**Situating Women in Urban Slums: Socio-economic Dataset from Slums in Lucknow, India**

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**Keywords:** Gender data, urban slums, women, socio economic, Lucknow.

**Abstract:** The present study provides field based socio-economic data of women slum dwellers in the city of Lucknow, the administrative capital of Uttar Pradesh, India. Being one of the most developed cities in Uttar Pradesh, Lucknow attracts a lot of migrants most of whom come for better economic opportunities and settle in the low-income neighbourhood of the city. Consequently, the number and population of slum colonies has grown simultaneously. In the present times, an increasing number of women migrate independently and are the principal wage earners for themselves and their families. However, since women come with limited job skills and other limited resources, many of them end up in urban slums wherein they remain at a disadvantage in terms of equitable access to work and other aspects compared to their male counterparts. In order to draw a holistic picture of the status of female slum dwellers, an exhaustive socio-economic field survey (2020-21) for 240 women respondents, across 21 slum colonies, was carried out, collecting data on 121 diverse aspects. This high granularity socio economic dataset can be used for carrying out interdisciplinary research as well as formulation and implementation of slum development and urban poverty alleviation programmes.

Supplementary data to this article can be found online at **https://data.mendeley.com/datasets/2g6y7g24tw/1**

**Introduction**

With rapid increase in urbanisation in the country, there has been a steady shift in the concentration of poverty to towns and cities (State of Slums in India, 2013). Being one of the most developed cities in Uttar Pradesh, Lucknow attracts a lot of migrants most of whom come in search for better economic opportunities and settle in the low-income neighbourhood of the city. Consequently, the number and population of slum colonies has grown simultaneously. While the urban population grew from 36.48 lakh in 2001 to 45.90 lakh in 2011 (Census 2001, 2011), the slum population rose concomitantly from 12.95 per cent in 2001 (Census 2001) to 27 per cent in 2011 (Revised City Development Plan of Lucknow city- Vol. II., 2015). Average population density in the slums is 76,559 people per sq.km which is almost ten times higher than city density. This is quite in keeping with the urbanisation scenario at the national level wherein the 2011 Census of India put the urban population of the country at 377.1 million which is likely to double to reach 600 million by 2030.

In the present times, an increasing number of women migrate independently and are the principal wage earners for their families. However, since women come with limited education and job skills, most of them end up in urban slums wherein they remain at a disadvantage compared to their male counterparts (Chant, S., 2011). Urban poverty has a distinct gendered dimension (Tacoli, C., 2012). It is experienced differently according to gender, age, caste, class and ethnicity. These women invariably face severe economic exploitation as they frequently find themselves working in the informal sector which lacks worker protection aspects like minimum wages, safe workplace conditions, and stipulated hours of work. Based on exhaustive field survey carried out in 2020-2021, an attempt has been made to provide high granularity field data regarding the social and economic conditions of women in slums of Lucknow city. The data collected includes data on 121 variables spread across 10 diverse categories like income and expenditure patterns, accessibility to financial systems, levels of literacy and education, accessibility to basic infrastructural facilities like toilets, health status, incidences and types of violence faced and other similar aspects have been analysed.

**Methods**

The primary aim of the survey was to better comprehend the social and economic milieu of women folk in the slums of Lucknow; to understand the problems faced by them, both socially and professionally and how do these women contribute to the household income. Value of the dataset:

* High granularity dataset focussing exclusively on women in individual slum colonies of Lucknow.
* Gender dataset will help in understanding the existing status of the socio-economic conditions of women as well as the gaps in their accessibility of resources in the marginalised slum communities.
* It can help governments understand the advancements and setbacks in women’s lives and create policies and programs for slum development and urban poverty alleviation.
* The datasetcan facilitate inter disciplinary research. Aspects covered in the study can have implications for urban planning, demographers, economists, gender studies and governments and policy makers alike.
* The dataset can be further analysed using more advanced statistical techniques to generate more insights into understanding the lives of women in marginalised slum colonies in a fast-urbanising Lucknow city.

**Data sources**

In order to achieve the above objectives, the study is based on data obtained from both primary and secondary sources. The primary data were collected from ground survey of the sampled slum colonies (2020-21), while the secondary data were obtained from the offices of the State Urban Development Authority (SUDA) and District Urban Development Authority (DUDA), Lucknow.

**Sampling procedure**

As per the District Urban Development Authority, 2001, there are total 609 slum colonies in the city, of which 502 are regularised slum colonies and remaining 107 are non-regularised slum colonies. Out of the regularised slums, 427 lie in the Cis Gomti region. For the selection of wards, initially, the slum colonies were put in descending order of their population size. Arithmetic mean of the whole distribution was then computed which led to its classification into two groups. The mean of each of the two groups further led to creation of four groups with lesser intervals. Thus, twenty-one slums were obtained for field survey. The selected slums have 4, 804 households of which 5 per cent (240 households) were selected for detailed analysis. The sample size of 240 was determined with only one female respondent from every household being interviewed. In order to ensure fair representation, every fifth household was selected for the survey. This was purposely done due to high density of households in the slum colonies.

**Data collection and survey execution**

The field study was executed in Lucknow city, India in two stages, the first lasting from March till May, 2020 covering 10 slums and second from August till October, 2021 covering the remaining 11 slums. It was accomplished with help from sanitary inspectors or *‘safai nayaks’* of the respective wards of the city, who are entrusted with the task of maintaining sanitary conditions through regular cleaning and solid waste management. They provided the researcher with vital information including the socio-economic milieu of the slum dwellers.

Data were collated by the researcher proficient in Hindi and English. Personal interviews were conducted using a semi structured socio-economic questionnaire. The questionnaire also comprised of some open-ended questions which allowed the respondents to voice their difficulties and issues faced by them. Before the administration of the questionnaire, it was tested preliminarily on 30 respondents in a specific slum not a part of our sampled colonies. This was done to ensure that the questions are in keeping with the research objectives and are relevant and meaningful to the study. After the preliminary testing, the questionnaire was modified and finalised for field data collection.

Interview was conducted with one female respondent of the household who was found to be at home at the time of survey. Care was taken to make the research as *participatory* as possible, which often required the researcher to visit a particular household in a slum more than once, expending a significant amount of time observing and interacting with the respondent. This helped build rapport and trust thereby ensuring a high degree of validity in the answers especially in context of sensitive questions regarding violence faced at home and contraception as well as not making the interviewing exercise look like a formal question- answer session. *Repeated interview methodology* was adopted which ensured reduced social desirability bias, as well as checked for any contradictions and falsities within the respondent’s narratives.

To complement the collated data as well as to ensure precision, a few *direct observations* were made regarding following aspects: whether there was garbage dumped around or near the household, stagnant water, open drains, visible deposits of solid waste, human excreta around the house, type of toilet used, source, regularity and quality of water used and other similar aspects. *Transect walks* were taken through the selected slums colonies with special attention being paid to the sanitation facilities present there. During these walks people were randomly asked questions about sanitation conditions in their area. The data thus gathered were studied daily for comprehensiveness.

The data gathered during the survey underwent cleaning and was stored as Excel worksheets for quantitative analysis including median, arithmetic mean, simple percent, and charts and bar graphs.

*The questionnaire*

In addition to questions relating to socio-demographic and infrastructural details, certain other questions relating to aspects like reproduction, contraception, decision making and autonomy as well as violence faced at home/workplace were selectively drawn from the National Family Health Survey (NFHS) 5 Woman’s questionnaire (2019-21).

**I Socio demographic parameters**

The population of women respondents in the slums of Lucknow is young, with majority (29.17%) of the respondents belonging to **age group** of 16-30 years (Table1). This is followed by 24.17% respondents belonging to age group of 41-50 years. The median age of the respondents is 44 years. Majority of the surveyed households (56.67%) are **Hindus** and in terms of **caste**, a significant proportion of minority communities were found to be living in the slums. Majority 52.08% were from other backward classes (OBC), followed by SC and ST communities. The native language for all the slums surveyed is Hindi.

[Insert Table 1 here]

From the sampled respondents, almost equal percentages of literates and semi literates were found with the proportion of literates (35%) being slightly higher than semi literates (33.75%). Literates were people who had completed at least their primary education while primary school dropouts were considered as semi literates. The highest level of education was that of post-graduation (1.25%) while the majority consisted of respondents who had completed their primary education level. Both literates and semi literates however, could read and write their names in their native language. Remaining 31.25 % were illiterates for whom formal education was never initiated (25%).

Lack of interest (48.33%) followed by financial constraints (22.08%) were the two most commonly cited reasons for quitting education. Marriage as a reason for quitting education accounts for 22.92%. Additionally, one of the underlying causes for dropping out of school was fear of elopement (The Hindu, September, 2019). Frequent absenteeism of teachers and not having female teachers in school also keeps away many girl students from going to school. Furthermore, frequent illnesses, household chores as well as greater distance between the home and school discourage them from going to school.

**Marital status** of women is one of the most important considerations while determining her status in the family and society. Our study revealed that 67.92% female respondents were married and 6.67% were never married. Another 5.42% were divorced while 5.83% were separated from their husbands. Remaining 14.17% were widowed.

**II Infrastructural facilities**

Majority respondents were staying in **owned** (58.33%) **pucca** houses (72.92%). Almost all houses had **access to electricity** (86.67%) as a means of home lighting followed by usage of kerosene (41.67%) and candles (25.42%). Another 17.92% reported stealing electricity through makeshift connections made by throwing a ‘katiya’ or a bent wire over the nearby main power line. The selected slums had adequate **supply of water** through tapped supply water, community tanks, hand pumps and public taps. More than 70 per cent of the slum dwellers accessed tap water supply through individual water connections from the Lucknow Municipal Corporation followed by community tanks, public taps and handpumps as reliable sources of potable water. The duration of piped water supply across the selected slums varied between 1 to 2 hours daily. However, there were issues related to the regularity and quality of water supply particularly during the summer season.

An important determinant of the status of women in a society is the type of **sanitation facilities** used by them. Hundreds of thousands of people living in the slums and informal settlements are challenged on a daily basis by inadequate access to sanitation facilities. These sanitation disparities often have critical implications on the health and social status of women and girls as it is directly connected with their need for privacy, safety and cleanliness. In most cases, women are routinely compelled to use hazardous spaces for their sanitation needs which invariably puts them at a greater risk of gender-based violence. As far as respondents’ **access to sanitation** is concerned, almost all respondents had access to toilets, with a majority using private toilets (67.92%) followed by shared (53.33%) and community toilets (20.83%) on pay and use basis (Table 2). Many respondents also consented to open defecation (21.53%). Corburn, J and Hildebrand,C. (2015) found in their study on Nairobi’s slum found out that faecal contamination due to open defecation in urban slums contributes to high rates of  
cholera, typhoid fever, dysentery, and intestinal parasites. This burden of diseases ultimately culminates into higher expenditure on health, morbidity and mortality.

[Insert Table 2 here]

**III Reproduction**

Most respondents reported getting their first menstrual period at 16 years of age. While cloth (79.58%) was the most popular **method of protection**, sanitary napkins were used by 30.83 per cent of respondents (Table 3). This is similar to the findings by Nongkynrih, B. and Reddaiah, V.P., (2004) in their study on menstrual hygiene practices by women in a resettlement colony in Delhi.

[Insert Table 3 here]

Average **age at marriage** for women in slums of Lucknow is 20 years. However, 35.42% of all women in the survey were married before attaining the age of 18 years while only 14.58% were married after attaining18 years of age. The median **age at first pregnancy** was found out to be 21 years. This is similar to the findings by Shukla, M. et.al. (2015) who found that a significant proportion of women from slum communities were married before the age of 18 and that majority were above 18 years of age at the time of first conception. The maximum and minimum **age for first pregnancy** was 27 and 13 years respectively. On the other hand, maximum and minimum age at last pregnancy was fount out to be 41 and 19 years respectively. Thus, the female slum dwellers have a larger fertility window compared to their urban non- slum counterparts in the city. This partially explains larger family size in the surveyed houses in the sums. This is consistent with the findings of Sambisa, W. et.al. (2013) on their study on women in urban Bangladesh.

The urban poor households tend to have bigger family size as they have limited access to education and awareness, higher mortality rate, early marriage and gender stereotypes as well as need for extra labour. It was found that just 16.06 per cent families had the **number of children** ranging between 1 and 2, while a whopping majority, 77.66 per cent families, had total number of children ranging between 3 and 6 in the study area. This was followed by 6.24 per cent families having more than 6 children (Table 4). The median of total number of children in the slums of Lucknow is 4. These are comparable to reported values in various slum studies of Lucknow (Gupta, P. et.al., 2010).

[Insert Table 4 here]

The age at which women get married has serious implications on their fertility, level of education, health, life expectancy as well as their social status. Early marriage and consequent childbearing can have adverse health impacts on both the mother and the offspring including malnutrition, high rate of morbidity and mortality (Marphatia, A.A. et. al. 2017). Quite a few respondents (38.75%) reported suffering a **miscarriage** while instances of **still births** and **neo natal deaths** were also reported. 15 per cent respondents reported **terminating** the pregnancy with economic constraints (8.33%) being the most common reason followed by the pregnancy being unplanned (7. 08%).

**IV Contraception**

Majority respondents (50.45%) reported knowing and having used at least one form of contraception. Condoms (65.49%) followed by oral contraceptive pills (OCPs) (27.43%) were the most popular methods of contraception (Table5). This is supported by the findings of NFHS-5 as well as the study made by Rizvi, A. et.al. (2013) on contraceptive use by married women in urban slums in Lucknow. Respondents prefer buying them from government dispensaries/ hospitals (24.17%) followed by drug stores/ pharmacies (22.08%). It is worth noting that female sterilisation as a method of contraception was adopted by 17.70% respondents, most of whom were aged 40 years and above and had at least one male child as one of their surviving children. Similar results were obtained in other studies done on women slum dwellers in Bangalore city (Edmeades, F. et. al. (2012)).

[Insert Table 5 here]

**V Health and contact with community health workers**

Majority women reported meeting with a community healthcare provider (ANM/ LHV/ ASHA worker) in the last three months at home (54.97%), at health facility (30.99%) and at Anganwadi centre (AWC) (14.04%). These community level healthcare workers are appointed in urban areas by the government under the National Urban Health Mission (NUHM) and play the crucial role of facilitating access to public healthcare by the poor and marginalised sections in urban areas. Malaria control (29.58%), education regarding nutrition/ health/ pre-school/ family life (24.58%), obtaining supplementary food (21.25%) and immunisation of children (22.08%) were the most common purposes to meet a community health care worker.

Amongst the commonly reported **chronic infectious diseases,** dysentery was commonly reported (58.75%). This can be attributed to the consumption of unclean drinking water and food. Malaria (47.08%), common flu (43.33%), jaundice (40.83%), urinary tract infections (UTI) (36.7%) were the commonly reported chronic infectious diseases. Women are physiologically more prone to a UTI infection than men (Tan, C.W. et.al., 2016). Unavailability of clean bathrooms and toilets as well as long working hours with no access to toilets are the most common cause for the spread of the disease. Most of the women preferred visiting a government hospital for the treatment (Riley, L.W.,2007).

Most cases were dealt through self-medication.

Amongst the **chronic non-infectious diseases**, obesity was the most commonly reported (36.25%). This was followed by 27.08 percent women respondents reported suffering from acute respiratory issues with bronchial asthma being the next most commonly reported ailment. Women across all age groups reported suffering from asthma including girls as young as 10 years. Apart from genetic predisposition, exposure to severe air pollutants and irritants as well as weak immune system is the probable causes of asthma.

[Insert Table 6 here]

It should be noted that all aforementioned diseases were self-reported by the respondents. The health status of women slum dwellers was examined through an important measure of the Body Mass Index (BMI) (Table 6). In terms of BMI, majority women fell the ‘underweight’ category with the BMI being below 18.5, indicating the fact that they are malnourished. It should however, be noted that a significant proportion of respondents (29.59%) were in the ‘overweight’ and ‘obese’ categories and are at a greater risk of diseases compared to those in the healthy BMI range. This is consistent with the findings of Purwaningrum et al. (2012) who are of the view that the major risk factors for obesity among poor women living in urban slum areas were partly due to low level of physical activity and excessive carbohydrate intake. Higher BMI also explains the prevalence of cardiac issues amongst the respondents albeit a small percentage (3.33%). Reduced physical (in) activity due to reasons like inflammation of the knee joint as well as access to calorie dense foods are the possible reasons for obesity. A relatively lesser percent of women fell in the ‘healthy’ category with BMI ranging between 18.6-24.9.

Mental health problems like anxiety, depression as well as thoughts of self-harm, low self-esteem and substance abuse were reported by a small percentage of women. As serious as the impacts of chronic infectious diseases are, perhaps, even more damaging are the impacts of mental health problems as they are often ignored, go unreported, undiagnosed and therefore untreated. In fact, the social causes of women’s mental health problems are often overlooked. These can have long lasting impacts on an individual’s overall wellbeing. The trend is worrisome because mental health services are in an appalling state in India as mental health care has been given very less importance. As compared to 15% of all women, 11% of all men suffer from mental health problems (N.B. Sarojini et.al., 2006).

**VI Women’s occupation and financial inclusion**

Our study found that 53.33% respondents were working and earning a monthly income while the rest 47% were not. The latter included the elderly, housewives, medically unfit people, students, housewives. Almost all working respondents were found to be employed in the informal sector as there are little or almost insignificant barriers of skill, training and other formalities in the informal sector (Chaudhuri, S., 2018). Women enter into these odd jobs so as to supplement their family income and their interest is simply in survival. As a result, many of them are not able to succeed in making enough income to make ends meet.

Of the women who were working, majority were employed as domestic help (34.88%) for cooking, washing, cleaning. 12.40% respondents were engaged as commercial workers, employed as teachers in a private school, labourer in a garment factory, worker in a nearby brick kiln and flour mill.

The graph below shows the monthly income patterns of the respondents and their contribution to monthly household expenditure (Fig. 1). 24.81% women earned between Rs. 2,500-5,000 (30-60 USD) monthly out of which they spent 71% on basic amenities (Fig. 2). Majority respondents (28.68%) earned between Rs. 5,001-7,500 (60-90 USD) per month and spent 62% on basic amenities. 20.16% respondents earned between Rs. 7501-10,000 (90-120 USD) and spent 51% on basic amenities. Average monthly expenditure on food is the highest (Rs. 1,541) (18.54 USD) followed by monthly expenditure on health/medicines (Rs. 967) (11.63 USD). These are comparable to findings on slum dwellers’ expenditure on food and health by Malik, F. A., et.al. (2018) and Nayak, S & J., Surendra. (2023) The monthly median income for sampled women respondents in the slum in Lucknow is Rs. 7,500 (90.23 USD).

[Insert figure 1 here]

[Insert figure 2 here]

It is worth noticing that expenditure on education has received due importance across all income categories with respondents spending as less as Rs. 350 (4.21 USD) to as much as Rs. 2,570 (30.92 USD) monthly, depending on their income. Almost all women reported sending their children to nearby government schools/ Anganwadi centres where the students have access to quality education at no or minimal fee. Free books, uniform as well as free meal at the school provides the required encouragement to both the students and the parents to send the children to school. This also reflects the aspiration of women who want to ensure a better future for their children by making sure they send them to school.

However, it should be noted that while it is encouraging to see respondents across income groups sending their children to school, expenditure on education accounts for only 5.5% of total income. Other aspects like food (18.98%) health (12.19%), clothing (5.91%), debt repayment (5.7%) take far greater precedence. These are similar to the findings by Roy, D et.al (2018) in their study on slums of Bangalore.

**VII Financial inclusion**

Majority respondents did not own a bank account (52.08%) while 47.92% respondents did. This is supported by the findings of Malik,F.A. et.al. (2020) in their study on financial inclusion of beggars and slum dwellers in Lucknow. Of the women who owned a bank account, it was not older than 8 years (11.30%) followed by another 10.43% who owned a bank account since 5 years. However, their frequency of usage of bank account was very low, ranging between 2 to 3 times in a year. A meagre 5.22% women reported availing a loan from the bank. Amongst the major problems which deterred the respondents from availing credit from formal banking institutions was unavailability of valid income and residence proof (32.08%), no guarantor (23.33%) as well as insufficient collateral (13.75%). These problems have also been identified by Bhatia, N. and Chatterjee, A. (2010) in their study on financial inclusion of slum dwellers in Mumbai. The study also revealed that availing informal credit was popular amongst women (97.5%) with majority (55.13%) choosing to borrow from their relatives followed by availing credit from chit funds (41.45%) to which they regularly contribute a small amount also (Table 7). Rupambara, (2007) in their study are of similar view wherein they state that borrowing from friends/relatives is always preferred even at exorbitant rates as lenders live within the borrowers’ community and understand the latter’s financial predicament and constraints.

[Insert Table 7 here]

Majority women (24.41%) borrowed small amounts ranging up to Rs.1000 (12.03 USD) followed by another 19.25% who borrowed between Rs.1001-2000 (12-24 USD). Popular purposes for availing credit include providing for medical expenses (30.42%), family emergency (16.67%) as well as repaying past loans (36%). As far as savings are concerned as many as 50% respondents choose to save money in cash at home followed by 34.17% contributing to chit fund as a means to save money. These are similar to findings by Aliber, M. et.al., (2015) in their study on informal finance in slums of India and Uganda.

**VIII Decision making and autonomy**

In terms of decision making and autonomy, the results are in confirmation with a patriarchal outlook. For majority of working women, it was their husbands who decided how the money she earned would be spent (28.13%). This was followed by 25.78% women who along with their husband s decided how the money she earned would be spent. Only 16.41% respondents decided on their own about spending the money they earned. Most women’s monthly earnings were less than their husbands’, sons’, fathers’. Similar trend could be deciphered when for most respondents, it was their husbands who were the decision makers regarding their own health, regarding making major household purchases as well as deciding on the respondent’s visit to her maiden home.

Majority respondents reported that they had to be accompanied with someone while visiting the market (61.25%), health facility (88.75%), places outside the slum/ community (92.92%). These findings are in keeping with the findings of Sangappa, J and Kavle, L. (2010) who state that women are far behind their male counterparts in terms of decision-making autonomy and nutritional status. They have to continuously seek permission, typically from husbands and in laws in financial sphere and also for healthcare.

**IX Domestic violence**

Kinds of abuse women suffer can be broadly divided into physical and oral. Emotional and mental distress caused by verbal abuses is as much a crime as is the bodily hurt and injury caused by physical violence. Domestic violence is perhaps the most common form of violence against women as well as the most common cause of non-fatal injury to women in the developing countries. Almost all of the women respondents had experienced some form of violence either at their workplace or at home (Table 8). While married women reported often being subjected to physical and verbal abuse at the hands of their husbands and in laws, other women respondents suffered abuse at the hands of their fathers, brothers as well as colleagues at workplace. It should be noted that 27.92% women did not consent to answer questions on violence.

Instances of physical violence were very common with slapping in the face being the most widely reported (30.83%). Instances of emotional violence including humiliation (71.25%) and insults (70.42%) were reported as happening ‘often’ (64.17%) by a majority of women. Withholding sexual activity or affection was the most form of sexual violence (27.92%) followed by being forced to have sex against her will (22.92%). Husbands (37.50%) followed by father-in-law (1.25%) were the people commonly reported committing this violence.

[Insert Table 8 here]

As far as the physical impacts of these instances of violence is concerned, almost all respondents reported sustaining injuries, bruises, cuts, fractures, joint dislocations of varying magnitude and seriousness on different parts of the body. Equally serious are the mental health consequences of violence, which if left untreated, can have long lasting impacts on an individual’s overall wellbeing. It was found out that 18.75% women suffered from poor self-esteem, while 16.25% women reported having difficulty in sleeping soundly. Feeling constantly stressed, isolated, emotionally withdrawn, experiencing frequent intrusive negative thoughts as well as lacking trust on family members are indicators of mental and emotional distress. Even more disturbing were the instances of substance abuse, wherein women reported drinking or overeating as a means to numb and cope with the negative feelings. This partially explains the high incidences of obesity/ overweighted as one of the chronic non-infectious diseases. These are similar to the findings by Mechanic, M.B. et.al. (2008) on their study on mental health impacts of intimate partner abuse.

**X Help seeking behaviour**

Most women (30.42%) never told anyone about the violence they suffered. Only 15% women sought help. Respondents’ own family and relatives (14.58%) were the most commonly contacted people by the respondent for help followed by neighbours (4.17%), police (1%) and school administration (1%). These findings are consistent with the findings by NFHS-5 (2019-21).

**References**

1. Nagpal, A., Hassan, M., Siddiqui, M.A., Tajdar, A, Hashim, M., Singh, A., Gaur, S., Missing basics: a study on sanitation and women’s health in urban slums in Lucknow, India, Geo Journal, 1-13 (2019). https://doi.org/10.1007/s10708-019-10088-0(0123456789().,-volV)( 01234567
2. Nongkynrih, Baridalyne & Reddaiah, V.P.. (2004). Menstruation: Knowledge, beliefs and practices of women in the reproductive age group residing in an urban resettlement colony of Delhi. Health and Population: Perspectives and Issues. 27. 9-16.
3. Sangappa, J., & Kavle, L. (2010). Gender Discrimination: Women’s Work and Autonomy. *The Indian Journal of Political Science*, *71*(2), 425–437. http://www.jstor.org/stable/42753706
4. Gupta P, Srivastava V, Kumar V, Jain S, Masood J, Ahmad N, Srivastava J. Newborn Care Practices in Urban Slums of Lucknow City, UP. Indian J Community Med. 2010 Jan;35(1):82-5. doi: 10.4103/0970-0218.62570. PMID: 20606927; PMCID: PMC2888375.
5. Sambisa W, Angeles G, Lance PM, Naved RT, Thornton J. Prevalence and correlates of physical spousal violence against women in slum and nonslum areas of urban Bangladesh. J Interpers Violence. 2011 Sep;26(13):2592-618. doi: 10.1177/0886260510388282. PMID: 21831870; PMCID: PMC3845968.
6. Edmeades J, Pande RP, Falle T, Krishnan S. Son preference and sterilisation use among young married women in two slums in Bengaluru city, India. Glob Public Health. 2011;6(4):407-20. doi: 10.1080/17441692.2010.533686. PMID: 21218299; PMCID: PMC3101305.
7. Riley LW, Ko AI, Unger A, Reis MG. Slum health: diseases of neglected populations. BMC Int Health Hum Rights. 2007 Mar 7;7:2. doi: 10.1186/1472-698X-7-2. PMID: 17343758; PMCID: PMC1829399.
8. Monica, Agarwal & Imchen, Tsusennaro & Rehman, Hossain & Yadav, Kriti & Singh, Sujata & Shukla, Mukesh. (2015). Utilization of Maternal Health Care Services in Slums of Lucknow, Capital of Uttar Pradesh. 2.
9. Purwaningrum, D.N., Hasanbasri, M. & Trisnantoro, L. Obesity and the poor women living in urban slum areas: health system response. *BMC Public Health* **12** (Suppl 2), A12 (2012). <https://doi.org/10.1186/1471-2458-12-S2-A12>
10. Rupambara, (2007), ‘Financial Inclusion of the Urban Poor: Issues and Options’, Cab Calling, July-September 2007.
11. Malik, Firdous Ahmad & Yadav, Devendra & Adam, Hebatallah & Omrane, Amina. (2020). The Urban Poor and their Financial Behaviour: A Case Study Of Slum-Dwellers In Lucknow (India).. 10.1201/9781003097921-17.
12. Malik, Firdous Ahmad & Yadav, Devendra & Jain, Ranu. (2018). Income and Expenditure Mismatch of Poorest of the Poor: An Analysis of Financial Requirement of Slum Dwellers: ICEF 2018. 10.1007/978-3-319-99555-7\_15.
13. Aliber, M. (2015). The importance of informal finance in promoting decent work among informal operators: a comparative study of Uganda and India.
14. Nayak, Sanatan & J., Surendra. (2023). Basic Amenities, Deficiency-induced Ailments, and Catastrophic Health Spending in the Slums of Lucknow, Uttar Pradesh. Economic and Political Weekly. lVii. 40-49.
15. National Family Health Survey (NFHS)- 5 (2019-21) Compendium of fact sheets, Key indicators, Ministry of Health and Family Welfare, Govt. of India.
16. Corburn J, Hildebrand C. Slum Sanitation and the Social Determinants of Women's Health in Nairobi, Kenya. J Environ Public Health. 2015;2015:209505. doi: 10.1155/2015/209505. Epub 2015 Apr 28. PMID: 26060499; PMCID: PMC4427764.
17. Roy D, Palavalli B, Menon N, King R, Pfeffer K, Lees M, Sloot PMA. Survey-based socio-economic data from slums in Bangalore, India. Sci Data. 2018 Jan 9;5:170200. doi: 10.1038/sdata.2017.200. PMID: 29313840; PMCID: PMC5759370.
18. Bhatia, Navin & Chatterjee, Arnav. (2010). Financial Inclusion in the Slums of Mumbai, Economic and Political Weekly, Vol. 45, Issue no.42.
19. Cohn EB, Schaeffer AJ. Urinary tract infections in adults. ScientificWorldJournal. 2004 Jun 7;4 Suppl 1:76-88. doi: 10.1100/tsw.2004.50. PMID: 15349531; PMCID: PMC5956445.
20. Marphatia AA, Ambale GS and Reid AM (2017) Women’s Marriage Age Matters for Public Health: A Review of the Broader Health and Social Implications in South Asia. Front. Public Health 5:269. doi: 10.3389/fpubh.2017.00269
21. Chant, Sylvia. (2008). The 'Feminisation of Poverty' and the 'Feminisation' of Anti-Poverty Programmes: Room for Revision?. The Journal of Development Studies. 44. 165-197. 10.1080/00220380701789810.
22. Tacoli, C. (2012) Urbanization, Gender and Urban Poverty: Paid Work and Unpaid Care Work in the City. International Institute for Environment and Development, United Nations Population Fund, London, UK.