Assessing Impediments to Healthcare Access for Children Under Five in Larkana, Pakistan Using the Three Delays Model

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Abstract
Background: Despite national improvements, Larkana district in Pakistan suffers from high under-five child mortality. This study employs the Three Delays Model (TDM) to identify impediments to healthcare access for children under five in Larkana, informing interventions to combat preventable deaths.

Methods: In January–April 2021, Larkana hospitals randomly sampled 390 parents/guardians for a cross-sectional study. For the TDM’s three delays—recognizing and acting on sickness, obtaining care, and receiving sufficient treatment—semi-structured interviews examined sociodemographics, care-seeking habits, and obstacles. Sociodemographic characteristics and care-seeking habits were examined using frequencies, percentages, and chi-square tests in SPSS v22.

Results: Results show 47% of mothers and 29% of dads were uneducated. Homebirths were 49.7% of all births; 36% of respondents preferred traditional healers, contributing delay-1. Transportation issues (17%) of cases, and extensive travel durations, surpassing 3 hours in 84%, caused delays. Healthcare costs, with 43% of people spending above 1000 rupees, are one of three delays. Low-literate women are more likely to give birth at home (44% vs. 13%, p<0.001) and less likely to recognize danger indicators (61% vs. 89%, p<0.001). 86% of the population used rickshaws for transportation.

Discussion: This TDM-based analysis shows numerous interconnected impediments to child healthcare in Larkana. Targeted community education initiatives are needed since maternal education affects care-seeking and danger flag identification. Home births are common, thus institutional delivery procedures are needed. Government-subsidized transportation or increased health insurance are needed due to high expenses and lack of transit.

Keywords: child health, access to care, Pakistan, delays, children

Layman Summary
This research examined why Larkana, Pakistan, children had trouble accessing healthcare. Researchers utilised the "Three Delays Model" to highlight three key challenges: delays in recognising and reacting to sickness, delays in getting treatment owing to transportation or financial constraints, and delays in obtaining effective care at healthcare facilities. The research discovered that many moms are uneducated, which raises the risk of home births and missing early indicators of disease in their children. Families sometimes utilise rickshaws, which might take hours to reach healthcare services, particularly in outlying locations. Many families avoid medical attention for their unwell children due to hefty prices. Finally, lack of resources and skilled staff at certain hospitals makes service questionable. The researchers suggest education programmes for moms, better transportation, financial aid for families, and better healthcare professional equipment and training. We can provide all Larkana children the healthcare they need by solving these issues.
Introduction
While there has been significant advancement in child health worldwide, there still exist significant inequalities between affluent nations and underdeveloped ones, with Pakistan being confronted with a distressing situation [1]. Pakistan’s under-five mortality rate is 69 per 1,000 live births, which is higher than that of its neighboring countries in the region [2]. The situation is exacerbated by geographical disparities, since rural areas like as Larkana in Sindh province are disproportionately affected [3]. The dire situation in Larkana is shown by its elevated poverty rates, inadequate literacy levels, and restricted availability of healthcare services [4, 5]. The combination of these variables results in an alarming child death rate of 142 per 1,000 live births, which is more than twice the national norm [5]. The current occurrence of illness epidemics, like as HIV, highlights the susceptibility of children in Larkana [6].

This research examines the particular obstacles that parents and caregivers have while trying to get timely and suitable healthcare for their children under the age of five in the Larkana region. We use the Three Delays Model (TDM) as a fundamental framework for our inquiry [7]. The TDM was initially designed to examine maternal mortality by Thaddeus T, and Maine D [7]. It identifies three specific obstacles to accessing healthcare: (1) delays in identifying and responding to a child’s illness, (2) delays in reaching healthcare facilities due to logistical or financial limitations, and (3) delays in receiving appropriate care within the healthcare system [7]. Although not often used in the context of child health, the TDM provides a helpful perspective for analyzing the intricate interaction of variables that hinder healthcare access at many levels. By shedding light on these obstacles through the TDM’s comprehensive framework, this study aims to inform targeted interventions that will ultimately empower parents and caregivers in Larkana to make informed healthcare decisions for their children. Our findings hold the potential to contribute to the reduction of preventable child deaths and the broader improvement of child health outcomes in this vulnerable population.

Materials and Methods
Study Design and Setting
This cross-sectional study was conducted between January and April 2021 in five major hospitals located across Larkana district, Pakistan. Larkana experiences significant disparities in child health outcomes compared to the national average, making it an ideal setting to investigate underlying barriers to healthcare access.

Study Population
Eligible participants were parents or guardians of children under five years old seeking outpatient care at the selected hospitals. Participants were systematically recruited using simple random sampling from the outpatient department registers. To ensure representativeness, participants were stratified by hospital and age group (0-23 months and 24-59 months) before selection. Exclusion criteria included children hospitalized within the previous month, parents/guardians unable to provide informed consent, and children diagnosed with chronic medical conditions.

Prior to participating, all individuals underwent a thorough informed consent process. Participants received detailed information about the study’s objectives, methodology, potential risks and benefits, and data confidentiality procedures. They were explicitly informed of their right to voluntarily participate and withdraw from the study at any stage without providing any explanation. Signed informed consent forms were obtained from all participants, ensuring their understanding and agreement with the study procedures. This commitment to voluntariness and participant autonomy aligned with the Declaration of Helsinki principles. Additionally, the study protocol received prior approval from the Institutional Review Board of SZABIST, further ensuring adherence to ethical principles and participant welfare throughout the research process.

Sample Size Estimation
An appropriate sample size was determined using a priori power analysis based on an anticipated prevalence of 50% for encountering at least one barrier within the TDM framework. Considering a design effect of 1.5 and a desired margin of error of 5%, the calculated sample size was 384 participants. We aimed to recruit 390 participants to account for potential dropouts. The sample size was estimated based on an anticipated prevalence of 50% for the primary outcome variable. Additionally, a formal power analysis was conducted using G*Power software with the specified parameters, assuming an alpha level of 0.05 and a beta level of 0.2. This analysis resulted in a power estimate of 0.8, indicating sufficient power to detect the hypothesized effect size.

Recruitment
To achieve a representative sample of participants, the study employed a multi-step systematic random sampling approach. First, participants were stratified by hospital and age group to ensure representation from various segments of the population. Within each stratum, random selection lists were generated from outpatient registers, identifying individuals at predefined intervals. Trained research assistants then approached these individuals in waiting areas and clinic registrations, providing informed consent information and inviting their participation in the study. This approach aimed to minimize selection bias and ensure a diverse and representative sample.

Inclusion Criteria:
- Parents or guardians of children under five years old seeking outpatient care at the selected hospitals in Larkana district, Pakistan.
- Able to provide informed consent and participate in a semi-structured interview.
- Children within the specified age range (0-23 months and 24-59 months) to ensure representation across different developmental stages.
- No diagnosed chronic medical conditions, as these could introduce confounding factors.

Exclusion Criteria:
- Parents or guardians unable to provide informed consent due to language barriers, cognitive impairment, or other reasons.
- Children hospitalized within the previous month, as their experiences might not be representative of the general population seeking outpatient care.
- Healthcare workers or individuals with prior knowledge of the study, as this could introduce bias.

Potential Sources of Selection Bias and Mitigation Strategies
This study acknowledges various potential biases like non-response (mitigated by high participation rate and strict inclusion/exclusion criteria), recruitment setting (addressed by community outreach), sampling (improved by stratification by religion, ethnicity, and mother’s education), self-reported data (minimized by careful questionnaire design, anonymity, and pilot testing), and informed consent (prevented by neutral information and emphasizing voluntary participation). These efforts aim to generate reliable and generalizable findings reflecting the true challenges faced by parents/guardians seeking healthcare for children under five in Larkana.

Data Collection
Data for this study was collected through face-to-face interviews conducted by trained research assistants using standardized questionnaires translated into local languages. These questionnaires explored three main areas: 1) Sociodemographic information like parental age, education, and income, 2) Care-seeking practices, including preferred providers, utilization of healthcare facilities, and reasons for delays in seeking care, and 3) Barriers to healthcare
access, assessed through the Three Delays Model framework, covering factors like lack of knowledge about danger signs, transportation difficulties, and perceived quality of healthcare services. This comprehensive data collection approach aimed to gain a deeper understanding of healthcare access challenges faced by families in the study population.

Quality Control Measures
The questionnaires were piloted on a small sample before the main study to assess clarity and feasibility. Interviewers underwent comprehensive training on data collection procedures, ethical conduct, and interview techniques. Regular supervision and monitoring were conducted to ensure data quality and consistency.

Statistical Analysis
Data was analyzed using SPSS v22 software. Descriptive statistics (frequencies, percentages) were used to summarize categorical variables. Chi-square tests were employed to assess associations between sociodemographic factors and care-seeking patterns, with statistical significance set at p<0.05. Additional analyses, such as logistic regression, could be conducted to explore the strength and direction of identified associations, depending on the distribution of variables and available sample size.

Ethical Considerations
The study protocol was approved by the Institutional Review Board of SZABIST. Informed consent was obtained from all participants, ensuring adherence to the Declaration of Helsinki principles. Participants were informed about the study’s aims, data collection procedures, and their right to withdraw at any time. Anonymity and confidentiality were maintained throughout the research process.

Results
Characteristics of the participants (Table 1)
Our participants primarily identified as Muslim (97.4%) and Sindhi (92.1%). Nearly half of mothers lacked formal education (46.9%), mirroring a similar trend among fathers (28.5%). Worryingly, almost half of children (49.7%) were delivered at home, highlighting low skilled birth attendance.

The table 1 reveals the distribution of various characteristics within the analyzed population. The vast majority (97.4%) identify as Muslim, with smaller fractions identifying as Hindu (1.8%) and Christian (0.8%). Similarly, Sindhi ethnicity dominates (92.1%), with smaller groups of Punjabi (3.8%), Balochi (3.1%), and others (1.0%). Education levels are generally low, with nearly half of mothers (46.9%) being illiterate and over a quarter of fathers (28.5%) sharing the same status. Primary education holds the next highest share for both parents (16.7% and 26.2%, respectively). Higher education attainment remains modest, with graduate degrees present in only 2.8% of mothers and 12.6% of fathers. Similarly, Sindhi ethnicity dominates (92.1%), with smaller groups of Punjabi (3.8%), Balochi (3.1%), and others (1.0%). Education levels are generally low, with nearly half of mothers (46.9%) being illiterate and over a quarter of fathers (28.5%) sharing the same status. Primary education holds the next highest share for both parents (16.7% and 26.2%, respectively). Higher education attainment remains modest, with graduate degrees present in only 2.8% of mothers and 12.6% of fathers. Interestingly, almost half of the births (49.7%) occurred at home, compared to 33.8% in health facilities and 16.4% in other locations.

Main findings
Barriers corresponding to the Three Delays Model were assessed via the survey responses (Table 2). For delay 1, 36% preferred traditional healers as the first point of care during child illness. Delay 2 barriers included lack of transportation (17%) and long travel times to reach care (>3 hours for 84% of participants). Delay 3 results showed 43% spent over 1000 rupees (approx. 1000 Pakistani Rupees-PKR) for healthcare costs.

Barriers related to the three delays were also identified through focused survey questions. Table 4 summarizes the results. For delay 1, 26.7% preferred home care and 35.9% preferred traditional healers as the first recourse during child illness episodes. Delay 2 barriers included lack of transportation (17.7%), travel times exceeding 3 hours (84.1%), and transportation costs (58.6% spent >200 rupees). Delay 3 results showed that 40.3% were referred to another facility due to lack of supplies and 15.4% due to provider inability to manage the condition.

The results identified numerous barriers across the Three Delays Model that likely impede healthcare access for children under five in Larkana district. Low maternal education, home births, lack of knowledge about danger signs, and inadequate care at facilities all appear to play a role. Targeted interventions in these areas have potential to improve care seeking and child health outcomes. The tables provide a concise yet comprehensive summary of the study’s statistically strong results.
Discussion
This study, meticulously employing the Three Delays Model (TDM) framework, unrolls the intricate web of socio-economic, cultural, and logistical barriers impeding healthcare access for children under five in Larkana, Pakistan. The findings illuminate critical areas demanding tailored interventions to improve child health outcomes in this vulnerable population.

1. Unpacking the Socio-Economic Roots of Healthcare Disparities:
The high prevalence of home births (49.7%) among mothers with low education aligns with established research in similar contexts [8, 9]. This practice carries increased risks for both mothers and newborns [10]. Community-based health education programs targeting uneducated mothers, as the study suggests, hold promise [11]. Additionally, considering the high proportion of illiterate fathers (28.5%), interventions addressing gender dynamics and male involvement in healthcare decision-making could be valuable [12].

Early childhood development initiatives fostering female literacy and empowerment alongside programs educating fathers on the importance of skilled birth attendance and institutional deliveries, as proposed by the study, deserve long-term consideration [13].

Alternative Explanations
- Cultural beliefs: Certain cultural norms or beliefs regarding pregnancy, childbirth, and child healthcare might influence delivery location choices beyond education levels. Exploring the role of specific cultural beliefs and attitudes could further explain home birth prevalence.
- Distrust in healthcare system: Previous negative experiences with healthcare services or lack of trust in healthcare providers could contribute to home births, even among mothers with some education. Qualitative research delving into community perceptions of healthcare could shed light on this aspect.

Limitations of self-reported data
Self-reported data on reasons for home births and healthcare utilization might be subject to recall bias or social desirability bias. Future research employing mixed methods approaches, including observations and in-depth interviews, could provide more nuanced insights.

2. Beyond Transportation: Deconstructing Accessibility Challenges:
While the study highlights reliance on rickshaws (86%), further investigation into affordability, availability, and reliability of other options for women and young children, especially over long distances (84.1% facing travel times exceeding 3 hours), is crucial [14]. Geographical disparities within Larkana exacerbate the problem [15]. Exploiting mobile healthcare clinics or telehealth initiatives, as suggested by the study, could bridge the gap and improve accessibility for remote areas [16].

Alternative Explanations
- Availability and affordability of alternative transport: While the study highlights rickshaw reliance, the lack of data on accessibility and affordability of other options like cars or public transport makes it difficult to draw definitive conclusions. Further research exploring availability, affordability, and reliability of different transport options, especially for vulnerable groups, is necessary.
- Social norms and gender roles: Cultural norms or gender roles might restrict women's mobility, limiting their ability to utilize even available transport options for accessing healthcare. Investigating the influence of social norms and gender dynamics on travel decisions could provide valuable insights.

Limitations of self-reported data
Self-reported data on travel times and distances might be prone to estimation errors. Utilizing GPS tracking or GIS mapping could offer more accurate information on accessibility challenges.

3. Financial Burdens: Eroding Trust and Deterring Care-seeking:
High healthcare costs (43% spending over 1000 rupees) identified in this study present a significant barrier, disproportionately impacting vulnerable families [17]. Delving deeper into types of expenses, as recommended, would provide further insights. Evaluating the effectiveness of existing health insurance and financial assistance programs, as suggested, is crucial to identify gaps and limitations [18]. Targeted subsidies for vulnerable groups, improved insurance schemes, and cost-reduction measures within healthcare facilities, as proposed by the study, can alleviate financial constraints and encourage timely care-seeking [19].

Alternative Explanations
- Informal healthcare expenses: The study focuses on reported healthcare costs, but informal payments or hidden costs not captured might contribute to the financial burden. Examining the prevalence and impact of informal payments could provide a more comprehensive picture of financial barriers.
- Knowledge of financial assistance programs: Lack of awareness about available financial assistance programs or challenges in accessing them could contribute to delayed care-seeking even among eligible families. Assessing the reach and effectiveness of existing programs is crucial.

Limitations of self-reported data
Self-reported data on healthcare expenditures might be subject to recall bias or underreporting. Utilizing healthcare facility records or conducting detailed expenditure surveys could provide more accurate information.

4. Quality of Care: A Cornerstone of Effective Healthcare Delivery:
The high number of referrals due to lack of supplies (40.3%) and provider limitations (15.4%) raise concerns about quality of care. Resource deficiencies, inadequate equipment, and insufficient provider training, as identified by the study, can erode trust in healthcare services and deter further utilization [20]. Upgrading healthcare facility resources, implementing comprehensive provider training programs, and establishing robust quality monitoring systems, as suggested in the study, are essential to ensure efficient and effective care delivery, ultimately improving child health outcomes [21].

Alternative Explanations
- Provider workload and burnout: High referral rates due to lack of supplies or provider limitations might be influenced by factors like heavy workloads or provider burnout. Investigating workforce challenges and their impact on quality of care is important.
- Perceived quality of care: The study identifies concerns about quality, but these perceptions might not always reflect actual service quality. Including patient satisfaction surveys or objective assessments of care quality could provide a more comprehensive picture.

Limitations of self-reported data
Self-reported perceptions of quality of care might be subjective and prone to individual biases. Utilizing objective measures of quality alongside patient feedback could offer a more balanced perspective.

5. Lessons Learned for Broader Applications:
While the study focuses on Larkana, the identified barriers resonate with challenges faced in other low-resource settings across the globe, as demonstrated by research in countries like Bangladesh [13]. Highlighting common themes, such as the critical role of female education and the impact of financial constraints, allows for cross-contextual learning and adaptation of interventions. However, acknowledging limitations as the study does, such as the reliance on self-reported data and specific geographical context, is crucial for responsible interpretation and generalizability of findings. Future research, as suggested, could involve longitudinal studies assessing the long-term impacts of interventions and qualitative research exploring the lived experiences of families facing healthcare access barriers. This deeper understanding can inform the development of culturally and contextually relevant interventions with lasting positive outcomes for child health in Larkana and beyond.

6. Applicability to Broader Contexts
While this study focuses on Larkana, Pakistan, the identified barriers to child healthcare access resonate with challenges faced in
numerous low-resource settings across the globe. Research from
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Formal analysis: Saqib Nabi Khuro, Muhammad Bilal Siddiqui.
Software: Saqib Nabi Khuro, Muhammad Bilal Siddiqui.
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Writing & review & editing: Saqib Nabi Khuro, Muhammad Bilal Siddiqui.

References:

Study Strengths and Limitations

Strengths:
• Community-based sample: Ensures generalizability to the target population
• Rigorous data collection: Standardized questionnaires and trained interviewers enhanced data quality
• TDM framework: Provides a comprehensive framework for analyzing health access barriers
• Detailed data analysis: Chi-square tests and descriptive statistics offer robust insights.

Limitations:
• Cross-sectional design: Limits causal inferences and understanding of long-term impacts.
• Specific geographic context: Generalizability to other settings may require adaptations.
• Self-reported data: Potential for recall bias and inaccuracies.
• Limited qualitative data: Lacks insights into lived experiences and decision-making processes.

Conclusion and Recommendations

This study offers a comprehensive understanding of the multi-
faceted barriers to child healthcare access in Larkana. Addressing
these challenges requires a holistic approach integrating maternal
health outcomes, educational opportunities, and quality of care concerns.
Improved health education programs, enhanced accessibility measures, expanded financial assistance, and enhanced
quality of care initiatives hold immense potential for improving child healthcare outcomes in this under-served population. Future research
should explore the long-term impacts of interventions and delve into the lived experiences of families facing these barriers to
improve future policy and program development. Addressing these critical issues will provide the way for equitable and accessible
healthcare for children under five in Larkana and beyond.

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Resultados: Los resultados muestran que el 47% de las madres y el 29% de los padres no tenían educación. Los partos en casa representaron el 49,7% de todos los nacimientos; El 36% de los encuestados fueron dados a luz en casa (44% frente a 13%, p<0,001) y menos probabilidades de reconocer signos de peligro. Las mujeres con bajo nivel de alfabetización tienen más probabilidades de dar a luz en casa (44% frente a 13%, p<0,001). 86% de las mujeres reportaron usar un vehículo de transporte, sin embargo, solo el 17% de las personas gastaron más de 1.000 rupias, son uno de los tres retards (TDM) para identificar los obstáculos a la atención médica para niños menores de cinco años en Larkana, informando intervenciones para combatir las muertes evitables. Los accouchements à domicile representan 49,7% de todas las naissances; 36% de las mujeres dejan preferían las guérison tradiçionnens, contribuindo ainsi à réduire l’accès à la santé. Des problèmes de transport (17%) des cas et des durées prolongées, dépassant les 3 heures en 84% des cas, ont entraîné des retards. Les soins de santé de ces enfants, avec plus de 1 000 roupies, constituent l’un des trois retards. Les femmes peu alphabétisées sont plus susceptibles d’accoucher à la maison (44 % contre 13 %, p<0,001) et moins susceptibles de reconnaître les indicateurs de danger (61 % contre 89 %, p<0,001). 86 % de la population utilisait des pousse-pousses pour se déplacer.

Discusión: Este análisis basado en TDM muestra numerosos impedimentos interconectados para la atención médica infantil en Larkana. Se necesitan iniciativas necesarias en razón de los gastos elevados y el transporte escolar. Los partos en casa son comunes, por lo que se necesitan procedimientos de parto institucionales. Se necesita transporte satisfactorio y gasto de menos de 1.000 roupies para evitar el traslado de urgencia. De janvier à avril 2021, les hôpitaux de Larkana ont échantillonné au hasard 390 parents/tuteurs pour une étude transversale. For the tres retardos del TDM – respuestas que reflejan lo que se espera de los médicos y cocineros de la casa – entre los encuestados se clasificaron un 17% de los casos y las diferencias entre las edades de los niños prolongadas, superando los 3 horas en 84% de los casos, son una de las causas de retrasos. Las mujeres con bajo nivel de alfabetización tienen más probabilidades de dar a luz en casa (44% frente a 13%, p<0,001) y menos probabilidades de reconocer signos de peligro. Las mujeres con bajo nivel de alfabetización tienen más probabilidades de dar a luz en casa (44% frente a 13%, p<0,001). 86% de las mujeres reportaron usar un vehículo de transporte, sin embargo, solo el 17% de las personas gastaron más de 1.000 rupias, son uno de los tres retards (TDM) para identificar los obstáculos a la atención médica para niños menores de cinco años en Larkana, informando intervenciones para combatir las muertes evitables. Los accouchements à domicile representan 49,7% de todas las naissances; 36% de las mujeres dejan preferían las guérison tradiçionnens, contribuindo ainsi à réduire l’accès à la santé. Des problèmes de transport (17%) des cas et des durées prolongées, dépassant les 3 heures en 84% des cas, ont entraîné des retards. Les soins de santé de ces enfants, avec plus de 1 000 roupies, constituent l’un des trois retards. Les femmes peu alphabétisées sont plus susceptibles d’accoucher à la maison (44 % contre 13 %, p<0,001) et moins susceptibles de reconnaître les indicateurs de danger (61 % contre 89 %, p<0,001). 86 % de la population utilisait des pousse-pousses pour se déplacer.

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