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RURAL WOMEN'S ACCESS TO HEALTH SERVICE: A CASE STUDY OF MUZAFFARGARH

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ABSTRACT
Pakistan is a developing country with 67% people lived in rural areas. Health is one of its leading problems. Pakistan's rural communities is severely impacted by this issue. Allocation and distribution of resources in the Pakistan is unequal because of this inequality, rural community suffers a lot regarding serious health issues and facing many dangerous diseases. Several developing countries have contracted out public health facilities to the Non-Government Organizations (NGOs) to improve service utilization. A sample of 100 females was selected by using simple random sampling technique from randomly selected four UCs in which MuradpurJanobi, Sultan pur, Fathepur and KhairPur Sadat and 25 respondents were selected from each UC. In depth interview technique was used to collect data. Females were involved in nearly all activities ($p<0.05$), from domestic to field work, and they often had health issues. The role of rural women should be promoted through print and electronic media. Health promotion campaigns are needed to change existing health-seeking behaviors among rural women. Social arrangements should be thoughtfully considered to make the health system more responsive. More female staff needs to be deployed in government health facilities. Rural women poorer health outcome and less access to health care. In many rural areas, women's health providers are limited. Rural women's issues vary depending by region and state. Health care professionals should be aware of this issue and advocate for rural women's issues.
Keywords: Health services and facilities, rural women, health Reason

INTRODUCATION
Pakistan is usually underdeveloped state that has 130 million using minimal educational listing and the delivery rate is very substantial caused by inadequate financial position there may be substantial delivery and death rate. Women's and children's wellness position is usually pitiable, so the women's and children's is usually abandoned portion in the contemporary society according connected with healthily and mother's fatality rate MMR was 340 away from 100, 000 live delivery (United Nations around the world, 2001). The biomedical concept of health and illness, as well as an individualistic explanation of health problems, form the basis of health policy in this developing country, just as they do in other developing countries. The ways in which people's health is related with the social and material circumstances of their life have received a significant amount of study, while the structural basis of ill health has received a far less amount of attention. The decision-makers in government haven't yet given great attention, that policymakers have ignored health care system hurdles for rural women's (Hossen, 2011). In traditional and biomedical health care systems in Bangladesh, rural women's health was mostly ignored (Islam, 2000). This article highlights rural women's health care access issues. It begins with a discussion of the social and health situation of women in, paying special emphasis to the women who are older and poorer in the country. Then, the health care system

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and government efforts to improve access in rural areas are described. The issues that prevent poor rural women from getting health care are then analyzed. The article concludes with policy recommendations for achieving better success in this regard. Constitutionally, the government is responsible for the health of the people. Therefore, the discussion is limited to the government-run health care delivery system (Hossen, 2011). According to the Pakistan Demographic and Health Survey 2012–13, just 48% of births occur in a health institution and 52% are attended by experienced birth providers (PDHS,2012-13). Women's health is important to any country's health system. Women care for family health. Children's health depends largely on the mothers. They are the foundation of health system/status of a family and community at large (Saravanabavan, 2021). Pakistan is usually stunted using sexual category inequalities, and irrespective of work there's a broad distance in between both males and females regarding job opportunities, settled work, use of wellness providers and wellness effects in Pakistan. The sexual category inequality provides deep root base in Pakistani contemporary society. Culturally, ladies are near a problem through delivery, and they are subject to discrimination during their whole living course in Pakistan, while guys are recognized financial and societal power. This sexual category inclination might be considered by simply out of balance sexual category ratio (91 ladies for each and every 100 men) in Pakistan, as compared to industrialized countries. Women children are, consequently, prone to deal with more overlook and are now living in poor health when compared to man children. Early on marriage predisposes these kinds of girls to help beginning carrying a child and child delivery with the believed 42% conceiving a child prior to grow older connected with twenty years. Women of all ages committed while children seem in lead with regard to home-based violence off their husbands and his or her in-laws. 6Frequent burns up among committed ladies caused by cooker bursting more often by simply husbands and in-laws point in direction of nearly all intense forms of home-based violence in Pakistan (Nasrullah & Bhatti 2012). High mother's fatality in Pakistan is usually a measure connected with overlook connected with women’s wellness, nevertheless, from the lack of precise mother's wellness data, the actual specifications connected with problem in rural elements of America is usually challenging to help assess. Sindh may be the second nearly all population domains connected with Pakistan. High full sperm count rate (4. 4) and unacceptably substantial mother's fatality paints a disappointing snapshot connected with women’s wellness from the province5. Human population dependent mother's wellness reviews connected with urban squatter settlements connected with Karachi report a mother's fatality ratio in between 276-310 each 100, 000 live births. 45 % ladies endure anemia, which usually as soon as in addition to hemorrhagic difficulties connected with carrying a child and labor will increase chance connected with dangerous consequence for the mommy. Any kind of delays in looking for look after obstetric difficulties can easily endanger mother's living. The need with regard to powerful tips for supply connected with healthcare to help rural ladies is usually vital and takes a study connected with mother's awareness and suffers from in the healthcare system (Safdar et al., 2002 and Alina 2009). Pakistan would be the seventh most population land in the world along with last in Parts of Asia which has a population 130.6 million in1998. Using a development fee involving 2.4%, the population of Pakistan wills two times to be able to 260 million because of the season 2035. The economic inference of this rapid development is actually huge and translates into very poor standard of living along with wellbeing with an average Pakistani. Pakistan provides one particular of the most severe records in female health insurance and education and learning within South Parts of Asia. Databases in Pakistan regarding women’s' health is deficient; biomedical, epidemiological along with socio-economic data are essential to be able to determine females’ wellbeing standing and to evaluate similar interventions (Ali et al., 2000 and Agarwal 2002). Each tehsil and sub tehsil has a Rural Health Center. Each RHC serves 100,000 individuals per year with 10–20 inpatient beds. Lady Health Workers maintain close links between rural health centers and indigenous communities (LHWs). For the selection of RHCs, the list of RHCs was obtained from the department of health, Government of the Punjab (Zakar et al. 2012). The World Economic Forum Pakistan is the ranks 151st ’s Global Gender Gap Report, third from last on the list (World Economic,2020). Women in three groups were included: women in the community under the age of 18 to 25; Community Resource Persons (CRPs) from the National Rural Support Program (NRSP), the largest community development program for women aged 26 to 49, working with 3.6 million poor households in Pakistan. CRPs are rural women who are recruited into community organizations and are trained in leadership, communication, and community support. They are involved in several development initiatives, including the provision of healthcare (PINS,2021). There are 5,336 Basic Health Units

(BHUs) and 560 Rural Health Centers in Pakistan, which together make up the country's well-structured system for the delivery of primary healthcare services (RHCs) (MOF,2006). However only 22% of the population uses government health services and utilization of primary care units is particularly low (PSLM,2012).

Objective

Identify economic issues affecting rural women's health care access
In exploring the sociocultural factors that play a role in rural women's access to health care
To provide gender-equitable access to health services for rural women.

REVIEW OF LITERATURE

In rural areas Pakistan's population 68 percent lived. Most Pakistan's national NGOs, the government, and the media do not pay special attention to the health problems that are prevalent in the country's rural areas, even though some smaller groups and UN bodies are aware of the situation in Pakistan. The health care system in Pakistan suffers from structural fragmentation, insensitivity to gender issues, limitations of resources, inefficiency, and a lack of accessibility and utilization. (Anwar,2013).

Problem Identification

Rural areas lack emergency maternity centers. From May 2010 to December 2011, the survey was performed. 314,623 women at 16 hospitals in Punjab, Sindh, and Islamabad were surveyed to determine maternal and neonatal issues. There were 94 cases of maternal mortality that were very close to missing the threshold, and there were 38 maternal deaths, for a total maternal mortality rate of 299 per 100,000 births. (Iftikhar,2014)

Rural healthcare access

Maternal mortality and morbidity are problems in rural Pakistan. Progress highlighting proportion of women (15-49) who gave birth in last 3 years and were accompanied by trained birth attendants is rather satisfactory; maternal mortality is unsatisfactory. The mortality rate has declined. Out of 100,000 live births, 350 mothers died from pregnancy problems in 2000-2001 and 400 in 2004-2005, when the MDG target is 140. Skilled birth attendants and antenatal care targets are on track but still need work in Pakistan. The mortality rate has declined. Out of 100,000 live births, 350 mothers died from pregnancy problems in 2000-2001 and 400 in 2004-2005, when the MDG target is 140. Skilled birth attendants and antenatal care targets are on track but still need work in Pakistan (Iftikhar,2017).

Health Services Access

Patient and care-delivery variables hinder rural communities' access to health care. Rural residents are more likely to be impoverished, uninsured, or heavily reliant on Medicaid and Medicare. They also travel further to receive medical, dental, and mental health treatment. Less than half of rural mothers live within 30 minutes of a perinatal hospital. Within a journey time of sixty minutes, the percentage rises to 87.6 percent in rural communities and 78.7 percent in the most isolated regions (Hart,2005).

Behaviors Related to Health

When compared to urban inhabitants, rural dwellers have less access to nutritious food and fewer opportunities to be physically active, both of which can contribute to obesity and high blood pressure. Rural residents smoke more, increasing the risk of chronic diseases (Jones2008).

Health Care Access

Rural counties have fewer doctors, nurses, critical care units, emergency facilities, and transportation choices. Uninsured residents live further from health services (Frost,2013).

Theoretical framework

Theoretical frameworks are crucial in research because they define the constructs and their relationships. An understanding the research's theoretical constructs helps the researcher understand when, how, and why things occur. Moss's complete model of elements impacting women's health was used to construct a theoretical framework (Raza,2022). A Framework for the Patterning of Women's Health," she explains how socioeconomic and gender inequality determinants affect women's health. The framework uses historical, geographical, legal, and political models to describe how men and women live, including cultural aspects that affect their behavior (Moss, 2002). Several situations, long-established values in the families become too inflexible in Pakistan. Marriages are unfair between genders due of economic inequality (Siddiqui, Farah, & Malik, 2021).

Significance of the study

Pakistan's rural population increased 1.58 percent from 2019 to 2020, to 138,797,696. Pakistan's rural population increased 1.6% in 2019 to 136,637,555. Pakistan's rural population increased 1.72 percent in 2018 to 134,412,664. Pakistan is an agriculture country in which 70 percent of the population lives in rural areas. There is a lack of facilities in rural areas in which education, health and necessity of the life. Pakistan total population is 130.6 million in 1998 in which almost 52 percent female 48 percent mail. 70 percent of the whole population of Pakistan lives in rural areas where people face many problems and live very difficult life. The lively hood of the people in rural areas concerned with agriculture and its related occupations. Female of the rural area live a very hard life and work in different accepts domestic work, cultivation of (crops, wheat's, etc.) and bearing the children. But unfortunately, all her hardships there is no reward for women. When a female fell in disease there is no proper health facilities in their area so that family member uses traditional practices to recover her. Government also does not concern to give health facilities in rural areas that's why people who live in rural areas indulge in many physical and mental diseases especially women because if there is any health center it is not in the essay access of women in rural areas. The health center in rural areas does not have proper medical staff and medicine. During pregnancy rural women face problems and make delivery from local Mid Wife due to non-availability of Lady Doctor in their area.

Description of Muzaffargarh

Muzaffargarh is usually a section in the southerly with the Punjab domain of Pakistan. It can be part of Saraiki Waseb. It can be distribute in excess of a region of 8, 249 km². Muzaffargarh Section is based on your reel between streams Chenab along with Indus, which usually transfer your Asian along with American limitations respectively with the section along with variety some sort of triangle at Ali Pur Tehsil with the Section. This Section is bounded to the north simply by Section Layyah, on the southerly simply by Bahawalpur along with Rahimyar Khan Zones throughout the water Chenab. Zones Multan along with Khanewal is generally on the Japanese side of Section Muzaffargarh, throughout the water Chenab. Section Jhang details that on the northeast. Dera Gahzi Khan along with Rajan Pur Zones lies on the traditional western side throughout the water Indus. It can be certainly one of older zones of Punjab. Based on the 1998 census of Pakistan, people with the Section seemed to be 2, 635, 903, which 12. 75% were being Urban.

METHODOLOGY

Sampling

A sample of 100 females was selected by using simple random sampling technique from randomly selected four UCs in which MuradpurJanobi, Sultan pur, Fathepur and KhairPur Sadat and 25 respondents were selected from each UC. The researcher conducted in-person interviews with the female family members who were selected for the sample. In this research the process of information collection engaged at random selection of women contributors in BHUs along with RHCs connected with center Muzaffargarh. Members had been driven via several unification councils known as Fateh Pur, Murad Pur, and Sultan Pur along with Khair Pur Sadat farm areas. This researcher's verbally spelled out the emphasis of the study and it is aspires, plus spelled out the benefit of the study. Ethical consideration (such seeing that secrecy confidentiality, in addition to well informed consent) had been furthermore enchantment. This analysts made use of spoken well informed agreement; the primary reason pertaining to employing this kind of well-informed agreement seemed to be in which some of the girls (participants) did not realize how to go through and a few did not realize how to generate. This is performed so that each of the contributors could well be on the same level concerning the participation from the study; consequently we all chose an all-inclusive technique connected with well-informed agreement.

Statistical Analysis

Chi-Square

The Chi-Square test was used to investigate the nature of the link between the independent and dependent variables, and the values of X2 were determined by applying the formula that follows:

$$X2= \Sigma\ (fo-fe)2fe$$

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.181[a]	1	.140		
Continuity Correction[b]	1.060	1	.303		
Likelihood Ratio	3.808	1	.051		
Fisher's Exact Test				.209	.151
Linear-by-Linear Association	2.159	1	.142		
N of Valid Cases[b]	100				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 1.65.
b. Computed only for a 2x2 table

Chi- Square Test

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.280[a]	2	.004
Likelihood Ratio	7.567	2	.023
Linear-by-Linear Association	.428	1	.513
N of Valid Cases	91		

cells (50.0%) have expected count less than 5. The minimum expected count is .31.

Chi- Square Test

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.619[a]	*9*	.382
Likelihood Ratio	10.172	*9*	.337
Linear-by-Linear Association	.026	*1*	.872
N of Valid Cases	100		

a. 8 cells (50.0%) have expected count less than 5. The minimum expected count is .10.

RESULTS

The representation of age of respondent's age was broad, with 9 percent between 18- 22 years, 13 percent from 23-27 years, 25 percent from 28-32 years, 17 percent from 33-37 years, 19 percent from 38-42 years and 17 percent between 43-47 years. Table shows that most of the respondent's 25 percent were from the age group range 28-32 years followed by 19 percent respondents from age group 38-42. While a smaller number of respondents 9 percent were from the age group 18-22 years. The representation of respondents by their marital status. There was a 95 percent respondent were married, one percent was divorced, and 4 percent were widow. So that most of the respondents were married from information were collected. Most of the respondent 95% are married who face health related problems. The result shows that most of the respondents from information were collected married that also face the health problems in that area. The respondents by their age at the time of marriage. There was 42 percent respondents said that at the time of their marriage their age were between 15-18, 36 percent in 19-22, 20 percent in 23-26 and only 2 percent respondent's marriage in 27-30. Table shows that most of the respondent's 42 percent were from the age group range 15-18 years at the time of marriage followed by 36 percent respondents from age group 19-22 years at the time of marriage. While a smaller number of respondents only 2 percent were from the age group 27-30 years at the time of marriage. So early marriage practices are most commonly in District Muzaffargarh. In respondents by their number of children. There were 35 percent respondents said that they have 0-2 children, 32 percent 3-5 children,25 percent have 6-8 and 8 percent respondents have 9-11 children. Table shows that most of the respondent's 35 percent respondents have 0-2 children followed by 32 percent respondents have 3-5 children. While a smaller number of respondents only 8 percent respondents have 9-11 children. The data shows that 43 percent respondents were illiterate, 32 percent were primary, 7 percent were middle, 9 percent were matric, 9 percent were intermediate, 3 percent were graduation and 3 percent were master. We can conclude

that most of that majority of the respondents were illiterate. So, education also matter awareness about health-related problems and also with education women can take decision about their health and also can provide better heath to their children. The respondents by their occupation and among the total respondents, 90 percent were housewife and 10 percent were working in the private and public job. From the above table it is observed that, majority 90 percent respondents were housewife. The result shows that most of the women from information was collected were housewife that totally dependent on their family especially their husbands in the rural areas that's why they don't have proper information and also not economically strong. The distribution of respondents by their family monthly income. Among the total respondent's 40 percent of the total family monthly income were Rs.5000-10000 while 41 percent family monthly income were Rs. 10001-20000, 14 percent monthly family income were Rs. 21000-30000 and 5 percent respondents' monthly income were above Rs. 30001-40000. The respondents by their family type that 30 percent respondents live in nuclear family system and 70 percent joint family system. Most of the respondents 70% are living in joint family system. The result of the question shows that most of the respondents live in the joint family system in which head of the family was male who decide about all the family matters due to male headed family women totally ignored. The respondents by their general health status that 6 percent respondent's health was normal, 9 percent were living in good health and 85 percent were in bad health status. So that most of the respondent 85% are living in bad health condition. The result shows that in rural areas women live in the bad health condition and face many problems due unavailability of the health facilities. Females in those areas also bondage in their traditional unfair activities and spiritual myths. In it respondents by their reasons of the bad health status that 56(65.9%) respondents were think that reasons behind their bad health is due to general diseases, 22(25.9%) respondents associated bad health reasons with pregnancy,7(8.2%) respondents indulge any other particular disease. The result of the above question shows that most of the rural women involve general heath diseases in which fever, cough and etc. this is bad thing that in that areas there is not availability of treatment regarding general diseases so that women face many problems in the rural areas. Respondents by their causes of illness that 34(36.2%) respondents said that their illness causes is domestic issues, 32(34%) respondents associated illness with economic pressure and 28(29.8%) respondent said that it is due to other causes. The result of the above question shows that in rural areas women face health problems due to low economic condition, domestic issues and many other family related problems domestic issues and many other family related problems. In the rural areas women face many problems these are health, mental and many other problems. In it 7(7.2%) respondents said that not their illness is not the issue of whole family and 90(92.8%) respondents said that their illness is the issue of the whole family. So that 92.8% respondents replied that their illness is the issue of the whole family. The result of the above question shows that in rural areas when any one of the family members fell ill they consider whole family issue. In the rural areas it is common thing that when an individual of the family fell ill it become the whole family concern and all members of the family try their best to recover that family member especially when female was not feeling well because all the work of the home done by the woman. Respondents by their family behavior towards them that 34(37.8%) respondents said that their family behavior positive, 23(25.6%) respondents said that their family behavior negative and33 (36.7%) respondents said that their family behavior normal. The women said that when they fell ill the response of the family members was positive and try to solve the problem but most of the time medicine take from the nearest health center means the wise women or men of their areas. The respondents said that health related issues may affect them. So that 100% respondents answer that the health-related issues affected them. The result of the above question shows that health related issues affect overall the women in the rural areas. 40 percent respondents said that they face physical problems, 55 percent mental stress and 5 percent face other problems. So that 55% respondent face mental stress due to health-related problem. In the rural areas women face many forms of health-related problems in which physical, mental and many other problems. Respondents by their visit doctor whenever they sick. Among the total respondents that 22 percent said that they did not visit doctor whenever they sick, 78 percent said that they visit doctor whenever they sick. In the rural areas most of the women do not visit the doctor or lady doctor when they face health problems and prefer the traditional treatment from the wise man and women in their area. Among the total respondents 11(14.1%) said that they visit every time when sick, 20(25.6%) visit some time and 47(60.3%) depends on the intensity of illness. In the rural areas when a female fell ill firstly there is no availability of the health center or any medical center also private medical complex that's why

when female or any member of the family fell ill they preference the traditional treatment activities. The respondents have health facility in their area. Among the total respondents11 percent said that they did not have health facility in their area and 89 percent answer yes, they have health facility in their area. 89% respondent replied they have health facility in their area. In the rural areas there is no proper health treatment and people face trouble because health center is far away. Also due to unavailability of traffic in the rural areas people face much hardship to reach the health center. The respondent is satisfied with available facility at their area. Among the total respondents 48(53.3%) said that they did satisfy the health facilities available in their area and 42(46.7%) were satisfied the health facilities available in their area. So that 53.3% respondent are not satisfied the availability of health facility in their area. Respondents have easy access to health care facility. Among the total respondent's 85 percent said that they did not have easy access to health care facility and 15 percent have access to health care facility. In the rural areas very a few health center and also lack of the any doctor because no doctor ready to work in the fare away rural areas that's why people face many problem especially female regarding health facility. The data shows that distribution of respondents have not easy access to health care facility then what are the reasons behind. Among the total respondents25 (29.8%) said that they have transportation problems, 47(56%) said health facility are expensive and costly and 12(14.3%) said non-cooperation of family. Table shows that 56% respondent not easy access to health care facility due to expensive and costly treatment. The 9 percent respondents said no when they fell ill the decision of their treatment made by their family and 91 percent said yes, the decision made by their family. So that 91% of respondent answer when they are ill the decision of their treatment taken by their family member. In it that the respondent illness condition whether the decision of their treatment be made. Among the total respondents80 (87.9%) said that their husbands made decision when they fell ill and 11(12.1%) said any other member of the family made decision. Table show that 87.9% decision made by their husband. The 29 percent respondents said that they did not experience gender discrimination during the course of treatment and 71 percent respondents said that yes they have experienced gender discrimination during the course of treatment.71%respondents experience gender discrimination during treatment. Table shows that 9(12 .7%) respondents said that they experience gender discrimination during treatment due to social prejudice, 24(33.8%) respondents said that they have experienced gender discrimination during the course of treatment due to gender biasness and 38(53.5%) respondents said that they have experienced gender discrimination during the course of treatment due to economic constrains. 53.5% respondent experience gender discrimination during treatment due to economic constrains. In its data shows that 9 percent respondents said that they did not experience the associate problem of pregnancy and 91 percent respondents said that yes they experience the associate problem of pregnancy.91% respondents answer they face pregnancy problem. In the rural areas females has no awareness about the any pregnancy related problem and also female specific problems because there is a few health visitors those not regularly visit the homes. The 43(47.3%) respondents said that they face prenatal problems, 18(19.8%) respondents said that they face intra-natal problems and 30(33%) respondents said that they face postnatal problems.47.3% respondents answer they face pregnancy prenatal problems. The rural women indulge the pregnancy related diseases in which most of the female involved in parental or heredity diseases and inter-natal and some of the women face postnatal diseases because the unavailability of the health facilities. Table shows that 33(36.3%) respondents said that they discussed the associated problem of pregnancy with their mother, 7(7.7%) respondents said that they discussed the associated problem of pregnancy with their mother-in-law and 51(56%) respondents said that they discussed the associated problem of pregnancy with their husband. The rural women feel ashamed to discuss their pregnancy related problems to their entire family member they discuss mostly their husband, parents and mother-in-law or any other old female family member. Table shows that 20 percent of respondent said that no facility of female medical staff in their area and 80 percent of respondent are said that yes.80% respondents have not female medical staff. Table shows that 4(5%) of lady doctor in area and 76(95%) are lady health visitor. Table shows that 89 percent of respondent suffering complication during pregnancy and 11 percent respondent said that are no complication during pregnancy. Table shows that 20(22.5) suffering blood pressure during pregnancy, 63(70.8%) are suffer in anemia and 6(6.7%) are suffer in any other diseases.70.8% respondents face the anemia problem during and after pregnancy. Table shows that 25(25.3%) respondents not their family did not believe in traditional practices of midwifery and 74(74.7%) answer yes their family still believe in traditional midwifery. **T**able shows that 19(25.3%) respondents

said their family belie traditional practices of midwifery due to social taboos, 4(5.3%) belie due to their rigidity and 52(69.3%) answer those traditional practices of midwifery due to traditionally belief system through generation to generation. Table shows that 87percent respondents said not availability of transportation and 13 percent respondents said yes there is availability of transportation in emergency. Table shows that 3(3.4%) respondents said that in case of emergency they use their convince and 85(96.6%) use private transport. Table shows that 78 percent respondents said that they have no access to nutrition food during pregnancy and 22 percent answer yes they access to nutrition food during pregnancy. Table shows that 19(24.4%) respondents said that they have not access to nutrition food during pregnancy due to unawareness, 44(56.4%) answer due to economic barrier and 15(19.2%) replied due to careless attitude of family.

DISCUSSION

This study aimed to highlight the factors underlying the absence of adequate health services in rural areas and recommend remedial approaches to improve the situation in remote Pakistan. According to the information that was gathered in India, almost 80 percent of the country's 25,300 primary health clinics did not have a doctor, 38 percent did not have a laboratory technician, and 22 percent did not have a pharmacist. Even in health facilities where the staff had been posted; their availability remained in question because of high rates of absenteeism. The majority of the respondent 95% are usually hitched exactly who experience health related issues. Matrimony as well as wellness are usually strongly related. Married people expertise reduce morbidity as well as fatality around like diverse wellness hazards because cancers, center assaults, as well as medical procedures. Simply being hitched, in addition to the high quality regarding one's marital life, has been connected to diverse actions regarding wellness. Investigation offers looked at the particular social-cognitive, psychological, behavior as well as scientific functions involved in most of these back links. The majority of the women through details was gathered were household girl which fully relying on their own loved ones especially their own husbands from the non-urban areas that's the reason that they don't have got proper details plus not monetarily strong. Normally, inhabitants teams which suffer the particular worst type of wellness position can also be those that have the biggest lower income premiums plus the lowest knowledge. Disparities in profits as well as knowledge levels are usually related to variances from the event regarding illness as well as passing away, which include heart problems, diabetes, unhealthy weight, improved body amount, as well as low delivery excess weight. Greater incomes let increased having access to health care, allow people to pay for much better homes as well as reside in better communities, as well as boost the chance to participate in health-promoting behaviors. 89% respondent replied they have health facility in their area. Because Pakistan is a developing country, its women, particularly those living in rural regions, are forced to contend with many health issues. It is estimated that about 1,600 women per 100,000 die during childbirth. 53.3% respondent are not satisfied the availability of health facility in their area. The main reasons of this alarming percentage are lack of education, health care centers and tribal customs that restricted the women from clinical tests. In most of the rural areas most of the tribal customs forbid women to work and to be visited by male doctors, as a result most of the women do not go to hospital for check-ups. 85% respondents have not easy access to health care facility. The primary objective of this portion of our research is to identify the most effective measure that the villagers can do to lower the number of maternal mortality rates. Based on several studies that have been conducted about health and education in Pakistan's rural areas, it is safe to say that most of the rural population is not educated. Consequently, by taking into consideration the high degree of illiteracy that exists within the rural people in Pakistan, we intend to use the icon base design. The following essential elements are going to be incorporated into this style of design: 56 percent respondent not easy access to health care facility due to expensive and costly treatment. 91% of respondent answer when they are ill the decision of their treatment taken by their family member in which and 87% respondents answer that there is not transportation availability in emergency. 78% respondents answer that they have no access to nutrition food during pregnancy.100% respondent's answer that education can improve health status of rural women. 63% respondents answer that with education it can be better approach to health facilities.

The early stages of pregnancy are when the baby is growing, and personal behaviors like smoking, drinking, coffee, using certain medications, and using illicit drugs can have a detrimental and irreversible impact on this process. The role of rural women should be promoted through print

and electronic media. It is necessary to conduct health promotion initiatives to effect a change in the health-seeking behaviour of rural women. To make the healthcare system more adaptable, significant consideration ought to be given to the existing social systems. In government health facilities, there should be a greater proportion of female employees. Rural women face inferior health outcomes and have less access to health care than urban women. In many rural areas, the number of medical professionals, particularly those who specialize in the care of women, is severely lacking.

CONCLUSION

The country of Pakistan's health care system has been ignored for a very long time. The social, professional, and financial opportunities available to physicians who work in rural health care facilities are severely constrained. A powerful component in motivating medical professionals to work in rural parts of Pakistan and ensuring that they stay in those positions is to hire them on a temporary rather than a permanent basis and pay them more than the going rate in the market. In Pakistan, the multi-disciplinary approach that aims to achieve a rural work-friendly environment that is comprised of well-paid doctors who are also in touch with the mainstream health industry through continuous professional development is the need of the hour. This approach was developed with the goal of achieving this environment. Because eventually all these measures will not only help in improving the health of rural Pakistanis, but they will also help decrease the load on tertiary care hospitals due to unnecessary referrals for understaffed rural health centers. This is because eventually all these measures will become effective. The findings of this survey also revealed that the respondents are taking part in community and school screening camps for their various health-related issues. To summarize, one could reach the conclusion that the sole source available to the community in rural areas for the acquisition of health care facilities was through community centers and non-government organizations.

Suggestion

- Government should provide Lady Doctors in Basic Health Unit because our cultural values became hurdles to treat the women from male Doctor.
- Government should provide Ambulance for emergency at every Basic Health Unit.
- Government should insure the presence of Medical staff at every Basic Health Unit.
- Government should provide necessary medicine on every nearest Basic Health Unit.
- Government should telecast awareness programs women related issues on Television or Radio.
- Lady Health worker visit properly to the homes to give awareness the women about health related problems.
- Parents should give at least primary education to female children.
- Family members should positive response to women access to health services.
- Family member avoid from local mid wife during delivery.
- Parents/Family members should avoid to local and cultural treatment regarding women health.
- Parents/Family members should avoid the practice of early child marriage.
- Parents should give preference only two children.
- Parents should give basic information related pregnancy and its complication to the female after marriage.
- Husband/Family member should provide proper nutrition to the women when they are pregnant.
- Husband/Family members should avoid put over burden on female during pregnancy.
- Women should care herself during pregnancy and take proper rest.

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