Vol. 23(2), 2023, pp.197-215, ISSN: 2072-0394(Print), ISSN: 2663-8886(Online)

Impact of Social Factors on Inequality in Healthcare Access among Rural Females: A Study in District Sargodha

Zebish Shah

Tauqeer Ahmed Lak

&

Azka Murtaza
Ph.D. Scholar
Department of Sociology and Criminology
University of Sargodha

Abstract

The primary objective of the research was to ascertain the social determinants that underlie the rural female population's ability to obtain healthcare services. This research also aimed to examine the association between gender discrimination and various other socio-cultural inequalities rural women face in Pakistan regarding their access to healthcare. The nature of the study was quantitative and descriptive, utilising a cross-sectional approach. The Universe of the study was based on district Sargodha and a multi-stage sampling technique was applied. The present study employed a simple random sampling design to select the tehsils, union councils, and villages. In contrast, a convenient sampling technique was utilised to select the respondents (who were young and adult women). The sample size was comprised of 200 respondents. Data were collected using a questionnaire, which underwent pretesting. The data were analysed using SPSS software, in which frequencies, percentages, and Chi-square Tests were applied for hypotheses testing. The results validate the existence of a pervasive gender-based disparity in healthcare accessibility for women residing in rural areas. The results validate the existence of a pervasive gender-based disparity in healthcare accessibility for women residing in rural areas. This analysis suggests that social factors contribute to differences in healthcare access for individuals facing various economic, social, and psychological challenges. Women who lack efficient ownership, control, or access to resources and healthcare amenities are particularly affected, leading to difficulty achieving a basic standard of living. The study advocates for the imperative of ensuring the complete involvement of women in social and political domains to enable their meaningful contribution towards the development process.

Keywords: Social Factors, Inequality, Access to Healthcare, Rural Women, Gender Discrimination.

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تلخیص

تحقیق کا بنیادی مقصد ان سماجی عوامل کا پتہ لگانا تھا جو دیہی خواتین کی صحت کی دیکھ بھال کی خدمات حاصل کرنے کی اہلیت پر اثر انداز ہوتے ہیں۔ اس تحقیق کا مقصد پاکستان میں دیہی خواتین کو صحت کی دیکھ بھال کی سہولیات تک رسائی کے حوالے سے صنفی امتیاز اور دیگر سماجی و ثقافتی تفریق کے درمیان تعلق کا جائزہ لینا بھی تھا۔ مطالعہ کی نوعیت ایک کراس سیکشنل اپروچ کو استعمال کرتے ہوئے مقداری اور وضاحتی تھی۔ مطالعہ کا علاقہ ضلع سرگودھا تھا، اور ایک مختلف مراحل کے نمونے لینے کی تکنیک کا استعمال کیا گیا تھا۔ موجودہ مطالعہ نے تحصیلوں، یونین کونسلوں اور دیہاتوں کو منتخب کرنے کے لیے ایک سادہ اتفاقی نمونہ بندی کو استعمال کیا۔ اس کے برعکس، جواب دہندگان (جو نوجوان اور بالغ خواتین تھے) کو منتخب کرنے کے لیے نمونے لینے کی سہولیتی نمونہ بندی کا استعمال کیا گیا۔ نمونے کا سائز 200 جواب دہندگان پر مشتمل تھا۔ ڈیٹا ایک سوالنامے کا استعمال کرتے ہوئے اکٹھا کیا گیا تھا، جس کی پہلے سے جانچ کی گئی تھی۔ اعداد و شمار کا تجزیہ SPSS سافٹ ویئر کا استعمال کرتے ہوئے کیا گیا، جس میں تعدد، فیصد، اور Chi-square ٹیسٹ مفروضوں کی جانچ کے لیے لاگو کیے گئے تھے۔ نتائج دیہی علاقوں میں رہنے والی خواتین کے لیے صحت کی دیکھ بھال تک رسائی میں صنفی بنیاد پر وسیع تفاوت کے وجود کی توثیق کرتے ہیں۔ اس تجزیہ سے پتہ چلتا ہے کہ سماجی عوامل مختلف معاشی، سماجی اور نفسیاتی مشکلات یا رکاوٹوں کا سامنا کرنے والے افراد کے لیے صحت کی دیکھ بھال تک رسائی میں تفاوت کا باعث بنتے ہیں۔ وہ خواتین جن کے پاس موثر ملکیت، کنٹرول، یا وسائل اور صحت کی دیکھ بھال کی سہولیات تک رسائی نہیں ہے وہ خاص طور پر متاثر ہوتی ہیں، جس کی وجہ سے زندگی کے بنیادی معیار کو حاصل کرنے میں دشواری ہوتی ہے۔ یہ مطالعہ سماجی اور سیاسی شعبوں میں خواتین کی مکمل شمولیت کو یقینی بنانے کی ضرورت کی وکالت کرتا ہے تاکہ ترقی کے عمل میں ان کی بامعنی شراکت کو ممکن بنایا جا سکے۔

کلیدی الفاظ: سماجی عوامل، صحت کی دیکھ بھال تک رسائی، عدم مساوات، دیہی خواتین، صنفی امتیاز

Introduction

According to the World Health Organization, health is a comprehensive well-being encompassing mental, physical, and social dimensions. Moreover, it depends on the absence or presence of sickness and disease. It means that a person is to be considered fit or healthy and should not suffer from infirmity or illness. (WHO, 1948). There has been a substantial improvement in both the quality and accessibility of healthcare in several emerging nations in recent years. However, huge gaps persist in health and health service consumption between urban and rural populations (Guo et al., 2020) because of the rural population's limited income, fewer health services, and less availability of health insurance. This is true in Pakistan and other developing nations like Ethiopia and Uganda (Ahmed et al., 2022; Arcaya et al., 2015).

Braveman et al. (2019) state that health disparities are unfair and may reflect injustice. Eliminating poverty and prejudice, as well as the helplessness and inaccessibility to well-paying work, quality schooling and housing in secure settings, and health care that they

entail, are two of the most critical ways communities may work to reduce health disparities. Disparities in health status or the distribution of risk factors among different demographic subgroups are two ways to classify health disparities. Natural variations and individual choice account for specific healthcare disparities, but the external state and external conditions are mostly beyond the control of individuals (Arcaya et al., 2015; WHO, 2018; Braveman et al., 2019).

There is a need to understand that healthcare utilisation is "The effective use of individual healthcare services to achieve optimal health outcomes." (IOM, 1993, p.46). Many citizens have easy access to health insurance, allowing them to use the Government's social service system fully. Many others encounter roadblocks, making accessing even the most rudimentary medical care services challenging. A large-scale study and the previous National Healthcare Disparities Reports (2010) both confirmed that certain racial or ethnic groups and those of low socioeconomic status are disproportionately represented among those who have access problems. Medical insurance was found to be the most important factor after the National Healthcare Quality Report and the National Healthcare Disparities Report were published. Those without medical coverage were less likely to be prescribed preventative treatment, such as mammograms, dental exams, fitness programs, and influenza vaccines. There is a personal and a societal price to pay for inadequate access to healthcare (NHDR, 2010).

Global factors, such as those which shape international interactions, domestic norms, and standards, influence societies' growth patterns. They, in turn, influence how society is structured at both the national and local levels, giving rise to different forms of social function and order in which populations are stratified by variables such as wealth, education, occupation, gender, and ethnicity. Humans' exposure to risk factors for and consequences of illness are affected by their position in the social order (WHO, 2009; Braveman et al., 2019).

Gender-based discrimination significantly impacts a woman's health risks, knowledge, vulnerability, adaptability, capacity, self-esteem, and access to social support systems that aid in addressing health challenges as they arise. The limited exposure of girls to formal education has been found to adversely affect their social and economic prospects (Anwar et al., 2012).

The status of women in Pakistan exhibits variation across social classes, areas, and the rural-urban divide, owing to disparate development levels and the influence of family-related, feudal, and industrialised social systems (Panezai et al., 2020). The gender gap in Pakistan is especially problematic for women because of the lack of affordable healthcare options. Pakistan has a huge gender difference in employment, paid labour, fitness, and health. The status of women in healthcare in Pakistani society has deep historical origins. While men are viewed as contributing to Pakistan's economy and

society, women face discrimination and inequalities they enter the community. Compared to affluent countries, Pakistan has a significantly higher proportion of women than men (91 to 100), reflecting this bias (Qadir, 2011; Ahmed et al., 2022).

Literature Review

This research literature also emphasises the crucial factors that have influenced unequal access to healthcare for women. In Pakistan, it is more typical to focus on the health of distinct sex groups. Children's health is prioritised more than women's, and in the realm of children, favours are accorded more to sons than daughters (Tunio & Ahmed, 2021; Qadir et al., 2011). It is widely believed that sexism exists against women in all facets of Pakistani society (Tunio & Ahmed, 2021).

The gender-based disparities in healthcare access for women in Pakistan have deep-seated historical and cultural underpinnings. From an artistic standpoint, it is evident that females in Pakistan are inherently disadvantaged and are subjected to discriminatory practices throughout their entire lifespan. This starkly contrasts males, who are typically afforded greater financial and social worth. The manifestation of gender preference in Pakistan can be quantified through the perturbed gender ratio, which stands at ninety-one females for every one-hundred males compared to developed nations (Qadir, 2011; Gilbert et al., 2017).

Social factors and healthcare access:

In 2018, researchers in rural Bangladesh found a statistically significant difference in coverage depending on the sex of the child, with boys receiving more coverage (89.2% compared to 85.9% for girls). Statistics from across Pakistan show a wide disparity in the vaccination rates of boys (68%) vs girls (63%) (Ahmed et al., 2022). Major gender-related immunisation hurdles include women's poorer socioeconomic status, race, marital status, education, age, and sociocultural environment, as well as gender roles, health literacy, and females' perceptions of service quality (Feletto & Sharkey, 2019).

Habib et al. 2021 described research they did in a rural district of Sindh Tando Allahyar to evaluate people's knowledge about tuberculosis and women's access to medical care. For the study, 36 people were interviewed. The study's findings confirmed the existence of barriers to healthcare access for women, especially among younger women, such as limited authority in domestic and financial decisions, social disapproval of independent travel, lengthy travel times, a lack of priority investing in women’s health, and insufficient availability of lady healthcare personnel.

Economic Factor:

Current evidence suggests that a person's health status and access to healthcare are affected by socioeconomic status, ethnicity, age, gender, illness, and migration status. A study demonstrates that women and disabled children are vulnerable groups more likely to exhibit unequal healthcare admittance behaviour; furthermore, such groups may encounter several forms of discrimination (Braveman et al., 2019).

Research conducted in Nigeria has revealed that women are disadvantaged in accessing healthcare, even after controlling for socioeconomic variables. This is attributed to their lower participation in decision-making and a higher likelihood of experiencing domestic violence (Singh & Erica, 2013). This confirms the results of previous research in Pakistan that found women to have less say in medical decisions, particularly in low-income urban and rural settings (Hamid et al., 2010). Consequently, women's access to financial resources is restricted in several countries, and their level of financial literacy is comparatively lower than that of men.

Decision-making Power:

According to research on gender and health policy in Pakistan, female patients have little choice when making treatment decisions. Especially in rural areas, women are more likely to be sick because they are subjected to societal norms favouring males over females in decision-making, putting females in subordinate positions (Ahmed et al., 2022; Iqbal et al., 2019). The causes of these gender disparities are multifaceted and include individual and societal factors. The need for economic and political engagement and advocacy underscores the significance of women's health rights. The research results in Pakistan regarding the ecological, financial, and societal factors linked to reduced immunisation rates demonstrate the intricacy of gender-based health factors (Rizvi & Nishtar, 2008; Habib et al., 2021).

Women need autonomy to obtain and use primary healthcare to be concerned about their well-being as well as the welfare of their children. For men to have full decision-making authority, they must be well-versed in and invested in their children's health and education. Sociocultural influences and gender norms have been shown to undermine such autonomy in various research contexts, both nationally and internationally (Rahman et al., 2018; Singh & Erica, 2013; Hamid et al., 2010).

According to Maheen et al. (2020), Pakistani women have a prominent role in their homes but little autonomy in making life decisions and defining family priorities. Adverse effects on health and an increased chance of dying prematurely have been linked to social isolation and inferior treatment. The strains of unemployment, poverty, and gender inequities especially damage rural females (WHO, 1993; Anwar et al., 2012).

Freedom of Mobility:

According to the Human Development Report (2006), the absence of healthcare providers and medical services and the need to travel long distances or visit health centres pose significant challenges to accessing medical care in Pakistan, Afghanistan, and Qatar. This is particularly true for rural women who may face mobility restrictions, financial constraints, or time limitations that prevent them from accessing these services (Tunio & Ahmed, 2021; Shaikh & Hatcher, 2017). Despite measures intended to save the mother, 50% of pregnant women who present late with problems like bleeding or obstructed labour nevertheless lose their babies (Tunio & Ahmed, 2021).

In addition, when women and girls face restrictions in their physical movement and cannot make their own decisions, it can make it more difficult for them to access and benefit from healthcare services (Anwar et al., 2012).

Research Objectives

- To discover the social factors that support inequality in rural women's health care access.
- To study "Economic Access" as a determinant of rural females' healthcare access.
- To find out the relationship between decision-making and consciousness about physical health.
- To explore the relationship between the freedom of mobility and good health condition.

Research Methodology

The primary objective of the research was to investigate the impact of socioeconomic factors on the healthcare accessibility of women residing in rural areas of District Sargodha. The nature of the study was quantitative and descriptive, utilising a cross-sectional approach. The research participants were female individuals living in the rural region of District Sargodha. The study employed a multi-stage sampling technique to procure the information. During the initial stage, a simple random sampling technique was used to select two of the seven tehsils (Bhera and Silanwali) in the Sargodha district. During the second stage of the study, a simple random sampling technique was employed to select two union councils, namely UC-9 Rakh Charagah Tehsil Bhera and UC-95 Sillanwali Tehsil Sillanwali. Four villages (125 NB, 128 NB, Chak Qazi, Shah Hussain) were selected randomly during the third stage. In the fourth and last stage,

respondents were selected through a convenient sampling technique. Implementing specific methodologies facilitated data acquisition efficiently and cost-effectively for the researcher. The sample size consisted of 200 female participants from the Sargodha district. A structured questionnaire was developed to collect the data. Statistical approaches for data analysis, such as descriptive statistics based on frequencies and percentages, were applied; with the help of SPSS, the Chi-square Test and Gamma test were used for Hypothesis Testing.

Results & Discussions

Descriptive Analysis

Table 1:

Demographic Information of Respondents

Demographic Characteristics	Frequency	Percentage (%)
Age		
18 to 27	84	42.0
28 to 37	43	21.5
38 to 47	54	27.0
48 and above	19	9.5
Marital Status		
Single	88	44.0
Married	92	46.0
Widowed	17	8.5
Divorced	3	1.5
Household Head		
Male	173	86.5
Female	27	13.5
Household Type		
Owned	188	94.0
Rented	12	6.0
Educational Status		
Illiterate	19	9.5
Primary	38	19.0
Metric	68	34.0
F.A/FSc	13	6.5
Graduate	39	19.5
Post Graduate	23	11.5
Family Members		
2-4	55	27.5
5-7	102	51.0
8-10	20	10.0

above 11	23	11.5
Family Income		
Up to 9000	29	14.5
10000 to 20000	60	30.0
21000 to 31000	52	26.0
32000 to 42000	28	14.0
43000 to 70000 above	31	15.5
Income Source		
Agriculture	83	41.5
Business	48	24.0
Employee	56	28.0
Relying on donations, Zakat,	10	5.0
and Pension	3	1.5
Total	200	100%

Table 1 showed that nearly half, about 42% of respondents, were 18 to 27 years old. It was also found that about 44% were single, and 46% were married. The majority, about 86.5% of respondents, claimed that household heads were male. It was also found that 94% claimed they have their own houses. Regarding educational status, 19% were Primary pass, 34% were matric, 19.5% were graduates, and 11.5% were post-graduate. More than half, 51% of respondents, claimed they have 5 to 7 family members.

Table 1 also shows that regarding family income, 14.5% have up to 9000 monthly payments, 30% have 10000 to 20000, 26% have 21000 to 31000, 14% have 32000 to 42000, and 15.5% have 43000 to 70000 above. About 41% of respondents claimed that their family income source was agriculture, 24% claimed that their family income is based on business-related activities, and 28% were employed.

Empowerment refers to a person's ability to influence institutions and practices directly impacting their welfare. Each level holds significant importance and warrants individual consideration and comprehensive analysis with the other groups. The study also takes into account various social variables that are associated with ethnicity, gender, religion, geography, and other such factors (Dudwick & Kuehnast, 2006). The following table helps to analyse the level of empowerment of rural females of district Sargodha.

Table 2

Major Findings Related to Women's Empowerment

Statements	Yes		No	
	f	Percentage	f	Percentage
Did you participate in domestic decision-making?	94	47.0%	106	53.0%
Do your husband and family respect your judgment when planning your future?	94	47.0%	106	53.0%
Is there any presence of gender inequality within the domestic sphere of your household?	77	38.5%	123	61.5%
The men in our family take the lead in most decisions.	148	74%	52	26%
I am the one who makes the call on the career future of the younger family members:	64	32%	136	68%
Did you find it hard to participate in festivals, religious gatherings, or other community events on an equal footing with others?	84	42%	116	58%
Do you found an opportunity to participate in the labour market?	111	55.5%	89	44.5%
Can you access a microcredit program or other means of obtaining loans from public or private banks?	45	22.5%	155	77.5%
Do you have the chance to start your own business?	63	31.5%	137	68.5%
Do you own any property?	79	39.5%	121	60.5%
Are there any differences in property rights between men and women in your household?	133	66.5%	67	33.5%
Do you have easy access to healthcare services in your community?	111	55.5%	89	44.5%

Table 2 showed that 53% claimed "NO" in response to "Did you participate in domestic decision-making?" More than half, almost 53%, responded "No" to the statement "Do your husband and family respect your judgment when making plans for your future?" It was found that 61.5% of respondents responded "No" to "Is there any presence of gender inequality within the domestic sphere of your household? About 74% claimed that the men in their families lead most decisions.

In Table 2, More than half, about 68%, responded "No" to the statement "I am the one who makes the call on the career future of the younger family members", and 58%

responded “No” to the statement “Did you find it hard to participate in festivals, religious gatherings, or other community events on an equal footing with others? About 55.5% of respondents responded “Yes” to “Have you found an opportunity to participate in the labour market?”

Also, table 2 shows that The majority, 77.5%, responded “No” to the statement, “Can you access a microcredit program or other means of obtaining loans from public or private banks?” The majority, 68.5%, responded “No” to the statement “Do you have the chance to start your own business?” The majority, 60.5%, do not have property, and 66.5% claimed “Yes” to the statement, “Are there any differences in property rights between men and women in your household?” More than half, 55.5%, responded “Yes” to “Do you have easy access to healthcare services in your community?”

Bi-Variate Analysis

Hypothesis 1: A positive relationship exists between socio-cultural factors and inequality of rural women's healthcare access.

Table 3

Cross-Tabulation between Socio-Cultural factors and inequality in health care services.

Socio-Cultural Factors	Inequality in Access to Healthcare			
	Low	Medium	High	Total
Low	44	31	9	84
Medium	13	63	7	83
High	5	15	13	33
Total	62	109	29	200

Chi-square=57.160 df=4 P-value=.000** Gamma=.558 **=Highly significance

Table 3 shows that the present study investigates the correlation between socio-cultural factors and disparities in healthcare service accessibility among the participants. The statistical analysis reveals a significant correlation between sociocultural factors and the gap in healthcare accessibility among women residing in rural areas, as indicated by the high Chi-square value *(57.160)*. Their Gamma value *(.558)* displays a positive

relationship between variables. The P-value *(p.000)* is highly significant, so the hypothesis "There is a positive relationship between socio-cultural factors and inequality in healthcare access of rural women." is accepted. Barnett & Casper (1991) describe the sociocultural setting as the immediate physical and social context in which people live, or an event or phenomenon emerges. It includes the norms of the communities with which one interacts and the persons from which one draws inspiration.

Maheen et al. (2021) also discussed in their study that owing to cultural norms, females residing in the region tend to disregard signs of acute infection for an extended period before seeking medical assistance. It is common for females' health to take a back seat to that of their family and friends. Significant delays in obtaining therapy due to this will worsen clinical problems. The situation is worsened because most women do not know enough about health and fitness to be dangerous.

Hypothesis 2:A positive relationship exists between high income or status and better health conditions of rural females.

Table 4

Cross-Tabulation between Monthly Income (family or own) and illness status in the last year

Monthly Income (Family or Own)	Have you experienced any illnesses within the past year?		Total
	Yes	No	
Up to 9k	25	8	33
10k to 20k	39	12	51
21k to 31k	18	38	56
32k to 42k	10	20	30
Above 43k	9	21	30
Total	101	99	200

Chi-square=24.774 df=4 P.value=0.000** Gamma=0.445 **=Highly significance

In Table 4, the chi-square value *(24.774)* denotes a statistically significant relationship between elevated income or status and improved health status. The gamma value *(.445)* also indicates a robust positive association between variables. A P-value *(.000)* is highly

significant, so the hypothesis "There is a positive relationship between high income or status and better health condition of rural females." is accepted. As previously stated, socioeconomic factors are a crucial determinant of access to healthcare services. Also, the findings of the study by D'Silva et al. (2018) show that women who are not dependent on their husbands financially are more likely to use services without their husbands' permission. This is especially difficult when there is a social stigma associated with the service, as when seeking medical care for a sexually transmitted virus. The selection of a healthcare provider is heavily influenced by one's ability to pay for that selection. It has been found that in Morocco, male patients prefer more expensive private clinics. In contrast, female patients are more likely to seek care through traditional medicine, pharmaceuticals, or community health centres (D'Silva et al., 2018).

Hypothesis 3: A positive relationship exists between independence in decision-making and consciousness about physical health.

Table 5

Cross-Tabulation between independent Decision making and conscious about Health

Independence in Decision Making	Conscious about Health			Total
	To a larger extent	To some extent	Not at all	
Yes	56	27	22	105
No	20	41	34	95
Total	76	68	56	200

Chi-square=22.327 df=2 P-value=.000** Gamma=0.443 **=Highly significance

Table 5 indicates that the chi-square value *(22.327, p.000)* suggests a statistically significant correlation between the independent variable of decision-making and the dependent variable of awareness regarding physical health. The gamma coefficient *(.443)* exhibits a robust positive correlation among the variables. The hypothesis is as follows "There is a positive relationship between independent in decision-making and consciousness about physical health" is accepted. Also, Mathur et al. (2018) found that it is essential for husbands and wives to have honest conversations and reach a consensus on family planning options. Maternal mortality and morbidity rates, mental and physical exhaustion among mothers who have given birth multiple times, complications during

childbirth, unsafe abortions, infants with low birth weights, and malnourishment are all strongly correlated with women's decision-making and autonomy in both household and community settings, as well as access to good healthcare services.

According to research by Chauhan et al. (2014), having girls participate in household decision-making positively affects the health of young children. Specifically, there has been an uptick in vaccination rates, which has resulted in a decrease in mortality rates for children younger than five.

Hypothesis 4: A positive relationship exists between freedom of mobility and good health conditions.

Table 6

Cross-Tabulation between Freedom of Mobility and Health condition (ill since last year)

Freedom of Mobility	Health condition (ill since last year)		Total
	Yes	No	
To a larger extent	12	35	47
To some extent	50	43	93
Not at all	42	18	60
Total	104	96	200

Chi-Square=5.073 df=2 P.value=.002* Gamma=.252
*=Significant

The findings in Table 6 demonstrate a statistically significant relationship between increased participation in social activities and improved health status, as evidenced by the Chi-square value *(5.073)*. The Gamma quantity *(.252)* indicates a moderate positive correlation between the variables. So, the hypothesis “There is a positive relationship between high participation in social activities and good health condition.” is accepted. According to the results, a woman's limited mobility can negatively affect her psychological and social growth, particularly in her ability to interact with her family and express herself. Also, the outcomes of research conducted in Jordan have revealed that females are socialised to experience apprehension in specific settings from a young age. They are instructed to feel defenceless and dependent on men while discouraged from interacting with the larger community. Women's disobedience to the demands of their

husbands or other family members sometimes leads to social isolation, divorce, or the loss of parental rights (Kennedy et al., 2021; Munthali et al.,2017).

Discussions

Health outcomes within a population are affected by gender in terms of actual health status, perceived health popularity, healthcare-seeking behaviour and attitudes, and the outcomes of healthcare providers and society. The role of women as primary carers within various regions underscore the potential impact of gender-based discrimination on the well-being of children, families, and communities (Rahman et al., 2018; Ouakrim & Badr, 1998). Guidelines and programs designed to improve people's health should seriously consider the impact of gender on health and make special accommodations for the different health concerns that women and men face at different points in their lives.

The study's participants offered vivid accounts reflecting their comprehension and encounters with social exclusion or inequality. They expounded on how such phenomena engender unemployment, poverty, and disparities in gender and how socio-cultural factors exacerbate their limited access to healthcare facilities. The present study focused on the participation of women residing in rural areas. This decision was made considering the societal barriers that hinder their ability to obtain healthcare services. The factors above encompass, yet are not restricted to, restricted participation in decision-making procedures, patriarchal familial frameworks, insufficient financial resources and accessibility, inadequate knowledge regarding treatment alternatives, physical impediments to access, and limited availability of publicly subsidised or governmental healthcare establishments. The negative impact of these factors on rural women's access to healthcare services was a crucial consideration in the study.

The social exclusion and limited access experienced by females residing in rural areas can be attributed to various factors. The study's findings indicate that many women experience a significant physical, psychological, and social burden due to a diagnosis of limited access to health services. This burden is further compounded by their impoverished living conditions and unemployment status. Managing and adapting to a diagnosis is multifaceted and can elicit significant stress. A common way to conceptualise gender disparity is through the lens of poverty, hardship, and destitution, emphasising the personal anguish of unmet needs, dissatisfaction, and material deprivation that results (Feletto & Sharkey, 2019; Azad et al., 2020).

Inequality might result from multiple opposing views on traditions. One perspective posits that the limited involvement of women in social domains or sectors reduces accessibility to healthcare services. The impact of social factors on healthcare and inequality pertains to a range of social, cultural, and economic deficiencies

experienced by women who lack sufficient control, ownership, or access to resources necessary for achieving a basic standard of living.

Conclusion

The research found that rural women were excluded from mainstream roles. This study's findings provide credence to the study's overarching goals: determine the effects of socio-cultural factors on rural women's access to health services and evaluate the relationship between social factors impacting healthcare and inequality in this population. The findings pointed to a connection between socioeconomic determinants and healthcare disparities. This research demonstrates that socioeconomic inequalities make women more likely to have poor health. Women in rural areas of Pakistan face barriers to health care because of persistent social exclusion. The participants' accounts clarify the complexity of the social factors contributing to inequality and its far-reaching effects on their lives. However, recent evidence suggests that disparities in educational opportunity, female labour force participation in rural areas, and gender inequality are historically low. According to the participants, inequality stems from a lack of social engagement or material resources and a need for a more political voice, public services, and educational opportunities.

Limitations and Recommendations

Social service providers, such as social workers, should be aware of the difficulties presented by social factors (low income, joblessness, lack of political and social empowerment, cultural barriers, and male dominance), as these are what primarily determine rural women's unequal access to healthcare services.

The experts have the potential to assume an active role in promoting health services, given their frequent interaction with individuals who have limited access to such resources.

Those who work in social services should do well to examine inequality from various angles, as various causes of gender disparity cannot be addressed with a uniform approach.

It is imperative to shift the focus from solely examining the absence of financial resources towards a comprehensive evaluation of human impoverishment and the curtailment of capabilities. This approach is essential to address the fundamental structural factors that engender disparities in healthcare access, which policymakers can leverage to promote women's empowerment.

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Ms. Zebish Shah is a Visiting Lecturer in the Department Sociology and Criminology, University of Sargodha, Punjab.

Mr. Tauqeer Ahmed Lak is a Lecturer in the Department Sociology and Criminology, University of Sargodha, Punjab.

Ms. Azka Murtaza is a Ph.D. Scholar in the Department of Sociology and Criminology, University of Sargodha, Punjab.