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Bridging Gaps Through Rural Health Camps: Reflections from Khyber Pakhtunkhwa

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In our experience organizing free health camps in rural Hazara District (Khyber Pakhtunkhwa, Pakistan), we witnessed how outreach clinics can overcome longstanding barriers to care. Here we draw three lessons from two one-day camps in 2023 (in Oghi and Attar Seesha): (1) camps cut geographic and financial barriers to primary care; (2) they enable health literacy and community linkage through education and referrals; and (3) camp data can inform local policy and resource allocation.

1. Reducing Geographic and Financial Barriers

Many Hazara residents live in remote, mountainous villages far from district hospitals. In Hazara's rugged terrain, over 70% of the population resides in rural communities [1]. Under normal circumstances, many treatable illnesses "go unnoticed and… untreated" because health facilities are sparse [2]. We held two one-day camps (Oghi and Attar Seesha) that served over 1,600 patients (~200 of whom were referred for higher-level care), indicating a significant unmet need. Camps eliminate both direct costs (consultation fees, diagnostics, medicines) and indirect costs (travel and lost wages). This is critical, since a recent KP study found primary care needs were often unmet due to prohibitive costs at each stage of care [1]. A local report notes that villagers "often can't even afford… the journey to see a doctor," meaning the poorest cannot reach regular clinics [3]. Although Khyber Pakhtunkhwa has introduced health cards for the poor, public hospitals remain overwhelmed post-pandemic [2], so mobile clinics fill vital gaps in access and equity.

2. Health Literacy, Community Linkage, and Trust

In addition to treatment, our camps prioritized health education and formal referral links to build trust and continuity. Each camp included group talks on hygiene, nutrition, and disease prevention (in the local language). We found that communities engaged more actively when they understood why care mattered, for example, many antenatal patients learned the importance of regular check-ups and a healthy diet. This approach mirrors successful models; for instance, the Shifa Foundation's camps combine free consultations and medicines with community sessions on hygiene, maternal/child health, and chronic disease prevention [4]. Likewise, the Alliance Pakistan Health Council explicitly recommends that camps include "awareness sessions" on nutrition and hygiene, as well as a built-in referral system for critical cases [5]. In our camps, we provided priority referrals (e.g., direct appointments at district hospitals) for patients with severe hypertension, complicated pregnancies, or other urgent conditions, formally linking them into the health system. These linkages visibly strengthened trust; patients saw a clear follow-up plan in place. As Alliance Pakistan observes, outreach like this "strengthens trust between communities and healthcare providers" [5]. Our findings align with broader evidence that enhanced communication and outreach are crucial for meeting the needs of vulnerable populations [1].

3. System-Level Catalyst: Data to Guide Policy

Finally, systematically recording camp data can guide district health planning. By tallying diagnoses and referrals, camps reveal local disease patterns and service gaps. In our camps, the top diagnoses were hypertension, diabetes, and antenatal cases, reflecting Pakistan's shifting health profile. Indeed, KP health surveys report ~29.2% adult hypertension (32.7% of women) and roughly 5–7% diabetes prevalence [6], much of it undiagnosed. The large number of new NCD cases we identified (hundreds in two days) highlights the hidden chronic burden in rural KP. It could justify expanding local NCD screening and medication stock. Likewise, referral tallies indicate missing capacity (for example, if many patients require advanced imaging or obstetric care). Other initiatives illustrate this feedback loop: during Pakistan's 2022 floods, UNICEF's emergency plan explicitly included health camps and mobile units in hard-hit districts to deliver antenatal care, vaccines, and medicines [7]. Integrating camp reports into the district health information system (e.g., DHIS2) would bridge outreach with formal policy. As Alliance Pakistan emphasizes, camps can "bridge gaps in healthcare access" and "reduce disease burden through early detection" [5], but these gains depend on utilizing the data to target resources effectively.

In reflecting on these lessons, we stress that camps must be sustainable and integrated into existing health systems. They work best when local authorities co-plan them (for example, involving Lady Health Workers in organizing camps and tracking referrals) and when camp data feed back into district planning. Training community health workers to run camps ensures continuity beyond the one-day event. Provincial health plans should explicitly include well-designed medical camps in their outreach strategies, with dedicated funding, monitoring, and data sharing. When camps combine free clinical services, public health education, and data-driven referrals, they do more than fill short-term gaps: they extend equitable coverage, improve system trust, and inform more intelligent allocation of resources.

Policy Takeaway:

In Pakistan's rural Khyber Pakhtunkhwa, recurring, integrated medical camp models paired with multidisciplinary outreach clinics, community health education, and clear referral pathways can sustainably accelerate progress toward universal health coverage. Decision-makers should support NGO-government camp partnerships, incorporate camp data into district health planning, and ensure continuity through community engagement. Such locally led outreach is a pragmatic strategy for bringing care to underserved communities and strengthening under-resourced district health systems.

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