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Exploring Women's Access to Healthcare in Karachi's Scattered Settlements

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Abstract

Like the developing countries, the health sector in Pakistan has always been in a state of disarray, especially the health of women. Although women's health is currently the focus of attention around the world, SDGs have been followed by the MDGs to highlighted women's health, among other issues, as a major issue internationally. Pakistan is not only involved in these endeavors but is also working hard to achieve *the desired goals. The biggest hurdle in achieving health is lack of easy access to health facilities. These problems are not limited to rural areas but also in the adjoining areas of developed cities like Karachi. In order to assess the provision of women's health facilities in these areas, research materials were collected through interviews with 200 women under the snowball and purposive sampling method in selected areas. An analysis of the material obtained revealed that the provision of health facilities is not satisfactory. The number of government hospitals is almost non-existent. However, the private sector and welfare organizations are trying to provide health facilities to the people. Ensure accessible, affordable and quality health services for women living in scattered areas, as well as provide incentives to professionals working in these areas.*

Keywords: Healthcare services, lady health worker, Midwife, scattered settlements, Sexually Transmitted diseases.

Introduction

Good health enables to a person to achieve better work results and enjoy a healthier life only a mentally and physically healthy person can lead a healthy society (White, et al, 2024). Health plays an important role in prosperity and wealth and even in economic development because the healthy population of a society is more productive, saves more and lives longer. Of course, health is of equal importance to every member of society, but the importance of women's health also increases, because women represent the basis of the overall health of a family (Kuhlthau et al 2022), making sure that their access to quality care can also lead to

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better health for children and families, meaning family health is linked to women's health (Ali & Kamraju, 2023). Women and girls have specific health needs that are to some extent different from men's and are not only ignored in the health system around the world but are still not giving much attention. The WHO highlighted a decade ago that women's health has become an immediate priority today, yet data on the issue is limited and often unreliable. (WHO, 2009)The situation is more or less the same today, the lack of data or inaccuracies are also a big obstacle in the way of solving the health problem. MDGs and SDGs also addressed the women's health and provide a complete frame work for improving the status of women's health (WHO & UN Women, 2018). There are innumerable reasons for poor health of women such as transportation problem, lack of government hospitals, unavailability of lady doctors and other female staff in hospitals, lack of facilities in hospitals etc. and most importantly is that women have easy access to all these facilities (Arifeen, 2018). Access to these facilities will not only improve women's health and safety, increase economic independence and personal empowerment, but also change family life and status of women as well. What is important about the provision of health care is the extent to which it is accessible to the public, especially women, how easy it is to access and how beneficial it is.

Regarding women's health, the biggest issue is of access to health facilities. Lack of hospital, inadequate number of lady doctors and backward socio-cultural norms and taboos are the main hurdles for female health. In terms of access to health facilitates, the lady health worker program is one of the most beneficial, successful and accessible in the rural and sub-rural areas but is not enough for women (Chwadmin,2018) . Sociocultural, policy changes (Olubodun, et al, 2024), gender pay gap (Bhat, 2022), low salaries, delay in payments, contractual jobs, political influence and lack of funds are the major factors that have made it weak and inefficient in the scattered settlements (GOP, 2022). However, it does not matter that these areas are part of a developed city like Karachi.

Much of the evidence confirms that many people in the developing world, especially women, die early due to minor illnesses due to lack of proper health care (Matin, et al, 2021), although in recent times such there are facilities that they can take full advantage of and enjoy life by improving their health (Margaret et al., 2018). The poor in developing countries are less likely to receive effective health care because most people here do not have access to modern healthcare. Concerns about the level of health and the distribution of services in the developing world require that steps be taken to address both. These measures include effective healthcare policies and improved access to these facilities for the poor, especially women (Tearne, et al, 2021).

The International Conference on Population and Development (ICPD) set the reproductive health agenda for the world, followed by the Millennium

Development Goals (MDGs) and then the Sustainable Development Goals (SDGs) on health, especially women's health as a priority. The question now is whether poor countries will be able to improve health outcomes between women and children through comprehensive, good quality services that meet the needs of the poor.

Significance of the Study

South Asia has not yet achieved the momentum for health and reproductive health interventions (Abbas et al, 2021), quality improvement and financial management to ensure that women in the region - especially the poorest - are on these global agendas able to achieve the desired good results (chaudhry, 2017, Mohd Rosnu, etal, 2022).

The aim of this research paper is to analyze the availability of healthcare services and women's access to these services in the scattered areas of Karachi as well as highlight the issues that have exacerbated women's health issues.

Objectives of the research

1. To find out the Availability of health facilities
2. To find out the access of women to health facilities
3. To explore the effects of non-provision of medical facilities on women's health
4. To find out the gaps within health facilities

Methodology

The present study is based on the findings of a survey conducted in three squatter-settlements in Karachi, where population belong more or less same socio-economic back ground. These three selected areas (Malir, Bin Qasim and Gaddap) represent a good combination of mix population urban and rural. These multi linguistic habitants are belong different ethnic and cast. A quantitative approach was used to women's perceptions and their understanding of their access to health care. This approach seeks to study respondents' experiences and to help identify potentially modifiable factors for improving the healthcare system. The 200 women participants have been randomly selected for collecting primary data.

The age of participants ranges from 15-50 years and above. The following table shows the details.

Table 01: Distribution of respondents according to their age group

Age of respondents	Frequency	Percentage
15 to 20	14	7%
21 to 25	26	13%
26 to 30	27	13.5%
31 to 35	38	19%
36 to 40	32	16%
41 to 45	17	8.5%
46 to 50	27	13.5%
Above 50	19	9.5%
Total	**200**	**100%**

The most of the women participants are illiterate. The maximum level of education is middle (8 grade). The table shows that there is no woman who matriculate, intermediate or graduate.

Table 02: Distribution of respondents according to their academic qualification

Academic qualification	Frequency	Percentage
Illiterate	194	97%
Primary	5	2.5%
Middle	1	0.5%
Metric	0	0.0
Intermediate	0	0.0
Graduate	0	0.0
Total	200	100%

According to the below table, most of the participants are married women and then unmarried. The divorced and widows also participated in the research.

Table 03 Distribution of respondents according to their marital status

Marital Status	Frequency	Percentage
Unmarried	42	21%
Married	128	64%
Divorced	20	10%
Widowed	10	5%
Total	200	100%

The below table reveals that most of the participants belong to extended family structure. However, the representation of nuclear family structure has significant presence.

Table 04 Distribution of respondents according to family structure

Family structure	Frequency	Percentage
Extended family	130	65%
Nuclear family	70	35%
Total	200	100%

The present study consisted face to face interview with semi-structured questionnaire in selected areas of Karachi. Participants ranged in age from 15 to 60, had lived in the area for about 20 years and needed or used health services available in their specific area. Most of respondents 158 (79%) were married and mostly illiterate while some have primary education. Before they took part in the study, they signed (thumbed) the informed consent form and the participants voluntarily participated in the study. Based on the participants' preferences, the interviews took place in convenient locations for each participant, mostly in women's homes and in some workplaces. The research instrument includes the demographic information such as name, education, marital status, number of children, employment status and family system then asked questions about their perceptions and experiences about health services. After collecting data from participants, it was analyzed by simple

frequency and results were compiled and in the light of these results recommendations formulated.

Review of literature

The definition of access to healthcare in the narrowest sense, geographical availability and broader definition identifies four areas of access: availability, accessibility, affordability, and acceptability (Anawade, et al, 2024). In fact, the four are intertwined, and if any one of them is less, the real benefit cannot be gained. That is to say, to take advantage of a facility, it is not enough just to have it, but also to have physical presence, it should be easy to reach, that facility can be obtained and also beneficial (Sauman, 2016).

Almost 400 million people in all over the world do not have access to health care services, while about 8 million people die whose health problems are treatable. In the developing countries a major issue is access to effective health care facilities. Millions of people die from diseases or conditions for which effective healthcare facilities are available but people do not know about them, or even if they know but they do not have access to them (Lafarga Previdi et al, 2022). Where healthcare facilities are available and people have access to them but their effectiveness is far less than the potential utility because often the quality is severely reduced. If the same standard of care is available everywhere, the number of deaths can be prevented or significantly reduced. (Harvard, 2018) Implementing tailored and context-specifc program approaches and interventions can address issues and challenges at the individual level (Khatri & Assefa, 2022).

Mumtaz, (2012) & Kumar, (2019) found out in their study that many maternal deaths could be controlled if health services were accessible (Souza, et al, 2024). Health facilities and working hours were inconsistent with the provision of around-the-clock essential services, depriving and endangering the lives of many in need. Many vacant positions are waiting appointments from health ministries. They suggested the geographic obstacle to timely access, poor infrastructure and lake of medical machinery in hospitals, larger paramedical staff absenteeism require instant attention and positive action (Dotse-Gborgbortsi, et al, 2022).

Many basic and important health facilities cannot be provided due to lack of resources (Getahun, et al, 2023). That is why there is a big difference between the real health expenditure of poor countries and the cost of providing essential health care packages. Lack of resources is at the root of many problems. But at the same time, it is important to note that many effective interventions are not usually expensive even for the poorest countries. For example, maternal health problems during maternity and child mortality can be reduced by half through home services (Omer, et al, 2021) . Where healthcare is available, quality is often severely compromised, leaving its effectiveness far below potential. Like many developing

countries, public primary health care in Pakistan is also associated with poor quality of care (Ilyas. 2023) As long as the lack of quality persists, the effective services provided will not work and the situation will remain the same. Resources are widely distributed unequally, in fact that the neediest people use the least amount of health care (Avan, et al, 2023). Although the number of poor in the world is high and they are less healthy and their access to health care is also less. With regard to the healthcare programs that are created, the evidence shows that there is a rich bias in the distribution of benefits of these programs.

Access of various basic necessities of life is the essential right of every human being. It is the responsibility of the government, the private sector as well as the welfare and non-governmental organizations who work for basic human rights specific in the health sector (WHO, 2022). Health department and health ministry is also responsible to arrange the basic health facilities. Lady health worker (LHV) had been appointed in the past in these areas, but due to a lack of proper utilization of human resource (Hashim, et al, 2021), lack of funds and lack of a proper monitoring system, they are no longer active. Most of the respondents 83.3%stated that LHV visited monthly for consultations but they lacked adequate facilities and they could just give advice or suggest going to hospital and consult with a doctor. But the role of the LHV is very important in these areas even though they mainly provide guidance to women (Singletary & Waqar, 2024). According to the recent census, the total population of Pakistan is 208 million of which 49% are women. Fortunately, a large portion of the country's population is young, with an estimated 29% of the total population in the 15-29 age groups, half of whom are women. (Censes, 2017)

Many factors are responsible for hindering the achievement of the desired results in terms of population health, due to which opportunities to reap huge benefits are wasted. As cultural and educational factors can reduce potential benefits from disease identification and health care while economic barriers can prevent use, even if the benefits are recognized, economic instability creates difficulties both individually and collectively (Osypuk et al.,2015).

Religious factor, social norms, backward traditions are considered the main obstacle in the application of family planning methods (Irshai, 2024). Based on the results of the present study; lack of proper and quality health facilities such as hospitals, lady doctors, new technology, proper machinery and access to all these facilities are most important factors and it is required urgent basis implementation. Even though, the public-sector is unrestricted and non-discriminatory providing these health facilities. Because of high rate of population, requirements of medical care centers are continually increasing day by day and it also increasing burden on them. In contrast, the private hospitals provide better services and facilities but these have a restrict access on account of affordability.

In addition to the charges levied by healthcare providers, there are significant travel expenses (Habib, et al, 2021) and healthcare utilization costs (Taylor, et al, 2021))such as X-rays, ultrasound and medical expenses (Jang, et al, 2021) that poor or low-income people cannot afford. In addition, in rural areas or in urban slums, distance from health care facilities and poor road conditions mean time, effort and cost.

Table 05 : Situation of Pakistan in Regional Human Development Index (HDI)

Country	Life expectancy at birth			Infant mortality Rate (per 1,000 live births			Maternal Mortality Rate (per 100,00)			Under 5 Mortality Rate (per 1,00)			Population Growth (annual %)		
Country Name	016	017	018	016	017	018	016	017	018	016	017	018	016	017	018
Pakistan	6.8	6.9	7.1	0.5	8.8	7.2	54.0	43.0	40.0	3.8	1.5	9.3	.1	.1	.1
India	8.9	9.2	9.4	3.2	1.5	9.9	58.0	50.0	45.0	1.1	8.7	6.6	.1	.1	.0
Bangladesh	1.8	2.1	2.3	8.0	6.5	5.1	00.0	86.0	73.0	3.9	1.9	0.2	.1	.1	.1

From the above statistics it is clear that the situation in Pakistan is constantly improving in terms of life expectancy at birth. According to the facts, it was 66.8% in 2016 which increased to about 67.1% in 2018, although it is still the lowest among the regional countries. The infant mortality rate per 1000 lives is 57.2% which is better than previous years within the country, however the maternal mortality rate (MMR) is 140 out of 100,000 lives in Pakistan, compared to India (145) and Bangladesh (173). Although the under-five mortality rate is 69.3 per 1,000 lives, which is much better than in previous years, there has been no improvement in Pakistan in terms of annual population growth.

Table 06: Registered medical and paramedical staff

Health Manpower	2012	2013	2014	2015	2016	2017	2018	2019
Doctors	160,880	167,759	175,223	184,711	195,896	208,007	220,829	233,261
Dentists	12,692	13,716	15,106	16,652	18,333	20,463	22,959	24,930
Nurses	82,119	86,183	90,276	94,766	99,228	103,777	108,474	112,123
Midwives	31.503	32,677	33,687	34,668	36,326	38,060	40,272	41,810
Lady Health Visitors	13,678	14,388	15,325	16,448	17,384	18,400	19,910	20565

The Government of Pakistan is particularly reforming in these areas: population control, health insurance, and the expansion of family-based healthcare. The number of medical and paramedical personnel has been gradually increased over the last six years to provide better health care to the people as shown in the table above. In addition to hospitals, increasing the number of female medical and paramedical personnel is essential to provide health services to the public. Pakistan signed the International Health Partnership (IHP +) in 2010 and the country published the National Health Vision 2016/2025 to achieve health indicators. Currently a total of registered doctors (233,261), dentists (24,930), nurses (112,123), midwives (41,810) and lady health workers (20,565) are working to achieve Universal Health Coverage (UHC) by 2030.

Findings and discussion

The respondents of the study are from 15 years to above 50 years old. The details of respondents age variance is give as under. It has been noted that the maximum participation of respondents were by 31-35 years old and minimum participation was by 15-20 years old. The details are as under.

Table 07: Distribution of respondents according to their age group

Age of respondents	Frequency	Percentage
15 to 20	14	7%
21 to 25	26	13%
26 to 30	27	13.5%
31 to 35	38	19%
36 to 40	32	16%
41 to 45	17	8.5%
46 to 50	27	13.5%
Above 50	19	9.5%
Total	200	100%

Illiterate women highly participated in the study and there were no participation by matric to graduate respondents. Education is not primary focused in the study area.

Table 08 Distribution of respondents according to their academic qualification

Academic qualification	Frequency	Percentage
Illiterate	194	97%
Primary	5	2.5%
Middle	1	0.5%
Metric	0	0.0
Intermediate	0	0.0
Graduate	0	0.0
Total	200	100%

Married women's participation is very high. The study also includes single, widows and divorcees.

Table 09 Distribution of respondents according to their marital status

Marital Status	Frequency	Percentage
Unmarried	42	21%
Married	128	64%
Divorced	20	10%
Widowed	10	5%
Total	200	100%

The below table shows that maximum participation is by women of joint family.

Table 10 Distribution of respondents according to family structure

Family structure	Frequency	Percentage
Joint	130	65%
Single	70	35%
Total	200	100%

Access to health care in developing countries has always been difficult (Clarke, et al, 2023). Infectious diseases can adversely affect women's health and their reproductive functions (Gay, et al, 2021). Infectious diseases during pregnancy are of special importance which affects not only the woman (Jorgensen, et al, 2022) but also the unborn child (Khan, et al, 2025). There is a special focus on women's health around the world. Maternal mortality rate is very high in South Asian countries (Goh, et al, 2024) including Pakistan (Shaeen, et al, 2022). Maternal mortality rate in Pakistan is 186 deaths per 100,000 live births and it is about 26% higher in rural areas than in urban areas (NIPS, 2020).Unfortunately about 94% of maternal deaths occur in developing countries (WHO, 2019).

Like other developing countries, Pakistan has taken some steps in the health sector, to improve the health sector and address gender imbalances, such as

providing basic health care and basic health services in rural areas as well sca Hellottered settlements. Another major initiative was the establishment of the Lady Health Workers (LHWs) program (Kiran, et al, 2023, Tharwan, et al, 2024). Under the program, 26,584 LHWs in rural areas and 11,967 LHWs in urban areas have been recruited to provide basic health care to women at lower levels, including family planning. Other initiatives to further improve the health sector include village-based family planning workers and expanded immunization programs, nutrition and child survival, cancer treatment, and media involvement in health education. Although many steps have been taken to improve the health sector, the problems are increasing day by day. If look at the situation in the backward areas connected only to the city, do not see encouraging results. There is a clear gap between the needs of the population and the health facilities.

Table 11 Distribution of respondents according to the availability of a maternity hospital in their area

Maternity hospital in their area	**Frequency**	**Percentage**
Yes	38	19%
No	162	81%
Total	200	100%
If yes than who provide		
Government	0	0%
NGO	22	57.9%
Community	16	42.1%
Total	38	100%
If not than who assist in home delivery		
Midwife	118	72.8%
Elderly women	36	22.2%
Neighbors	8	4.9%
Total	162	100%

Healthcare is administered throughout Pakistan by both private and public healthcare providers, and is practiced in Karachi as well as across the country.

Health care is a basic right (Anjum, et al, 2021) and it is the responsibility of the state to provide it, but the government does not allocate sufficient funds in its budget to provide for the health services, more often the private sector involved in health services but it is too expensive. Although some non-governmental and community based organization provide health facilities in the different part of rural, sub-rural areas and scattered settlements as well. Despite the involvement of the private sector, due to rapid population growth, health facilities are inadequate for the people. Primary statistics show that only 19% of respondents have a maternity hospital in their area, while 81% do not. Of these, 57.9 % respondents said that NGOs provided these maternity homes, 42.1 % said that some community based organizations provide maternity hospitals in their areas while no hospital has been set up by the government in his area.

According to 72.8% respondents, due to no availability of hospitals, midwifes assisted in the home delivery of babies, while 22.2% said elderly and experienced women helped in the home deliveries. Respondents stated that they often they try to go to a hospital but most normal deliveries are done at home. It has also observed that despite the availability of private maternity home in most of the poor areas, people cannot avail due to poverty and only go to the hospital in case of complications (Malik, et al, 2022). Because the situation has deteriorated and then out of their control, they have to compel to go to the hospital, and if the midwife is guiding the delivery, she also suggests going to the hospital immediately.

Table 12 Distribution of respondents according to whether they get monthly check-up during pregnancy

Check up during pregnancy	Frequency	Percentage
Yes	95	60.2%
No	63	39.8%
Total	158	100%
If yes than by whom		
Midwife /Daai	42	44.2 %
Lady health worker/ visitor	31	32.6%
In hospital	22	23.2%
Total	95	100%

It was already mentioned that158 respondents were married out of 200 including those divorced while 42 were unmarried. Data in the above table shows that only 60.2% respondents had check-up during pregnancy, while 39.8% did not have any. According to 44.2% respondents, they had a check-up from a local Daai (A trained person (typically a woman) to assist women in childbirth), 32.6% had a check-up by lady health workers/ visitor while 23.2% said they went to a hospital for a check-up.

It is important to provide skilled care and protection to mothers during pregnancy (Udenigwe et al, 2021), childbirth, and postpartum to avoid complications. A study by the World Bank (2000) indicated that pregnancy-related conditions account for 13% of the total disease burden, while infectious and additional diseases account for 38%. in Pakistan, due to male dominancy in sexual relationship and lack of information women are at high risk for sexually transmitted diseases such as HIV/ AIDS etc. the repot further highlighted that the incidence of STDs (Hepatitis B) affecting women is increasing in Pakistan. Ahmed (2016), Murad et al (2013) also found same evidence in their studies.

A major impediment to women's access to health is the lack of female professionals in rural and scattered areas (Okyere, et al, 2021). Strengthening the delivery of public services and training and deployment of professional midwives or lady health workers as primary birth attendants are important steps (Anderson, et al, 2022).

Table 13 Distribution of respondents according to the availability of lady health worker in their area

Availability of lady health worker	Frequency	Percentage
Yes	167	83.5%
No	33	16.5%
Total	200	100%
If yes than how frequent her visit		
Weekly	0	0%
Monthly	136	81.4%
Sometimes	31	18.6%
Total how to	167	100%

Pakistan's rural or under developed areas have access to two types of healthcare providers, the first is a community health provider called Lady Health Worker (LHW).

Data shows that 83.5% respondents said that there are lady health worker are available in their area while 16.5% had no lady health worker in their area. According to 81.4% respondents, lady health worker visited their homes on monthly bases while 18.6% said they visited only sometimes. Lady health workers are playing an important role in these areas, due to restricted mobility of the women and unavailability of proper public transportation. Lady health workers visit their allocated area and provide health services at the people's doorsteps. Although it is not an alternative to a professional doctor, the lady health workers do provide primary health services in their absence.

LHWs are field workers who visit homes, especially targeting families with young children or women, and provide a wide range of maternal and child health services including prenatal and postnatal care. These include care, well-being of the child, monitoring of the child's development, and a series of immunizations in childhood, family planning, and basic health education etc.

The Basic Health Unit (BHU) is second type of healthcare provider that typically provides basic healthcare to multiple villages within a particular area. LHWs are responsible for referring all pregnant women to BHU, which provides additional prenatal and postnatal care services and treats all types of minor illnesses.

Table 14 Distribution of respondents according to information about family planning

Information about family planning	**Frequency**	**Percentage**
No	42	26.6 %
Yes	116	73.4 %
Total	158	100%
Use contraception		
Yes	19	16.4%
No	97	83.6%
Total	116	100%
Reason for not using		

Lack of facility	12	12.3 %
Lack of information	44	45.3 %
Forbidden by husband	41	42.2%
Total	97	100%

A large number of respondents know about family planning but are unable to follow it because they either do not know how to use it or do not have access to these facilities. According to 26.6% respondents, they did not know about family planning while 73.4% were familiar with family planning. Most of respondents were not aware about the necessity, importance and methods of family planning but they knew about WAQFA (gap between pregnancies).

16.4% respondents used contraceptives while 45.3% out of 83.6% respondents said they did not use any contraceptives, due to lake of information, 42.2% said their husbands forbade them to practice family planning, as they said it is a *gunnah (*sin) and according to 12.3% respondents there is lack of availability of contraceptives. However respondents sometimes used herbal medicines or domestic method for abortions. Some respondents said they do not need to use any contraceptives as they believe that their purpose in life is to procreate and they should not make any plans to stop it. Most people were not aware of the need of family planning, while some people believed it was against their religion.

No doubt, taking initiatives of family planning helps us to achieve the Sustainable Development Goals (SDGs) by focusing on birth space and reducing mortality and morbidity linked with pregnancy (Nadeem, et al, 2021). In the decades since Pakistan's independence, family planning programs have seen many different phases and the results are clearly mixed. But family planning was included in the central policy to deal with population growth during the 1960's. From the beginning, the government faced strong opposition from religious leaders to family planning (Sarfraz, et al, 2023). Even today, some religious leaders view family planning as a forbidden practice. Many religious leaders in Pakistan have strong influence in politics as well as in local communities (Naz & Acharya, 2021)). For many years, their opposition to family planning has been an obstacle. (Marshal, 2015) Many people in Pakistan still do not pay attention to family planning just because of interpretation of religion.

Conclusions

The statistics evident that reproductive health services uptake rate is very low in Pakistan. The majority of people in Pakistan do not have access to basic health care due to inadequate health facilities, whether in urban or rural areas. Although the situation is somewhat better in urban areas, the outskirts of the city are even worse off than in rural areas.

There has been a lot of effort in the past to promote and improve reproductive health in Pakistan, and still continue. But in spite of all these, access to health services has not improved much, even in those places that are developed or associated with cities where services are more accessible than lower areas. Infant and maternal mortality rates in Pakistan are still very high compared to other developing countries in South Asia. Lack of skilled health professionals, especially female skilled health professionals and lack of hospitals also contributes to the increase in women's health problems in Pakistan.

In Pakistan, the Ministry of Health has proposed strategies to improve women's health and especially reproductive health, such as providing reproductive health services to pregnant women, increasing the number of nurses, and creating women friendly hospital, providing nutritional supplements to pregnant women particularly in rural and sub-urban areas. Policies have also been formulated to improve human resource strategies, including increasing the number and training of lady health workers (LHWs), improving the working conditions of doctors, nurses, paramedics and other health workers. But despite such efforts at the policy level, there has been a significant slowdown in practice, and especially in poor areas. However, welfare organizations in the poorer areas are stepping down, such as in the Bn Qasim Town, where Zafar and Atia Foundation Charitable Trust has set up a hospital specifically for women's reproductive health. In South Asia, this is the only treatment centre of fistula on charity bases, as well as other organizations also set up numerous health units.

Recommendations

1. Increase the quality and quantity of basic health care services for women and children health care in scattered or slum areas.

2. In addition, incentives should be provided to these professionals working in scattered areas, as the results show that access to health services is very low in these areas.

3. Introduce different / additional methods of family planning and their advantages and disadvantages and ensure easy access to these facilities.

4. Educate women and the community about the nutritional needs and importance of maternal and newborn care.

5. Ensure accessible, affordable and quality health services for women living in scattered areas of Pakistan.

6. Interventions are required to specifically focusing on men and religious leaders to educate about family planning.

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