbansci1040031

Turner, B. L., Kasperson, R. E., Matson, P. A., McCarthy, J. J., Corell, R. W. Christensen, L. Eckley, N., Kasperson J., Luers, A., Martello, M. L., Polsky, C., Pulsipher, A., & Schiller, A. (2003). A framework for vulnerability analysis in sustainability science. *Proceedings of the National Academy of Sciences,* 100(4). 8074-8079.

United Nations Human Settlement Programs (UN- Habitat). (2006). *State of the world's cities 2006/7: The millennium development goals and urban sustainability: 30 years of shaping the habitat agenda.* https://sustainabledevelopment.un.org/content/documents/11292101_alt.pdf

World Health Organization (WHO). (2010). *Hidden cities: Unmasking and overcoming health inequalities in urban settings.*

https://www.who.int/publications/i/item/9789241548038