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Role of Social Capital, Health Literacy and Health Access Regarding Well-Being and Resilience among Elderly Women of Sargodha

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ABSTRACT

The proposed study aims to explore the connection between the resilience and well-being of older women in Sargodha and the access to social capital and health literacy. Pakistani elderly women are faced with several social-educational and social-physical challenges. The proposed study will explore the problem of resilience and well-being of older women in Sargodha at the intersection of social capital, health literacy, and healthcare access. Recent publications point to the fact that social capital, especially within networks and community ties, has little relevance in fostering psychological well-being and resilience in old age. There is also evidence that health literacy and accessible health services enables the elderly to make appropriate health decisions which is the first step to attaining and maintaining future well-being. However, as far as we know, there is little data available in economically deprived countries such as Pakistan, especially on the elderly women population. There is a clear need for socially appropriate and community based programs for health literacy as well as gender responsive and socially appropriate health care services for elderly women in rural Pakistan. Slotted within the frameworks of the WHO Healthy Ageing and Communicative Health Capital Models, the research adds to the international discourse on equity in ageing and offers policy recommendations on reinforcing the social care systems for older adults in marginalized positions.

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1.0 Introduction

Population aging is one of the most significant social transformations of the twenty-first century, influencing every domain of human life from family systems and economic productivity to healthcare and social policy. According to the (Organization, 2023), by 2050, nearly 1.6 billion people worldwide will be aged 60 years or above, and women will constitute the majority of this population due to higher life expectancy rates. This long life span is however, not necessarily good health, independence and life satisfaction. In developing countries, the fragility of social safety nets and healthcare systems tend to expose women to new social exclusion, poverty, and health inequity issues, especially with aging (WHO, 2020); (Mathews, 2024).Therefore, it is now of international and regional interest to know about the social determinants of well-being and resilience of elderly women.

The rate of aging of the population in Pakistan is growing at a very rapid rate. According to the latest report of the Pakistan Bureau of Statistics (Women, 2021), it is now evident that 15 million people now are of age 60 and above, which is close to 7 percent of the entire population. The age-religious distribution of women is a bit more than the age-religious distribution of men since women have a higher life expectancy but are more vulnerable. Pakistani older women tend to be cumulatively disadvantaged due to gender inequalities that accumulate throughout their lives, low levels of education, financial reliance, and their inability to move (Haque et al., 2020);(Mushtaq & de Visser, 2024). Destruction of the extended family systems through migration, urbanization and modernization have destroyed the old forms of support systems that formerly provided emotional and material support to the aging women. Through this, older women have increasingly had to rely on weak kinship bonds, informal groups, or overstretched health care systems to survive and thrive (Ashiq & Asad, 2017); (Banik et al., 2020).

In this context, social capital is the central element of the lives of the older generations. Social capital is defined as the system of trust, norm and social ties that enable cooperation and offer emotional as well as instrumental assistance (Putnam, 2015); (Kawachi & Berkman, 2000). With the elderly women, robust social groups are able to counter the impact of loneliness, useful assistance during illness and reassert a sense of belonging and protection. European and Asian literature has indicated that increased social capital levels are linked to improved self-rated health, reduced depression, and increased life satisfaction in elderly people (Nyqvist et al., 2013); (Y. Zhong et al., 2017). Social capital can be a protective buffer against the psychological and material demands of aging in collectivist cultures, like Pakistan, in which the importance of the family and community is enormous (Fayyaz et al., 2020); (Tahir et al., 2021). Nevertheless, due to the shift of family modes and the loss of a sense of community with urbanization, the loss of social capital can expose older women to social isolation and emotional vulnerability (Mushtaq & de Visser, 2024).

Intimately associated with social capital is the notion of health literacy which is the capacity of an individual to access, comprehend and use health information in making informed choices (Nutbeam, 2000). Health literacy gives the elderly the ability to cope with chronic diseases, treatment regimes, and overall interaction with medical providers. In (Berkman et al., 2011), poor

health literacy was linked with poor health outcomes, increased hospitalization, and reduced prevention care. In the developing world, poor health literacy among the elderly women is made worse by the lack of education and access to information. The research carried out in Pakistan and Iran has revealed that elderly low-literacy women experience problems in understanding the medication prescriptions, interpreting the doctor recommendations, or being aware of the initial signs of illness (Ashiq et al., 2022); (Alinejad et al., 2025). In this regard, the issue of health literacy should be not only an educational concern but a question of social empowerment and gender equity.

Access to healthcare is another factor that significantly defines the well-being of the elderly because it is the degree to which one can access the appropriate healthcare services in a timely and fair way. (Penchansky & Thomas, 1981) found five dimensions of access including availability, accessibility, affordability, accommodation as well as acceptability. The subsequent (Gulliford et al., 2002) stressed that access is a social and structural phenomenon in that access does not merely exist in the form of health facilities but also in the form of individuals utilizing it. Healthcare in Pakistan is limited by geographic inequalities, poor infrastructure, excessive out-of-pocket expenses, and male chauvinism that limits movement because women are expected to stay at home (Ladha et al., 2009); (Ahmad et al., 2018). In rural and semi-urban regions like Sargodha, elderly women usually rely on the accompanying male family members to get transport or financial support, making them less independent and slowing down the treatment process (Banik et al., 2023). Therefore, presence of health facilities does not always mean that the facilities are being used as they would be impeded by socio-cultural and economic factors.

According to the WHO Healthy Ageing Framework (WHO, 2020), to age successfully, one should have functional ability, be socially engaged, and independent. It requires interventions that can improve the enabling environments and individual capacities. Aging-related policy is however disjointed in Pakistan. The lack of a well-developed geriatric care model, insufficient infrastructure facilities that are elder-friendly, as well as gender-insensitive healthcare services, impair the advancement towards the aims of the WHO (Gul & Rahman, 2025). Programmes like the Sehat Sahulat Card and the Benazir Income Support Program offer certain relief of the financial burden but do not incorporate the use of integrated approaches to solve the problem of social isolation and health education to older women. Sargodha is a semi-urban area in central Punjab that represents these issues.

1.1 Objectives of the Study:

- To examine the influence of social capital on the well-being and resilience of elderly women in Sargodha
- To assess the role of health literacy and health access in enhancing well-being and resilience among elderly women

2.0 Literature Review

The social capital concept has emerged as a focal point in explaining the relationship between the social relationship and network and health and well-being in old age. Social capital, which is based on norms, trust, and reciprocity in collective action and exchange of resources, in

a group of individuals, was first suggested by (Bourdieu, 2018) and then enhanced by Robert Putnam (2000) and (Coleman, 1990). Social capital is a serious social determinant of health in the population of older adults, as it affects emotional health, resiliency, and care access (Pradana, 2024). Numerous studies indicate a positive relationship between superior levels of social capital and psychological well-being and life satisfaction in older adults ((Nyqvist et al., 2013), (Forsman, 2015), (Nyqvist et al., 2013; ROBERT L GIUNTOLI et al., 2006), (Windle, 2011); (Kawachi & Berkman, 2000)). Indicatively, in a study conducted in Nordic, older participants who had good community affiliations registered a reduced rate of depression and increased life satisfaction (Nyqvist et al., 2013).Elsewhere, the neighborhood trust and reciprocity decreased anxiety and amplified a sense of belonging in older adults (Kim & Park, 2017)). These results imply that bonding (family/friends) and bridging (wider networks) social capital are useful in promoting psychological resilience and well-being in adulthood.

Recent studies focus more on multidimensionality of social capital, structural (network participation, organizational membership) and cognitive (perceived trust, reciprocity, belonging) dimensions (Y. Zhong et al., 2017), (Chen et al., 2024), and (B.-L. Zhong et al., 2017); (Sen et al., 2022). An example is that a study conducted in China revealed that cognitive functioning and satisfaction with life among older adults were associated with being involved in voluntary associations and neighborhood activities (Y. Zhong et al., 2017). Similarly, social confidence and a decline in loneliness were more frequent among elderly women in India who were participants of self-help groups (Sen et al., 2022). To this end, in China, a structural-cognitive model, the structural social capital influence on self-rated health was completely mediated by cognitive social capital amongst older adults in urban areas. There is also an examination of the role of social capital in buffering cumulative disadvantage by scholars. According to (Bourdieu, 2018) the social capital is engaged with the economic capital and cultural capital, accordingly, people can balance the lack of a certain domain through the others. On the one hand, close kin ties can alleviate the economic crisis experienced by older women with low economic capital due to emotional and instrumental assistance(Ahmad et al., 2018). (Fayyaz et al., 2020) demonstrated in Punjab, Pakistan, that older women integrated in harmonious families networks were happier and psychologically stable than older women who experienced family neglect. In a different research, the social isolation and low levels of interpersonal trust were associated with low life satisfaction and high levels of depressive symptoms in rural elder's women (Ashiq et al., 2022), (Iftikhar, 2025). These results indicate that social capital plays a role of informal insurance among older adults where the institutional supports are poor.

Systematic evidence at the global level always confirms the good correlation between social participation and resilience. In Iran, community-engagement programmes facilitated by an organized community approach contribute to the development of perceived self-efficacy and resilience among the elderly women (Taherian & Motamedi, 2022). A Spanish investigation in the European region had discovered that community-based health education alleviated psychological distress and enhanced self-esteem in older adults (Lapena et al., 2022), (Coll-Planas et al., 2017), and (Campoy-Vila et al., 2025)). These findings demonstrate that social connectedness facilitating

through systematic programmes can aid mental health and coping adaptability in old age. Indeed, the massive group-based intervention trial AEQUALIS showed the beneficial effect to the health literacy and depressive symptoms and self-management in older adults in low-income urban neighborhoods.

The connection between health literacy and social capital has been of significance. Social networks facilitate the process of health literacy i.e., acquiring, comprehending and implementing health information (Nutbeam, 2000); (Sørensen et al., 2012b), particularly in low-educated populations. Research evidence indicates that when older adults are integrated into favorable social surroundings, they most likely acquire health information and undertake preventive behaviours (Berkman et al., 2011; Cui et al., 2021). The Chinese older adults as an example, the social capital was associated with eHealth literacy and mediated its impact on health behaviours. It is further explained in the concept of Communicative Health Capital (CHC) (Chinn, 2011);(Shim et al., 2020) that the ability to communicate effectively in a healthcare environment is determined by the social and cultural capital of an individual. The resilience and well-being of elderly women with greater communicative skill acquired through literacy classes and social organizations were better deemed in an Iranian study (Alinejad et al., 2025). Likewise, (Lee et al., 2004; Wang et al., 2024) also observed that the communication skills mediated the correlation between social participation and self-reported health among Taiwanese older adults.

In the South Asian context, educational differences, gender norms and socioeconomic restrictions have critically low health literacy of older women. (Ahmad et al., 2018) conducted research in rural Punjab, Pakistan, where the low literacy and dependency on male family members negatively affected the knowledge of healthcare instructions in women. In Bangladesh, Mansfield, (Hossain et al., 2021) observed that the low level of awareness about preventive care and low level of education among older women meant that they depended on informal sources.

These articles highlight that improving women health literacy needs individual and community level interventions that would facilitate access to culturally acceptable forms of communication. Another determinant is health access the structural capacity to utilize the healthcare services on a need basis. The aspects of access (availability, accessibility, affordability, accommodation and acceptability) used by (Penchansky & Thomas, 1981), and discussed by (Gulliford et al., 2002) indicate that access to services is culturally and socially acceptable, and such factors frequently define service utilization. In such nations as Pakistan, older women have a limited access to healthcare due to structural and cultural factors (Banik et al., 2023), (Ladha et al., 2009). In Karachi, 68 percent of older women have put off or avoided visiting the doctors because of lack of female doctors and also because of stigma surrounding personal health issues (Ladha et al., 2009). Such results indicate that access limitation to older adults can be relieved by establishing trust and reciprocity in communities.

Social capital, health literacy and healthcare access can be interconnected to create a triadic well-being model during old age. Social capital makes it possible to exchange information and have trust; health literacy helps to interpret and act on information; and access to healthcare transforms resources into reality. The intervention studies reveal that social participation alongside

the health education initiative improves self-management and the quality of life in older adults (Vassilev et al., 2014); (Coll-Planas et al., 2017). The relationship between quality of life and social participation in older adults was also mediated by health literacy in Portugal (de Almeida & Veiga, 2020). These lessons highlight that the health of the aged cannot be dependent on a medical service but should be supported by socially entrenched and knowledge-based care systems.

Indeed, the patterns are convergent on evidence in Pakistan and its neighboring countries in South Asia. The attendance of the religious events by the Pakistani elderly females helped to improve the psychological strength and the perceived well-being of elderly female participants (Tahir et al., 2021). The social engagement was supported through informal support groups that were organized through the mosques and community centers and were managed in spite of mobility limitations (Gul & Rahman, 2025). It is also indicated that regional studies indicated that elderly women who have stronger interpersonal trust and more health information competence reported more optimism, more autonomy and more self-worth (Ashiq et al., 2022); (Ahmad et al., 2018). Such local findings resonate with international outcomes and substantiate the opinion that relational and informational empowerment is one of the central issues of older-age well-being.

Although a lot of evidence has been collected, it is still lacking in certain areas of concern on the interaction of the three factors in a low-resource environment. The majority of studies consider the meaning of social capital or health literacy separately and do not consider how they intersect in the context of resilience and subjective well-being ((Windle, 2011); (Nyqvist et al., 2013). In addition to that, there is a lack of research specifically on old women as an analytic group, although they are a separate social group in a patriarchal society. This study will fill a major gap in literature by highlighting the role of social capital, health literacy and health access in predisposing elderly women in Sargodha to resilience and well-being in a previously overlooked demographic.

3.0 Methodology

The research design used in this study was a quantitative cross-sectional design, which was used to evaluate the relationship between social capital, health literacy, and health access to the well-being and resilience of elderly women in Sargodha, Pakistan (Creswell et al., 2014); (Babbie Ed D, 2021). Quantitative designs are suited to the purpose of establishing the correlation between several social variables and offer objective and reproducible results, which contribute to the increased generalizability of the findings (Creswell et al., 2014);(Neuman, 2014).

The research was carried on in Sargodha District in the Punjab Province in the semi-urban area of Pakistan with a combination of rural and urban characteristics (Wazir & Goujon, 2021); (Ashiq et al., 2022). Sargodha was chosen as the field location because of its heterogeneous age demographic and the apparent socioeconomic differences in women, especially the access to education, health access and services, and social inclusion (Ahmad et al., 2018); (Mushtaq et al., 2011). The population of interest was women aged 60 and older that were either retired, widowed, or living with the relatives (Fayyaz et al., 2020). Simple random sampling along with a sample size of 220 respondents is used followed by convenient sampling. The data was gathered using structured questionnaires via a 4-point Likert scale to measure such variables as emotional support,

social participation, knowledge of health practices and perceived access to care. In the questionnaire, the sections included five segments namely: demographic information, social capital, health literacy, health access, and psychological outcomes. An adaptation of the Onyx and Bullen Social Capital Scale was found to measure social capital, containing bonding (family and friends), bridging (community and organizations) and linking (institutional trust) facets (Onyx & Bullen, 2000); (Putnam, 2015). The European Health Literacy Survey Questionnaire (HLS-EU-Q16) was used to assess health literacy and it includes 16 items that question the ability to access, understand, appraise and apply health-related information (Sørensen et al., 2012a);(Berkman et al., 2011). The measures of access to health were based on the model created by (Penchansky & Thomas, 1981)that included the aspects of affordability, availability, accessibility, and acceptability (Gulliford et al., 2002); (Banik et al., 2020). Lastly, well-being and resilience were assessed with WHO-5 Well-Being Index and Brief Resilience Scale (BRS) which were used to determine emotional satisfaction and potential capacity of coping among the older adults ((Smith et al., 2008); (Windle, 2011).

The SPSS version 26 was used to analyze the data to conduct descriptive and inferential statistics (Pallant, 2020). In sum, this study methodology gave a strict basis to examine the dynamic interaction of social capital, health literacy, and access to influence the health and stability of aging women.

4.0 Findings and Results

4.1 Linear Regression Analysis

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	5230.379	3	1743.460	162.465	.000[b]
	Residual	2317.966	216	10.731		
	Total	7548.345	219			

a. Dependent Variable: Wellbeing

b. Predictors: (Constant), HealthAccess, Social capital, Health Literacy

The ANOVA table shows that the regression model is statistically significant in explaining the variation in the dependent variable, wellbeing. The regression sum of squares is 5230.379 with 3 degrees of freedom, indicating that a large portion of the total variance in wellbeing is explained by the independent variables Health Access, Social Capital, and Health Literacy. The residual sum of squares is 2317.966 with 216 degrees of freedom, showing the portion of variance not explained by the model. The F-value of 162.465 is very high, suggesting a strong model fit, and the significance level (Sig. = .000) indicates that the model is statistically significant at $p < .001$. This means that the predictors, when taken together, have a highly significant impact on wellbeing and that the likelihood of this relationship occurring by chance is virtually zero. Overall, the ANOVA results strongly support the conclusion that Health Access, Social Capital, and Health Literacy

collectively play a vital role in predicting wellbeing among the respondents.

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.407	1.465		3.007	.003
	Social capital	.167	.091	.093	1.834	.068
	Health Literacy	.392	.047	.462	8.395	.000
	HealthAccess	.406	.057	.377	7.101	.000

a. Dependent Variable: Wellbeing

The coefficients table provides insights into the individual contribution of each predictor Social Capital, Health Literacy, and Health Access towards predicting wellbeing. The constant value is 4.407, which represents the baseline level of wellbeing when all predictors are held at zero. Among the predictors, Social Capital has an unstandardized coefficient (B) of 0.167 with a p-value of .068, which is above the conventional significance level of .05. More specifically, while Social Capital has a positive impact on wellbeing, within this model its impact is negligible. On the contrary, Health Literacy is shown to have strong and highly significant effects with B = 0.392, Beta = 0.462, t = 8.395, and $p < .001$, demonstrating that an increase in health literacy greatly enhances wellbeing. In the same manner, Health Access also demonstrates strong and significant effects with B = 0.406, Beta = 0.377, t = 7.101, and $p < .001$, asserting its important contribution to wellbeing. To sum up, Health Literacy and Health Access stand out as the strongest and most significant predictors of wellbeing in the respondents, while Social Capital is positive yet in this model has no statistically significant impact. This indicates that Social Capital may be less important than health literacy and health access in predicting the wellbeing of the elderly women in this study.

4.2 Regression Analysis

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	327.366	3	109.122	49.746	.000[b]
	Residual	473.811	216	2.194		
	Total	801.177	219			

a. Dependent Variable: Resilience

b. Predictors: (Constant), Health Access, Social capital, Health Literacy

The ANOVA table shows that the regression model is statistically significant in explaining the variation in resilience. The regression sum of squares is 327.366 with 3 degrees of freedom,

indicating that the predictors Health Access, Social Capital, and Health Literacy together explain a substantial portion of the total variance in resilience. The residual sum of squares is 473.811 with 216 degrees of freedom, representing the part of the variance that is not explained by the model. The F-value of 49.746 is quite high, showing that the overall model fit is strong. The significance level (Sig. = .000) indicates that the model is highly significant at $p < .001$, meaning the likelihood that these results occurred by chance is virtually zero. Overall, the ANOVA results confirm that Health Access, Social Capital, and Health Literacy collectively have a significant impact on resilience, making them important predictors in understanding the resilience levels of the respondents.

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	8.597	.663		12.976	.000
	Social capital	-.008	.041	-.014	-.206	.837
	Health Literacy	.218	.021	.790	10.339	.000
	HealthAccess	-.090	.026	-.256	-3.479	.001

a. Dependent Variable: Resilience

The coefficients table provides detailed insights into how each predictor Social Capital, Health Literacy, and Health Access individually contributes to explaining resilience. The constant value is 8.597, representing the baseline level of resilience when all predictors are set to zero. Social Capital shows a negative unstandardized coefficient (B = –.008) with a very low standardized Beta (–.014) and a non-significant p-value (.837). This indicates that Social Capital does not have a statistically significant effect on resilience in this model, and its contribution is negligible. Health Literacy, however, demonstrates the strongest and most significant impact on resilience, with B = .218, Beta = .790, t = 10.339, and $p < .001$. This means that higher levels of health literacy are strongly associated with greater resilience among the respondents. Health Access, in contrast, has a negative but statistically significant effect on resilience, with B = –.090, Beta = –.256, t = –3.479, and p = .001. This suggests that while access to healthcare is important, in this context, greater reliance on health access might be linked with lower resilience, possibly because respondents who face frequent health issues depend more on healthcare services rather than internal coping mechanisms. Overall, the results highlight that health literacy is the most influential positive predictor of resilience, while social capital shows no significant role, and health access demonstrates a significant but negative relationship with resilience.

5.0 Discussion and Conclusion

The quantitative data were proved right, with the higher the social connectedness, literacy, and health access among the elderly women, the better life satisfaction and adaptive capacity of elderly women (Windle, 2011); (Wang et al., 2022). Descriptive analysis showed that although a

small group of participants had high well-being, most of them had moderate and low levels of satisfaction, as evidenced by the complexities of living well within a patriarchal and economically limited surrounding (Mushtaq & Ali, 2020); (Gull & Dawood, 2013). The findings found that women who were integrated into supportive networks, i.e., family, communities, and religious sets of people, had better coping mechanisms and emotional health than socially isolated women (Fayyaz et al., 2020); (Sen et al., 2022). Similarly, women with better health literacy levels were found to be more engaged in healthcare, interpretation of medical prescriptions, and prevention of health (Berkman et al., 2011);(Sørensen et al., 2012b). There are greater challenges to widowed women since they have less emotional support and are financially dependent on others and access to health facilities is low. Richer families offer greater safety and health. The primary hindrance to women is transport since women are reliant on others and they do not get health facilities and miss their routine checkups. Lastly, better physical and financial access to healthcare facilities was seen to result in improved well-being and greater control of health outcomes, especially in respondents (Gulliford et al., 2002);(Banik et al., 2023).

5.1 Discussion

The theoretical framework that supports the connection between social capital and well-being is supported by the empirical findings. The fact that social capital was a stronger predictor is consistent with the definition that (Bourdieu, 2018) attempted to bring about the idea of social networks as useful resources that can be used to access information, trust, and collaborative support (Putnam, 2000); (Phillipson, 2013). In such societies as Pakistan, where family and community relationships are the core of identity and survival, the robustness of these networks turns out to be crucial to managing the frailty of old age (Ashiq et al., 2022); (Ahmad et al., 2018). These findings are in line with other research findings conducted across the world that social engagement and emotional support improves psychological resilience in elderly groups (Nyqvist et al., 2013); (Windle, 2011). Relational resources are useful in the setting where social security or pensions are low since they offer emotional and financial security (Dolan et al., 2020); (Gull & Dawood, 2013). The next powerful factor of well-being was health literacy, which indicated the significance of informational empowerment in the elderly women (Nutbeam, 2000); (Sørensen et al., 2015).

The findings can be related to the Communicative Health Capital (CHC) framework created by (Shim et al., 2020), which states that the communicative skills (assertiveness and health-related vocabulary) of individuals positively contribute to their effective interaction with healthcare providers (Alinejad et al., 2025); (Liu & Hu, 2022). The better the communicative capacity, the greater the access and agency in the context of the patriarchal society, where elderly women usually require intermediaries within the family to contact the doctors (Ashiq et al., 2022); (Mushtaq & Ali, 2020). These results therefore extrapolate the CHC model to a South Asian sociocultural setting, and show that knowledge and communication are important cultural resources to a healthy aging (Phillipson, 2013). The high proportion of healthcare access but low proportion of structural inequality show that the healthcare system in Pakistan is characterized by structural inequality (Banik et al., 2023); (Ladha et al., 2009). Although there are basic health units

and the Sehat Sahulat program, the elderly women experience hindrances like mobility, transport, and gender segregation in health services (Ashiq et al., 2022); (Ahmad et al., 2018).The results are consistent with the model developed by (Penchansky & Thomas, 1981) that access is viewed as multidimensional that includes availability, affordability, and acceptability. Social acceptability and mobility constraints in Sargodha is another reason why women do not avail of the services even when available (Gulliford et al., 2002); (Banik et al., 2023). Thus, equal healthcare must not only have the infrastructure but also social and cultural amenities that will allow women to pursue care free of stigma and in a position to do so solely (WHO, 2020);(Tahir et al., 2021).

The findings also confirm the Cumulative Disadvantage Theory (Dannefer, 2003), which shows how inequalities in the sexes throughout the life course accumulate in old age. Women who are older and did not receive education and employment are more prone to the lack of social, cultural, and economic capital, which makes them more vulnerable to being ill-healthy and socially marginalized (Amoah, 2018); (Ashiq et al., 2022).Nevertheless, the results also indicate that resilience that is backed by strong social ties and coping based on faith can help many women to stay emotionally healthy despite economic deprivation (Windle, 2011); (Tahir et al., 2021). It proves that the aging experiences are not homogeneous but influenced by cultural and community forces which can turn the disadvantage into adaptive power (Nyqvist et al., 2013); (Liao et al., 2025).

5.2 Recommendations

According to the results, some evidence-based policy recommendations can be made. To begin with, the most effective approach is to establish social support networks within the community on local government and nongovernmental organizations to enhance social capital in elderly women (Nyqvist et al., 2013); (Kim & Park, 2017). These may be intergenerational clubs, women self-help groups, neighborhood care circles where mutual trust, participation, and emotional sharing are developed (Sen et al., 2022); (Fayyaz et al., 2020). Second, the primary healthcare systems and adult education should include health literacy programs to equip the elderly women with effective facts about nutrition, chronic diseases management, and preventive care (Sørensen et al., 2012b); (Berkman et al., 2011). Such efforts may be carried out using female community health workers and awareness campaigns conducted via the radio to access illiterate people (Ashiq et al., 2022); (Mushtaq et al., 2011).

Third, the government ought to increase access to gender-sensitive healthcare by making sure that female doctors are available in the local hospitals and mobile clinics (Banik et al., 2023); (Ladha et al., 2009). The infrastructure development must be aimed at helping elderly women to commute, particularly in rural regions, where range and affordability are significant discouraging factors (Gul & Rahman, 2025). Fourth, the policy interventions are advised to encourage the introduction of social capital into the frameworks of public health by acknowledging community involvement as a factor of well-being in the policies of aging (Phillipson, 2013). Lastly, longitudinal and mixed-method research designs should be used in the future to investigate causal relationships and comprehend the lived experiences of older women in relation to statistical trends (Creswell et al., 2014); (Windle, 2011).

Future research may use qualitative or mixed-methods designs (life histories, focus groups, in-depth interviews) to investigate how resilience, well-being, and social capital are experienced by older women in daily life. Beyond survey data, this would offer cultural depth.

5.3 Conclusion

Finally, this paper has shown that the combination of social, cognitive, and structural resources has an influence on well-being and resilience in elderly women. Social capital is an emotional support and identity, health literacy is a communicative empowerment, and it turns out that health access is a guarantee of institutional inclusion (Dubbin et al., 2013). Such a powerful explanatory effect of these variables proves that aging is not only a biological process but a process that is socially embedded (Phillipson, 2013). The study adds to the sociological and gerontological literature by applying the groundbreaking theories on capital and communicative health in a South-Asian context with identifying the gendered aspects of healthy aging (Alinejad et al., 2025); (Liao et al., 2025).

This research finds that one of the important factors to promote dignified aging among Pakistani women is the improvement of the social networks, their health literacy, and the provision of equal access to healthcare services. NGOs, policymakers, and healthcare institutions have to work together to generate comprehensive, community-based, and culturally responsive frameworks which tackle social and structural determinants of well-being (Ashiq et al., 2022).

Shahzeen Muzaffar: Problem Identification and Theoretical Framework
Nimra Aslam: Data Analysis, Methodology and Revision, Drafting
Tauqeer Ahmed: Supervision

Conflict of Interests/Disclosures

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