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Health Disparities By Gender And Socioeconomic Status In Pakistan's Major Cities

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Abstract

Social gaps in access to health care for women and children have been highlighted in recent research, investigations, and evaluations conducted in metropolitan Pakistan. Extensive surveys and profiles were conducted in urban slums. A current list of low-income areas and others was requested, as was information on vaccination rates and access to health care. These studies are utilized to better understand the impact of gender and socioeconomic status on health in urban slums. The Urban Slum Profiles employed quantitative and qualitative techniques. Three hundred surveys of urban ghettos and polls of immunization rates were conducted in Pakistan's five most populous cities. Health care access, women's workforce participation, gender-sensitive health services, education and literacy, social networks, and autonomy are the six factors considered. Too few clinics, female physicians, and high-quality buildings limit the health care options available to women and children in low-income areas. The findings indicate that there are not enough women who can read and make independent decisions, not enough individuals who are vaccinated and not enough people who have social connections outside of the house. These factors contribute to the maintenance of harmful ideas about women, a lack of health education, and restricted access to care. More women should be employed in the health sector, urban health action plans should include costs, and the political environment should be conducive to community organization and fair health service delivery; all of these can be introduced through the use of slum profiles and coverage studies.

Keywords: health disparities, slum areas, developing country, social inequality.

Introduction

As health care systems throughout the world move toward eradication and elimination targets for vaccine-preventable diseases (VPDs), increasing policy and planning emphasis is being paid to reaching the final 10-15% of unvaccinated or partly vaccinated persons, including 20.3 million children in 2019. Several research (Crocker-Buque et al., 2017; Mushtaque et al., 2021) demonstrate that this last category of inaccessible persons are disproportionately low-income, concentrated in urban areas, or geographically dispersed.

Several large-scale studies demonstrate that the vaccination rate varies by gender (Boyce et al., 2019). Girls were substantially less likely

to have been vaccinated than boys were throughout three separate National Family Health Surveys conducted in India between 1992 and 2006. Researchers in rural Bangladesh discovered that in 2018, 89.2% of males were covered but just 85.9% of girls (Rahman et al., 2018). Researchers in Pakistan found that just 63% of girls and 68% of boys had received all of their recommended vaccinations. Vaccination rates among women are lower than those among men because of many factors, including their lower social status (including their income status, race, marital status, age, level of education, and sociocultural surroundings), gender norms, lack of health knowledge, and negative experiences with the quality of services they have received (Hamid et al., 2010; Nawaz et al., 2021)). Women should have access to and be able to utilize primary health care services for themselves and their children, regardless of whether they are male or female, given their societal position as primary caretakers. In order to make their own choices regarding their children's health and education, fathers need more information. Gender roles and other social variables are found to restrict this form of autonomy in a number of research and reviews (Singh et al., 2012; Sawangchai et al., 2022). There was a significant correlation between socioeconomic status and the decision to fully vaccinate a kid, as well as family decision making and domestic violence (Rainey et al., 2011). Especially in low-income urban neighborhoods and rural communities, women in Pakistan lack the autonomy to make their own health care decisions, according to previous studies. Because of this, they have less opportunity to get medical treatment (Mitchell et al., 2009). Women in Pakistan are more likely to get sick because cultural norms that favor males making decisions and put women in a submissive position make them less able to make decisions about seeking health care (Sarfraz et al., 2022).

These gender gaps arise from the complex interplay between industry-specific and societal factors that influence people's propensity to seek medical care (Nasrullah et al., 2013). Support for reproductive health, education, economic and political involvement, and other variables are all important (Panezai et al., 2017). The complexity of men's and women's health concerns is illustrated by a new research from Pakistan that examines the economic, environmental, and social consequences of low vaccination rates. A cross-sectional study of measles immunization in one Pakistani district (Mitchell et al., 2009) found that the likelihood of a person being vaccinated was higher among those whose mothers had completed formal education, who discussed vaccinations at home, who had access to adequate medical care, and who lived in a safe neighborhood. Having a healthy pregnancy and giving birth at a hospital might be challenging when you are married young (Nawaz et al., 2021).

Researchers in Pakistan examined the intersection of gender and primary healthcare (PHC) in a number of studies. The location, accessibility, staff compensation, hours worked, and organizational structure of PHC facilities all have a role in making it more difficult for women to get these services, as shown by the aforementioned research (Aziz & Hanif, 2016). Women in Balochistan are more likely to use family planning services if they have easy access to a female doctor, a female health worker, contraceptives, and high-quality services (Paterson, 2008). Men and women in rural Pakistan were not equally happy with the PHC services they used, according to another survey. Women were more concerned with access to health facilities and reproductive health care, while males were more concerned with how soon aid was provided, how often personnel was there, and what hours they were open. The following study confirmed that cultural barriers might

prevent women from receiving medical attention (Mannion & Davies, 2018). These researches illustrate the complex interplay between gender, socioeconomic position, and Pakistan's health care system as barriers to and facilitators of health care utilization.

A person's willingness to be immunized and use the healthcare system may be influenced by their level of health literacy (Adil et al., 2021). The health outcomes illustrate the complexity of these interplays. For every year a mother completes high education, the number of infants born to her decreases by 1.4, and the number of newborns that die decreases. Increased immunity helps kids develop and teach (Ahmed et al., 2023). Gender, health, and society are all components of a complex adaptive system that interact with one another and provide feedback to one another. As a result, policymakers and planners have a hard time identifying policy and planning points of engagement (Bloom, 2011) to alter gender stereotypes that limit access to health care in the home.

Using slum vaccination coverage surveys (UNICEF, 2020) and slum demographic profiles (UNICEF, 2020b), this research looks at how gender plays a role in the provision of primary health care (PHC) to the urban poor in 10 of Pakistan's largest cities. In these profiles of urban slums, we examine vaccination and primary care services. Primary health care (PHC) policy and practice have much to gain from a deeper understanding of the interplay between health care accesses and economic, social, and gender issues.

The profiles aimed to update the list of slums and other places in Pakistan's urban poor regions that haven't been cared for, learn more about immunization and health care coverage, and serve as a starting point for urban health programs. To better understand the role of gender and socioeconomic variables in explaining health disparities in low-resource communities, researchers have turned to these types of studies.

Research Design and Methodology

Urban slum profiles and coverage surveys were performed. The investigation included both qualitative and quantitative methods. The research drew on the Urban Slum Profiles and the Immunization Coverage Survey of Urban Poor Areas to examine slum conditions in five different Pakistani cities. Areas with low vaccination rates and high vaccine refusal rates, as well as urban slums according to the international definition of slums, were identified by surveyors and provincial managers. The urban slum profiles contained data from several sources, such as the union council (UC) health resource assessment, the evaluation of EPI Facilities (n = 300), the mapping of coverage regions, and the physical verification of slums and underserved areas. The evaluation of urban poor vaccination coverage in 5 cities was included to the health profiles. Analysis of urban slum profiles and field-based focus groups on the issues of vaccination and access to healthcare were coupled with the results of these surveys. The coverage survey inquired as to things like housing conditions, household income, maternal background, and immunization history.

Population and Sampling Criteria

The survey team personally visited each UC to double-check the slum and poor neighborhood data against the official health ratings. After visiting the locations, it was useful to speak with locals in groups to learn more about the people and the activities that took place there. One meeting was held with each union board in a low-income neighborhood. From the pool of respondents, anything from three to five were selected to participate in open, facilitated discussions. Those with at least two years of local experience who were familiar with the area's

physical infrastructure and other services were considered. No one with less than two years of experience was accepted. Structured questions are used for EPI website polls. Accessibility, availability, quality, quantity, cold chain, waste management, water quality, and cleanliness were all measured through on-site inspections of EPI facilities in close proximity to slums and undeveloped regions. We surveyed all 300 EPI sites in poor, inaccessible neighborhoods. District-level discussions in each city informed residents about the city's public health resources, including physical exams, socioeconomic profiles, and facility assessments.

Statistical Analysis

The research on gender and social issues was founded on the searching of urban slum profile reports and coverage survey data for gender-related data, analysis, comments, and viewpoints. In order to give a social determinants of health viewpoint, the survey instruments were constructed by taking into consideration a variety of characteristics, such as population, infrastructure, social services, health services, anticipated slum health resource availability, and family history.

Results

Table 1

Study variables	Type of Data
Verification of an Urban Slum Physical Description	The sociological profile of slums and underdeveloped regions was gathered through in-person interviews and focus groups.
Investigations of Urban Slums Conducted by the EPI	The quantity, quality, and convenience of access to EPI services, as well as the availability of EPI workers, EPI vaccines and supplies, the cold chain, waste management, water, and cleanliness, all underwent on-site examinations.
Profile of a City Slum: Mapping the Resources That Are Available	Slums and other sites with substandard construction were labeled on the maps provided by the union council. To determine the locations of the various hospital services, a real-time geographic information system was utilized.
An Analysis of the Resources Found in Slum Areas	At the union board level, information is given about how health care services are set up, who works there, and how easy they are to get.
Rate on the Prevalence of Vaccination	The WHO cluster poll method was utilized in order to obtain information on vaccination rates, the length of time individuals retained their cards, as well as other topics such as family income, the level of education received, the quality of housing, and understanding regarding vaccines.

1. Access to medical care

Access to reproductive health care might vary from one location to another depending on the kinds of services that are offered and the facilities that are available to provide those services. According to the findings of the research pertaining to health resources, a total of 26% (n = 121) of the UCs did not possess EPI Facilities, and 31% (n = 101) of the UCs did not own any health facilities (public or private). The vast majority of reproductive health care can only be provided in one location at a time. Despite the

fact that 29% (n = 285) of slum and neglected districts do not get health outreach services from established organizations, just 3% (n = 132) of these locations are within 3 kilometers of slum regions. Another significant problem is the availability of adequate transportation. According to the Urban Slum Profile, it is difficult for female caregivers in Quetta, which is located in the region of Balochistan, to go to healthcare facilities since there are no gender-neutral means to get there. In other words, there are no gender-neutral routes. Only 11% of the public health clinics in Karachi's slums have access to an ambulance, despite the city's population of 9,642,936 people. Even though there has been an increase in the number of births that take place in hospitals, approximately one in every three newborns is still delivered at home.

2. Women's Involvement in the Labor Force

Workforce involvement in gender and health refers to how much women work in the general or health workforce. The nationwide coverage survey surveyed 141 moms in communities and underserved regions of five cities about their families and the jobs of their women and men. These statistics were used to survey national coverage. Only 6% (n = 33) of the 141 low-income and disadvantaged women in five cities had outside jobs. Only 3% of women worked outside the home in Rawalpindi (26 mothers) and Faisalabad (13 mothers). All of the women polled had 6- to 12-month-old children, which may explain why so few women work. A research that compared vaccination coverage in affluent and impoverished regions found that unemployed women are economically disadvantaged. 54% (n = 149) of the 300 families polled depend on hourly earnings, and 56% (n = 151) regularly or permanently lack finances. Only 6% of families save, indicating their funds surpass their requirements. Urban Slum Profiles show that Lady Health experts (LHWs) and other field health experts are essential to improving slums' social and physical problems. The National Urban Slum Profile calls the lack of women in medicine "discouraging" for women and children seeking medical treatment. LHWs often travel to economically poor regions to give education, health motivation, and basic medical treatment. Lady Health Visitors (LHVs) focus on new moms and their babies' health.

3. Healthcare that is inclusive of all genders

The phrase "gender-friendly health services" is used in the profiles to characterize the degree to which some aspects of the physical environment, such as the layout of waiting rooms and the water and sanitation systems, are designed with gender in mind. There were no gender-specific waiting spaces in 47 percent (n = 149) of the 102 facilities that were investigated across eight different locations (out of a total of 102 facilities). 37% (n = 19) of the 199 institutions lacked gender-segregated restrooms for their customers, while 53% (n = 151) of their employees did not have access to such facilities. Only 76 out of a total of 112 sites (or 47%; n = 76) were found to have water systems that were working. 31% (n = 97) of the 111 institutions that were looked into had waiting spaces that were specifically designated for men or women. In seven out of the eight cities, there were not sufficient seats available in clinics that were located in or adjacent to poor communities and slums. According to the findings of the National Urban Slum Profile, there was a "cultural barrier for females for easy use" due to the fact that 31% of the bathrooms were shared by both sexes. This was especially true in regions such as Peshawar and Quetta, where the lack of facilities like these may discourage female caretakers from vaccinating their children. The concerns regarding the lack of privacy in the clinic's exam rooms were not investigated. Examples of gender-friendly health services include the availability of job

opportunities for women, accessibility to reproductive healthcare, and the design of facilities that are welcoming to both men and women. The results of studies pertaining to various fields, such as education, social networks, welfare services, and an individual's capacity for decision-making, will now be presented alongside the data from studies pertaining to health.

4. Social Relationships

The Urban Slum profiles offer in-depth information on the number of official and informal groups that are present in slums and underserved districts, as well as the existence of community-based and civic organizations in eight of the five cities. In addition, the profiles include information on the types of residents that live in these areas. According to the findings, there are not enough social networks or community-level groups operating in the fields of health and education. In addition to the other results, the fact that only 6% of the women who were polled had paid occupations outside the home demonstrates that community organizations and social networks are not doing enough to address the discrepancy between the demand for and supply of services in their respective communities. It lends credence to the findings of earlier research, which discovered that only a small percentage of families were aware of the advantages of vaccination. It also raises concerns about whether or not women have adequate access to informational resources that would enable them to make autonomous and educated judgments about how to make use of contemporary health and educational alternatives. This raises problems about whether or not women have sufficient access to informational resources that would enable them to make such decisions.

5. disparities in terms of both health and social results

It seems likely that the results for reproductive health and child death in 2018 will be similar to what the PDHS found. This is because it has been said that there aren't enough female doctors, medical centers, or services for reproductive health. Even though there are only small differences between fully immunized boys (65%) and fully immunized girls (45%) in the immunization coverage survey in slums and underserved areas, the role of women as primary health care providers, which helps both girls and boys get better access to immunization and other health services, is an intervention that needs to be thought about from a gender and public health point of view. In 2018, the Pakistan Demographic and Health Survey (PDHS) found that only 44% of Pakistani children had gotten all of their recommended vaccines. The urban health coverage study, on the other hand, found that 67% of children had all of their vaccines. The results of a study on vaccine coverage that was done in five cities showed that between 39% and 69% of children in Multan and 69% in Quetta had gotten all of the required shots. This was shown by memory and card retention. Pakistan was where the study was done.

Conclusion

In slums and undeveloped regions, the Urban Slum Profiles and Immunization Coverage Survey discovered that the variables that impact health and gender inequality interact with each other and have a wide variety of consequences on the urban poor's access to primary healthcare (PHC). Given that this is the situation, it will be necessary to devise an initial strategy with a time frame ranging from the short to the medium term in order to pave the way for a PHC or natural technique that will be used over the longer run. The findings of this research provide us with the opportunity to develop a gender-focused and pro-equity urban health strategy as well as coasted action plans that are congruent with national and provincial health programs. It is possible to

accomplish this goal through expanding the number of female workers in the health care industry and ensuring that institutional policies encourage improved community organization and service availability for primary health care (PHC). Mainstreaming gender into urban health strategy and operations has the potential to offer women more influence and contribute to the creation of a more equitable society between men and women. Considering that over 13 million people reside in these urban poor neighborhoods in the 5 cities, this is a need. It may also make it simpler for people to gain access to the necessary social and health services in their communities. By carrying out this action, mainstreaming gender policy demonstrates that it have the potential to make a significant contribution to Pakistan's overall economic and social development.

References

1. Adil, A., Usman, A., Khan, N. M., & Mirza, F. I. (2021). Adolescent health literacy: factors effecting usage and expertise of digital health literacy among universities students in Pakistan. BMC Public Health, 21(1). https://doi.org/10.1186/s12889-020-10075-y
2. Ahmed, S., Rosario Yslado Méndez, Naveed, S., Akhter, S., Iqra Mushtaque, Malik, M. A., Ahmad, W., Roger Norabuena Figueroa, & Younas, A. (2023). Assessment of hepatitis-related knowledge, attitudes, and practices on quality of life with the moderating role of internalized stigma among hepatitis B-positive patients in Pakistan. Health Psychology and Behavioral Medicine, 11(1). https://doi.org/10.1080/21642850.2023.2192782
3. Aziz, S. Z., & Hanif, I. (2016). Primary care and health system performance in Pakistan: A study of basic health units of South Punjab. JPMA. The Journal of the Pakistan Medical Association, 66(12), 1632–1636. https://pubmed.ncbi.nlm.nih.gov/28179704/
4. Bloom, D. E. (2011). The value of vaccination. Advances in Experimental Medicine and Biology, 697, 1–8. https://doi.org/10.1007/978-1-4419-7185-2_1
5. Boyce, T., Gudorf, A., de Kat, C., Muscat, M., Butler, R., & Habersaat, K. B. (2019). Towards equity in immunisation. Eurosurveillance, 24(2). https://doi.org/10.2807/1560-7917.es.2019.24.2.1800204
6. Crocker-Buque, T., Mindra, G., Duncan, R., & Mounier-Jack, S. (2017). Immunization, urbanization and slums – a systematic review of factors and interventions. BMC Public Health, 17(1). https://doi.org/10.1186/s12889-017-4473-7
7. Hamid, S., Johansson, E., & Rubenson, B. (2010). Security lies in obedience - Voices of young women of a slum in Pakistan. BMC Public Health, 10(1). https://doi.org/10.1186/1471-2458-10-164
8. Mannion, R., & Davies, H. (2018). Understanding Organisational Culture for Healthcare Quality Improvement. BMJ, 363(363). BMJ. https://doi.org/10.1136/bmj.k4907
9. Mitchell, S., Andersson, N., Ansari, N. M., Omer, K., Soberanis, J. L., & Cockcroft, A. (2009). Equity and vaccine uptake: a cross-sectional study of measles vaccination in Lasbela District, Pakistan. BMC International Health and Human Rights, 9(S1). https://doi.org/10.1186/1472-698x-9-s1-s7
10. Mushtaque, I., Dasti, M. R., Mushtaq, M., & Ali, A. (2021). Attitude towards Covid-19 Vaccine: A Cross-Sectional Urban and Rural Community Survey in Punjab, Pakistan. Hospital Topics, 1–8. https://doi.org/10.1080/00185868.2021.2001399

11. Nasrullah, M., Zakar, R., & Krämer, A. (2013). Effect of Child Marriage on Use of Maternal Health Care Services in Pakistan. Obstetrics & Gynecology, 122(3), 517–524. https://doi.org/10.1097/aog.0b013e31829b5294
12. Nawaz, M. A., Saeed, L., & Mushtaque, I. (2021). Mediating Role of Spousal Support on Internalized Stigma and Marital Satisfaction among depressive Patients. Review of Education, Administration & LAW, 4(4), 561–572. https://doi.org/10.47067/real.v4i4.207
13. Panezai, S., Ahmad, M. M., & Saqib, S. E. (2017). Factors affecting access to primary health care services in Pakistan: a gender-based analysis. Development in Practice, 27(6), 813–827. https://doi.org/10.1080/09614524.2017.1344188
14. Paterson, R. (2008). Women's empowerment in challenging environments: a case study from Balochistan. Development in Practice, 18(3), 333–344. https://doi.org/10.1080/09614520802030383
15. Rahman, A., Reza, A. A. S., Bhuiyan, B. A., Alam, N., Dasgupta, S. K., Mostari, S., & Anwar, I. (2018). Equity and determinants of routine child immunisation programme among tribal and non-tribal populations in rural Tangail subdistrict, Bangladesh: a cohort study. BMJ Open, 8(10), e022634. https://doi.org/10.1136/bmjopen-2018-022634
16. Rainey, J. J., Watkins, M., Ryman, T. K., Sandhu, P., Bo, A., & Banerjee, K. (2011). Reasons related to non-vaccination and under-vaccination of children in low and middle income countries: Findings from a systematic review of the published literature, 1999–2009. Vaccine, 29(46), 8215–8221. https://doi.org/10.1016/j.vaccine.2011.08.096
17. Sarfraz, M., Waqas, H., Ahmed, S., Rurush-Asencio, R., & Mushtaque, I. (2022). Cancer-Related Stigmatization, Quality of Life, and Fear of Death Among Newly Diagnosed Cancer Patients. OMEGA - Journal of Death and Dying, 003022282211406. https://doi.org/10.1177/00302228221140650
18. Sawangchai, A., Raza, M., Khalid, R., Fatima, S. M., & Mushtaque, I. (2022). Depression and Suicidal ideation among Pakistani Rural Areas Women during Flood Disaster. Asian Journal of Psychiatry, 103347. https://doi.org/10.1016/j.ajp.2022.103347
19. Singh, K., Haney, E., & Olorunsaiye, C. (2012). Maternal Autonomy and Attitudes Towards Gender Norms: Associations with Childhood Immunization in Nigeria. Maternal and Child Health Journal, 17(5), 837–841. https://doi.org/10.1007/s10995-012-1060-5
20. UNICEF. (2020a). Coverage Survey in Slums/Underserved Areas of 10 Largest Cities of Pakistan. https://www.unicef.org/pakistan/media/2936/file/Coverage%20Survey%20in%20Slums%20of%2010%20Largest%20Cities%20of%20Pakistan.pdf
21. UNICEF. (2020b). Profiles of Slums/Underserved Areas of 08 Largest Cities of Pakistan. https://www.unicef.org/pakistan/media/2926/file/Profiles%20of%20Underserved%20Areas%20of%2008%20Largest%20Cities%20of%20Pakistan.pdf