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An Analysis of the Access and Utilization of Reproductive Health Care Services among Women in District Kohat

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Abstract

This study examines the obstacles hindering women in rural Kohat, particularly in Jungle Khel, from obtaining reproductive healthcare. It highlights gaps in knowledge and a strong dependence on informal sources for reproductive health information. Cultural, societal, and logistical barriers contribute to high maternal mortality rates, limited family planning methods, and gender inequalities in healthcare access. Women's choices are restricted by cultural standards, including patriarchal influences and a societal bias towards male offspring, which impede discussions about contraception. The study's main objectives are to identify barriers to accessing reproductive healthcare, understand cultural influences on women's health decisions, and evaluate the effectiveness of existing healthcare facilities and educational resources. Women face considerable difficulties accessing reproductive healthcare due to geographical distance, transportation issues, and financial constraints. Despite NGO efforts to provide contraceptive information and services, there remains a gap between stated goals and actual awareness and utilization among women. Negative side effects from contraceptive use, such as severe hemorrhaging and low red blood cell counts, also cause hesitation in adopting methods like the intrauterine device (IUD). The study employs a mixed-method approach, integrating quantitative surveys and questionnaires with qualitative in-depth interviews, focus group discussions, and participant observations. It targets married women aged 18 to 40 and local Reproductive Health Care (RHC) providers to gather comprehensive data on reproductive healthcare in Jungle Khel. Findings reveal a significant lack of awareness about available healthcare services, with many women relying on informal sources for information. Cultural norms, including the preference for male children, heavily influence reproductive choices, limiting contraceptive use. Logistical challenges such as geographical distance, transportation issues, and financial constraints further hinder access to healthcare services. The study recommends improving healthcare infrastructure, initiating community-based programs, and enhancing educational efforts to address these barriers, emphasizing women's empowerment and collaboration between the government and NGOs.

Keywords: Reproductive health , Health care access , Health service utilization , Women’s health , Maternal health service , Rural health care.

1.0 Introduction

A fundamental human right, access to sexual and reproductive health is impeded for many women and girls, especially those living in poverty, by stigma, discrimination, and restrictive regulations.

(Maqbool, Mudasir, 2022). Ensuring these rights, which have an impact not just on individuals but also on families, communities, and economies, has not happened quickly. In the past, women faced difficulties such as risky delivery and shortened lifespans. (Ghani, Imran, 2022). Reproductive health is crucial to general health and should be prioritized from youth to old life. Menopause is not the end of a person's reproductive life; it is a lifetime concern, and many life phases have an impact on one's future health. (Ara Irfat, 2022). In Pakistan, women's access to health care and family planning services is limited by a variety of social barriers These barriers are rooted in women's social status, notions of honor, and practices that separate the sexes. Unmarried girls face the harshest restrictions on movement, even within their own villages. Both men and women have positive attitudes toward health care and family planning services, but there are fewer restrictions on women's access in the villages. However, unmarried girls face difficulties even within the village. Women rarely venture out alone, making it difficult to obtain services outside their villages. Mobility to pursue education or employment is further limited by concerns about reputation. These results have important implications for health and family planning programs in Pakistan. To address these barriers, services should prioritize single girls and consider providing home-based services. The key is not to remove existing social barriers, but to empower women to overcome them by providing greater access to life-saving health services. (Khan,1999) Maternal death continues to be a persistent problem, particularly in poor nations, where there has been little reduction in maternal mortality rates over the past two decades, despite improvements in other health indicators. (Bhutta, ZA, 2013) The majority of maternal deaths still happen in low-resource settings, specifically at home. This occurs due to a combination of factors including poverty, inexperienced home births, inadequate care seeking, and weak health infrastructures. Pakistan accounted for half of all maternal deaths worldwide in 1993, making it one of the six countries with the highest number of maternal deaths. Pakistan's predicted maternal mortality ratio was 533. By means of a sequence of targeted initiatives, the latest figures show that the load has dropped to 260.The Pakistani government has been implementing measures to improve the health of expectant mothers in recent years. In an attempt to solve the issue of competent birth attendance, a new group of community-based midwives (CMWs) has been brought in to provide professional care in places with limited resources. Trained to help with home deliveries, Community Midwives (CMWs) offer individualized care to expectant mothers and their babies. They interact with the community to encourage healthy habits, provide direction and counseling, and assist women in practicing self-care. They also include the family in resolving unforeseen emergencies and getting ready for childbirth. The communities that the CMWs serve must utilize their services in order for them to succeed. Based on the most recent Pakistan Demographic and Health Survey 2012-13, it is currently observed that approximately 48% of births occur in a healthcare facility, while 52% are assisted by trained birth attendants. The source of the information is the Pakistan Demographic and Health Survey conducted in 2012-13. Therefore, the desired effect of increasing the presence of trained professionals during childbirth in rural regions of Pakistan has not been accomplished. Pakistan, a country ranked sixth in terms of size, has a population of 153 million. It also has a significant maternal mortality rate, as reported in the Pakistan Economic Survey 2003-04. Shockingly, one out of every 38 women in Pakistan faces the danger of death due to complications associated to childbirth. (Tinker, 1998) The level of female literacy, especially among rural women, is one of the lowest globally. Girls lag significantly behind boys in terms of educational achievement. The survey indicates that 38% of the male population and 65% of the female population are illiterate. The source of this information is the United Nations Population Fund report from 2004. Maternal mortality ratio (MMR) is a crucial global indicator of maternal health, despite measuring challenges. More than five million women conceive in Pakistan every year, and 700,000 of them—or 15% of all pregnant women—are likely to face obstetrical and medical

difficulties. The MMR is 276 per 100,000 births yearly, according to the most recent data, and an estimated 30,000 women die each year from pregnancy-related reasons. The state of maternal health and survival in Pakistan is reviewed in this review, with special attention paid to the country's economic and social vulnerability, undernutrition, early marriage, high rates of pregnancy, unmet needs for contraception, a shortage of trained healthcare professionals, subpar services, and evidence-based interventions that can lower maternal mortality (Khan, Yasir P., 2009).

1.1 Problem Statement

In rural areas, women confront formidable barriers when seeking to access and effectively utilize reproductive health care services. These hurdles span inadequate healthcare infrastructure, deeply ingrained cultural obstacles, socioeconomic constraints, religious beliefs, and a strong preference for male children. Consequently, women in these regions are at an increased risk during pregnancy and childbirth, have limited access to family planning services, contend with higher maternal mortality rates, and face restricted opportunities for education and economic empowerment. In rural areas like Kohat, a notable scarcity of healthcare facilities specifically addressing women's reproductive health needs poses a significant obstacle to their overall well-being. Even when available, reproductive health services face barriers such as societal norms, financial constraints, limited awareness, restricted decision-making power, the influence of religious beliefs, and the strong preference for male children, particularly among husbands and in-laws, hindering efficient utilization. Reproductive health services in rural areas are underutilized, increasing maternal complications and maternal morbidity. Gender disparities in healthcare access, particularly in Kohat, further exacerbate these issues. Addressing these multifaceted challenges requires prioritizing comprehensive solutions. This research aims to conduct a comprehensive analysis of the factors influencing the access and utilization of reproductive health care services among rural women, with a particular focus on Kohat. The study aims to identify barriers, including the strong preference for male children and religious beliefs, understand their underlying causes, and propose strategies to enhance access and utilization. By improving the healthcare landscape in Kohat through enhanced service accessibility, removing utilization barriers, and empowering women to make informed reproductive health decisions, this research seeks to foster family stability and contribute to the sustainable development of the region

1.2 Research Objectives

1. To Assess the level of Awareness and knowledge about reproductive health care services amongst women
2. To examine the assess and utilization pattern of reproductive health care amongst rural women
3. To analyze the barriers and challenges in accessing reproductive health care services by women in rural areas

2.0 Literature Review

A health system consists of all organizations, people, and activities whose main goal is to promote, restore, or maintain health. This includes both engaging in activities that directly improve health and attempting to alter elements that affect health outcomes. (McCoy, 2021) There is more to a health system than the chain of command comprising all government-owned facilities offering specific medical services. It includes a number of things, like a mother caring for her ill child at home, private healthcare providers, behavior modification programs, efforts to lessen the spread of disease, health insurance providers, and laws pertaining to workplace health and safety. Health workers engage in inter-sectoral action by supporting the ministry of education to promote female

education, which is widely acknowledged as a critical component in enhancing health outcomes (WHO, 2007).

Pediatricians are essential medical professionals for teens and young adults, especially in the case of younger teens. They play a vital role in meeting this age group's continuing needs for sexual and reproductive health, which include STI (sexually transmitted illness) prevention and unwanted pregnancy prevention. Hoover (2010) is listed as the source. promoting the development of wholesome and pleasant relationships with others.1. It might not be possible to provide all necessary sexual and reproductive health care in one visit. Depending on the unique needs of every patient, services might need to be provided over a number of appointments.

The legal system's continued disrespect for women's reproductive health is a component of a larger, systemic prejudice against them. Women's access to reproductive health services is hampered by the law. Rarely or insufficiently are laws safeguarding women's reproductive health enforced. Furthermore, there aren't many laws or policies that support giving women access to reproductive health treatments. Cook (1993) Feminist legal techniques and epidemiological data shed light on the law's blatant disrespect for women's reproductive health and dispel long-held, fundamentally harmful notions about its neutrality. (Toth, 2022) Empirical evidence can be used to evaluate if alternative legal strategies could offer better protection for individual rights and to evaluate how well laws are being applied. The use of international human rights treaties, such as the ones included in this article, to demonstrate how laws that deny women access to reproductive health treatments are in violation of their fundamental rights is growing.

Review of psychological studies on women's reproductive health, with an emphasis on specific menstrual, pregnancy and delivery, infertility, and menopausal components. (Nodirove, 2022) Studies in several fields have concentrated on the detrimental psychological and physical side effects of these health problems. Nonetheless, studies show significant individual variation, with the majority of women adjusting to changes in reproductive health quite well. Research has improved our understanding of the multifactorial biological, psychological, and social factors on women's reproductive health and related outcomes, despite methodological and conceptual flaws that have hindered the ability to draw definitive conclusions. (Stanton, 2002)

The goals of family planning programs are to assist people in having the number of children they want, decrease unwanted pregnancies, enhance the health of women and children, and promote economic growth. A Working Group was formed in 1987 by the Committee on Population of the National Research Council to evaluate the health effects of managed fertility and the use of contraceptives. (1989, National Research Council) The Working Group discovered many health advantages of family planning initiatives in underdeveloped nations. By giving women safe and practical ways to manage the quantity and timing of their pregnancies, they lower the number of high-risk pregnancies and enhance maternal health. Using family planning to space out births can help improve the health of newborns. (O.R., 2022) Improving the availability of family planning services is crucial to advancing the wellbeing of women and children. Family planning is even more important in areas where safe abortion is not available since it provides a medically safe way to limit the number of unintended pregnancies and prevent maternal death and harm from unsafe abortion practices. (Parpieva, 2022).

Social norms, which include beliefs and ideals around sexuality, are accepted expectations within a community about appropriate behavior. These norms shape social perceptions of what is "normal" and what behaviors are acceptable or unacceptable, including sexual health-related behavioral patterns. These standards may also be followed by medical professionals, which could have an effect on the availability and caliber of therapies for sexual health. Marcus (2021) The intentional avoidance of conception through artificial or natural means is referred to as contraception. It is imperative to have access to a range of contemporary contraceptive methods

and services to guarantee their accessibility, affordability, and acceptability. Smith (2021) Skilled healthcare professionals should provide these services in environments that adhere to high standards of care without using compulsion. Since contraception avoids unwanted births and their associated problems, such as unsafe abortions, it is incredibly cost-effective. It also helps to improve newborn and child health and lower maternal and neonatal mortality. By giving girls greater educational possibilities and improving their socioeconomic standing and general well-being, access to contraception also empowers them. (Ashford (2017).

Pakistan has not been successful in significantly reducing the maternal mortality ratio (MMR). According to the World Health Organization (WHO), the estimated MMR in Pakistan is 260 deaths per 100,000 live births (Ronsmans C, 2006). Despite some progress in reducing maternal mortality, Pakistan is still falling behind many other South Asian countries. Hemorrhage, pre-eclampsia, and puerperal sepsis are responsible for 57% of maternal mortality in Pakistan, according to the World Population Review in 2014. Access to basic antenatal care services is crucial in preventing the majority of these deaths (Ronsmans C, 2006). The lack of sufficient access to and underutilization of the healthcare system are significant contributors to the poor health indicators observed in developing nations (Ronsmans C, 2006).

These data indicate the inadequate healthcare-seeking behavior among pregnant women in Pakistan.

When a woman is pregnant, her choice of healthcare practitioner and facility is typically influenced by her social and physical surroundings. According to Bloom SS (2001), women who have more control over their income, decision-making power, and freedom of movement are more likely to seek and get healthcare during pregnancy. Health services can be utilized for regular prenatal care, childbirth, medical treatment, or emergency situations. According to the Pakistan Demographic and Health Survey (PDHS) 2006–07, only 65% of women avail routine healthcare during pregnancy, and out of these, 4% seek healthcare from sources other than the formal health system. According to the Pakistan Demographic and Health Survey 2006-07, 65% of women gave birth at home, whereas only 39% of deliveries occurred with the assistance of a skilled birth attendant, such as a doctor, nurse, midwife, or lady health visitor.

According to the Pakistan Demographic and Health Survey 2006-07, the percentage of women receiving postpartum care was lower (43%) compared to the percentage of women receiving antenatal care (61%). Pakistan ranks as the sixth most populous country and is projected to keep this position based on its current fertility rate [World Population Review, 2014]. In general, 65% of the population lives in rural areas. A significant portion of the population has a restricted level of education, with only 24% of women and 65% of men having had formal schooling. Furthermore, the living conditions in households are frequently below standard, with just 22% of households having access to piped water, and a staggering 88% of households lacking a latrine connected to a piped sewerage system. The living conditions in Sindh province are notably difficult, with typical temperatures ranging from 30 to 40 °C [Climate of Sindh 2014]

The majority of rural residences are situated at a minimum distance of 10 kilometers from the district hospital or maternal and child health facility. Traditional birth attendants (TBA), alternative medicine practitioners, and pharmacists are the primary health care providers in these localities, according to the Pakistan Demographic and Health Survey 2006-07. Pakistan's health care system consists of both state and private sectors. The public sector provides services at the primary, secondary, and postsecondary levels. The primary level comprises rural health centers, these include basic health units, primary health care facilities, dispensaries, first aid posts, mother and child health clinics, and community health workers referred to as Lady Health Workers (LHW). The secondary level of healthcare comprises the district and Tehsil Headquarter hospitals, whereas the tertiary level of treatment is provided by teaching hospitals.

The private sector encompasses both allopathic and spiritual/traditional healers, as mentioned by Shaikh BT in 2005. Pakistan is facing a significant challenge due to its rapid population expansion and limited resources. This situation has severe consequences for the country's health, economy, and society, including an increase in poverty rates and potentially disastrous environmental effects. Pakistan was among the few Asian nations to establish a national family planning program in the 1960s, although its execution has been irregular. The citation is from a publication by Mahsud-Dornan in 2007. In recent times, the government has reaffirmed its commitment and significantly boosted its investments in family planning as a signatory to the Family Planning 2020 promise. Despite the promises made, Pakistan's advancement in family planning has come to a halt and the decrease in fertility rates has been slower compared to its neighboring countries. The UNFPA conducted a Population Situation Analysis of Pakistan, as shown in the United Nations Population Fund report of 2016. Approximately 20% of married women in Pakistan have a desire for family planning that is not being addressed, while the rate of modern contraceptive use has not changed significantly between 2012 and 2018, remaining at 26% and 25% respectively. The source of the information is the National Institute of Population Studies, The DHS Program ICF Pakistan demography and health survey conducted in 2017.

Many countries in East and South Asia have a pronounced cultural bias towards favoring sons. The source cited is Arnold F, 1998. In these countries, sons are highly valued compared to daughters due to several social and economic factors. This includes their significant financial and labor contributions to the family, their capacity to provide support to their parents, and their role in carrying on the family name. (Arnold, F., 2001) In many nations, particularly in South Asia, male offspring also contribute to the family's wealth through dowry (Das Gupta M et al, 2003) and have exclusive rights to carry out specific religious rituals. Son preference may arise from parents adhering to the societal norm of favoring men and consequently undervaluing females. (Das Gupta, M., 1987) Simultaneously, numerous parents in this locality desire to have a minimum of one female offspring. The citation provided is from Arnold F's work published in 2001. Research conducted in Bangladesh, India, Nepal, Pakistan, and Sri Lanka has substantiated the prevalent existence of son preference in South Asia and its influence on reproductive attitudes. (Stash, S. 1996) Son preference frequently results in bias against females in terms of nutrition, schooling (Burgess R and Zhuang J, 2002), and healthcare (Pande RP, 2003), all of which can have negative consequences on their health and overall welfare, and may even contribute to higher rates of female mortality. The citation is from Pelletier's work published in 1998. Not all studies have recorded or reported such negative consequences: An examination of 306 child nutrition surveys did not uncover any consistent prejudice towards female undernutrition (Marcoux A, 2002). Similarly, a study of 41 Demographic and Health Surveys arrived at a comparable finding regarding stunting, underweight, and wasting. The reference is cited as "Sommerfelt AE and Arnold F, 1998". It is crucial to acknowledge that significant geographical variations in son preference exist within South Asia. Son preference exhibits a significantly greater intensity in the northern and central uplands of India compared to the southern region. The reference for this information is Bhat PN and Zavier AJ, 2003. Likewise, there has been a significant preference for male children in the state of Punjab, resulting in a notably skewed sex ratio. (Das Gupta, 1987) Based on the 2001 Census data, the ratio of females to boys among children aged 0-6 in Punjab was 798 girls for every 1,000 boys, whereas in India as a whole, the ratio was 927 girls per 1,000 boys. Obtaining the desired number of male children and the preferred gender balance within the family can result in the discontinuation of having further children, the deliberate termination of female fetuses, and in severe situations, the killing of female infants. The source of this information is a publication by Arnold F in the year 2002. A decrease in fertility, without a simultaneous decrease in the demand for male children, can result in an escalation in the practice of selectively aborting

female fetuses or committing female infanticide. The citation is from a publication by Yount in the year 2000. Recent research conducted in India has established a correlation between son preference and the occurrence of high male-to-female sex ratios at birth. This correlation serves as compelling proof of the practice of sex-selective abortion. (Das Gupta M and Bhat PN, 1997).

3.0 Methodology

This study was based on mix method approach the mixed method research is based on both qualitative and quantitative research. The study employs a quantitative method to gather quantifiable data on reproductive health care in Jungle Khel, Kohat. This involves collecting information on access to healthcare facilities, frequency and types of reproductive health services used, and barriers such as financial constraints, transportation issues, and the availability of healthcare professionals. Additionally, sociodemographic data including age, education, income, employment, marital status, and number of children will be collected. Structured surveys and questionnaires will be used as the primary tools for data collection.

3.1 Study Area

Area of the study is jungle khel a part of the Kohat district in Khyber Pakhtunkhwa, Pakistan. This area is predominantly rural with a significant portion of its population living in poverty. The region is characterized by its rugged terrain and limited access to urban centers, which further exacerbates the difficulties in accessing healthcare services. The healthcare infrastructure in Jungle Khel is notably insufficient. The region lacks adequate medical facilities, trained healthcare professionals, and essential medical supplies. This scarcity is particularly detrimental to women's health, as it limits access to necessary reproductive health services, including maternal care and family planning. The socioeconomic landscape of Kohat is marked by low educational attainment, with many residents lacking access to quality education. This has an impact on health literacy generally, along with high rates of poverty. due to its reliance on agriculture and manual labor, which often fail to meet basic family needs. Traditional and patriarchal norms limit women's autonomy and decision-making, especially regarding health, further restricting their access to healthcare and contributing to gender disparities. The region's inadequate healthcare infrastructure, low education levels, and socioeconomic challenges create a unique environment impacting women's health. This study aims to understand these factors to develop effective interventions and policies to improve reproductive health services and outcomes for women in Jungle Khel and similar rural settings.

3.2 Sampling Technique

The study uses a purposive sampling technique to investigate reproductive health care access and utilization among women in the Kohat district. This method was chosen to ensure the inclusion of participants with specific characteristics relevant to the research objectives. Purposive sampling allows for targeted insights from individuals who have direct experience and knowledge about the issues being studied, making it more efficient and practical than random sampling. This approach also supports the research's goal of gaining a deep understanding of socio-cultural barriers and personal experiences, which is crucial for addressing the specific healthcare challenges faced by women in Kohat. Overall, purposive sampling is the most appropriate method to gather detailed and relevant data for this study. The focus is on understanding the patterns, challenges, and opportunities associated with the delivery and uptake of reproductive health services in the region. This intentional approach allows for in-depth exploration, information richness, and optimization of resources. Data is collected through structured questionnaires, and the study aims to provide valuable insights into the access and utilization of reproductive health care services among rural women in the selected areas. The findings will be used to inform policy recommendations and healthcare improvements.

3.3 Sample Size

The sample size for this study comprises 46 respondents. The inclusion criteria for participation are as follows: women aged between 18 and 40 years who are married. Additionally, local Reproductive Health Care (RHC) providers will be selected for interviews to gain comprehensive insights from both the service users and providers. This selection ensures that the study focuses on women who are most likely to utilize reproductive health services, thereby providing relevant and valuable data on access and utilization of these services in the Kohat district.

3.4 Data collection Tools

In this study, a mixed-method approach combining both quantitative and qualitative research methods was employed to gain a comprehensive understanding. Various methods of data collection, such as personal interviewing and telephone interviews, were utilized. The tools used for data collection in this study included:

3.4.1 Primary Data:

Questionnaires Structured questionnaires with open and closed-ended questions were used, employing the interview method.

Interview Guide Semi-structured interviews were conducted using an interview guide to ensure consistency while allowing flexibility to explore respondents' perspectives in depth.

3.4.2 Secondary data:

Secondary data was collected from various sources such as research paper, research articles, research journal, newspaper.

3.5 Data Analysis

Descriptive statistics were used to analyze the quantitative data collected through structured questionnaires. This analysis included frequency distributions, percentages, and cross-tabulations to summarize the respondents' demographic characteristics and their responses related to reproductive health services. Such cultural norms, along with patriarchal influences, significantly limit women's reproductive health choices and access to family planning methods.

The thematic analysis of qualitative data from semi-structured interviews and open-ended questionnaire responses identified several major themes. Cultural and societal barriers, including a preference for male offspring and restricted decision-making power, impede open discussions about contraception and limit the availability of essential reproductive health services. Logistical and financial constraints, such as geographical distance, transportation difficulties, and financial limitations, further exacerbate these challenges.

4.0 Results and Discussions

4.1 Awareness and Information about reproductive health care

Based on the graph and the provided information, it's evident that there is a concerning lack of awareness about reproductive health services among women in rural areas, particularly in Kohat. The majority of respondents rely on information from family members, indicating a gap in access to proper reproductive health facilities or educational resources. A significant portion of women (39.1%) are only slightly aware, while 26.0% have a moderate level of awareness. However, a concerning 19.5% are not aware at all. Only a small percentage (15.2%) of women are aware of reproductive health facilities, indicating a lack of outreach or visibility of such services in the community. The primary source of awareness for women is their family members, suggesting a reliance on informal channels rather than formal healthcare facilities. There seems to be a lack of prominent NGOs or reproductive health facilities that are well-known or accessible to the community.

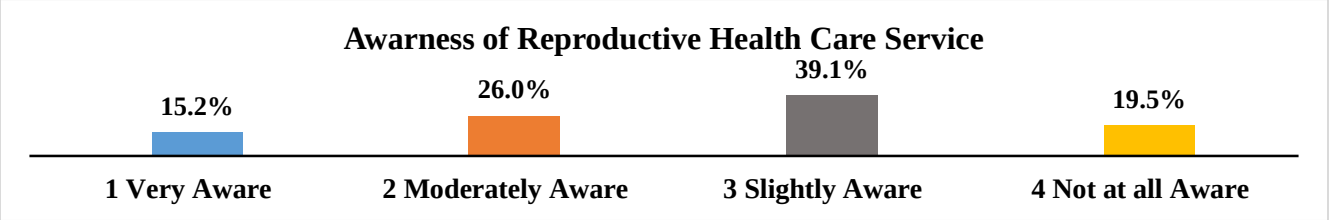

Figure 4. 1: Awareness of the Reproductive Health Service

4.1.1 Family Reliance for Rural Women's Reproductive Health:

The research examined the sources of information about reproductive health care services among rural women, revealing that the primary platform relied upon is family members. The majority of women obtain information from their families rather than healthcare professionals or reproductive health centers. This preference for family-based sources suggests a strong sense of trust and reliance on familial opinions among women in the community. Interestingly, while half of the respondents seek reproductive health care due to their knowledge, there is minimal reliance on community health workers for support and healthcare issues. However, this could lead to the spread of misinformation and misconceptions if family members lack accurate knowledge. The minimal use of community health workers indicates a gap in accessing professional guidance. This underscores the need for targeted educational interventions and better integration of health workers to ensure accurate and beneficial health information is disseminated, one of the respondents said that "As we have a doctor in our family why should we go to reproductive health center there is no use of it we can get information from the family doctor" the information from family is not always correct as One respondent's experience illustrates the risks of this reliance: despite having a family doctor, she suffered severe abdominal pain that family advice misinterpreted, and only a proper medical checkup revealed a uterine tumor. This case underscores that while family opinions are trusted, consulting healthcare professionals is crucial for accurate diagnosis and treatment.

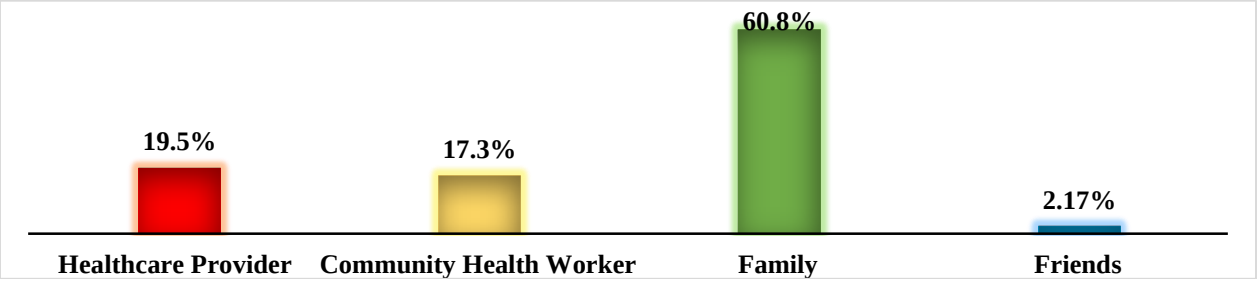

Figure 4.1.1 : Family Reliance for Rural Women's Reproductive Health

4.1.2 Infrequent Utilization of Reproductive Health Centers (RHC):

Based on the data collected, the assessment of the frequency of seeking information about reproductive health care services reveals significant trends. Only a minimal percentage (0.5%) of women seek information and frequently visit RHCs. This indicates a low level of proactive engagement with reproductive health services among the community. A notable proportion (28.3%) of women occasionally visit RHCs, often during pregnancy, suggesting that reproductive health services are primarily sought during specific life events rather than on a regular basis. A majority (60.9%) of women rarely or never go to health centers, with some expressing a preference for giving birth at home. This preference reflects cultural or personal beliefs about childbirth and healthcare practices. After childbirth, many women do not prioritize postpartum check-ups, indicating a gap in postnatal care services and potentially contributing to health concerns going unaddressed.

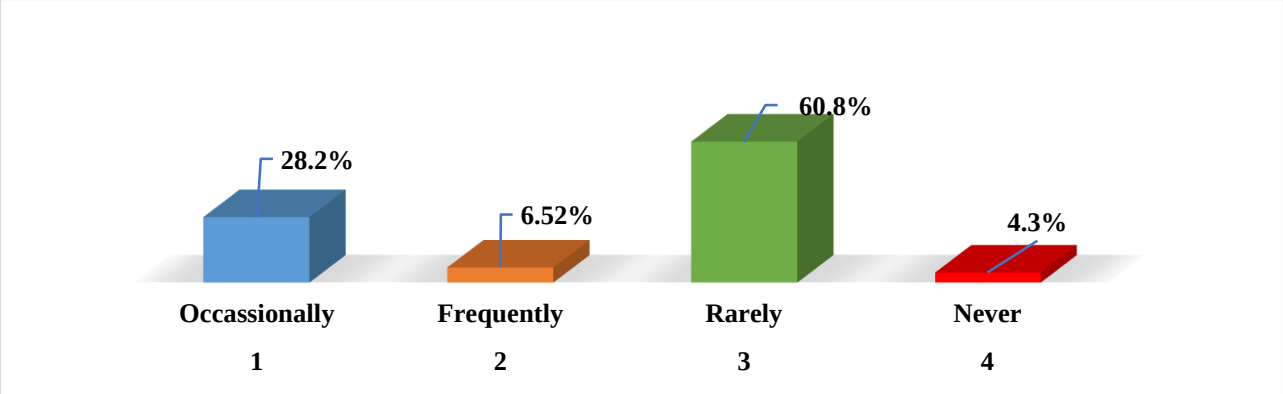

Figure 4.1.2 :Infrequent Utilization of Reproductive Health Centers

4.1.3 Contraceptive knowledge and engagement with healthcare providers in Kohat:

Conversations about contraceptives with healthcare providers are notably infrequent among women in Kohat. A substantial number of women reported rarely engaging in discussions about contraceptives with their healthcare providers, and an additional indicated that they never engage in such discussions. Only 19.5% of women reported having some level of knowledge about contraceptives, indicating that the vast majority lack essential information regarding reproductive health. This lack of communication with medical professionals further perpetuates the cycle of misinformation and limited knowledge. Due to the lack of contraceptive knowledge and access to reproductive health care, many women end up having more children than they desire. Despite claims of contraceptive availability and education by NGOs, the data collected does not support this assertion. Respondents, including an NGO representative, expressed dissatisfaction with the lack of contraceptive knowledge and options available.

One of my respondents was the NGO lady which worked there. She didn't have satisfactory responses as she told me that there is very much knowledge but during my research the data collected was not satisfying as she said that there are 3 to 4 types of contraceptives IUDs have been used in that NGO but none of the respondents knew about those contraceptives, One of my respondents said "she used cooper T for 6 months but had severe bleeding which caused her to be anemic and other then that due to bleeding she could not bear the pain after 6 months when copper T was removes, she then again got pregnant and had to endure a lot of pain during pregnancy. according to the findings most women said copper T does not work on women rather it causes bleeding short slightness and other women problems and they are not comfortable with copper T which NGO is providing and while in research on copper t there are so many problems and copper t cause most death rates in women. And it is not tested object and it should not be used in my opinion.

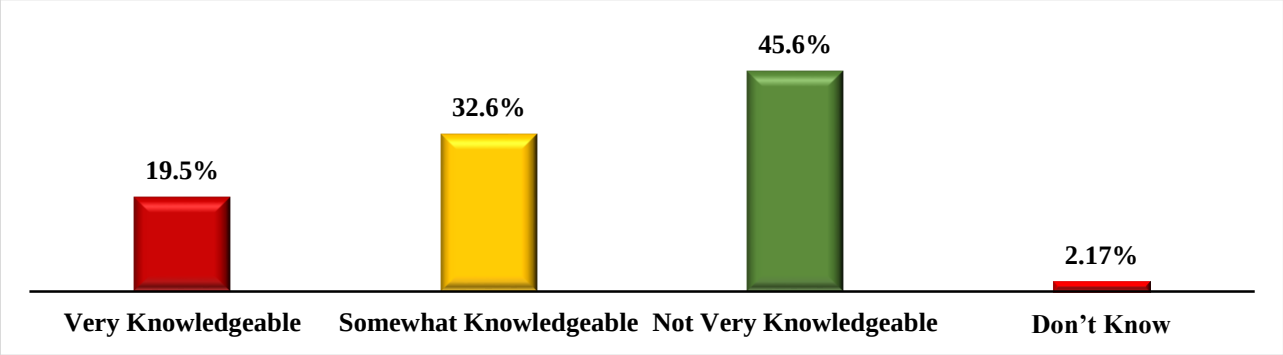

Figure 4.1.3 : Low Contraceptive Knowledge

4.2 Analyze the Barriers and Challenges in Accessing Reproductive Health Care Services by Women in Rural Areas

The significant impact of cultural and societal beliefs on women's access to reproductive health care. Taboos, gender norms, religious convictions, and economic constraints collectively impede women's autonomy and impede discussions surrounding contraception and family planning. Misinformation and inadequate healthcare infrastructure exacerbate these challenges, perpetuating barriers to accessing essential services.

A notable finding is that 69.5% of respondents perceive cultural and societal beliefs as having a very significant influence on women's access to reproductive health care. This sentiment is exemplified by the experiences of one respondent who, despite having nine daughters, faced pressure from her husband and in-laws to continue having children until a son was born. Such pressures reflect deeply ingrained cultural preferences for male children.

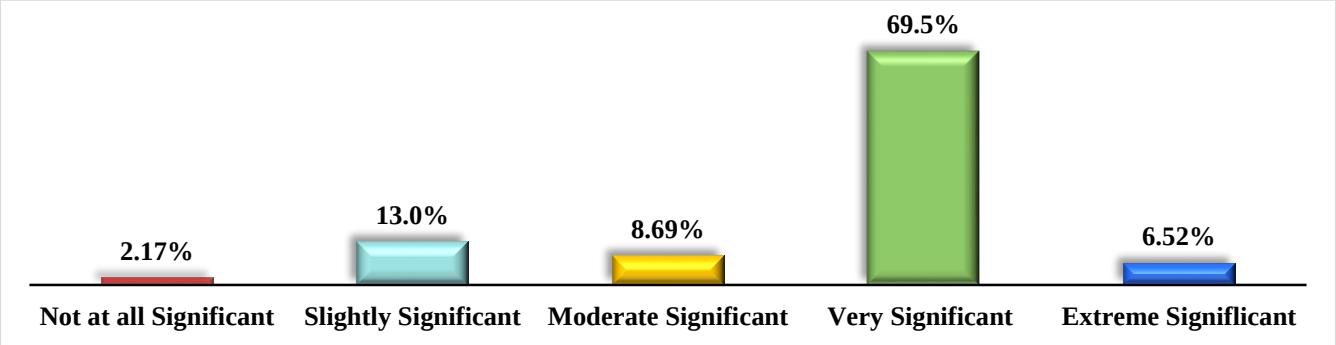

Figure 4.2: Impact of Cultural and Societal Beliefs

4.2.1 Awareness of Reproductive Health Facility:

Based on the research findings, it is evident that there are various factors influencing women's awareness and access to reproductive health care services in the community: The data highlights significant gaps in awareness regarding health facilities in Kohat Jungle Khel. A large portion of respondents, 37.78%, reported being unaware of any available health services in their area. Awareness of specific facilities was generally low, with only 6.52% of respondents aware of Liaqat Memorial Hospital (LMH), CMH Kohat, Health ways Hospital, NGO: Rehnuma Clinic, Rural Health Centers (RHCs), and Basic Health Units (BHUs) respectively. In contrast, 26.09% of respondents were aware of private clinics. These findings underscore the need for better information dissemination and community engagement to enhance awareness and utilization of healthcare services in the region.

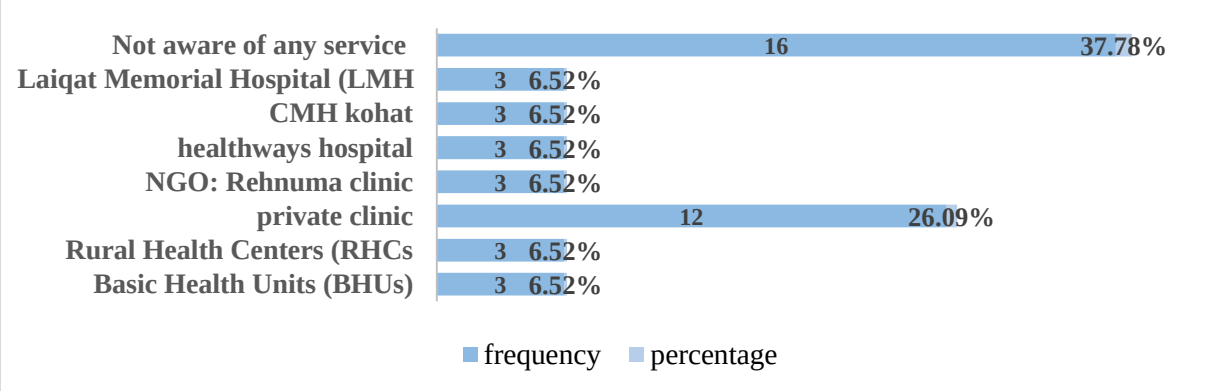

Figure 4.2.1: Awareness of Reproductive Health Facility

4.2.2 Barriers to Access Health Care Services:

Several barriers to accessing reproductive health care services were identified. Lack of knowledge and support from family members (6.5%) was cited as a significant barrier. As one of the respondents said that "she is not allowed by her husband and in laws to go out of the house" Religious beliefs (2.2%), shyness and pardah (2.2%), one of the respondents said that due to pardah system they cannot go alone to avail any facility other than that they must go with one male form home" and adherence to cultural values (4.3%) were also mentioned as hindrances. From NGO respondent said that "yes barriers like pardah system and lack of support from family is a big barrier for the women due to which they cannot avail any kind of reproductive healthcare facility and majority of women say its gunnah to stop children as it's a blessing from Allah so their husbands and in laws says".

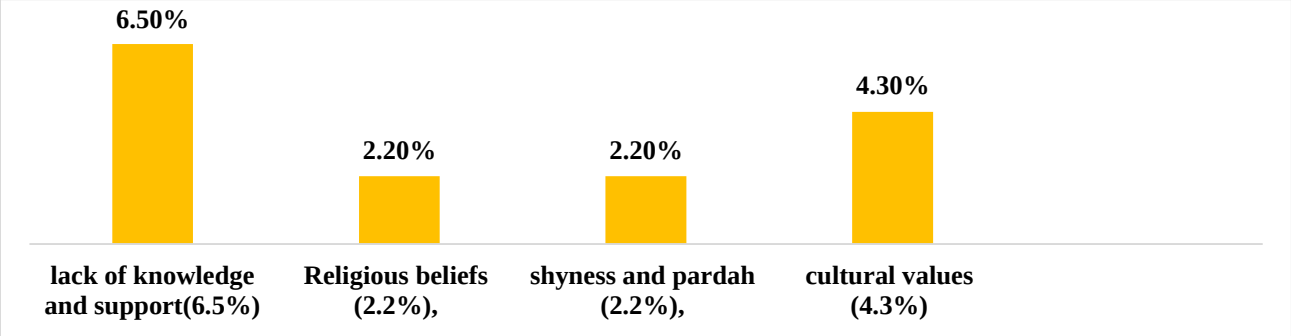

Figure 4.2.2: Barriers to Access Healthcare Service

4.2.3 Strong Cultural Preference for Male Babies due to Traditional Roles:

The data reveals a deep-seated cultural preference for male babies within the community. An overwhelming majority of respondents, 80.4%, strongly agree with the notion that having a male child is favored, reflecting the societal norm and pressure towards valuing male offspring more highly. This strong agreement suggests that many families may prioritize having male children due to cultural, economic, or social reasons, possibly influenced by traditions and expectations of lineage continuation or financial security. In contrast, a smaller segment of the population, 13%, disagrees with this preference, indicating a minority that challenges the prevailing gender bias and advocates for gender equality in childbearing. This group likely represents those who are either personally unaffected by the traditional preferences or are actively working against them. Additionally, 6.5% of respondents strongly disagree with the preference for male children, further underscoring the presence of some resistance against this cultural norm, although it remains a minority view. Interestingly, none of the respondents chose to agree or remain neutral, suggesting that opinions on this matter are quite polarized. The lack of neutral responses indicates that individuals within this community have strong feelings about the issue, with most leaning heavily towards a preference for male children. This data highlights the significant cultural and possibly familial pressures women may face, potentially impacting their reproductive choices and the utilization of contraceptive methods due to the strong desire or obligation to produce male heirs. One of the respondents said that she had 9 daughters just because her husband and in laws wanted a male baby. One of the other respondent said that male child is what really matters in their family and it makes the women (mother) status strong in the family and having more then one male baby the women status is considered high.

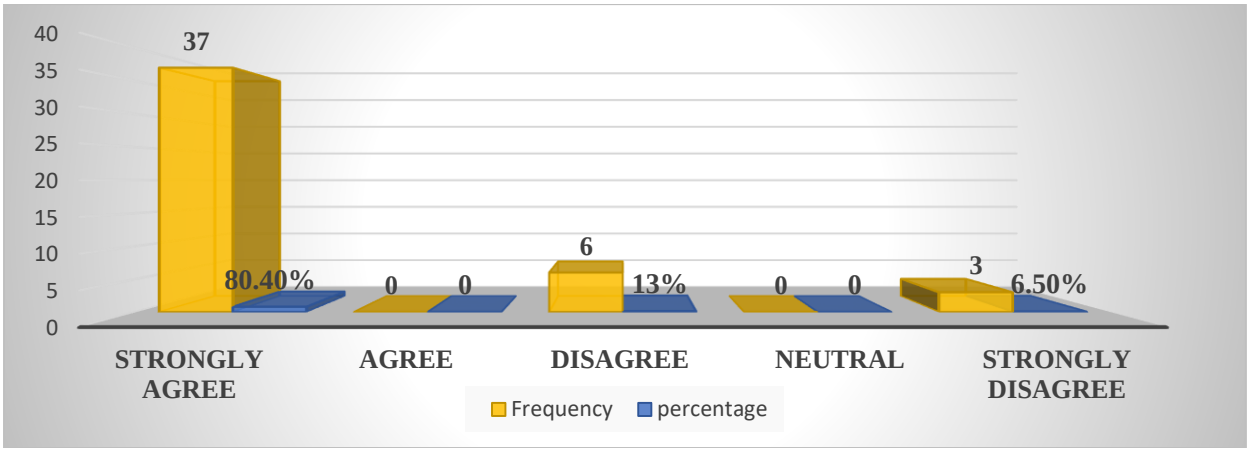

Figure 4.2.3: Cultural Preferences for Male Babies

4.3 Enhance the Accessibility and Utilization of Reproductive Health Care Services in the Rural Community:

The table illustrates the key themes and their corresponding frequency and percentage in terms of improving healthcare services in the surveyed region. The most frequently cited theme, accounting for 22.9%, is the need for more hospitals and clinics. This is closely followed by the requirement for more Lady Health Workers and door-to-door healthcare services, which represent 20.6% of the responses. Awareness and education on reproductive health are also significant, with 17.2% of the respondents highlighting its importance. Hospital maintenance and cleanliness were mentioned by 11.4% of the participants, indicating a need for better facilities. NGO involvement and support, as well as the availability of contraceptives and medicines, were identified by 9.1% and 8.0% of the respondents, respectively. The demand for 24/7 healthcare services is relatively lower, at 5.7%, while mobile health units or clinics were noted by 4.5% of the respondents as a necessary improvement.

Theme	Frequency	Percentage
More Hospitals and Clinics	20	22.9
Lady Health Workers and Door-to-Door	18	20.6
Hospital Maintenance and Cleanliness	10	11.4
Awareness and Education on Reproductive Health	15	17.2
24/7 Healthcare Services	5	5.7
NGO Involvement and Support	8	9.1
Availability of Contraceptives and Medicines	7	8.0
Mobile health units/clinic	4	4.5

Table 4.3: Community Healthcare Needs and Suggestions

5.0 Conclusion

The study "Examines Access to and Use of Health Services Among Women's Health in Societies Using Kohat as an Example" explores the critical issue of restricted availability of reproductive health services for women in the Kohat area. The primary challenges include insufficient healthcare facilities designed to meet women's unique health needs, leading to significant barriers in accessing and utilizing these services. The lack of medical facilities specifically dedicated to women's reproductive health in Kohat creates substantial obstacles, resulting in severe consequences such as high maternal mortality rates and limited family planning options.Several factors contribute to the restricted utilization of reproductive health services. The geographical distance to healthcare facilities poses a significant challenge for women living in rural areas. Cultural traditions deeply rooted in society impose significant limitations on women's mobility and autonomy, especially affecting unmarried females. Financial hurdles further impede women's access to healthcare services, as poverty and economic dependence restrict their ability to seek necessary care. Inadequate awareness and education about reproductive health services exacerbate the problem, leaving many women uninformed about available resources and their importance.The research underscores the significant obstacles and deficiencies in the knowledge and utilization of reproductive healthcare among women in rural Kohat. The findings reveal a widespread lack of understanding about reproductive health, compounded by a heavy reliance on informal sources such as family members instead of trained healthcare providers. This lack of knowledge and education is a major barrier to the effective use of reproductive health services. A significant portion of women in Kohat exhibit limited awareness about contraceptives, with only 19.6% having a basic understanding of contraceptive methods. The absence of professional guidance and restricted availability of reproductive health facilities are key factors contributing to this poor awareness.Statistics indicate a lack of communication between women and healthcare providers regarding contraceptives, leading to the spread of misinformation and limiting women's access to accurate reproductive health information. Despite claims by non-governmental organizations (NGOs) about the availability and education on contraceptives, their tangible efforts and impact appear limited. Cultural and societal barriers further exacerbate the situation. Patriarchal norms and the cultural preference for male children significantly influence family planning decisions, often restricting women's autonomy in reproductive health matters. Many women avoid discussing contraceptives with their husbands due to prevailing societal conventions, which in turn limits the use of contraceptive methods. Additionally, societal disapproval of conversations about reproductive health acts as a barrier to accessing essential information and services.Financial constraints also play a significant role in limiting access to reproductive health treatments. Women's access to healthcare services and transportation is restricted due to financial dependence and poverty. The economic barrier is particularly evident in the use of contraceptives such as Copper T and Mirena, which, despite being provided by NGOs, remain unaffordable for many women. Postpartum care is another area of concern. Most women do not attend postpartum visits due to a lack of information about the importance of postnatal care, along with practical and cultural barriers. The absence of postpartum check-ups can lead to untreated health issues for both mother and child, highlighting a critical gap in the continuum of reproductive healthcare.

5.1 Recommendation:

Enhancing reproductive healthcare in Jungle Khel, Kohat requires a multifaceted approach. Improving and expanding healthcare facilities specifically catering to women's reproductive health needs is crucial. Implementing community-based reproductive health programs that provide home-based services for unmarried girls and women with limited mobility can significantly improve access. Empowering women through education and community involvement will enable them to

make informed decisions about their reproductive health and overcome societal barriers. Strengthening collaboration between local government agencies and NGOs is essential for implementing effective reproductive health programs. This collaboration should focus on decentralizing healthcare delivery and involving local communities in planning and implementation. Establishing clear goals, indicators, and robust monitoring and evaluation systems will help track progress and ensure accountability in improving maternal and reproductive health outcomes. Community-based educational campaigns in Jungle Khel are necessary to raise awareness about reproductive health, contraception, and the importance of postpartum care. These initiatives should target both men and women to address gender norms and promote informed decision-making. Fostering women's autonomy in health decisions through education and community support is vital. Addressing cultural and societal norms that restrict women's access to reproductive health services, along with developing strategies to overcome logistical barriers such as providing transportation assistance and enhancing the reach of home-based services, will further improve access. Promoting a supportive community environment that encourages discussions about reproductive health and values women's health needs is essential. Engaging community leaders to foster cultural shifts towards accepting and prioritizing reproductive health care will help create a more inclusive and supportive atmosphere for women's health in Jungle Khel.

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