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Socio-Cultural Determinants of Healthcare Utilization in Rural South Punjab, Pakistan

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ABSTRACT

The use of healthcare in rural Pakistan is not only determined by the accessibility of medical services, but also by the socio-cultural factors that are deeply embedded and determine healthcare-seeking behavior. The paper will look at the socio-cultural factors that influence healthcare access in rural South Punjab, Pakistan, including traditional beliefs, gender-based limitations, and family decision-making models. The quantitative cross-sectional survey design was used, and 238 adult respondents who were under treatment in three large state-owned hospitals were surveyed: Nishtar Hospital Multan, Victoria Hospital Bahawalpur, and DHQ Hospital Dera Ghazi Khan. A structured questionnaire with validated scales was used to collect data, which were analyzed with SPSS 28 and SmartPLS 4. The findings show that socio-cultural factors have a negative and significant impact on healthcare utilization. Socio-cultural factors ($\beta = 0.38$, $p < .001$), traditional beliefs ($\beta = 0.29$, $p < .001$), and gender-based restrictions ($\beta = 0.31$, $p < .001$) were all identified to decrease the probability to use formal healthcare services. Correlation analysis also supported the significant negative links between healthcare utilization and socio-cultural barriers, which emphasize the influence of cultural norms, stigma, and family authority on the development of health behaviors. The results indicate that the use of healthcare in rural South Punjab is heavily limited by the traditional practices, patriarchal values, and family decision-making.



Introduction

Healthcare use is one of the key indicators of social development since access to preventive and curative services in a timely manner enhances population health, minimizes preventable morbidity and enhances community well-being (Acharya et al., 2026). The availability of healthcare services is not a determinant of healthcare use in low- and middle-income environments, where social values, family authority, gender relations, and culturally specific beliefs about illness and treatment shape the use of healthcare services (Sansakorn et al., 2024). These are particularly acute problems in Pakistan, as a notable portion of the population resides in rural regions, where health facilities are worse, and access is additionally limited due to poverty, distance, and social values. Recent UNICEF reports that approximately 64 percent of the population in Pakistan resides in rural community and that rural communities experience incessant deficits of trained personnel, apparatus, and available services (UNICEF, 2025). It is also demonstrated by the same evidence that socio-cultural and gender disparities still determine whether women and families will seek formal care at all (Ahmed et al., 2023).

In Pakistan, particularly rural South Punjab, the use of health care is not only determined by the presence of medical centers but is also entrenched within the socio-cultural set ups that define how people perceive, make decisions and take actions towards accessing health care (Shaikh and Hatcher, 2005). The presence of socio-cultural determinants such as traditional beliefs, gender norms and family hierarchies are a critical factor that determines health-seeking behavior (Sarfraz et al., 2023). The Pakistani people in most of the rural areas view illness culturally or spiritually and, as a result, many people prefer visiting traditional healers or home remedies instead of accessing formal healthcare services (Ali et al., 2006). These belief systems might postpone prompt medical care and have adverse health outcomes. Besides, the beliefs about contemporary medicine, fear of being labeled as a social outcast, and dependence on informal networks also strengthen the barriers to accessing healthcare (Hashim et al., 2019).

Another important socio-cultural obstacle is gender norms. In patriarchal cultures like rural South Punjab, autonomy of women when it comes to healthcare decision-making is mostly restricted (Amin & Petrova, 2023). The cultural norms often demand that women should consult with male relatives before receiving medical care, thus postponing or denying medical attention (Mumtaz & Salway, 2009). Research has always indicated that gender related limitations hugely limit access to healthcare among women especially in maternal and reproductive health conditions (Nisar & White, 2003). Mobility restrictions, purdah and economic dependency also contribute to these limitations and make women unable to seek healthcare services independently (Habib et al., 2021).

The family structure and the dynamics of decision making is also a key variable in healthcare utilization (Lee et al., 2025). Healthcare decisions are also often taken in extended family systems that are common in South Punjab but are dominated by older males in some cases that can supersede the needs of individuals (Qureshi & Shaikh, 2007). The family structure of authority has the potential to affect the seeking of healthcare, especially among women and children. Whether professional medical care is sought or not, in most instances, depends on the financial considerations, perceived severity of illness and cultural priorities (Wei et al., 2025).

Although there has been growing policy focus on enhancing healthcare accessibility in Pakistan, there has been a paucity of empirical studies that specifically focus on understanding socio-cultural factors that affect healthcare accessibility in rural South Punjab. The majority of the literature is concerned with economic and infrastructural obstacles and does not pay much attention to the

deeply rooted cultural determinants of health behavior. This gap must be addressed to develop culturally sensitive interventions that can help to enhance healthcare utilization.

Hence, this paper will focus on the socio-cultural determinants of health care seeking in rural South Punjab, Pakistan. It examines the effect of traditional beliefs, gender beliefs, and family decision-making patterns on healthcare-seeking behavior (Figure 1). The study adds to the bigger conversation around health equity by offering insight into these determinants in a nuanced way, as well as providing policy-relevant information on how to improve access to healthcare in culturally complex environments.

Objectives of study

1. To examine economic factors that are limiting access to health services.
2. To determine the impact of income, cost, and employment on healthcare utilization.
3. To investigate treatment delays and financial constraints.

Research Questions

1. To what extent are economic barriers a barrier to the accessibility of healthcare services by patients?
2. What is the relationship between income level and healthcare utilization?
3. Are there delays or avoidance of treatment due to healthcare costs?

Hypotheses

- H1: The use of health services is greatly affected by the socio-cultural factors.
H2: The traditional beliefs have adverse effects on healthcare utilization.
H3: The restrictions by gender greatly decrease the access to health care by women.

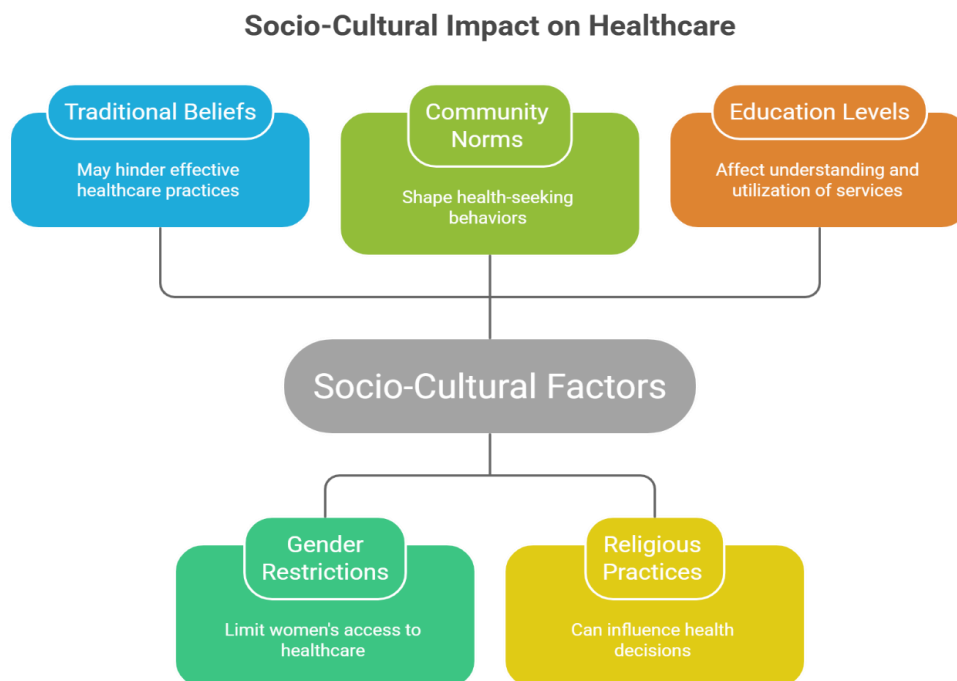


Figure 1 Conceptual Framework

Research Methodology

Research Design

This research took the quantitative research design that employed cross-sectional survey research method to investigate the socio-cultural determinants influencing the use of healthcare services in South Punjab rural region in Pakistan. It was believed that a quantitative approach would be suitable since it will enable the researcher to objectively measure variables and determine the strength and direction of relationships between them using statistical analysis. The cross-sectional design facilitated the researcher to gather information on respondents at one time point therefore appropriate in determining the patterns of association between socio-cultural barriers and healthcare-seeking behavior.

The research was carried out in 3 leading state-owned hospitals in South Punjab, namely Nishtar Hospital Multan, Victoria Hospital Bahawalpur and DHQ Hospital Dera Ghazi Khan. The hospitals were chosen due to the large populations (both rural and semi-urban) served by the hospitals and a wide range of patients with various socio-cultural backgrounds. Their inclusion enabled the study to embrace the differences in beliefs, traditions, family influence, and healthcare decision making patterns within the region.

Study Population

The study population was comprised of male and female patients aged 18 years and above receiving treatment in inpatient wards, outpatient departments, or emergency units of the chosen hospitals which were public. Adult respondents were used since they could comprehend the questionnaire and give informed consent. The target population of South Punjab was significant due to the cultural context of the region, high levels of social stratification and unequal access to healthcare, which are pertinent to the subject of the study.

Sampling Technique and Sample size

The research employed purposive and convenience sampling method to select respondents in the sampled hospitals. The reason why this method was selected is that, a full sampling frame of patients was not available and the researcher required respondents that fitted the inclusion criteria. A variety of patients with various departments were included in the sample to ensure that the sample was diverse in terms of age, gender, healthcare needs, and socio-cultural backgrounds.

G 3.1.9.7 was used in order to calculate the number of respondents required. The minimum sample size needed was 138 participants with a significance of 0.05, a statistical power of 0.95, a medium size of 0.15, and five predictors. This guaranteed that the study was powerful enough to identify significant effects.

Research Instruments

The main instrument of data collection was a questionnaire that was designed based on the existing and tested scales in the literature and the most appropriate area of the questionnaire to this topic was the Socio-Cultural Factors construct. This construct was gauged by six items (SCF1-SCF6) based on the Andersen and Newman model of healthcare utilization (1973), and Gopalan and Fox model (2008), which capture aspects including cultural beliefs, family influence, religious practice, preferential treatment to traditional practices, language barriers and social stigma. The items were constructed to assess the effect of social norms and cultural attitudes on the healthcare-seeking behavior, with one example being the item: Cultural beliefs affect my decision to access healthcare services. This construct is directly pertinent to the topic (measures the influence of traditional

beliefs, family authority and social values in determining the utilization of health services). The dependent variable utilization of health services was assessed using four questions (HS1-HS4) that addressed frequency and regularity of health services use (frequency and regular checkups, emergency visits, and delaying treatment). All the questions in the questionnaire were rated using a five-point Likert scale with 1 = Strongly Disagree and 5 = Strongly Agree. The questionnaire was pilot-tested on 20 respondents to determine the clarity, cultural appropriateness and understanding and to make slight amendments to the questionnaire based on the pilot results.

Data Collection Procedure

Data was collected with the consent of the appropriate Ethics Review Board (ERB) and hospital management. The researcher liaised with the hospital authorities so that the data collection process did not disrupt the routine or treatment of patients by the hospital. Inpatient wards, outpatient departments, and emergency units were sampled in order to make sure that a multitude of healthcare experiences was covered.

The questionnaire was completed on a face-to-face basis and the respondents were well informed of the study purpose, their rights and that this was a voluntary exercise. Informed consent was collected using written consent forms in a literate group and verbal consent was collected by reading the consent form to participants who had difficulty reading or were illiterate. In order to enhance understanding and have culturally relevant communication, the survey instrument was translated to Urdu. The time frame used in data collection was three months which helped the researcher to collect data on various days and times and thus enhance representativeness.

Data Analysis

The obtained data were processed with the help of SPSS 28 and SmartPLS 4. First, missing values, outliers and distributional problems were filtered out of the data. The frequency, percentage, mean, and standard deviation were taken as descriptive statistics to sum up demographic characteristics of respondents and important variables of the study. Reliability and convergent validity were evaluated by testing Cronbach alpha, composite reliability, factor loadings and average variance extracted (AVE) to evaluate the quality of the measurement instrument. The Fornell-Larcker criterion and HTMT ratio were used to measure discriminant validity. Structural Equation Modeling (SEM) was used to test the hypothesis. This approach was suitable since it enables the simultaneous examination of the relationships between variables and gives estimations of the strength and the significance of the proposed paths. The tests of the significance of the hypothesized relationships were performed by bootstrapping with 5,000 resamples.

Ethical Consideration

Ethics were upheld during the research. The involvement was purely voluntary, and all the respondents were made aware of the study aim and their right to leave any time. To maintain the confidentiality no personally identifiable information like names or addresses was gathered. Rather, the respondents were given identification numbers. All data were kept safely in password-protected files that could be accessed by the researcher. The IRB had granted prior permission to the study.

Results

Table 1: Demographic Profile of Respondent (N=238)

Variable	Category	Frequency	Percentage
Gender	Male	132	55.5%
	Female	106	44.5%

Age	18–30 years	64	26.9%
	31–45 years	91	38.2%
	46–60 years	56	23.5%
	Above 60 years	27	11.3%
Education	No formal education	58	24.4%
	Primary/Middle	71	29.8%
	Secondary	63	26.5%
	Higher education	46	19.3%
Hospital	Nishtar Hospital	96	40.3%
	Victoria Hospital	79	33.2%
	DHQ Hospital DG Khan	63	26.5%

In the final analysis, 238 respondents were involved in the study. The demographics (table 1) of the respondents indicate that 132 (55.5) males and 106 (44.5) females were included. In terms of age, 64 respondents (26.9%) were between 18–30 years, 91 (38.2%) were between 31–45 years, 56 (23.5%) were between 46–60 years, and 27 (11.3%) were above 60 years. In terms of educational status, 58 respondents (24.4%), 71 (29.8%), 63 (26.5%), and 46 (19.3%), had no formal education, primary or middle education, secondary education, and higher education. In terms of marital status, 181 respondents (76.1%) were married and 57 (23.9) were unmarried, widowed and separated. The sample of the respondents was taken in three state hospitals in South Punjab. Out of the entire sample, 96 (40.3%) respondents were selected at Nishtar Hospital Multan, 79 (33.2) were chosen at Victoria Hospital Bahawalpur, and 63 (26.5) were picked at DHQ Hospital Dera Ghazi Khan.

Table 2: Descriptive Statistics and Reliability

Construct	Mean	SD	A	CR	AVE
Socio-cultural factors	3.71	0.74	0.84	0.87	0.57
Traditional beliefs	3.84	0.81	0.81	0.85	0.55
Gender-based restrictions	3.67	0.79	0.79	0.84	0.53
Family authority/decision-making	3.76	0.77	0.83	0.86	0.58
Healthcare utilization	2.94	0.83	0.86	0.89	0.61

The central tendency and dispersion of the study variables were calculated using descriptive statistics (table 2). The findings show that the respondents have relatively high reported levels of socio-cultural barriers that impact healthcare use. Socio-cultural factors had a mean score of 3.71 and a standard deviation of 0.74 implying that socio-cultural factors were perceived to be a significant barrier to healthcare usage. The average score on traditional beliefs was 3.84 (SD = 0.81), which was a high dependency on traditional values, home remedies, and culturally influenced explanations of illness among respondents. Likewise, the average score in gender-based restrictions was 3.67 (SD = 0.79), which implied that the accessibility of healthcare to women was limited by social expectations and norms. Family authority and decision-making had an average score of 3.76 (SD = 0.77), indicating that family members greatly affected the healthcare decision-making process, with older males and household heads being the most influential. The mean of the dependent variable, healthcare utilization, was 2.94 (SD = 0.83), indicating moderate utilization of the formal healthcare services by the respondents.

In table 2 Cronbachs alpha, composite reliability (CR) and average variance extracted (AVE) were used to measure the measurement properties of the constructs. The results showed that there were satisfactory reliability and validity of all constructs. The alpha of socio-cultural factors was 0.84,

of traditional beliefs was 0.81, of gender-based restrictions was 0.79, of family authority and decision-making was 0.83 and of healthcare utilization was 0.86. These values were more than the suggested value of 0.70, which validates internal consistency. Equally, composite reliability was between 0.85 and 0.89, which showed good construct reliability. The AVE values were 0.53 to 0.61, and they were all greater than acceptable value of 0.50 thus creating convergent validity. All the items were found to have factor loadings of above 0.60 and this confirms the adequacy of the measurement model. The FornellLarcker criterion and HTMT ratio were also used to confirm discriminant validity and all HTMT values were below the cut-off of 0.85. Such findings validate the fact that the instrument employed in this research was successful and suitable to investigate the socio-cultural determinants of healthcare use in rural South Punjab.

Table 3: Correlation Analysis

Variable	1	2	3	4	5
1. Socio-cultural factors	-				
2. Traditional beliefs	0.58**	-			
3. Gender-based restrictions	0.54**	0.49**	-		
4. Family authority/decision-making	0.51**	0.46**	0.57**	-	
5. Healthcare utilization	-0.49**	-0.43**	-0.46**	-0.39**	-

The study variables were analyzed using Pearson correlation analysis to identify the relationship between them. The findings revealed (table 3) that there was a negative and significant relationship between socio-cultural factors with healthcare utilization ($r = -0.49$, $p < .001$). This means that there were higher socio-cultural barriers that were correlated with low utilization of healthcare services. Similarly, there was a considerable negative correlation between traditional beliefs and healthcare utilization ($r = -0.43$, $p < .001$), indicating that greater belief in traditional beliefs decreased the chances of seeking formal medical care. There was also a significant negative correlation between gender-based restrictions and healthcare utilization ($r = -0.46$, $p < .001$) and this shows that gender norms that are restrictive hindered access especially among women. Moreover, family authority and decision making had negative relationships with healthcare utilization ($r = -0.39$, $p < .001$), which illustrates that family approval tended to postpone or discourage healthcare seeking. In general, the results of correlation are the initial evidence of the hypotheses.

Table 4: Hypothesis Testing

	Path	(β)	t	p	Decision
H1	Socio-cultural factors $\rightarrow$ Healthcare utilization	-0.38	6.12	< .001	Supported
H2	Traditional beliefs $\rightarrow$ Healthcare utilization	-0.29	4.87	< .001	Supported
H3	Gender-based restrictions $\rightarrow$ Healthcare utilization	-0.31	5.26	< .001	Supported

The findings (table 4, figure 2) showed that socio-cultural factors affected negatively the utilization of healthcare ($\beta = -0.38$, $t = 6.12$, $p = 0$). The finding supports H1 which implies that the use of healthcare services in rural South Punjab is reduced because of social-cultural barriers like social norms, cultural expectations, stigma, and family influence. The finding implies that not only the availability of services determines the healthcare utilization, but also very powerfully the social and cultural context within which people live. The path coefficient between traditional beliefs and

healthcare use turned out to be negative and significant ($\beta = -0.29$, $t = 4.87$, $p = 0.001$). Thus, H2 was accepted. This finding shows that those people who have firm convictions in traditional beliefs, home remedies, or non-medical explanations of sickness are less likely to utilize formal healthcare. The result affirms that the traditional belief systems are a significant impediment to contemporary health care use among the rural population. The results also revealed that gender-based limitations had a considerable adverse impact on healthcare use ($\beta = 0.31$, $t = 5.26$, $p < .001$). In this manner, H3 was supported as well. This means that women who experience limitations in regard to mobility, authorization by male relatives and patriarchal decision-making systems are less likely to receive healthcare services. The outcome indicates that gender inequality is a significant factor in determining access to healthcare in rural South Punjab.

Hypothesis Testing in Healthcare Utilization

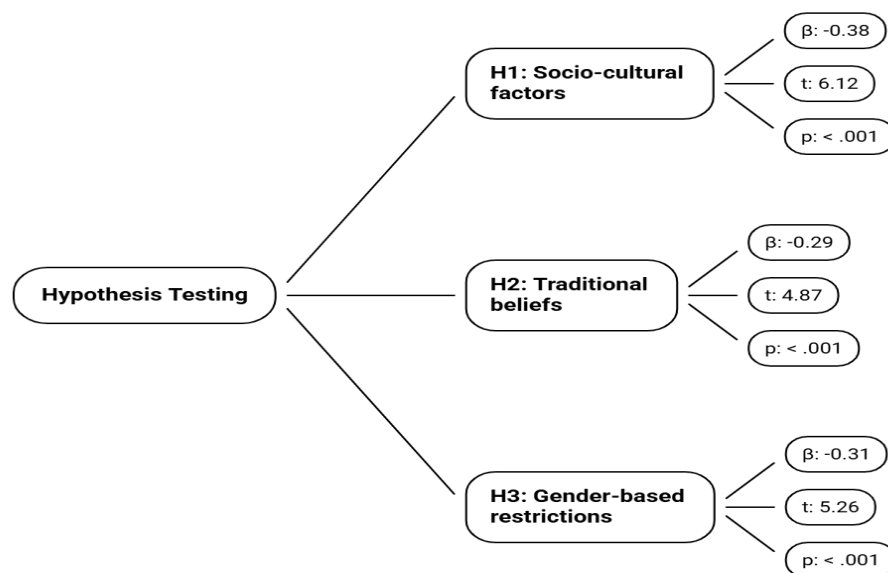


Figure 2 Hypothesis Testing

Discussion

The current paper intended to investigate how socio-cultural determinants influence the healthcare utilization in rural South Punjab, Pakistan. The results offer great empirical evidence of the fact that healthcare-seeking behavior, in rural areas, is not just predetermined by the presence of services but rather rooted in socio-cultural systems, ideologies, and values.

The results revealed that socio-cultural factors have a significant negative impact on healthcare utilization, supporting H1. This observation implies that people in rural South Punjab are guided by the existing social norms, stigma, and the societal expectations in their healthcare decision making (Fang & Mushtaque, 2024). Although healthcare facilities may be literally available, social-cultural factors may make people not seek medical treatment as soon as possible. This finding aligns with other studies that have reported that the use of healthcare in developing countries is highly influenced by social and cultural conditions (Shaikh and Hatcher, 2005;

Brandão et al., 2022). Social acceptance and adherence to traditional values in the rural society frequently override personal health requirements. Consequently, people can postpone or even evade healthcare services because of the apprehension of being judged by the society or even disapproved by it. Moreover, the results indicate that healthcare use is a socially constructed practice, and not strictly a rational choice. Cultural demands and social pressures provide the setting in which people choose to adhere to culture rather than to medical requirements (Latif, 2020). This highlights the significance of integrating socio-cultural factors in the healthcare policy and intervention development.

The research also established that traditional beliefs play a major and negative role in influencing healthcare usage and thus supported H2. Strongly held traditional healing practices, home remedies, and culturally based interpretations of illness decreased the likelihood of using formal healthcare practices among respondents. The given observation will be consistent with the available literature where the traditional beliefs are seen as the obstacles to the use of modern healthcare in rural areas (Ali et al., 2006). In most societies, sickness is perceived in spiritual or cultural contexts and due to this, people resort to traditional healers as opposed to medical practitioners. These practices may delay treatment and diagnosis, eventually leading to worsening health outcomes. The continuation of traditional beliefs is an indication that there is a lack of confidence in the formal healthcare systems and a lack of health literacy. In other instances, traditional remedies are a good choice because of their affordability, availability and cultural acceptance (Bashir, 2025). Nevertheless, this dependency may be counterproductive in situations where it substitutes medical treatment. The results imply that health education programs must be culturally aware and must strive to incorporate positive traditional practices with contemporary healthcare strategies as opposed to the rejection of the latter (Bresnahan & Zhuang, 2024).

The results also suggest that gender-related limitations considerably decrease female access to health care, which substantiates H3. The rural women in South Punjab are not only affected by the lack of autonomy and freedom of movement but also by the fact that they cannot make their own healthcare decisions, as they are under the care of their male relatives. These limitations greatly limit their capacity to access timely medical services. This finding is in line with the past research findings that have indicated gender inequality as a factor that restrains access to healthcare services by women (Mumtaz and Salway, 2009; Nisar and White, 2003). The women in the patriarchal societies usually need to seek the consent of husbands or older people in the family to visit healthcare centers. These delays may be very critical especially when dealing with maternal and reproductive health. In addition, cultural norms like purdah and social norms concerning the behavior of women also limit their movements and communication with care providers. The findings underline that to improve healthcare use among women, infrastructural change is not the sole solution that is necessary but change in social and cultural terms is necessary as well. Gender inequality should be addressed through policies that encourage the empowerment, education and autonomy of decision-making in women.

Limitations of Study

This paper has a number of limitations. To begin with, the cross-sectional design prevents the possibility of drawing causal relationships between socio-cultural variables and healthcare use. Second, self-reported data can be biased, such as through social desirability and recall bias. Third, the researchers used three state hospitals in South Punjab, and this could be a limitation to the applicability of the results to other areas. Fourth, purposive and convenience sampling can have implications on the representativeness of the sample. Lastly, the researchers employed a

quantitative design throughout the study, and it might not be sufficient to address the richness of the socio-cultural factors on healthcare behavior.

Implications of Study

The implications of the findings of this study are significant to policy, practice and future research. To begin with, the overwhelming power of socio-cultural factors implies that the healthcare policies should not only focus on the development of infrastructure but also on cultural limitations that restrict the use of healthcare. To eliminate the misunderstanding about contemporary healthcare and minimize the use of the traditional methods, which are harmful, policymakers need to develop culturally sensitive health awareness programs. Second, the high effect of gender-based limitations explains why women empowerment programs are important. The aim should be on enhancing the autonomy of women in healthcare decision making experience by educating them, engaging them in the community and creating specific health initiatives especially in rural settings. Third, the role of family authority implies that healthcare interventions need to have a family-centered approach. Key family decision-makers (elders and male heads) should be involved in awareness campaigns and health programs to promote responsive attitudes towards timely healthcare use. Fourth, medical practitioners must be sensitized to learn about local cultural specifics and provide patient-centered and culturally competent care, which will help build trust and motivate more people to use healthcare services. Lastly, in future studies, mixed-method methods should be embraced to understand more about the socio-cultural dynamics and to address other elements that impact healthcare use in rural areas.

Conclusion

This research finds that socio-cultural factors are influential in determining healthcare use in rural South Punjab, Pakistan. The results indicate that cultural beliefs, traditional practices, gender-based restrictions, and family authority all affect the decision to and the time of seeking formal healthcare services. Specifically, conservative ideologies do not encourage the adoption of modern healthcare, and gender roles and family decision-making processes restrict access to timely healthcare, particularly among women. The research indicates that the use of health care services in rural populations is not solely based on access to services, but also a strong social and cultural influence. Thus, to enhance healthcare access in South Punjab, it is necessary not only to increase health facilities but also to implement culturally aware interventions, community education, and to empower women and enable them to make independent healthcare decisions.

References

1. Acharya, S., Mishra, S. R., von Seidlein, L., Adhikari, B., & Parker, D. M. (2026). Reimagining primary health care: a historical and contemporary scoping review of community-based primary health care models and innovations. *Preventive Medicine Reports*, 103390. <https://doi.org/10.1016/j.pmedr.2026.103390>
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. Ali, M., Bhatti, M. A., & Kuroiwa, C. (2008). Challenges in access to and utilization of reproductive health care in Pakistan. *Journal of Ayub Medical College Abbottabad*, 20(4), 3–7.

4. Amin, S., & Petrova, E. (2023). *Advance social science archive journal Research on sociocultural factors impacting rural women's healthcare access in Sargodha District.*
5. Bashir, A. M. (2025). Integration of traditional and modern medicine: a review of Somali healing practices. *PubMed*, 57(1), 2546057–2546057. <https://doi.org/10.1080/07853890.2025.2546057>
6. Brandão, D., Paúl, C., & Ribeiro, O. (2022). Health care utilization in very advanced ages: A study on predisposing, enabling and need factors. *Archives of Gerontology and Geriatrics*, 98, 104561. <https://doi.org/10.1016/j.archger.2021.104561>
7. Bresnahan, M., & Zhuang, J. (2024). Culturally safe healthcare: changing the lens from provider control to patient agency. *Journal of Communication in Healthcare*, 17(3), 1–10. <https://doi.org/10.1080/17538068.2024.2323856>
8. Fang, S., & Mushtaque, I. (2024). The Moderating Role of Health Literacy and Health Promoting Behavior in the Relationship Among Health Anxiety, Emotional Regulation, and Cyberchondria. *Psychology Research and Behavior Management*, Volume 17, 51–62. <https://doi.org/10.2147/prbm.s446448>
9. Habib, S. S., Jamal, W. Z., Zaidi, S. M. A., Siddiqui, J.-U.-R., Khan, H. M., Creswell, J., Batra, S., & Versfeld, A. (2021). Barriers to Access of Healthcare Services for Rural Women—Applying Gender Lens on TB in a Rural District of Sindh, Pakistan. *International Journal of Environmental Research and Public Health*, 18(19), 10102. <https://doi.org/10.3390/ijerph181910102>
10. Hashim, M., Manj, Y. N., Shabbir, S. W., & Rizwan, M. (2019). Health Policy and Ladies Health Workers Stress During Fields Work: Case Study of District Muzaffargarh. *STATISTICS, COMPUTING and INTERDISCIPLINARY RESEARCH*, 1(1), 41–53. <https://doi.org/10.52700/scir.v1i1.20>
11. Khadija Liaqat, Hira Zulfiqar, & Ahmed Jamal. (2025). Health Disparities in Pakistan: Analyzing the Impact of Socioeconomic, Geographic, and Educational Determinants on Healthcare Access and Outcomes. *Journal of Health and Rehabilitation Research*, 5(1), 1–6. <https://doi.org/10.61919/jhrr.v5i1.1758>
12. Latif, A. (2020). The Importance of Understanding Social and Cultural Norms in Delivering Quality Health Care—a Personal Experience Commentary. *Tropical Medicine and Infectious Disease*, 5(1), 22. <https://doi.org/10.3390/tropicalmed5010022>
13. Lee, K. G., Gagliardi, A. R., Lofters, A. K., Pinto, A. D., & Maunder, R. G. (2025). Shared decision-making, the working alliance, and patient-centered care: A simultaneous concept analysis and review of the literature. *Patient Education and Counseling*, 109316–109316. <https://doi.org/10.1016/j.pec.2025.109316>
14. Mumtaz, Z., & Salway, S. M. (2007). Gender, pregnancy and the uptake of antenatal care services in Pakistan. *Sociology of Health & Illness*, 29(1), 1–26. <https://doi.org/10.1111/j.1467-9566.2007.00519.x>
15. Nisar, N., & White, F. (2003). Factors affecting utilization of antenatal care among reproductive age group women (15–49 years) in an urban squatter settlement of Karachi. *Journal of the Pakistan Medical Association*, 53(2), 47–53.
16. Qureshi, R. N., & Shaikh, B. T. (2007). Women's empowerment and health: The role of institutions of power in Pakistan. *Eastern Mediterranean Health Journal*, 13(6), 1459–1465.
17. Sansakorn, P., Mushtaque, I., & Muhammad Awais-E-Yazdan. (2024). The Relationship between Cyberchondria and Health Anxiety and the Moderating Role of Health Literacy among the Pakistani Public. *International Journal of Environmental Research and Public Health*, 21(9), 1168–1168. <https://doi.org/10.3390/ijerph21091168>

18. Sarfraz, M., Iqra Mushtaque, Mamun, M. A., & Raza, M. (2023). Death Anxiety Among Pakistani HCWs: The Role of COVID-19 Vaccine Acceptance and Positive Religious Coping Strategy. *Omega - Journal of Death and Dying*. <https://doi.org/10.1177/00302228231186360>
19. Shaikh, B. T., & Hatcher, J. (2005). Health seeking behaviour and health service utilization in Pakistan: Challenging the policy makers. *Journal of Public Health*, 27(1), 49–54. <https://doi.org/10.1093/pubmed/fdh207>
20. UNICEF. (2025). *Health*. Wwww.unicef.org. <https://www.unicef.org/pakistan/health>
21. Wei, S., Long, H., & Tian, Y. (2025). Factors influencing healthcare-seeking behavior and its process analysis among ethnic minority residents: a qualitative study in rural China. *Frontiers in Public Health*, 13. <https://doi.org/10.3389/fpubh.2025.1627392>