ORIGINAL ARTICLE

Urban Inequality and the Dystopian Landscape: A Case Study of Urban Dystopia in Islamabad

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ABSTRACT

Objective: This study investigates how the post-colonial transition of the economy unleashed a wave of restructuring through modernity and capitalism. Originally planned to ensure holistic well-being, the city's utopian vision has produced dystopian realities for marginalized communities. We explore how the development of the 'perfect city' was based on aesthetics rather than health and well-being as its cornerstones. Therefore, the research seeks to understand how health has evolved and has been taken into practical consideration among the underprivileged residents of the Katchi Abadi population (slums, squatter settlements, and permanent temporaries of the city).

Study Design: Qualitative study inclusive of participant observation among slum dwellers, unstructured interviewing (with residents and officials from state bureaucracy), and archival data (CDA documents).

Place and Duration of Study: This fieldwork was conducted in the Katchi Abadies of Islamabad, Pakistan, from June 2022 to December 2024.

Methods: In-depth interviews, ethnography, and participant observation examine Katchi Abadi health norms and their relation to Islamabad's utopian planning. The study is purposive in locating the forgotten or ignored realities and how they are patronized in settled and planned hierarchies of Islamabad.

Results: The study shows how Islamabad's utopian vision is experienced differently by socio-economically marginalized residents. The study finds that a more substantial relation with the city is mainly based on understanding who lives where within the city's socio-spatiality. Therefore, Dystopia emerges for many residents despite Islamabad's utopian ideals.

Conclusion: We have argued that the utopian vision of Islamabad is turning into a dystopian reality for many of its urban poor. The Katchi Abadi Walay, often seen as the city's neglected population, includes many who face homelessness, addiction, and social exclusion. However, it is essential to recognize that not all their hardships stem from government inaction; a lack of personal initiative, reluctance to work, and dependence on begging also play a role. Real change demands both systemic reform and individual responsibility.

Keywords: *Disease, Dystopia, Health.*

How to cite this: *Bibi M, Qadar A. Urban Inequality and the Dystopian Landscape: A Case Study of Urban Dystopia in Islamabad. Life and Science. 2025; 6(4): 553-560. doi: http://doi.org/10.37185/LnS.1.1.616*

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Received: Feb 01, 2025; 1st Revision Received: Jun 23, 2025
2nd Revision Received: Aug 18, 2025; Accepted: Aug 21, 2025

Introduction

The post-colonial transition of the states and societies unleashed a wave of restructuring in administrative, social, and economic spheres. We have attempted to locate how functional power in the construction of Islamabad was elevated in utopic ways to embody a new look of Pakistan. The development of Islamabad was one of the most ambitious projects of the twentieth century, celebrated nationally and internationally as an embodiment of progress and development.[1] The city

was planned to promote well-being as a holistic concept for every citizen; however, a dystopian reality has prevailed over the marginalized sections of the city. The research presents Katchi Abadies (slums) of Islamabad to understand (ab) normalcy of representation in colonial modern capitalism. Of a population of 0.37 million, is living in the capital, Islamabad, which is not included in the 1.7 million population of the mainstream population.[1] The mere numbers presented above indicate how Islamabad is a model of perfection–a utopic vision is still only an imagination. Utopia firmly believed that what looked perfect on paper was perfect in reality.[2] Hence, Former President dreamed of creating a utopic reality in the shape of Islamabad when it was proposed as the new capital of Pakistan. Islamabad, imagined as the capital of an emerging country with particular aspirations, was given an architectural shape of power and political ideals.[3]

The evolution of society during the transition from an agrarian to an industrial economy led to an urban explosion.[4] Therefore, government policies favored and encouraged migration from rural to urban areas, forming metropolitan cities.[5] The push factors caused a massive population increase and gave birth to stress in urban development that temporarily boosted the economy, permanently entrenching inequality of wealth, health, privilege, human rights, and well-being.[6,7] Currently, more than 4.3 billion people live in urban areas, approximately half of the world's population living in urban settings.[8] According to UNO, for the first time in history, the human population is living more in cities than in rural areas.[9] By 2050, 68 percent of the population will have migrated to urban areas. Urbanization and the demographic transition from rural to urban settings are associated with a shift in the global economy, according to the UN, from an agriculture-based to an industrialized, technologically dependent one.[7,10]

Industrialization has created modern megacities, pushing rural populations into cities; however, these populations were never planned to be accommodated in urban settings. According to the 2021 report of the WHO, Public health and social problems have emerged, negatively impacting the quality of life.[11] As a result, we are witnessing problems of uninhabitable ecological relationships, fragile law and order situations, and increasingly hostile bio-cultural environments. We treat the notion of well-being as a holistic, subjective, and multifaceted aspect of life that is influenced by the scale of such urbanization, which has never been part of human experience. Consequently, modern urban planning tends to oversimplify the complexity of human life by separating people into enclaves and gated communities. At the same time, unprivileged sections are urban poor in slums and squatter settlements.

Thus, we examine the subjective lived experiences of both extremes in Islamabad regarding health and well-being to determine whether the city's architecture affects individuals' well-being, regardless of socio-economic class. The objective of the research is to understand the conception of health in the spatial and temporal spheres of the Katchi Abadies in Islamabad. We are of the view that health and sickness are thoroughly integrated into the structure of the city. Our research questions examine the extent to which the construction of Islamabad was shaped more by aesthetic and architectural ideals than by a commitment to inclusive and healthy life worlds.

Methods

Methodologically, Islamabad, the capital city, is used as a field to understand the utopian architectural planning by Constantinos Apostolou Doxiadis of Islamabad and the dystopian reality epitomized by Katchi Abadies. By dystopia, we refer to the lived experience of exclusion, inequality, and systemic neglect that emerges as the shadow side of utopian urban imagination. In political philosophy and literature, dystopia has historically been understood as the antithesis of utopia in societies marked by oppression, control, or decay.

However, contemporary urban studies argue that dystopia is not simply the opposite of utopia, but often its unintended consequence: the pursuit of order, beauty, and progress for some inevitably produces exclusion, displacement, and suffering for others. In this sense, Islamabad represents how utopian ideals of modernity and planned order simultaneously generate dystopian conditions for marginalized communities.

The conception of dystopia is analyzed through

participant observation among state officials, field visits, and In-depth interviews with residents and political activists. Two purposeful focus group discussions were also conducted with individuals from Katchi Abadies to understand their understanding of Islamabad as a city and their well-being. The study is based on long-term ethnographic fieldwork initiated in June 2022 to December 2024 after taking exemption from the Intuitional Review Board and Ethical Committee of National University of Medical Sciences, Rawalpindi, Pakistan vide letter no: 06/IRB&EC/NUMS/103, dated 20th April, 2022 and ongoing at the time of writing, encompassing repeated visits to Katchi Abadies, interviews with residents and officials, and participant observation in both community and bureaucratic settings.

We are of the view that understanding of well-being is not shared solely by people living in Islamabad's privileged sectors or by people of Katchi Abadies. The phenomenology of the channelization of the docility of the urban poor will also be examined to understand why it has become a natural social order.[12] In the perfect city, how imperfection came into being is explored by participant observation. The relevant literature has been reviewed to examine the history, transition, and current state of well-being in a so-called healthy city, and its disparities across different social groups in urbanism. The socio-spatial segregation of people in all aspects of life and well-being is known through formal and informal interviews. Furthermore, experts in urban planning, healthy cities, and well-being were approached to reflect on the parallel realities of Islamabad, in order to develop a systematic understanding of their perceptions of health and urbanism in the context of dystopian realities.

Results

The study reveals that Islamabad's utopian vision, designed to symbolize progress and modernity, is experienced unevenly across socio-economic groups. Field observations and interviews indicate that marginalized residents of Katchi Abadies face systemic exclusion, poor living conditions, and limited access to healthcare, clean water, and sanitation. While elite sectors benefit from planned infrastructure and private healthcare, slum dwellers navigate structural violence, insecure housing, and environmental hazards. The research finds that residents' experiences of illness, well-being, and citizenship are shaped by their socio-spatial location in the city. Thus, Islamabad's utopian ideals of order and development simultaneously generate dystopian realities for its marginalized communities.

The utopian vision of Islamabad, designed to symbolize modernity and progress, is marked by uneven socio-economic conditions. The study reveals, through field observations and interviews, that the population of Katchi Abadies is marginalized and faces systemic exclusion, poor living conditions, and limited access to healthcare, clean water, sanitation, and legal services. Whereas the population of higher socio-economic status benefits from the planned infrastructure of Islamabad, the healthcare and social security systems. On the other hand, slum dwellers have to navigate structural violence, insecure housing, and environmental hazards. The residents of Islamabad's experiences of illness, well-being, belonging, and citizenship are profoundly shaped by their socio-spatial location within the city.

The households of Katchi Abadies are mostly multi-generational; the responsibilities for generating income, household chores, and care are shared. Collectivism is a resilient survival strategy but can be fragile in the face of forced evictions or eviction threats, natural disasters, or sudden job loss. Women bear a hefty burden, balancing domestic labor with limited access to health services, often relying on informal remedies, herbal medicines, or sporadic medical camps. Children are exposed to chronic environmental risks, such as open drains, contaminated water, overcrowded living spaces, and air pollution from nearby construction, shaping early experiences of illness and normalized hardship.

The medical camp organized by an NGO, the Awami Workers Party, in G8/1, illustrates the precarious situation and circumstances of healthcare access. The number of Abadi residents who attended the camp for free medical checkups indicated the demand for medical attention and facilities, as well as the lack of formal health infrastructure. The medical professionals in the in-depth interviews highlighted that the residents of the community lack the understanding of chronic disease management, including insulin-dependent diabetes and septic

conditions in children, reflecting both informational and systemic gaps. As they lacked health and medical facilities, their coping strategies included self-medication, like over-the-counter drugs, and alternative medicine; it is the autonomy born out of necessity. Other management strategies included intermittent fasting, not as a pattern for planned health practice, but instead skipping meals when resources are limited and improvising with available resources. These coping mechanisms are pragmatic adaptations due to the long-term lack of basic infrastructure and health rights.

Most of the abadis are located in compounds that are zones of infrastructure deficiencies and environmental hazards. These compounds are prone to floods, irregular water supply, pollution, and poorly ventilated houses built with iron or wooden sheets. Disease spreads through water contamination and multiple points, as water is stored in the same containers for drinking, cooking, and sanitation. This fosters a high prevalence of respiratory infections, gastrointestinal diseases, malnutrition, anemia, and musculoskeletal issues. Residents face bureaucratic hurdles, such as a lack of identity cards, that limit their access to healthcare services.

The residents of Katchi Abadies have a critical awareness of the urban inequality they are forced to experience. They use humor, irony, and storytelling as strategies to navigate systemic marginalization and vulnerability. This reflects their consciousness of expulsion from the city's utopian narrative; hence, structural violence is not only experienced in physicality but also in rationality, embedded in the intersection of social hierarchies, urban planning, and daily life.

Discussion

The World Health Organization, in 1948, defined health as complete physical, mental, and social well-being, not merely the absence of infirmity. Michael Winkelman, in his book “Culture and Health”, defined health as not merely the absence of disease or distress, but a positive state of physical, emotional, mental, personal, and spiritual well-being and a balance with nature and the social world.[13,14] This helps in establishing the notion that health constitutes a relative explanation within the socio-spatial topographies of Islamabad.

In the contemporary era of growing urbanization, we see an outgrowth of inequalities resulting in structural violence applied differently to individuals, ethnicities, and communities.[13] Furthermore, health problems and social determinants of health are often ignored while strategizing aspirations about development and progress. These are common perceptions among people in Islamabad that the city's planning lacked a coherent layout to address issues that now seem permanent. For example, one can easily dissect how a healthy lifeworld remains missing from the emerging techno-spatial city planning.[15] Most of our participants in the study reminded us that the very idea of health and disease makes sense differently to people depending on their localities in the city.

As a case in point, among the Katchi Abadies of G8/1 and G8/2, people living with pulmonary fibrosis and hepatitis are convinced of the selective amnesia of the state when it comes to their rights of access to safe and clean drinking water. Regardless of age, yellow eyes and dark, dry lips seem normal to them because of congested living conditions in houses made of iron and wood, without proper windows or access to gas for cooking. We observed that people tend to make jokes when asked about their belief in state services, and they quip about their needs concerning everyday work, managing both ends meet. The Katchi Abadies, known by residents commonly as colonies, remain congested and over-crowded, where one of the respondents remarked that their colony can be taken as one big house and everyone is a family member with the same set of socio-economic and lego-political problems.[16]

The first author was a witness to a medical camp in the G8/1 colony on 4th December 2022, where almost 400 people attended for various health problems. The camp did not look like a typical health facility, and it was instead a loosely arranged setting where seeing a doctor was more of an exciting sort of activity. Residents from the colonies seemed excited to avail free checkups—critically needed in some instances, which are otherwise unaffordable for most of the residents of these Katchi Abadies. Even the doctor was clear when he stated, during an interview with the first author, that these people are left out of the state's responsibilities.

We have also found that understanding of the health of Katchi Abadies remains markedly different from that of the city's middle and elite classes. Therefore, the theoretical premise about the urban poor might not accurately reflect the people of Katchi Abadies.[15,17] The most striking health differential is not between urban and rural areas, but rather between socio-economic groups within the city itself.[18] These distinctions are reflected in starkly different forms of habitation and access. For example, residents of the elite and upper-middle classes benefit from private healthcare and planned healthcare infrastructure. At the same time, the lower-middle class rely primarily on public facilities with varying quality, and slum dwellers in Katchi Abadies face precarious living conditions, limited sanitation, and highly constrained access to medical services.[19]

Similarly, differences in health conditions can be seen in the shared environmental risks, such as flood zones, and in risks associated with poor sanitation, which were experienced by marginalized slum dwellers, who are also deeply integrated to maximize their collective benefit from already reduced interventions.[20,21]

During one of our conversations with a senior official from the Capital Development Authority (CDA), it was claimed that during the government of 2018-2022, health cards were provided to everyone; thus, there are no health problems in Islamabad anymore. The officer also stressed by giving an example of his friend's driver who used a health card for his mother's major cardiovascular surgery. This is a general belief among state officials that the people of Katchi Abadies do not have health issues, as they now have health cards and can avail of health services from almost all well-reputed private and official hospitals. However, there are stark reminders of the serious internal contradictions in this statement and other such narratives. For example, many people in the Abadies live without National Identity Cards (NICs), leaving them without access to state services. Secondly, the procedure to issue a health card requires proper documentation, like home address, electricity bills, etc., which are also missing in the slum areas.[22] Hence, slums and non-slum urban areas are integrated into the mainstream when a policy is designed without specifying different needs. Farmer P pertinently reminds us to ask, “What is the public? Is it a family, a village, a city, or a country? Who are these people to say what the public is?.[17]

Katchi Abadies are mainly places for laborers, the unemployed, and home maids/servants. The search for such unrecognized and formally invisible work to meet both ends has been the major reason for migration to cities like Islamabad and resultant settling in such colonies.[4] However, the CDA claims that people migrated and settled in the capital because they knew courts or politicians would formalize their settlement. Whereas a female urban researcher, reminded during one interview that how “formality comes with its own cost.” She further added that the provision of selected human rights, i.e., the right to residence, was very much like the lip service paid to the fair distribution of wealth. Therefore, the whole framework deciding about legality/illegality and formality is chosen by the authorities, and according to one academician, such marginalized people with no recourse to equal rights have little to no incentive to build healthy houses, as they could face eviction at any time.[5,15]

In the face of apathy from the state, we have found that residents of Katchi Abadies suffer disproportionately from diseases like respiratory tract infection, digestive tract infection, epigastric problems, generalized body aches, malnutrition, iron deficiency, anemia, rheumatoid arthritis, diabetes, and random sugar issues. People believe that their respiratory and epigastric infections are usually associated with contamination of the environment.[23] Water supply, if any, is prone to contamination at multiple points since Katchi Abadies are located in such catchment areas of diseases. Water is usually stored in large containers used for drinking, toilet use, and communal purposes such as cooking. Houses are mostly in dilapidated condition, and the use of wood, besides polluting the air with noxious fumes, always poses a threat of fire due to the structure of the houses.

Although diseases such as respiratory and gastrointestinal infections could also be found in middle- or lower-middle-class groups living near industrial areas, the experience of illness in Katchi

Abadies remains distinct in marked ways.[24] In industrial neighborhoods, health risks often stem from pollutants released by factories, whereas in these colonies they are tied to structural exclusion, insecure tenancy contracts, overcrowded single-room houses, and overall resistance to state recognition. Many residents lack access to reliable water, sanitation, and waste disposal systems, forcing them into daily practices of improvisation such as storing contaminated water and cooking in congested spaces. Moreover, their status as informal settlements means that they are often excluded from public healthcare schemes and are at constant risk of displacement. This combination of legal precarity, environmental contamination, and infrastructural neglect makes the experience of disease in Katchi Abadies qualitatively different from that of other colonies.[25]

There is a striking difference between the realities of living conditions and the representations they evoke among people, as Dr Haider laments (while working with one medical camp) that people in the Katchi Abadies, according to him, don't follow hygiene protocols. On the other hand, an activist is of the view that these people from the Katchi Abadies who are chained to the peripheries near garbage dumps and nallahs, with no running tap water or electricity, are structurally denied such otherwise taken for granted basic hygiene protocols.

The right to health has to be accessible, achievable, equitable, and affordable, but this right still remains far from being universally attainable. Affordability is a key factor for residents of the Abadies, as they often face difficult choices between paying for basic necessities, such as groceries, and paying for health care, which often leads to malnourishment among all members. Moreover, such decisions leave families permanently vulnerable to crippling financial losses, reducing opportunities for housing, education, and health. One of the residents from G8/2 Abadi reminded us how they felt helpless to keep their houses clean when diseases like dengue and diarrhea became common.

Non-communicable diseases are also like an iceberg in the Katchi Abadies, where diabetes and arthritis are significant concerns, but their presence takes on a distinctive meaning in this context. Unlike middle- or lower-middle-income families who may at least have partial awareness of chronic disease management, residents of Katchi Abadies often perceive such conditions as secondary to survival. It is concerning that people disagreed that both of conditions needed serious consideration. Even with aching bodies and old age, they don't have respite from continuous work, and this leaves the people often resorting to self-medication or passive silence in the face of chronic exclusion from the formal system. During one of the medical camps, the doctor joined his hands and requested an old lady with her sugar level reaching 400 to 'have mercy on herself. According to the doctor, the lady was insulin dependent, but she had no idea of insulin and its effectiveness when required to be used regularly. Similarly, in another such case, a father who came with her nine-year-old daughter who underwent septic shock was unable to take an antibiotic. It was common knowledge that the people themselves could deal with a complex disease like the one in the girl. We argue that such an easy or indifferent approach results from charting a course through the complex conditions required to navigate structural disadvantages.[26]

Whenever given the opportunity, people are enchanted by free medication. Unfortunately, being judged by the doctors, one of them confided to the first author that they were not ill, they just wanted free medicine. On the other hand, we also agree with one of our academic respondents, for whom their attachment to medicine could be their firm belief that only medicine can help them. Structural violence is defined differently across communities, as is health and well-being. Amartya Sen et al. helped us understand that the victims of structural violence have freedom on paper, and we have seen it in reality, where people are chained to Katchi Abadies, poverty, and exclusion are institutionalized.[13] Thus, health and well-being remain neglected in the Katchi Abadies because the experiential subjectivities of the residents remain marginalized and peripheral to the utopian aspirations of Islamabad as a beautiful modern capital.

Conclusion

We have argued that the utopian vision of Islamabad as a city is currently turning into a dystopian reality

for many among the urban poor. These marginalized communities, often referred to as Katchi Abadi Walay, represent the other side of Islamabad. While poverty and lack of access to opportunities contribute to their struggles, social challenges such as dependency, substance abuse, and reluctance to engage in regular employment further complicate their circumstances. Addressing these issues requires not only governmental interventions but also a sense of individual responsibility and community engagement.

Acknowledgement: None

Conflict of Interest: The authors declare no conflict of interest

Grant Support and Financial Disclosure: None

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Author Contributions

MB: Conception and design of the work, manuscript writing for methodology design and investigation, data acquisition, curation, and statistical analysis, writing the original draft, proofreading, and approval for final submission

AQ: Validation of data, interpretation, and write-up of results, Revising, editing, and supervising for intellectual content