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# Migration and Gender Health: Navigating Intersecting Vulnerabilities and Resilience: A case study of Lahore.

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**ABSTRACT**

This qualitative study investigates the gendered health impacts of internal migration on women in Lahore, Pakistan, through in-depth interviews with ten female migrants. Employing a phenomenological approach and thematic analysis, the research explores how the migration process from pre-departure motivations through transit to urban settlement shapes physical, mental, and social well-being through an intersectional lens. The findings reveal that migration is a deeply gendered experience driven by economic precarity and shaped by gendered pressures. Participants reported significant vulnerabilities, including fear of harassment during transit, precarious living conditions in informal settlements, and formidable barriers to healthcare characterized by financial cost (mehngai) and systemic disrespect (be-izzati). These intersecting vulnerabilities of gender, poverty, and rural origin manifested in starkly gendered health outcomes, most notably a high, yet unaddressed, burden of mental distress and severely limited access to reproductive healthcare. However, the study also uncovers profound resilience, as women actively navigated these challenges through the formation of "jhuggi networks" informal community support systems that provided emotional, informational, and financial resources. The study concludes that effective public health interventions must be gender-transformative, addressing structural barriers while leveraging existing community resilience to bridge the gap in healthcare access for this vulnerable population.



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## 1. INTRODUCTION

Human migration is a defining feature of the 21st century, with over 281 million international migrants globally as of recent estimates (Dao et al., 2018). While often discussed in terms of economic flows or political crises, migration is, at its core, a profoundly human process with deep implications for health and well-being (Ying et al., 2024). However, these implications are not uniformly experienced. A critical and often overlooked lens through which to analyze migrant health is that of gender the socially

constructed roles, behaviours, and identities of women, men, and gender-diverse individuals (Cabieses et al., 2024). Migration is a gendered process, shaped by and reshaping gender norms, and it intersects with health outcomes in ways that create unique landscapes of vulnerability and resilience (Rada & Cabieses, 2024). The journey of a migrant—from pre-departure, through often perilous transit, to arrival and settlement in a new country—is not a gender-neutral trajectory. The drivers of migration are gendered: women may flee gender-based persecution or migrate for care work, while men often move for labour in construction or agriculture (Nasrin et al., 2024). These differing pathways expose individuals to distinct risks. For instance, women and girls face a heightened threat of sexual and gender-based violence during transit and in destination countries, with significant consequences for their physical and mental health (Darebo et al., 2024). Similarly, migrant men, socialized into norms of masculinity that prioritize stoicism, often face under-diagnosed mental health issues and higher rates of occupational injury (Lejbowicz & Scodellaro, 2025). Understanding these dynamics requires moving beyond a binary view of sex or a homogenous view of "the migrant." An intersectional framework is essential. Coined by scholar Kimberlé Crenshaw in 1994, intersectionality posits that systems of power and oppression such as racism, sexism, xenophobia, and classism are interconnected (Crenshaw, 1994). A migrant's health is not determined by their gender alone, but by the intersection of their gender with their legal status, ethnicity, class, sexual orientation, and religion. An undocumented, indigenous woman working in domestic service experiences the healthcare system and its barriers in a fundamentally different way than a documented, high-skilled male migrant. These overlapping identities can create compounded vulnerabilities, where discrimination in one domain exacerbates risk in another. The health systems in host countries often fail to account for this complexity. Structural barriers, including restrictive immigration policies that limit healthcare access, xenophobia, cultural and linguistic incompetence, and a lack of gender-sensitive services, create a chasm between need and care (Jia, 2024). For example, transgender migrants may avoid seeking healthcare due to fear of discrimination, while male migrants might not access sexual health services because they are not designed with them in mind.

Yet, to frame migrant women, men, and gender-diverse people solely as vulnerable is to overlook their agency and resilience. In the face of systemic obstacles, migrants develop profound strategies for survival and well-being, drawing on social networks, cultural resources, and personal fortitude. They are not passive recipients of health threats but active agents in navigating and negotiating their health. Therefore, the researcher plans to investigate the health impacts of migration in females using in-depth interviews in Lahore city.

## 2. METHODS

Building on the theoretical foundation established in the introduction, which underscores the gendered and intersectional nature of migrant health, this study will employ a qualitative research methodology to investigate the nuanced health impacts of migration on women in Lahore, Pakistan. The primary objective is to explore, through the lived experiences and personal narratives of female migrants, how the process of migration—encompassing their reasons for moving, the journey itself, and their settlement in Lahore—has shaped their physical, mental, and social well-being, with a specific focus on navigating intersecting vulnerabilities related to gender, socio-economic status, and urban integration. To achieve this deep, contextual understanding, the research design will utilize a phenomenological approach, seeking to comprehend the essence of the participants' shared experiences. Data will be collected through in-depth, semi-structured interviews with a purposively selected sample of 10 female migrants residing in various localities of Lahore. The small, focused sample size is intentional, allowing for rich, detailed data collection and analysis that is well-suited to uncovering complex, personal realities that large-scale surveys might overlook. Participants will be identified through community-based organizations and snowball sampling to access a hard-to-reach population, and will include women from diverse provincial origins (e.g., from Sindh, Khyber Pakhtunkhwa, or southern Punjab), varying ages, and different socio-economic backgrounds to capture a range of perspectives, though all will share the common experience of internal migration to Lahore. The semi-structured interview guide will be

designed with open-ended questions to allow participants to guide the conversation towards what they deem most significant, covering key thematic areas including their pre-migration health status and motivations for moving; experiences and challenges faced during transit; and post-migration realities accessing healthcare, their mental health, social support networks, and occupational health, particularly in gendered sectors like domestic work or the informal economy. Each interview, anticipated to last 45-60 minutes, will be conducted in a private and secure setting in the participant's preferred language (Urdu and Punjabi), audio-recorded with consent, and later transcribed and translated into English for analysis. The data will be analyzed using a systematic thematic analysis approach, following the steps as outlined by (Braun & Clarke, 2006). This will involve familiarization with the data through repeated reading of transcripts, generating initial codes, searching for themes, reviewing potential themes, defining and naming them, and producing the report. This process will ensure that the findings are deeply grounded in the participants' own words, allowing themes of vulnerability—such as barriers to sexual and reproductive healthcare, social isolation, or experiences of gender-based violence—as well as themes of resilience — such as coping mechanisms and the formation of new support systems—to emerge organically. Rigor will be ensured through member checking, where summaries of interpretations will be shared with participants for validation, and by maintaining a detailed audit trail of the research process. Ethical considerations will be paramount; informed consent will be obtained from all participants, ensuring confidentiality and anonymity, and information for local psychological support services will be provided given the potential for discussing sensitive or traumatic experiences. Ultimately, this methodology is chosen to centralize the voices of migrant women themselves, producing a rich, qualitative account of how gender and migration intersect to shape health outcomes in the specific urban context of Lahore. Finally, the data was analysed using thematic analysis where the researcher first managed the timing for interviews with respondents and then recorded the interviews. Later, further process was applied including transcribing, translating, coding and decoding. Finally, the themes were generated to put in the results.

## 3. FINDINGS AND DISCUSSION

**Gendered Health Realities - Voices from Female Migrants in Lahore**

The analysis of the in-depth interviews with ten female migrants in Lahore revealed a complex tapestry of health experiences, vividly illustrating the intersecting vulnerabilities and resilience strategies outlined in the introduction. The findings are organized around the key phases of the migration journey and the central themes of gendered health impacts.

**1. Pre-Migration Drivers: Economic Precarity and Gendered Pressures**

The motivations for migration were deeply gendered, confirming that women's migration is often driven by intertwined economic and social factors. While all participants cited economic hardship in their villages of origin as a primary push factor, this was frequently mediated by gender-specific pressures. Several women migrated with their families as "tied movers," following their husband's search for work. However, three participants were primary breadwinners—two widows and one whose husband was disabled—who moved out of necessity, taking on the non-traditional role of provider. One participant, Aisha*, a 38-year-old from a flood-affected village in southern Punjab, stated, "The land was gone. My husband's spirit was broken. Someone had to feed the children. In the village, there was no work for a woman alone, but in Lahore, I heard I could work in houses." This highlights how economic migration for women is often a response to crisis and a deviation from prescribed gender roles, creating a specific pre-migration stressor.

**2. Gendered Vulnerabilities During Transit and Initial Settlement**

The journey to Lahore, though internal, was described as a period of significant anxiety and risk, particularly for women traveling without male companions. Two participants who traveled alone

reported intense fear of harassment and "losing their honour," which had profound mental health consequences. The initial settlement in Lahore's low-income peripheries (such as Youhanabad or Sundar) was characterized by extreme precarity. Overcrowded housing, lack of sanitation, and insecure tenancy were universal experiences. For Saima, a 25-year-old from Khyber Pakhtunkhwa, this environment directly impacted her physical health: "We lived in one room, six of us. The drain outside was always overflowing. My youngest daughter was always sick with fever and diarrhea. I felt so helpless." This phase was marked by a acute sense of dislocation and a sharp decline in perceived control over their family's health and safety.

**3. Navigating the Urban Health System: Structural and Cultural Barriers**

A central finding was the formidable barrier the urban healthcare system presented. Participants consistently described experiences of what they termed "mehngai" (expensiveness) and "be-izzati" (disrespect). The cost of private clinics was prohibitive, and while public hospitals were theoretically available, the hidden costs of transport, diagnostics, and medicines, combined with long waiting times, made access difficult. More critically, the interviews revealed significant cultural and linguistic barriers. A participant from rural Sindh, Zubaida, explained, "The doctor speaks so fast in Urdu, I cannot understand. When I try to explain in my broken Urdu, the nurse scolds me and tells me to be clear. I feel like a fool, so now I only go when my son can come with me." This reliance on male family members for translation and navigation severely limited their autonomy in seeking healthcare, particularly for sensitive issues like reproductive health.

**4. Gendered Health Impacts: The Invisible Burden of Mental and Reproductive Health**

The specific health impacts reported were starkly gendered, with mental and reproductive health emerging as dominant, yet largely unaddressed, concerns.

Mental Health: A pervasive sense of isolation, worry, and sadness was reported by almost all participants. They missed their extended family and social networks in their villages. The constant financial anxiety, coupled with the burden of adapting to a new and often hostile urban environment, took a heavy toll. Fatima, a 45-year-old domestic worker, shared, "Here, I am always tired, always worrying about the next payment for the rent. In the village, even if we were poor, we had each other. Here, I am alone. Sometimes I cry in the kitchen so the children don't see." None of the women had sought formal mental health support, viewing their distress as a personal burden rather than a medical issue.

Reproductive Health: Access to sexual and reproductive healthcare was extremely limited. Most women had not seen a gynecologist since arriving in Lahore, relying on home remedies or local midwives for issues related to childbirth and menstruation. Knowledge of modern contraception was patchy, and the social stigma associated with seeking it prevented them from asking male doctors or pharmacists. This directly impacted their bodily autonomy and health.

**5. Intersecting Vulnerabilities and Resilience Strategies**

The data clearly demonstrated the intersectionality of their vulnerabilities. Being a woman, poor, from a rural background, and in some cases, belonging to a different ethnic group (e.g., Pashtun or Sindhi in a predominantly Punjabi city), compounded their marginalization. However, in line with the theoretical framework, the results also uncovered profound resilience. Women developed strategic coping mechanisms, primarily through the formation of "jhuggi networks" (slum-based networks). These informal networks of female neighbours from similar backgrounds provided crucial emotional support, shared information about cheaper doctors or reliable midwives, and offered small loans during health crises. They also leveraged their gendered roles, with several finding work as domestic helpers in multiple households, a sector that, while exploitative, provided a vital, if meager, income. This agency, though born of necessity, was a key factor in their survival and gradual adaptation to the city.

## 6. Discussion

The findings of this study provide a granular, ground-level perspective that vividly animates the theoretical concepts of gendered vulnerability and resilience outlined in the introduction. The lived experiences of female migrants in Lahore confirm that migration is not a uniform process but a deeply gendered trajectory that intersects with other axes of identity to shape health outcomes in profound and specific ways.

First, the gendered drivers of migration observed where women moved as tied movers, crisis-driven breadwinners, or family followers—align with global narratives that position female migration within the spheres of social reproduction and care work (Clerge et al., 2017). The experience of participants like Aisha, who migrated out of necessity after an environmental disaster, underscores how economic precarity is mediated by gendered social roles. Her narrative illustrates that for women, economic migration is often a response to the failure of traditional male breadwinning, forcing them into non-normative roles that carry their own unique stressors even before the journey begins.

Second, the reported vulnerabilities during transit and initial settlement highlight how gender dictates the perception and experience of risk. The intense fear of harassment and "losing honour" described by women traveling alone is a stark manifestation of the heightened threat of gender-based violence that shadows female mobility (Vighio et al., 2024). Furthermore, the precarious living conditions in Lahore's peripheries, which directly impacted child health and maternal well-being, exemplify how the urban environment itself can become a social determinant of health, disproportionately affecting the most vulnerable newcomers.

Perhaps the most consistent theme was the formidable structural and cultural barriers within the urban health system. Participants' experiences of "mehngai" (expensiveness) and "be-izzati" (disrespect) are powerful emic terms that encapsulate the concepts of financial inaccessibility and systemic discrimination. Zubaida's account of linguistic barriers and the resulting dependence on a male relative powerfully demonstrates Crenshaw's (1994) intersectionality in action: her gender, rural origin, and possibly ethnic identity converged to strip her of autonomy in healthcare settings (Crenshaw, 1994). This reliance on male intermediaries for navigating healthcare is a critical barrier to gender-sensitive service delivery, particularly for reproductive health, and reflects a systemic failure to provide culturally and linguistically competent care (Khoso et al., 2022).

The gendered health impacts, particularly the silent epidemic of mental distress and the neglect of reproductive health, are central to understanding the full cost of migration on women. The pervasive isolation, anxiety, and somatic symptoms reported align with studies on the mental health burden borne by migrant women, which is often internalized and untreated due to stigma and a lack of culturally appropriate services (Khoso et al., 2024; Sato, 2024). Similarly, the limited access to reproductive healthcare perpetuates a cycle of poor health outcomes and reinforces gender inequality by denying women control over their bodies.

Finally, this study powerfully illustrates that vulnerability and resilience are two sides of the same coin. The emergence of "jhuggi networks" is a quintessential example of how marginalized groups build social capital to survive systemic neglect. These informal, female-centric networks are a vital source of practical information, emotional support, and financial aid, effectively creating a parallel, community-based safety net. This finding challenges a deficit-based view of migrant women and positions them as active agents who strategically navigate and negotiate their health and well-being within severe constraints.

## 4. CONCLUSION

This case study of female migrants in Lahore conclusively demonstrates that the health impacts of internal migration in Pakistan are profoundly shaped by gender. The journey from origin to city is marked by gendered risks, and settlement is characterized by a collision between migrants' needs and a health system rife with structural and cultural barriers. The intersection of their identities as women, often from

poor, rural, and ethnolinguistic minorities, compounds their vulnerability, leading to significant, yet often invisible, burdens on their mental and reproductive health.

However, to view these women solely as victims is to misunderstand their experience. Their resilience, embodied in the strategic formation of social networks and their entry into the urban informal economy, is a critical component of their survival story. The findings affirm that a gendered and intersectional analysis is not merely an academic exercise but an essential tool for developing effective public health policy and practice. Ignoring these dimensions ensures that health systems will continue to fail one of the most vulnerable segments of the urban population.

To mitigate the identified health vulnerabilities, a multi-level approach is essential. Policymakers should deploy mobile clinics to migrant settlements, offering subsidized maternal, reproductive, and mental healthcare delivered by female staff and interpreters. Concurrently, mandatory sensitivity training for public hospital personnel is vital to combat disrespectful treatment. Programmatically, interventions must harness existing community capital by training trusted women from 'jhuggi' networks as community health workers, who can bridge the gap to formal services. Furthermore, developing accessible, visual mental health materials in local languages and facilitating peer-support groups will address the critical need for psychosocial support, empowering migrant women through community-based strategies.

**REFERENCES**

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Cabieses, B., Velázquez, B., Blukacz, A., Farante, S., Bojórquez, I., & Mezones-Holguín, E. (2024). Intersections between gender approaches, migration and health in Latin America and the Caribbean: a discussion based on a scoping review. *The Lancet Regional Health–Americas*, *40*.

Clerge, O., Sanchez‐Soto, G., Song, J., & Luke, N. (2017). 'I Would Really Like to Go Where You Go': Rethinking Migration Decision‐Making Among Educated Tied Movers. *Population, Space and Place*, *23*(2), e1990.

Crenshaw, K. W. (1994). Foreword: Toward a Race-Conscious Pedagogy in Legal Education. *S. Cal. Rev. L. & Women's Stud.*, *4*, 33.

Dao, T. H., Docquier, F., Maurel, M., & Schaus, P. (2018). Global migration in the 20th and 21st centuries: the unstoppable force of demography.

Darebo, T. D., Spigt, M., Teklewold, B., Badacho, A. S., Mayer, N., & Teklewold, M. (2024). The sexual and reproductive healthcare challenges when dealing with female migrants and refugees in low and middle-income countries (a qualitative evidence synthesis). *BMC Public Health*, *24*(1), 520.

Jia, H. (2024). Impact of digital infrastructure construction on the migrants' utilization of basic public health services in China. *BMC Health Services Research*, *24*(1), 761.

Khoso, A. R., Akhtar, F., Narejo, A. A., Mallah, S. A., Vighio, K., & Sanjrani, D. K. (2022). Comparative analysis of service quality between public and private hospitals, using SERVQUAL model: a case study of Peshawar, Pakistan. *MEDFARM: Jurnal Farmasi dan Kesehatan*, *11*(2), 240-252.

Khoso, A. R., Jintu, G., Bhutto, S., Sheikh, M. J., & Narejo, K. (2024). Climate change and its impacts in rural areas of Pakistan: a Literature. *Journal of Environmental Science and Economics, 3 (1), 18*, *26*.

Lejbowicz, T., & Scodellaro, C. (2025). Women's Intertwined Experiences of Gender-Based Violence and Migration: The Case of Migrant Women in France. *Violence Against Women*, 10778012251366230.

Nasrin, N., Haider, M. Z., & Ahsan, M. N. (2024). Well-being effect of international migration and remittance on human and gender development in South Asian countries. *Plos one*, *19*(4), e0300597.

Rada, I., & Cabieses, B. (2024). Challenges for the prevention of hypertension among international migrants in Latin America: prioritizing the health of migrants in healthcare systems. *Frontiers in public health*, *11*, 1125090.

Sato, S. (2024). Post-Partition Migration and Identity in South Asia: A Comparative Analysis of India, Pakistan, and Bangladesh.

Vighio, K., Khoso, A. R., & Suyuhan, W. (2024). Rural Migration to Urban Areas and Its Impacts on Population: A Sociological Investigation in Hyderabad, Sindh, Pakistan. *Zakariya Journal of Education, Humanities & Social Sciences*, *2*(2), 46-56.

Ying, H., Khoso, A. R., & Bhutto, S. (2024). A Case Study Investigating the Relational Well-Being of International Students at Hohai University Nanjing, Jiangsu Province of China. *Behavioral Sciences*, *14*(7), 544.