Real Experience of Adult men
Stage 2, Stage3 and Stage 4 COPD
Dhaka, Bangladesh

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Real Lived Experience

Introduction

This analysis presents a deeply perceptual exploration of the negative affects—sensations or feelings—that shape and contour the lived experience of adult men in Dhaka, Bangladesh, who face the intertwined challenges of Stage 2, Stage 3, and Stage 4 Chronic Obstructive Pulmonary Disease (COPD) alongside the persistent constraints of low socio-economic status. The affects described here are potential and not uniform; they manifest in varied kinds and intensities across individuals, underscoring the multiplicity of lived experience beyond simplistic or purely quantitative approaches.

Far from abstract or symbolic labels, these affects emerge in concrete, situated, and durational ways, flowing and blending within the continuous present of perception and action. They are inseparable from the body, environment, memories, social worlds, and material conditions that co-compose experience. This account attends to the relational genesis and persistence of these affects, revealing how they sustain, transform or resist within the rhythms and textures of daily life in Dhaka's dense urban and socio-economically constrained landscape.

Each affect arises not in isolation but within a qualitative multiplicity, interwoven and dynamically shifting in psychological time rather than clock time. Hence, the descriptions foreground how these sensations surface, coexist, fade, or intensify in relation to one another, and how their origins span personal histories as well as systemic and environmental forces. This approach honours the depth and complexity of the real, lived experience of adult men navigating COPD and poverty in this specific place and context.

Perception, Cognition, Beliefs, and Memory

Perpetual Cognitive Fog

The sensation of an ongoing mental haze that clouds clarity of thought often surfaces from the physiological impacts of COPD, such as hypoxia, compounded by chronic stress linked to financial insecurity. This fog disrupts attention and memory retrieval, making everyday tasks cognitively taxing. It is not merely a fleeting tiredness but a persistent dulling of mental sharpness that can vary with the progression of respiratory symptoms and environmental triggers like air pollution in Dhaka. Some adult men may experience this cognitive dimming more acutely, especially when burdened by the compounded anxieties of unstable income. This fog endures because cognitive rest is difficult to access amid pressing survival demands and inadequate healthcare support.

Fragmented Memory Trails

Memories become patchy, with moments slipping away or feeling disconnected from a linear narrative, reflecting both the neurological stress of chronic illness and the psychological strain of social marginalization. This fragmentation arises as the mind struggles to hold onto continuity amid episodes of breathlessness and hospital visits, often compounded by poor nutrition and sleep disruption. The experience varies—some men might notice gaps in recalling recent events, while others perceive a deeper erosion of autobiographical coherence. The persistence of fragmented recall is reinforced by repetitive health crises and the absence of stable routines or supportive environments.

Overwhelming Futurity Doubt

A pervasive uncertainty about the future colors perception and belief, emerging from the unpredictable trajectory of COPD symptoms and the economic precarity of low-income urban life in Dhaka. This doubt impairs motivation and constrains capacity to plan or aspire. It frequently intertwines with cultural and familial expectations of providing and sustaining social roles, which become increasingly difficult to fulfil. The affect persists as structural inequalities and inadequate social protections limit visible pathways to stability or recovery.

Internalised Stigma Whisper

A subtle but persistent internal voice of shame and diminished self-worth, shaped by social attitudes towards chronic illness and poverty, infiltrates the mental space. This whisper emerges from external social exclusion and cultural narratives that associate illness with weakness or failure, which are deeply felt in the tightly knit social fabric of Dhaka. It manifests variably, from quiet self-doubt to active self-censorship, and endures because social stigma remains unchallenged and embedded in everyday interactions and institutions.

Persistent Anxiety Tension

A continuous undercurrent of tension and unease that primes the mind for threat, arising both from the unpredictability of respiratory episodes and from the insecure living conditions typical in low-income Dhaka neighbourhoods. This tension affects decision-making and heightens perceptual sensitivity to potential hazards, often making social interactions or mobility daunting. The affect can escalate during pollution spikes or financial crises and resists easy resolution due to the chronic nature of external stressors.

Disrupted Sense of Agency

The experience of diminished control over one’s life trajectory and bodily capacities is shaped by progressive respiratory decline and economic constraints. It reflects a shrinking horizon of possibility, where everyday choices feel limited or overridden by health demands and financial imperatives. This sensation is deeply embodied and affects self-efficacy and engagement with social roles. The persistence is tied to the chronicity of COPD and the structural scarcity of supportive resources.

Shadowed Spiritual Disquiet

An uneasy questioning of meaning and purpose often arises as illness progresses and social participation reduces. For some, this spiritual disquiet takes the form of existential questioning or a sense of abandonment, influenced by cultural and religious frameworks prevalent in Dhaka. It manifests in fluctuating intensity and may accompany physical exhaustion or social isolation, persisting in the absence of community support or accessible spiritual care.

Heightened Sensory Overwhelm

The senses can become easily overloaded by the urban stimuli of Dhaka—traffic noise, crowds, and pollution—which interact with respiratory distress to generate a feeling of bombardment. This sensory overwhelm restricts capacities to engage with the environment or social settings, exacerbating withdrawal or fatigue. The intensity of this affect varies with environmental conditions and personal thresholds, often recurring during peak pollution or heat.

Entrenched Hopelessness Echo

This affect encompasses a deep, echoing sense of despair linked to repeated setbacks in health and economic stability. It is shaped by ongoing experiences of deprivation and marginalisation that diminish expectations for improvement. The echo reverberates through cognition and belief, making renewal of effort or hope challenging, and is sustained by systemic neglect and lack of accessible healthcare or social support.

Reluctant Acceptance Fatigue

A wearied submission to the constraints imposed by COPD and poverty develops over time, blending resignation with a pragmatic orientation to survival. This affect is not passive but complexly layered with moments of resistance and adaptation. It arises as a coping response to persistent adversity and limited alternatives, and endures due to the chronic nature of the condition and the socio-economic environment.

Body, Functioning and Movement

Breathless Constriction Weight

A physical sensation of tightness and struggle in the chest, central to COPD, creates a palpable burden that governs bodily movement and posture. This constriction emerges from obstructed airways and respiratory muscle fatigue and is intensified by exposure to urban air pollutants common in Dhaka. The weight limits physical endurance and spontaneity, often leading to cautious or reduced mobility. Persistence is linked to the progressive deterioration of pulmonary function and exposure to environmental irritants.

Exhaustion Drain

A pervasive bodily depletion that extends beyond momentary tiredness, reflecting chronic hypoxia, inflammation, and the metabolic demands of breathing difficulties. This drain undermines capacity for daily activities, impeding work and social participation. It may fluctuate but generally intensifies with disease progression and lack of nutritional support, often compounded by inadequate rest and stress.

Fragile Postural Instability

A sense of bodily precariousness when standing or walking, arising from muscle weakness, balance impairment, and fatigue. This instability can provoke anxiety about falls or injury and reduce confidence in movement, especially in the uneven and crowded urban terrain of Dhaka. Variability in this affect depends on the severity of physical decline and access to rehabilitation or assistive devices.

Chest Pain Twinges

Intermittent sharp or dull pains localized in the chest area, sometimes originating from coughing or respiratory muscle strain. These twinges remind the body and mind of vulnerability, disrupting concentration and sleep. Their occurrence and intensity are influenced by disease stage, physical exertion, and environmental triggers, persisting due to continual respiratory compromise.

Swollen Limb Heaviness

Edema in the lower limbs, a common consequence of advanced COPD and related heart strain, generates a sensation of heaviness and discomfort. This affects posture, gait, and the ability to wear normal footwear, limiting engagement in social or occupational roles. The heaviness endures as circulatory and respiratory impairments worsen, often exacerbated by limited healthcare access.

Chronic Cough Exhaustion

The repetitive and often violent coughing associated with COPD depletes energy reserves and causes soreness in the chest and throat. This exhaustion interrupts activities, sleep, and social interactions, reinforcing feelings of vulnerability. It is triggered by irritants prevalent in Dhaka's environment and inflammation, persisting despite medication and rest.

Diminished Appetite Pull

A weakening drive to eat, often resulting from breathlessness, medication side-effects, or depressive states linked to illness. This pull away from nourishment affects physical strength and recovery potential. It varies individually but frequently persists due to the cyclical relationship between poor nutrition and worsened respiratory function.

Sleep Fragmentation Weariness

Repeated interruptions to sleep caused by breathlessness, coughing, or discomfort produce a pervasive tiredness that reduces daytime functioning. This weariness undermines cognitive and physical resilience, complicating self-care and social engagement. It often persists because environmental noise, housing conditions, and health symptoms are rarely fully remediated.

Restricted Mobility Barrier

The experience of physical limitation that blocks free movement, shaped by breathlessness, muscle weakness, and environmental obstacles. This barrier reduces participation in valued activities and social roles. Its persistence is maintained by the ongoing progression of disease and lack of accessible transport or rehabilitation facilities in low-income Dhaka settings.

Medication Side-Effect Burden

The bodily discomfort and fatigue associated with side effects of COPD medications, such as tremors, dizziness, or gastrointestinal upset, add to the physical strain. This burden complicates adherence to treatment and can diminish quality of life. The persistence of these impacts relates to limited options for symptom management and economic barriers to alternative therapies.

Place, Space, Setting and Environment

Urban Pollution Saturation

The pervasive presence of airborne pollutants in Dhaka's atmosphere suffuses the environment with a tangible heaviness that aggravates respiratory symptoms and evokes a continuous sense of threat. This saturation constrains outdoor activity and heightens vigilance, especially in low-income areas where protective infrastructure is minimal. The affect persists due to systemic industrial emissions and

traffic congestion patterns.

Crowded Space Anxiety

The claustrophobic sensation arising from navigating densely populated streets, markets, and public transport, which exacerbates breathlessness and social discomfort. This affect limits movement and social interaction, intensifying feelings of vulnerability. Its endurance is tied to the spatial realities of Dhaka's urban density and limited accessible public spaces.

Housing Insecurity Unease

Living in structurally inadequate or temporary housing common among low-income populations generates a persistent undercurrent of unease, stemming from concerns over shelter stability, ventilation, and exposure to weather extremes. This unease impacts rest, health management, and psychological comfort, sustained by urban housing shortages and economic barriers.

Heat and Humidity Oppression

The intense climatic conditions of Dhaka, particularly heat and humidity, produce a sensation of bodily oppression that worsens breathlessness and fatigue. This environmental pressure restricts outdoor activity and adds to physical exhaustion. The affect fluctuates seasonally but remains a recurring challenge due to limited climate control in homes and public spaces.

Noise Pollution Wear-Down

Continuous urban noise from traffic, construction, and human activity penetrates living and resting spaces, creating a persistent sensory strain that exacerbates stress and interrupts restorative sleep. This wear-down reduces resilience and compounds physical symptoms. Its persistence is embedded in Dhaka's relentless urban tempo.

Lack of Green Space Withdrawal

The absence or inaccessibility of parks and natural settings produces a sense of withdrawal from calming and restorative environments. This diminishes opportunities for gentle physical activity and mental respite, especially critical for those with respiratory illness. This withdrawal endures due to urban development priorities and socio-economic segregation.

Public Facility Inaccessibility Frustration

Facilities such as clinics, transport hubs, and markets often lack accommodations for limited mobility or respiratory needs, provoking frustration and sometimes exclusion. This affect constrains autonomy and social participation. Its persistence arises from infrastructural neglect and insufficient disability-sensitive urban planning.

Domestic Space Confinement

The home environment, often small and overcrowded, can intensify feelings of confinement and claustrophobia, especially when illness restricts movement outside. This confinement shapes daily rhythms and social interactions, sometimes deepening isolation. The affect persists due to housing scarcity and economic constraints.

Transportation Barriers Weariness

Difficulty accessing affordable, reliable, and non-strenuous transport adds a weariness that limits engagement with work, healthcare, and social life. Navigating Dhaka’s chaotic transit systems while breathless can feel overwhelming, reducing mobility and opportunity. This affect persists due to infrastructural deficits and financial hardship.

Climate and Seasonal Fluctuation Vulnerability

The pronounced seasonal changes, including monsoon rains and winter chills, generate sensations of vulnerability as respiratory symptoms worsen with changing temperatures and humidity. This fluctuation shapes activity patterns and health management strategies. It endures due to limited housing insulation and economic capacity to adapt.

Social and Cultural Interactions / Engagement

Social Withdrawal Gravity

An inward pull away from social contact develops due to breathlessness, fatigue, and anticipated stigma, reducing participation in family and community activities. This gravity limits opportunities for emotional support and shared meaning-making. It persists as social and cultural expectations of productivity clash with illness limitations.

Familial Role Displacement

The experience of altered or diminished roles within the family, such as provider or decision-maker, creates a sense of displacement and loss. This is shaped by illness progression, economic hardship, and shifting household dynamics. The affect can provoke identity tension and persists due to entrenched gender norms and financial pressures.

Peer Isolation Shade

A shadow of exclusion or distance from peer groups arises when physical limitations or stigma reduce shared activities and communication. This shade disrupts social belonging and mutual support, particularly poignant in cultures valuing social cohesion. It endures due to mobility constraints and social attitudes towards chronic illness.

Workplace Marginalisation Strain

The pressure and strain of marginalisation or reduced opportunity at work due to illness symptoms and low socio-economic status create a persistent sense of precarity. This affects self-esteem and economic stability, reinforced by limited workplace accommodations and informal labor markets. The strain endures within systemic labour inequities.

Healthcare Interaction Vulnerability

A palpable vulnerability emerges in engagements with healthcare providers, rooted in power imbalances, financial constraints, and sometimes dismissive attitudes. This vulnerability shapes trust and adherence, often intensifying feelings of helplessness and uncertainty. It persists within

under-resourced health systems and socio-economic divides.

Cultural Expectation Burden

The weight of fulfilling cultural norms around masculinity, work, and family provision becomes burdensome as illness limits capacity. This burden can generate conflict between self-expectations and lived realities. It persists because cultural values remain rigid and social safety nets are limited.

Community Participation Frustration

Challenges in joining communal events or religious activities due to physical or social barriers create frustration and feelings of exclusion. This frustration undermines social identity and collective belonging. It endures because of environmental inaccessibility and stigma.

Intergenerational Communication Gap

Differences in understanding and attitudes about COPD and poverty between generations lead to communication gaps, fostering misunderstandings and emotional distance. This gap affects support dynamics and knowledge sharing. Its persistence is fueled by educational disparities and cultural taboos around illness disclosure.

Social Stigma Weight

The heavy burden of social stigma attached to chronic illness and poverty manifests in experiences of judgement, pity, or avoidance, deeply impacting social confidence and identity. This weight complicates help-seeking and social integration. It persists due to entrenched societal prejudices and limited public awareness.

Support Network Fragility

The fragile and often unreliable nature of informal support networks, strained by collective poverty and illness, generates uncertainty and stress. This fragility diminishes resilience and practical assistance. It remains due to widespread socio-economic precarity and competing demands within families and communities.

Resources, Finances, Products and Technologies

Financial Insecurity Strain

The persistent pressure of unstable or insufficient income undermines the ability to afford medications, nutritious food, and adequate housing, generating a strain that permeates decision-making and wellbeing. This strain limits access to vital resources and persists amidst fluctuating informal economies and healthcare costs in Dhaka.

Medication Access Barrier

Difficulty obtaining or affording essential respiratory medications creates a tangible barrier to symptom management, provoking anxiety and physical deterioration. This barrier reflects systemic healthcare inequalities and market limitations, persisting due to economic hardship and supply challenges.

Nutrition Scarcity Anxiety

The worry over securing sufficient and appropriate food to support health fuels anxiety, rooted in poverty and disrupted appetite. This anxiety impacts energy levels and immune resilience. It lingers because of food insecurity and limited nutritional education or support.

Inadequate Shelter Discomfort

Poor shelter quality lacking ventilation and protection from weather extremes causes physical discomfort and health risks, particularly respiratory aggravation. This discomfort constrains rest and physical recovery, sustained by economic deprivation and urban housing shortages.

Technology Exclusion Frustration

Limited access to digital and assistive technologies creates frustration as opportunities for health information, telemedicine, or social connection remain out of reach. This exclusion affects autonomy and engagement with evolving care modalities. It persists due to affordability and digital literacy gaps.

Transport Cost Constraint

The financial burden of transportation to clinics, workplaces, or markets constrains mobility and access to care, provoking a chronic sense of limitation. This constraint is sustained by income instability and inadequate public transport infrastructure.

Dependence on Informal Markets Anxiety

Reliance on informal or unregulated markets for medicines and supplies generates anxiety over quality and continuity, reflecting systemic gaps in formal provision. This anxiety persists as formal health infrastructure remains inaccessible or unaffordable.

Clothing Inadequacy Discomfort

Lack of appropriate clothing for weather conditions or breathability causes physical discomfort and vulnerability to infections, linked to financial constraints. This discomfort reduces confidence and wellbeing, enduring due to poverty and market limitations.

Information Scarcity Confusion

Insufficient or conflicting health information leads to confusion and uncertainty in disease management, compounded by low literacy and inconsistent communication from providers. This confusion impacts treatment adherence and health outcomes, persisting without targeted education efforts.

Overdependence on Caregiver Resources

The pressure to rely heavily on family or community members for financial or material support generates a sense of burden and constrained independence. This overdependence affects self-esteem and decision-making capacity, sustained by limited formal welfare systems and economic precarity.

Next Steps

Exploring and addressing the real lived experience of adult men with Stage 2, Stage 3, and Stage 4 COPD amidst low socio-economic conditions in Dhaka requires moving beyond superficial understandings to engage with the full richness of sensations, affects, and relational dynamics described here. Umio's Design for Real Lived Experience philosophy and approach, grounded in real experience models and experience ecosystem framing, offers enterprises a powerful method to deeply explore, validate, and learn from these lived realities, enabling the design of interventions and offerings that resonate authentically and create meaningful impact.

To explore how Umio can support development efforts or to engage in collaborative learning, please get in touch via:

Additionally, resources are available for download to provide further insight into the framework and practical applications, helping enterprises to thoughtfully respond to the complex, emergent nature of lived experience in this and other contexts.

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Umio
Grassroots Innovation Centre
46 Woodstock Road
Oxford
UNITED KINGDOM
0X2 6HT

info@umio.io
www.umio.io