



Role of Cultural Health Capital in Coping with Cancer: Perspective of Cancer Patients at Lahore, Pakistan

Sara Noor¹, Tayyaba Sohail² & Kiran Ikram³

¹Research Scholar, Department of Sociology University of Management and Technology, Lahore

²Assistant Professor University of Home Economics, Lahore

³Lecturer Sociology Lahore College for Women University, Lahore

ABSTRACT

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This research study aimed at correlating cultural health capital (CHC) and coping mechanisms with cancer patients in Pakistan using the framework of cultural health capital. The research aimed at understanding the concept of cultural health capital and its relation to coping mechanisms. A purposive non-random technique has been employed, where data was collected from 95 cancer patients who have undergone chemotherapy. A quantitative research method for data accumulation was aided by a developed questionnaire with two distinct portions. The first part was used to assess cultural health capital using the variables institutionalized cultural capital, objective and incorporated cultural capital, and a scale for coping Mechanisms. A self-developed questionnaire was used along with the Cope Scale to measure cultural health Capital. Data analysis was conducted using linear Regression. Data was collected from 95 respondents (51 females and 44 males) falling in the age bracket of 41-50. The findings of the study show a weak relationship between cultural health capital and coping mechanisms. Despite the presence of cultural health capital, it is not found to be a significant factor in coping with cancer. Religion was found to be a vital coping strategy used by cancer patients. Future studies can undermine the barriers to the utilization of CHC for coping purposes.

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Corresponding Author's Email: kkiranmalik@gmail.com

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Introduction

The objective of the present research is to examine how cultural health capital influences the coping strategies of cancer patients in Lahore. According to the cancer index of Pakistan, a significant number of individuals (101,000) lose their lives to cancer annually (Ferlay et al., 2019). The treatment for this disease is extremely painful and involves radiotherapy and chemotherapy. Cancer patients experience significant distress throughout the process of diagnosis, treatment, and recovery. Thus, coping mechanisms may help ease that suffering with the support of people and programs. The coping mechanisms remain unidentified and informal, ranging from appraisal-focused to adaptive behavioral-focused strategies in Pakistan. Many people find comfort in connecting a superpower with an organized belief system as a way to reduce stress (Koenig, 1992). However, using psychotropic drugs as a coping mechanism can be seen as ineffective (Vosvick, 2003).

Coping strategies contribute to enhancing the patient's wellbeing as these strategies have an association with an understanding of disease and its symptoms, which are being reported by patients and the way patients manage this illness, which is reflected in the patient's cultural health capital (Brown, 2001). Cancer patients employ various coping mechanisms to allow themselves to endure the treatment and stigma related to being diagnosed with cancer. With this specific notion, the researcher will conduct the study on cancer patients and their coping mechanisms in the context of cultural health capital in Pakistan. The importance of the research is manifold and has been separated into three different areas. Theoretically, this study is the first of its kind in Pakistan, Cultural Capital, although a vintage concept has only currently been investigated in the health paradigm globally. However, in Pakistan, there are no studies on cultural health capital and the relationship between the coping mechanisms of cancer patients. Methodologically, most previous studies on cultural health capital (Shim, 2010) have taken a qualitative approach; this study shall employ quantitative methods to explore cultural health Capital. For this, an indigenous tool has been developed as a result of the study.

As for the significance of the research, its implications may create awareness among the people of Pakistan by increasing their health literacy by using cultural health Capital. Specifically, the goal of the study is to raise awareness and cultivate the minds of the people to understand how cultural health capital can be used in their everyday lives. Also, it might be used as baseline research to design marketing campaigns and other soft interventions involving different stakeholders in the health system. In the current health disparity times, cultural health capital is crucial to be understood for better provision of health care services. Patients value certain components of CHC in their providers, such as their medical knowledge and expertise. They also appreciate providers who take the time to understand the personal context of their illness and approach it with empathy and without judgment (Leslie A. Dubbin, 2013). These aspects of CHC can be seen as valuable resources that can be exchanged between patients and providers to improve health outcomes. In today's healthcare system, where personal and social barriers are common (Clarke AE, 2003), patients are expected to actively participate in their healthcare and play the role of a consumer (K. Davis, 2005).

Cultural health capital is the collection of resources, including knowledge, attitudes, behaviors and cultural skills, that are acquired, valued, utilized and leveraged by patients and healthcare providers to improve healthcare experiences. However, the scope of the current study is limited to the CHC of patients. It is further discussed that the cultural health capital of patients is the composition of institutionalized cultural capital (academic background) (Abel, 2007), objectified cultural capital (patient-owned medical instruments and reading material) (Carlijn & Kamphuis, 2015) and incorporated cultural capital (healthy lifestyle, health literacy, participation in health-related activities and skills to manage health problems) (Nutbeam, 2000).

Health literacy and self-efficacy are seen as cultural assets and abilities that can assist a patient in engaging with healthcare professionals. According to Shim (2010), these resources may also provide a favorable environment for the health care provider to treat the patient in the sense that the patient may adequately define their health problem, which may lead to optimal treatment. Promoting health literacy is crucial for individuals to stay informed about health and healthcare, according to Coulter (2006). Health literacy can be described as a complex concept that includes both basic literacy skills and the ability to effectively communicate about health (Nutbeam, 2000).

Health literacy can also be explained as the level to which an individual has the capacity and ability to obtain and comprehend the most basic health knowledge and services that are necessary for making appropriate health choices (Medicine, 2004). Hence, health literacy may be interpreted as the ability to take, understand and correspond to knowledge to advocate, streamline and progress health in different settings of a person's life (Paasche-Orlow & Wolf, 2010). This poses a risk and adds to the disparity in health knowledge because the patients are unaware of their conditions and medical health professionals such as doctors and nurses are placed in a complicated situation where they are unable to fully communicate their instructions because the patients lack the skill and fortitude to comprehend their guidance and advice (Naeem, 2012). Thus, certain acquired skills have become essential for both patients and medical practitioners to effectively engage in discourse. All the above-mentioned studies contribute to developing a theoretical framework regarding cultural health capital by considering cancer patients' coping strategies. It also facilitates the assessment of the cultural resources, coping drives of caretakers and patients, and dispositions and interactional styles of patients.

2.0 Literature Review

Cultural Health Capital

Pierre Bourdieu, a prominent French sociologist and anthropologist, proposed a theory in the 1980s that highlighted tangible and non-tangible capital to comprehend the hierarchical structure of society and structural inequalities (Abel, 2007). Bourdieu's theory of capital differentiates capital as social, economic and cultural. The concept of "cultural capital" as used by Bourdieu refers to a collection of symbolic or meaningful items, such as abilities, tastes, posture, clothing, behaviour, and mannerisms, as well as material possessions that one may acquire by belonging to a particular social class or group (Jenkins, 2002). According to Bourdieu, the roots of social inequality occur when people with different forms of cultural capital interact with one another and develop a shared sense of identity and status. Social inequality may manifest as a lack

of another person's abilities, such as the knowledge of specific facts that would be beneficial to the individual. Bourdieu continued by stating that cultural capital can be institutionalized, objectified, or embodied. Embodied cultural capital can take the form of a person's accent or speech pattern; objectified cultural capital can take the form of a material object like a car; and institutionalized cultural capital can take the form of any credentials or qualifications that may denote cultural competence (Edgerton, 2014). To understand the influence further, Bourdieu gave three key concepts: habitus, Capital and field (Jenkins, 2002).

Habitus

Habitus, which pertains to the social circumstances that influence a person's behaviour, may also be connected to lifestyles, particularly healthy lifestyles. A person's habits, abilities, and dispositions may be referred to as the physical manifestation of cultural capital, which they may build according to their life experiences. Habitus in the context of health may be defined as the knowledge or behaviour one displays as a result of the education they have attained. It stands to reason that someone with a higher education would likely have more knowledge of how to manage an illness than someone without a higher education (Roksa & Robinson, 2017).

Capital

The term "capital" in this context refers to both the material and immaterial resources that an actor may acquire and profit from in a particular social sector (David V. McQueen, 2007). Bourdieu made a distinction between three types of capital: economic, social, and cultural, as was already mentioned. If this is applied to health, then economic capital in the form of money is used to buy products that promote good health as well as those that prevent disease and are necessary for maintaining a healthy lifestyle. Economic capital includes income, property, and financial assets. Social capital, also referred to as a network that people form via interaction, may be used by policymakers to introduce a policy that will aid in promoting health. Finally, cultural capital can refer to a person's behaviour or habit that is influenced by an educational title that confers a particular social prestige. It also includes power that is gained by the knowledge and tradition drawn from books and machines, or habits that occur because of a certain social position and are referred to as institutionalized cultural capital (Abel, 2007).

Field

The term "the field" describes how power is distributed among social actors who frequently compete with one another for the distribution of resources, needs, and supplies (Krarup & Munk, 2016). In the "field," power dynamics are vital in shaping the interaction. Health might be viewed as a field if it has the following traits: The way we cope with our health may be a daily mirror of the underlying social stratification processes that also contribute to social distinction through the various health lifestyles we adopt. Health has now turned into a place where people conform and decide which standards are right for others to follow. There is an expected distinction between the people who define proper medical practices for the rest of society; these individuals frequently possess the highest levels of scholastic achievement and frequently hold positions of more authority and prestige (Medical Health Professional). The health sector has unquestionably developed into a region of the economy that is expanding, where investments are still being made,

leading to profit margins, unequal consumption, and opportunities for gain.

The general concept of cultural capital and health care research, which is referred to as cultural health capital, can be defined as consisting of "all cultural-based resources that are available to people who pursue in favor of health," according to Bourdieu's theory (Bourdieu, *The Forms of Capital*, 1984). When combined with other factors, cultural health capital consists of information, operational skills, behavioral attitudes and norms, and values related to health (Abel T., 2008). By adopting healthy practices, such as using preventive measures, this sort of cultural capital becomes linked to health (Frohlich, 2014). Similar to life course research, research on cultural health capital also focuses on socialization to improve health-related outcomes. According to some theories, developing lifelong health-related knowledge and abilities begins in childhood and can continue through socialization and frequent encounters with healthcare professionals (Ross, 2003). According to the Cultural Health Capital Theory, people's behavioral alternatives and choices are structurally limited and inequitably distributed throughout different social groupings (Abel T., 2008).

According to Shim (2010), CHC is a distinct type of cultural capital that has been valued and exchanged in the context of health care, namely in the context of healthcare relationships. Similar to cultural capital, cultural health capital takes the form of embodied and habitual components of capital. Cultural health capital may be mobilized through deliberate strategies of action or more deliberate styles and habits of action (Swidler, 1986). Shim's conceptualization centered mostly on the cultural health capital components that healthcare professionals learn about patients as they navigate the healthcare system.

According to Leslie A. Dubbin (2013), the CHC components that are pertinent to patients include medical knowledge and skill, interactional variables including understanding the patient's personal context of sickness and treating the illness with sensitivity to the patient's feelings (i.e., with a non-judgmental mindset). These CHC components are kinds of capital that can be exchanged during interactions between patients and healthcare professionals to improve health outcomes and gain advantages. CHC is especially important in the current healthcare system because, despite the prevalence of personal and social barriers, patients are still expected to act as active consumers and actively participate in the delivery of care (Davis, 2005).

Coping Mechanisms

An array of psychological points are imperative for an individual to adapt to a disease like cancer. To precisely make a checklist of the points and adaptations when a person is suffering from a disease like cancer, it is necessary to assume that the process an individual goes through is multi-stage and contains situations that are challenging for a cancer patient every day. It should be noted that by no means are these situations less stressful and they may be more difficult to cope with as compared to other diseases. The different stages of psychological adaptation to these situations may vary from patient to patient and knowledge regarding the possibilities of predicting a later state of wellness is of immense importance (Wasteson, 2007). Patients must endure painful and grueling hours of treatment, which affect both their mind and their body (Šprah, 2004). Even after the treatment is dealt with, there may be a problem of the reintegration of individuals back into

society, which is as difficult as the cancer treatment itself and may cause irreparable psychological damage to the patients and their families (Bean, 1980).

There are four ways in which culture can affect stress and coping mechanisms. Firstly, the cultural environment can determine the types of stress that individuals are likely to face. Secondly, culture can influence how individuals perceive and experience distressing events. Thirdly, cultural differences can shape the coping strategies that individuals choose to use in different situations. Lastly, culture provides various institutional methods for managing stress. (Aldawin, 2004)

Different cultures may have different preferences when it comes to coping with emotions and problems. Some cultures may rely more on themselves for survival, while others may rely more on others. This can influence their preferred methods of coping, whether it be through internal or external control, and whether they prefer direct or indirect methods of mastery. The differences in emotion-focused coping can be attributed to variations in emotional control and expression, as well as patterns of emotional expression (Shek and Cheung, 1990).

In Pakistan, individuals with an illness may encounter difficulties when attempting to reintegrate into society because of societal bias. People employ various methods to deal with their negative emotions and the challenges they encounter in their present life circumstances. Certain strategies are employed to alleviate stress, which is crucial in both short-term and long-term crises such as cancer (Kasi et al., 2012). Overall, cultural health competence (CHC) is a set of skills that can improve health literacy and knowledge. Applying this knowledge can enhance one's health and promote further improvement. Cancer affects every aspect of a person's life, from diagnosis to recovery or death. Patients who not only suffer from the disease but also experience social exclusion may develop a need to cope. Therefore, various coping mechanisms and strategies have been developed to help these patients function in society. While their functioning may not be optimal or on par with others, it is crucial for cancer patients in Pakistan and other South Asian countries to be socialized and have the opportunity to recover without being isolated from others.

There remains a vast and distinct gap in the literature with regards to cultural capital and health in Pakistan. Although work has been done on cultural capital in Asian regions of the world (May Sudhinaraset, 2016), it has yet to be investigated in depth in Pakistan with regards to cancer and the support programs that are available to help the patients cope. To overcome this overwhelming gap, the researcher will employ techniques to understand cultural health capital in Pakistan as well as the coping mechanisms (Bemana, 2011) available for cancer patients. The concept of cultural health capital is a fact that can be found globally. Pakistan is a country where there can be a large economic gap visible among the people. This gap often does not allow them to visit hospitals where they can receive proper treatment, such as by regularly visiting their community health worker or visiting the hospital when it is too late. (Naeem, 2012) . There are even more patients who are unable to relate their illnesses to their doctors due to a lack of knowledge or a breakdown in communication. This barrier or breakdown has continually impeded the treatment of patients by their doctors, which has further affected their lives. Being diagnosed with cancer is a harrowing feat, which can psychologically be very distressing. On account of this, there is no cure for cancer; only excruciating treatment is available, which weakens the body and

mind.

Research suggests that Malay culture, which is infused with Islamic beliefs, has a significant impact on the coping mechanisms and perspectives of cancer patients (Ahmadi et al., 2018). The study has mostly focused on existential meaning-making coping, which is characterized by internalizing power, being charitable, loving one's family, seeking meaning via philosophical inquiry, and adopting a positive outlook on life (shukran—thankfulness). In Turkey, religious belief directly influences coping strategies, including non-religious strategies, in contrast to findings from comparable research carried out in other nations (Ahmadi et al., 2018).

3.0 Methodology

A quantitative research design was carried out to investigate the relationship between cultural health capital and coping mechanisms among cancer patients. The study used the survey method as a technique for gathering data from cancer patients while using a structured questionnaire as a tool for data collection. Cancer Patients who were currently diagnosed with cancer and going through the chemotherapy process were used as the sample population. The sample population was calculated using Cochran's formula. The total number of new cases diagnosed in Punjab is 16,486; the prevalence rate in Pakistan in 2022 is 40,797 (Tufail, 2023).

$$n_0 = \frac{Z^2 pq}{e^2}$$

$$N_0 = \frac{1.96^2 \times 0.178 \times 0.822}{0.0025}$$

$$N_0 = 224 \text{ Sample Population}$$

A multi-stage sampling method was employed for the research. In the first stage, a list of all government hospitals in Lahore with specialized oncology departments was compiled. Three hospitals (SKMH, MAYO, and INMOL) were randomly selected, taking into account accessibility and resources. A purposive sampling technique was used to choose the participants, as permission from most hospitals was not obtainable. Given the sensitive nature of the topic, the study adhered to all ethical considerations. The well-being and health of the cancer patients, who were the respondents, were the primary concerns of the researcher. The respondents were provided with information about the study and their informed consent was obtained. They were also informed about their right to withdraw from the study. Throughout the research, the anonymity and confidentiality of the respondents were upheld. Only cancer patients who expressed a willingness to participate were included in the study.

A large sample size was calculated, though; the data was collected from 95 respondents, unfortunately due to permission issues from the hospital's management as well as consent issues from patients. In addition, the study was not funded and conducted for academic fulfillment; therefore, completing research within the allocated time was necessary. Thus, after contacting people as per the calculated sample size and receiving their rejections, the student stopped contacting further patients or hospitals for further data collection. Only 95 respondents from two

cancer hospitals took part in the study. Hospitals such as Shaukat Khanum Hospital did not give permission for the study to be conducted on their grounds. The survey was conducted in hospitals Inmol Cancer Hospital located in New Muslim Town Lahore and MAYO Cancer Hospital located near Neela Ghumband Road Lahore, Pakistan.

The inclusion criteria were to include patients from 20 to 60 years of age who were undergoing chemotherapy. Their case was particularly intriguing because they had a tendency to employ more coping strategies than other stages of cancer patients. Adolescents and children less than 20 years of age were omitted from this survey, considering that they must lack understanding and explanation as their parents will be more aware of their illness. The age range above 60 years and over was also omitted, as when people get to this age, not necessarily with all patients but the majority come into denial and to the opinion that they are fine and nothing is wrong with them (it's like explaining to a child but very argumentative).

The CHC questionnaire was created based on Shim's (2010) framework of cultural capital. The coping strategies questionnaire used a modified version of the COPE scale developed by Carver et al. (1989). The Cultural Health Capital measures consisted of three main indicators: institutionalized cultural capital, objectified cultural capital, and incorporated cultural capital.

Institutionalized cultural capital refers to an individual's educational attainment or recognition from an educational institution. It assessed whether the individual had received any basic health training or first aid training before their hospital treatment. The questionnaire for cultural health capital included all three indicators, as per Bourdieu's theory of cultural capital (Bourdieu, 1997). The variables are further operationalized using indicators as follows:

1. Institutionalized cultural capital: (I) Education is defined as the highest degree attained by the respondent (Kamin et al., 2013).
2. Objectified cultural capital: the ownership of (I) health guide books and (II) machines (Abel, 2007) (yes/no)
3. Incorporated cultural capital: (I) skills (to operate the instruments or uses of medicine) (Shim, 2010) (II) Participation (Kamphuis et al., 2015) (III) Health literacy (IV) Health lifestyle (Abel, 2007) (Shim, 2010; Abel, 2007). (five levels of agreement, from highly agree to highly disagree)

In the questionnaire, the Likert scale was used to incorporate cultural capital from questions 15 to 34, and Cronbach's alpha was also used to test the interrelated correlation of these questions, which indicated a strong correlation.

4.0 Results

A total of 95 individuals agreed to participate in the survey, with 51 being female and 44 being male. 43% of the participants were between the ages of 41 and 50, as shown in Table 1.

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	44	46.3	46.3	46.3

Female	51	53.7	53.7	100
Total	95	100	100	

Reliability and Validity

Cronbach's alpha was used to make the data reliable, by analyzing reliability test the result of Cronbach's alpha is .824 which indicates that the items in the test are highly correlated.

Reliability Statistics

Cronbach's Alpha	No. of Items
.824	20

Table 2 displays that the average score for the Cultural Health Capital Scale was 3.2097, while the average score for the Coping Mechanism Scale was 2.4435.

Descriptive Statistics

	Mean	std. deviation	N
Mean Coping Mechanisms	2.4435	32375	95
Mean Cultural Health Capital	3.2097	82685	95

Table 3 shows that the p-value of Pearson Correlation for the mean Cultural Health Capital and mean coping mechanism was 0.019($p < 0.05$) which shows the existence of correlation among the two variables. The table depicts the correlations between the Mean Coping Mechanisms and Mean Cultural Health Capital. Corresponding with the chart the Pearson's correlation indicates a weaker relation. An optimum value expected should be closer to 1, however because the result shows a negative value it means that the corresponding values entered do not match the expected values hence a weaker relation almost negligible. The further the Pearson's Correlation is from the number 1 value (standard value representing the strongest possible relation) the weaker the data set relation. The Pearson's Coefficient is $-.305$ which is a weak negative correlation.

Correlations

		Mean Coping Mechanisms	Mean Cultural Health Capital
Pearson Correlation	Mean Coping Mechanisms	1.000	-.305
	Mean Cultural Health Capital	-.305	1.000
Sig. (1-tailed)	Mean Coping Mechanisms	.	.001
	Mean Cultural Health Capital	.001	.
N	Mean Coping Mechanisms	95	95
	Mean Cultural Health Capital	95	95

The model summary, presented in table 3, indicates that the relationship between the variables is weak, as evidenced by the low correlation coefficient value of 0.0214. The p-value in the Linear Regression analysis is 0.037 ($p < 0.05$), indicating that there is a statistically significant relationship between the variables, although it is not a strong one.

Model Summary

Model	R	R square	Adjusted R square	Std. Error of the Estimate
1	.305a	.093	.083	.30997

a. Predictors: (Constant), Mean Cultural Health Capital

b. Dependent Variable: Mean Coping Mechanisms

Over 61% of the participants utilized religion as a means of coping.

	Frequency	Percent	Valid Percent
I put my trust in God	82	86.3	86.3
I try to find comfort in my religion	81	85.3	85.3
I pray more than usual	65	68.4	68.4
I seek God's help	76	80.0	80.0

However, it is undeniable that there is presence of Cultural Health Capital (CHC) among cancer patients. This is also evident in the institutionalized form of CHC, as observed that 50.5% of the sample had an education level higher than matriculation, with 38.9% having completed graduation. Additionally, 51.6% of the sample possessed home medical equipment, and 56.8% used sources such as magazines, internet, TV, and others to gather information about their disease. The mean value of 66.89 for incorporated CHC is more than half of the total value for the scale, indicating that the cancer patients in this study possess various forms of Cultural Health Capital.

Qualification

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Illiterate	20	21.1	21.1	21.1
	Primary	2	2.1	2.1	23.2
	Matric	25	26.3	26.3	49.5
	Intermediate	11	11.6	11.6	61.1
	Graduate	19	20.0	20.0	81.1
	Masters	18	18.9	18.9	100.0
	Total	95	100.0	100.0	

Discussion

The research found a weaker connection between cultural health capital and coping Mechanisms. Some sections of the study showed a positive association, particularly among cancer patients who turned to religion for support. Religion has been known to help people navigate difficult situations and find comfort in times of illness. However, the study did not establish how cultural health capital is used as a coping mechanism.

Cultural health capital refers to the knowledge and skills individuals acquire to maintain a healthy lifestyle. While religion has been linked to coping with chronic illnesses, it does not provide sufficient information about the diseases themselves. A study conducted in Turkey investigated the impact of health literacy, a component of cultural health capital, on enhancing self-confidence among cancer patients. The study found that higher levels of health literacy were associated with increased self-confidence. Cultural health capital is a relatively new concept in the field of health research and can play a significant role in self-confidence and coping. However, the study had limitations due to time and financial constraints, and the researcher encountered difficulties in accessing various hospitals.

Recommendations

The recommendations that can aid in the research are as follows:

1. The phenomenon of cultural health capital needs to be further explored in a quantitative or statistical manner. This will aid in the understanding of the resources needed for patients to increase their capital in medical encounters with medical health professionals.
2. Coping strategies need to be implemented in hospitals so that patients can relieve stress, depression and anxiety. The mechanisms need to be properly implemented as part of treatment so that the re-socialization of these patients may be more comfortable.
3. The research was conducted on an academic level; for the successful implementation of coping strategies and the required cultural health capital, the research needs to be conducted on a nationwide level. Through this, the cultural health capital level of Pakistan can be found in each patient. It is possible that the CHC may be higher in other areas of Pakistan.
4. To improve the cultural health capital in Pakistan, health education and other health-related resources should be distributed among the public, regardless of their socio-economic status.

Conclusion

The cancer patients have cultural health capital, but they do not use it as a coping mechanism for their illness. Instead, they rely more on religion as their primary strategy for dealing with cancer. Coping strategies are employed to relieve stress, depression and anxiety. Because there is no proper implementation of these strategies, most patients unwittingly succumb to their thoughts, which may serve to increase their emotional distress and self-victimize, which may further alienate

them from society. The turnover may occur if patients can understand what they are going through and how they can synthesize themselves to avoid these situations. Hence, it may become imperative to increase their cultural health capital and implement them nationwide to aid in patients' recovery and treatment.

Sara Noor: Problem Identification and Model Development

Tayyaba Sohail: Data Collection, Results and Analysis

Kiran Ikram: Research Model and Hypothesis testing

Conflict of Interests/Disclosures

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