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Research on sociocultural factors impacting rural women's healthcare access in Sargodha District

Dr. Samina Amin, Dr. Elena Petrova

Department of Media and Communication Studies, University of the Punjab, Lahore

Department of Political Science, Moscow State University, Moscow, Russia

Abstract:

The primary objective of the study was to ascertain the social factors that impact the rural women's capacity to avail healthcare services. The secondary aim of this study was to examine the association between gender-based discrimination and other socio-cultural disadvantages that rural women in Pakistan face in terms of accessing healthcare. The study was characterized by a descriptive and quantitative approach, utilizing a cross-sectional design. The study was conducted in the district of Sargodha, using a multistage sampling procedure. In the present study, a simple random sample design was employed to choose the villages, union councils, and tehsils. Conversely, a pragmatic sample technique was utilized for the participants, specifically targeting adult and young women. The sample consisted of a total of 200 respondents. The data was collected by a pre-tested questionnaire. The data were analyzed using SPSS software, and frequencies, percentages, and chi-square tests were employed to evaluate the hypotheses. The findings confirm the existence of a significant gender disparity in the availability of healthcare services for women living in rural areas. The results confirm the existence of a significant gender disparity in the availability of healthcare services for women living in rural areas. The current research suggests that differences in healthcare access among persons facing various economic, social, and psychological challenges are driven by social determinants. Women facing disadvantages in terms of healthcare access, resources, or ownership are disproportionately affected, impeding their capacity to achieve even the most basic living standards. The research underscores the crucial need of ensuring women's complete involvement in social and political domains to enable their significant contributions to the development process.

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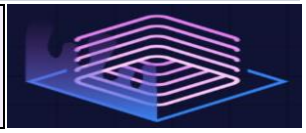

Introduction

According to the World Health Organization, health is a comprehensive condition that includes mental, physical, and social well-being. Furthermore, the presence or absence of sickness and disease has a decisive role. It indicates that a person should be physically well or strong, without any physical impairment or illness. The source of this information is the World Health Organization in 1948. In recent years, there has been a notable improvement in the availability and standard of healthcare in some developing nations. There are significant differences in health and the use of health services between urban and rural populations (Guo et al., 2020). The main reasons for this include the rural population's poor financial means, restricted availability of healthcare services, and insufficient health insurance coverage. Like Ethiopia and Uganda, the situation is similar in Pakistan and other developing nations (Ahmed et al., 2022; Arcaya et al., 2015). Braveman et al. (2019) argue that health disparities are unfair and may suggest the presence of underlying injustices. Reducing health inequalities in communities can be achieved by addressing poverty, discrimination, helplessness, and lack of access to safe housing, adequate education, and health care. Health disparities can be classified based on differences in the prevalence of risk factors or inequalities in health outcomes among different demographic categories. The existence of healthcare inequalities can be explained by inherent differences and personal decisions. However, most external factors and conditions are beyond an individual's control (Arcaya et al., 2015; WHO, 2018; Braveman et al., 2019). It is crucial to understand that healthcare usage refers to the efficient use of certain healthcare services to achieve targeted health outcomes (IOM, 1993, p.46). A significant number of individuals have readily available health insurance, allowing them to fully utilize the government's social assistance system. Many people encounter barriers that impede their access to even the most basic healthcare treatments. According to a comprehensive research and prior National Healthcare Disparities Reports (2010), some ethnic or racial groups, as well as persons from low socioeconomic origins, face a higher likelihood of experiencing access challenges. After the National Healthcare Quality Report and the National Healthcare Disparities Report were published, it was concluded that medical insurance is the most crucial factor. Uninsured patients had a lower probability of getting preventative care recommendations, such as influenza vaccinations, dental checkups, mammograms, and fitness programs. Lack of adequate healthcare access leads to negative consequences for both individuals and society as a whole (NHDR, 2010). Global influences, such as international exchanges, domestic norms, and standards, have an impact on societal growth patterns. As a result, these variables influence how society is structured at both the local and national levels, leading to the development of specific social roles and hierarchies that divide populations based on criteria such as wealth, employment,

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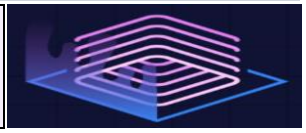

education, gender, and ethnicity. The social hierarchy has a significant impact on the extent to which individuals are exposed to risk factors and encounter the effects of sickness (WHO, 2009; Braveman et al., 2019). Gender-based discrimination significantly impacts several facets of a woman's life, such as her physical well-being, understanding, susceptibility, flexibility, capability, self-confidence, and ability to access social support networks that aid in resolving health issues as they arise. Studies have shown that women's social and economic prospects suffer when they have restricted access to formal education (Anwar et al., 2012).

Literary Evaluation

Moreover, this research emphasizes the crucial factors that have led to the inequality in women's access to healthcare. In Pakistan, there is a common practice of giving priority to the health of particular gender groups. Children's health is prioritized less than women's health, and within children, males are given greater advantages than daughters (Tunio & Ahmed, 2021; Qadir et al., 2011). Sexism directed towards women is an all-encompassing ideology that infiltrates all facets of Pakistani culture (Tunio & Ahmed, 2021). The disparities in healthcare access for women in Pakistan are mostly derived from cultural and historical underpinnings that are centered on gender. When examined from an artistic perspective, it becomes evident that women in Pakistan encounter intrinsic obstacles and discriminatory behaviors throughout their life. Conversely, males are commonly perceived as having greater social and economic worth. The existence of gender bias in Pakistan may be quantified by the disturbed gender ratio, which reveals a ratio of ninety-one females to one hundred men, in contrast to industrialized nations (Qadir, 2011; Gilbert et al., 2017). Research done in rural Bangladesh in 2018 found a considerable gap in healthcare coverage between males and females. Males were awarded a greater percentage of coverage (89.2%) compared to girls (85.9%). This disparity can be attributed to social barriers and limited accessibility to healthcare. Statistical data (Ahmed et al., 2022) reveals a notable disparity in vaccination rates between boys (68%) and girls (63%) in Pakistan. Gender-based obstacles to immunization include socioeconomic poverty, marital status, education, age, and the sociocultural environment. Furthermore, gender roles, health literacy, and females' views of service quality all hinder immunisation (Feletto & Sharkey, 2019). Habib et al. (2021) performed a comprehensive study in the rural Tando Allahyar area of Sindh to evaluate women's healthcare accessibility and public knowledge regarding TB. The study involved interviewing a total of 36 participants. The research findings confirmed the existence of barriers hindering women's ability to obtain healthcare, especially among the younger age group. The obstacles encompassed limited self-governance in household and financial affairs, cultural disfavor towards autonomous travel,

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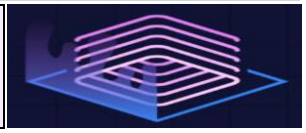

prolonged journey durations, insufficient allocation of resources towards women's health, and a scarcity of female healthcare practitioners.

Recent data suggests that an individual's health and access to healthcare can be affected by factors such as socioeconomic position, ethnicity, age, gender, sickness, and migratory status. Research indicates that children with disabilities and women are especially vulnerable to inequitable healthcare admission policies. Furthermore, these groups may encounter various forms of discriminatory behaviors (Braveman et al., 2019). Research undertaken in Nigeria has shown that women have substantial obstacles in obtaining healthcare, even when socioeconomic considerations have been taken into consideration. Factors such as an elevated likelihood of marital violence and less involvement in decision-making contribute to this phenomenon (Singh & Erica, 2013). This discovery provides more evidence for the outcomes of previous studies carried out in Pakistan, which shown that women had a reduced impact on medical choices, particularly in rural and economically disadvantaged urban regions (Hamid et al., 2010). Consequently, some countries limit women's access to financial resources, and their financial knowledge is notably lower to that of males.

Studies on the correlation between gender and health policy in Pakistan reveal that women patients have restricted agency in deciding their treatment options. The incidence of disease among women is significantly greater in rural areas as a result of cultural norms that value males over females in decision-making processes and assign women to lower roles (Ahmed et al., 2022; Iqbal et al., 2019). The gender differences arise from an intricate combination of individual and social variables. The significance of lobbying for and actively participating in economic and political matters underscores the crucial necessity of women's health rights. The research findings in Pakistan highlight the intricate relationship between gender-based health determinants and the decline in immunization rates. These factors encompass ecological, economical, and societal dimensions (Rizvi & Nishtar, 2008; Habib et al., 2021). Autonomy is essential for women to get and make use of primary healthcare services, ensuring the well-being of both themselves and their children. For males to have full control over decision-making, they must acquire extensive knowledge and show strong commitment towards the health and education of their children. Prior study has shown that autonomy is hindered in many research contexts, both national and international, as a result of sociocultural factors and gender norms (Rahman et al., 2018; Singh & Erica, 2013; Hamid et al., 2010). According to Maheen et al. (2020), Pakistani women have considerable power inside their homes, but their ability to choose their own lifestyle and set family priorities is restricted. Social isolation and inadequate treatment have been linked to abysmal health outcomes and an increased likelihood of early mortality. Rural women experience a greater

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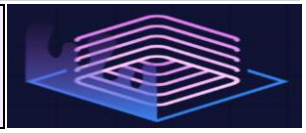

negative effect from unemployment, poverty, and gender inequalities compared to other groups (WHO, 1993; Anwar et al., 2012).

The Human Development Report (2006) highlights that Pakistan, Afghanistan, and Qatar face significant challenges in terms of medical care accessibility due to a scarcity of healthcare providers and medical services. Additionally, the need to travel long distances or visit health institutions further hampers the freedom of mobility for individuals seeking medical care in these countries. Particularly for women living in rural areas, their ability to utilize these services may be impeded by financial limitations, time constraints, or transportation difficulties (Tunio & Ahmed, 2021; Shaikh & Hatcher, 2017). Despite efforts to safeguard the well-being of the mother, half of pregnant women who arrive late with difficulties like as hemorrhage or obstructed labor still have miscarriage (Tunio & Ahmed, 2021). Furthermore, the lack of women's and girls' ability to exercise self-governance and the restrictions on their physical movement might hinder their access to and benefits from healthcare services (Anwar et al., 2012).

The following are the research objectives:

• The objective is to investigate the social factors that lead to inequalities in healthcare access for women living in rural areas. • The objective is to examine the impact of "Economic Access" on the healthcare accessibility of women living in rural areas. • To ascertain the association between the level of awareness regarding physical health and the process of making decisions. • To examine the relationship between healthcare status and freedom of movement.

Research Methodology

The primary objective of this study was to investigate the impact of socioeconomic factors on the accessibility of healthcare services for women residing in rural areas of District Sargodha. The study utilized a descriptive and quantitative approach, adopting a cross-sectional design. The research participants consisted of females residing in the rural region of Sargodha District. The study employed a multi-stage sampling process to get the required data. In the preliminary phase, a simple random sampling approach was used to choose two tehsils, namely Bhera and Silanwali, from the seven tehsils in the Sargodha district. For the next stage of the study project, two union councils—UC-9 Rakh Charagah Tehsil Bhera and UC-95 Sillanwali Tehsil Sillanwali—were selected using a simple random selection method. Four localities (125 NB, 128 NB, Chak Qazi, Shah Hussain) were randomly chosen in the third stage. In the conclusive and last stage, individuals were selected utilizing a pragmatic sampling technique. The researcher efficiently and inexpensively obtained data by employing certain procedures. The sample consisted of two hundred female participants from the Sargodha district. A systematic questionnaire was designed

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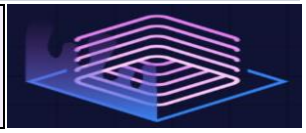

to collect the data. The data was analyzed using descriptive statistics, namely frequencies and percentages. Hypotheses were tested using the Chi-square test and gamma test, with the aid of SPSS.

Summary and Analysis

Thorough Assessment

Table 1: Finding on Women 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%

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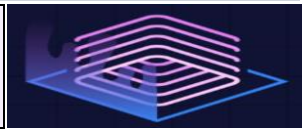

According to the data presented in Table 1, a majority of 53% of the participants responded negatively to the question "Did you participate in making decisions within your household?" Additionally, about 53% of the respondents expressed disagreement with the statement "Do your spouse and family members appreciate your opinions when it comes to making future plans?" The findings revealed that 61.5% of the respondents responded negatively when queried about the presence of gender disparity within the domestic realm of their households. According to 74% of respondents, men are the primary decision-makers in their families. Table 1 displays the participants' responses. A majority of 68% disagreed with the statement "I am the one who decides the career paths of younger family members." Likewise, 58% of the respondents reported facing challenges in participating in community events, religious gatherings, festivals, or other gatherings on an equal basis with others. Approximately 55.5% of the participants reported that they had found an opportunity to enter the job market. Furthermore, according to Table 1, a significant majority of respondents (77.5%) answered "No" when asked if they had access to a microcredit program or any other means of obtaining loans from public or private banks. The majority, 68.5%, also responded "No" to the question of whether they had the chance to start their own business."A considerable portion of the participants (66.5%) do not possess real estate, whereas 66.5 percent responded positively when asked if property rights vary between male and female members of their household. 55.5 percent of the respondents stated that they have convenient access to healthcare services in their local area."

Discussion

Gender influences health outcomes within a population with regard to perceived health popularity, healthcare-seeking behavior and attitudes, actual health status, healthcare provider and societal outcomes. The potential consequences of gender-based discrimination on the welfare of children, families, and communities are highlighted by the fact that women serve as primary caregivers in numerous regions (Rahman et al., 2018; Ouakrim & Badr, 1998). It is imperative that health-improving guidelines and programs give due consideration to the influence of gender on health outcomes and account for the unique health challenges encountered by men and women at different stages of life. The participants of the study provided detailed narratives that reflected their understanding and personal experiences of social exclusion or inequality. The authors elaborated on the ways in which these phenomena contribute to poverty, unemployment, and gender disparities, as well as how sociocultural factors worsen their restricted availability of healthcare facilities. The current investigation centred on the involvement of females who were rural residents. This determination was reached in light of the societal obstacles that impede their access to healthcare services. The aforementioned factors include, but are not limited to, limited access

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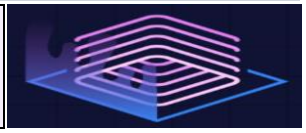

to publicly funded or government healthcare facilities, restricted participation in decision-making processes, patriarchal familial structures, inadequate financial resources and accessibility, insufficient knowledge regarding treatment alternatives, physical barriers to entry, and restricted availability of such facilities. The detrimental effects of these elements on the ability of rural women to obtain healthcare services constituted a pivotal aspect of the research. The social exclusion and restricted access that females living in rural regions endure can be ascribed to a multitude of factors. The results of the research suggest that a considerable number of women endure considerable physical, mental, and social strain as a result of being diagnosed with restricted access to healthcare services. Their precarious housing conditions and unemployment status exacerbate this burden even more. The process of adapting to and managing a diagnosis is complex and can induce considerable stress. Poverty, hardship, and destitution are frequently employed to conceptualize gender disparity, with an emphasis on the individual suffering that ensues from unfulfilled necessities, discontentment, and material deprivation (Feletto & Sharkey, 2019; Azad et al., 2020). Divergent perspectives on traditions may contribute to inequality. One viewpoint contends that the restricted participation of women in social spheres or sectors diminishes the availability of healthcare services. The influence of social factors on healthcare and inequality encompasses various economic, cultural, and social inadequacies encountered by women who do not possess adequate authority, possession, or access to essential resources required to attain a minimal standard of living.

Conclusion

According to the findings of the study, rural women were excluded from mainstream roles. The results of this research support the study's overarching objectives, which were to assess the correlation between social determinants of healthcare inequality and rural women's access to health services and to identify the ways in which sociocultural factors influence this population's access to healthcare. The results indicated a correlation between socioeconomic factors and inequities in healthcare. This study provides evidence that socioeconomic disparities increase the likelihood of women experiencing substandard health. The rural population of Pakistan is confronted with obstacles to accessing healthcare due to the enduring social exclusion they endure. The life-altering consequences of inequality and the intricate nature of the social factors that contribute to it are illuminated in the accounts of the participants. Nevertheless, emerging data indicates that gender inequality, discrepancies in educational opportunity, and female labor force participation in rural regions are at their lowest levels in recent history. Inequality, according to the participants, results from a dearth of material resources or social participation, as well as a demand for a greater political influence, public services, and educational opportunities.

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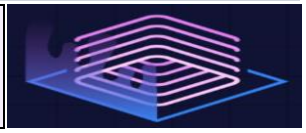

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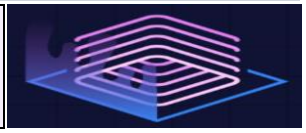

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