A Review of Barriers and Disparities in Reproductive Health Services: With Special Emaphasis on Young Mothers in Pakistan

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https://doi.org/10.62345/jads.2026.15.1.8

Abstract

Reproductive health is a key part of both public health and human progress, but there's still a huge gap between regions. Here, I'm pulling together what the research says about where things stand, focusing on the challenges young mothers face in places with limited resources—especially in Pakistan. It investigates multifaceted barriers (socio-economic, cultural and systemic) that limit access to and utilisation of essential RH services. The review highlights interactions between less-than-optimal reproductive health outcomes and other broader problems of poverty, gender inequality, and lack of female empowerment. Evidence shows that maternal mortality and morbidity are unacceptably high in Pakistan and are attributed to issues such as low rates of skilled birth attendance, unmet needs of family planning and early marriage. The findings underscore the need for targeted interventions on improving the quality, accessibility and acceptability of RH services as well as policies that enable women to make informed decisions about their sexual and reproductive life.

Keywords: Young Mothers, Reproductive Health, Health Disparities.

Introduction

Reproductive Health (RH) is traditionally defined by the World Health Organisation (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease in all matters relating to the reproductive system" (WHO, 2013). In this context, an individual has the rights to a "satisfying and safe sex life", to be able to conceive, to decide whether, when and how often to bear children, and the right to safe and effective and affordable methods of family planning and appropriate care in connection with abortion and maternity (Khan, Shaikh, & Abbas, 2007; WHO, 2013).

According to this definition, the RH issues base should not disproportionately hold back women of low social and economic strata around the world, especially since "women in the childbearing age lose millions of productive life years annually, and this crisis remains unresolved and neglected within the social and economic fabric of society" (World Bank, 2004; UNFPA, 2005c). With this premise, the present review focuses on assessing the reproductive health, both globally and nationally (Pakistan), to identify priority areas for effective planning, action, and response.

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Compliance with ethical standards: There are no conflicts of interest (financial or non-financial). This study did not receive any funding.

Conceptual Framework

This review is informed by a synthesised conceptual framework comprising the Social Ecological Model (SEM) and the Health Belief Model (HBM) to systematically analyse the multifactorial web underlying reproductive health outcomes. The SEM, as formulated by McLeroy et al. (1988), assumes that health behaviours are influenced by intrapersonal (individual knowledge and attitudes), interpersonal (family and social networks), organisational (health systems), community (cultural norms), and public policy factors. The model is especially applicable to the interaction between barriers at various levels that limit service use, including the lack of autonomy (intrapersonal), the husband's negative attitude towards contraception (interpersonal), and the unavailability of close health facilities (organisational) in the scenario.

This systematic knowledge is complemented by the HBM, which helps explain individual health decision-making. The HBM postulates that individuals are more inclined to do something to prevent disease when they believe they are susceptible to a state (perceived susceptibility), that they believe it would have severe outcomes (perceived severity), that they believe a course of action they can take will benefit them (perceived benefits), and they believe that they do not experience a lot of barriers to undertaking that course of action (perceived barriers) (Rosenstock, 1974). Using this in the Pakistani setting, a young mother might fail to take the antenatal care in the situation where she does not feel her pregnancy to be at high risk (low perceived susceptibility) or the situation where cultural demands (a barrier) would not allow her to go to a clinic alone. The combination of SEM and HBM can help this review not only investigate the structural and cultural obstacles but also examine how they are formed and how they affect individuals' perceptions and choices regarding access to reproductive health services.

Global Disparities in Reproductive Health

A large gap in sexual and reproductive health outcomes exists between high and low-income countries. While there have been improvements in some of the poorer regions, maternal conditions are the fourth highest cause of female deaths in these settings, behind HIV/AIDS, malaria and tuberculosis (WHO, 2013). The risk of maternal mortality over a lifetime is a clear and shocking expression of this imbalance: in Sub-Saharan Africa, for instance, about one in 16 women dies from a pregnancy-related cause, while in developed countries one in 4,000 dies (WHO, 2013). In developing nations, maternal health issues account for almost 20 per cent of the total disease burden (Wikipedia Foundation, 2007).

A critical social determinant of exacerbating these disparities includes the practise of early and forced marriage, which remains prevalent in parts of Africa and South Asia (Naheed, 1997; UNFPA, 2005a). This kind of sexual violence has devastating consequences, which restrict educational opportunities for girls (Jain and Kurz, 2007; Nguyen and Wodon, 2012) and expose them to reproductive health complications and HIV/AIDs (UNICEF, 2006; Shah et al., 2011).

The Routine Mortality and Morbidity of Maternal Health

For every woman who dies from pregnancy-related complications, an estimated twenty to thirty other women are injured or disabled, equating to eight to twenty million women every year (UNFPA, 2005a). A mother's death has a cataclysmic rippling effect, which leaves children vulnerable to suffer poor health, poverty and exploitation. Even non-fatal disabilities may destroy the ability of the woman to contribute to the welfare and economic stability of her family and perpetuate the cycle of poverty (UNFPA, 2005a).

Mothers encounter distinct challenges. Approximately sixteen million girls aged 15 to 19 give birth each year and face an elevated risk of developing obstetric fistula and are particularly susceptible to human immunodeficiency virus and other sexually transmitted infections (STIs) (Population Council, 2009; WHO, 2012).

The Context of Reproductive Health in Pakistan

In Pakistan, one in every 38 women is at risk of dying due to pregnancy-related causes. The quality of healthcare is a big barrier; utilisation is more strongly affected by perceived quality of care than is physical access to facilities (Acharya & Cleland, 2000). Many emergency obstetric scenarios can occur unexpectedly and unpredictably. That's why early detection of problems and having a reliable referral system are just as important as regular prenatal visits.

Service utilisation remains improper. One in three pregnant women in Pakistan receives any antenatal care at all, and only about 20% of deliveries are attended by trained personnel (Tinker, 1998). As a result, the lifetime risk of maternal death among Pakistani women is one in 38. The quality of healthcare is a significant barrier; utilisation is more strongly affected by perceived quality of care than is physical access to facilities (Acharya & Cleland, 2000). Obstetric emergencies can arise suddenly. Therefore, the ability to recognise problems and have a functional referral system is as important as the basic prenatal service.

Leading Factors

The crisis in the state of reproductive health in countries like Pakistan is caused by a combination of factors:

Socio-Economic Factors: Poverty, low level of female education and deeply rooted cultural issues, such as early marriage and lack of female autonomy, are some of the fundamental 'barriers'.

Women's Empowerment: The inability of women to make autonomous decisions concerning their own health, including the use of contraception or seeking medical care, continues to be a critical impediment.

Health System Deficiencies: The quality, availability, and accessibility of RH services are seriously impaired, including a shortage of skilled health personnel, especially in peripheral areas, and a lack of emergency obstetric care.

Knowledge and Perception: Community perceptions, attitudes, and practices regarding reproductive health, often shaped by misinformation and cultural taboos, profoundly influence service utilisation.

Conclusion

Reproductive health is not just a health issue; it's primarily a problem with social justice and human rights. This review has concluded that much of the inequality witnessed in Pakistan is neither the cause of personal malfunctions but a product of interdependent obstacles that act at multiple levels of the social ecosystem. The high levels of maternal mortality and low rates of service utilisation in Pakistan are very clear signs of failures systemic to the health system, an issue that is enhanced by the socio-cultural structures disempowering women, especially the young mothers. The utilisation of the Social Ecological Model and the Health Belief Model shows that effective interventions should not be confined to delivering services but should also aim to change perceptions, cultural norms, and the lack of systems that underlie why these interventions are not used.

The deep inequalities seen both between and within countries highlight the need for action. One of the lowest areas of utilisation of services is Pakistan, where the use of services is notably low, high maternal mortality and low service utilisation indicate failures in the health system and the underlying socio-cultural structures. To improve the reproductive health state of young mothers, the policymakers must adopt a multi-pronged approach:

Strengthen Health Systems: Train and deploy more skilled birth attendants , increase the availability of emergency obstetric care services, and ensure the quality of RH services.

Fulfil the Need for Family Planning: Increase access to a broad range of affordable, acceptable and modern contraceptive methods through effective community-based programmes.

Empower Women and Girls: Implement policies that foster girls' education, help delay early marriage. Moreover, enhance women's autonomy in decision-making regarding their health and fertility.

Community Engagement and Education: Launch awareness campaigns to break down harmful taboos, replace them with accurate information about reproductive health, and foster positive health-seeking behaviours.

Improve Data Collection and Monitoring: Develop stronger systems to track maternal deaths and complications, better understand causative factors, and measure the impact of interventions.

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