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The intersection of gender, caste, and health: Disparities in access to healthcare for marginalized women in Pakistan

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Abstract

This review applies Crenshaw's intersectionality theory to analyze the challenges Pakistani women encounter while seeking maternal healthcare services. The theory explains how various social factors such as: femininity, wealth or poverty, socio-economic class, and caste combine to create barriers to attaining healthcare. Gender bias is still an important socio-economic concern in Pakistan, where women are socially conditioned to fulfill household duties which curtails their freedom to take care of their health. Decisions regarding childbearing tend to be the domain of male relatives or mothers-in-law which further curtails women's autonomy. In addition, women from poorer, more rural areas experience increased financial burdens, lack of educational opportunities, and no access to healthcare markets which makes the situation increasingly difficult. Moreover, large geographical distances and high transportation costs worsen the situation. In addition, lower-caste women, like those of the Kammi caste, are discriminated against in the healthcare system, which further limits their ability to access care. This paper contends that there is a need for mothers' healthcare policies in Pakistan which are compassionate and sensitive to the realities of maternal healthcare services. (*Afr J Reprod Health* 2026; 30 [2]: 108-120).

Keywords : Intersectionality, Gender inequality, healthcare, Caste discrimination, Economic dependency, Pakistan

Résumé

Cette étude applique la théorie de l'intersectionnalité de Crenshaw pour analyser les difficultés rencontrées par les femmes pakistanaises dans leur accès aux soins de santé maternelle. Cette théorie explique comment divers facteurs sociaux, tels que la féminité, la richesse ou la pauvreté, la classe socio-économique et la caste, se conjuguent pour créer des obstacles à l'accès aux soins. Les préjugés sexistes demeurent un problème socio-économique majeur au Pakistan, où les femmes sont socialement conditionnées à accomplir les tâches ménagères, ce qui limite leur liberté de prendre soin de leur santé. Les décisions relatives à la procréation relèvent généralement de la famille masculine ou des belles-mères, ce qui restreint davantage l'autonomie des femmes. De plus, les femmes issues des zones rurales les plus pauvres subissent des difficultés financières accrues, un manque d'opportunités éducatives et un accès inexistant aux services de santé, ce qui rend leur situation encore plus difficile. Par ailleurs, les grandes distances géographiques et les coûts de transport élevés aggravent la situation. Enfin, les femmes des castes inférieures, comme celles de la caste Kammi, sont victimes de discrimination au sein du système de santé, ce qui limite encore davantage leur accès aux soins. Cet article soutient qu'il est nécessaire de mettre en place au Pakistan des politiques de santé maternelle empreintes de compassion et sensibles aux réalités des services de santé maternelle. (*Afr J Reprod Health* 2026; 30 [2]: 108-120).

Mots-clés: Intersectionnalité, inégalités de genre, soins de santé, discrimination de caste, dépendance économique, Pakistan

Introduction

Maternal health is a huge issue in Pakistan as it has one of the highest rates of maternal deaths in the world. According to the World Health Organization (2004), Pakistan along with India and Bangladesh makes a substantial portion of global maternal deaths

and births.¹ Maternal health is often considered a neglected area in women's health as women are still facing a lot of difficulties in accessing healthcare during pregnancy and after childbirth due to social gender norms. Such barriers limit a woman's freedom to exercise her choice regarding health. Within these cultural boundaries, gender divisions

impact maternal health across its lifecycle. These particular countries with strong cultural traditions face challenges over women's accessibility to vital healthcare services.

Gender, in the context of Pakistan, describes the responsibilities attached to men and women. These societal expectations stem from culture and profoundly impacts a woman's way of life, ranging from basic functionalities to her ability to avail healthcare services. For instance, a woman's health and nutrition during pregnancy and childbirth is usually the business of some male figure or older woman in the family like a husband or a mother-in-law.² This narrative stands for the overarching socio-cultural paradigm where women are expected to assume the primary responsibility as homemakers. Public life and healthcare decision-making is severely limited³

Apart from the issue of gender, class and even caste add more layers to the complexity of a Pakistani woman's access to healthcare services. Lower socioeconomic groups are financially less equipped to obtain maternal care and at times do not possess the education or requisite information that would enable them to understand their health rights.⁴ Culturally accepted norms such as *pardah* also constrain women's movement to and within healthcare facilities thus preventing trained medical personnel from providing crucial medical aid in times of need. Failure to receive care in a timely manner exacerbates the health of women which is manifested in increased rates of maternal death. This chapter aims to analyze the impact of gender roles, class, and caste inequalities as composite hindrances for women trying to access maternal healthcare services in Pakistan. It wishes to discuss the bound social practices and customs that restrict women's healthcare decisions in relation to pregnancy and childbirth. The chapter further seeks to address policies that help women, that strengthen their autonomy over their healthcare choices, and equal opportunities of accessing the maternal health care services. The focus of the chapter is on the serious concern of the issue of maternal health in Pakistan in terms of the inadequate healthcare facilities and services due to these noneconomic factors barriers in the country.

Intersectionality theory and women health in pakistan

Intersectionality theory of Kimberlé Crenshaw permits us to comprehend how distinct elements of a person's identity like gender, class, caste, and socio-economic position, accrues to pose certain form of discrimination or challenges.⁵ It also accounts for why Pakistani women experience several difficulties accessing maternal healthcare services. These challenges extend beyond gender, also involving class and caste systems that put some women at greater risk, making it more difficult to obtain the necessary care.

Pakistan continues to struggle with gender disparities. Women are required to comply with social norms and are not really allowed to control their own health. A large number of the patriarchal and matriarchal society revolve around pregnancy, childbirth and healthcare is dominated by men and elder women who dictate to the women and not vice versa⁶. Within this context, the attitude and behaviors of caregivers towards patients serves as a defining aspect which in turn constitutes the maternal healthcare services available to women. Of all concepts, social class can be called perhaps the most decisive factor. Women from low-income communities in Pakistan are bound to face a myriad of social and economic difficulties. For example, spending a particular amount for medicines is beyond their financial reach or it never occurs to them that they need to go through regular check-ups during the period of pregnancy.

Moreover, lack of sufficient education and inadequate access to medical facilities makes it extremely difficult for women in these categories to receive the necessary care.⁷ Even in the case of women from rural or under-developed regions, it is highly probable that healthcare services are out of reach in terms of location, cost and distance.

Caste as a socio-cultural phenomenon determines the status of all women in Pakistan and thus their access to primary medical attention. Lower caste women come from equally discriminatory low castes like the 'Kammi' caste and will find it extremely difficult to access healthcare facilities. Given that these women do not encounter personally

unacceptable treatment in the hospital, they are doomed to suffer inadequate medical attention.⁸ In most cases, women from upper castes or richer sections do not experience such overt discrimination but still suffer from authoritarian masculinity structures that mold their decisions.

This theory allows us to examine how gender, class, and caste combine to impede access to healthcare for specific women in Pakistan, emphasizing that women's obstacles are multifaceted. For instance, wealthy women may be restricted by gender-based barriers; however, their socioeconomic status relative to other women means that they typically possess better resources and access to healthcare than poorer women, who contend with both financial and societal constraints. Intersectionality theory is a useful approach toward understanding the complex challenges Pakistan women face concerning maternal healthcare. These women are economically marginalized and socially subjugated. Examining constituents like gender, class, and caste as an amalgamation reveals how they curtail access to care. Moreover, this provides insight into the need for comprehensive healthcare policies aimed at proactively meeting the discrepancies created by these challenges.

Methods

This review paper employs a systematic approach to explore the literature on barriers that women face in obtaining maternal healthcare services in Pakistan, with a particular focus on the intersections of gender, caste, economic standing, and region. The methodology consists of the following components:

Literature search

An exhaustive search was conducted across multiple academic databases, including PubMed, Google Scholar, and JSTOR. The search was performed using the keywords: "maternal healthcare," "Pakistan," "gender inequality," "intersectionality," and "access to healthcare." This search was limited to publications in English from 2010 to 2024 to ensure the relevance and recency of the materials. The search was conducted systematically to include a wide range of studies and reports, ensuring comprehensive coverage of the topic.

Selection criteria

Studies were included in the review if they specifically addressed barriers to maternal healthcare access in Pakistan, focusing on the research questions of gender, caste, and economic disparities. Both qualitative and quantitative studies were considered, along with government and policy reports and publications from intergovernmental agencies. Only those studies that met the selection criteria were included to maintain focus on the key issues.

Data analysis

A thematic synthesis approach was used to analyze the literature. The studies were categorized based on key socio-economic factors such as caste, education, economic status, and geographical region. Common themes and patterns were identified to explore how these factors influenced women's decisions to seek maternal healthcare and the resulting outcomes.

Interpretation

The literature was analyzed using an intersectional lens, considering how overlapping social identities (gender, caste, class, and region) impact women's healthcare experiences in Pakistan. This approach aims to highlight how these intersections contribute to the systemic exclusion of women from essential maternal healthcare services.

Policy recommendations

The analysis revealed significant gaps in gender equality and access to healthcare, which need to be addressed in policy formulations. The review calls for context-sensitive and comprehensive healthcare policies that account for the diverse barriers faced by marginalized women in Pakistan, particularly in terms of intersectional discrimination. Table 1. The World Health Organization indicates that Pakistan, India, and Bangladesh account for 27% of global childbirths and 34% of maternal deaths⁸. With regards to maternal mortality, previous research has studied several immediate causes that concentrate on the healthcare services and systems accessibility and availability.⁹ Meanwhile, a primary neglect factor in this particular discussion is the relationship of gender as a cultural hurdle in the access of care.

Table 1: Obstacles in maternal healthcare in Pakistan: gender, culture and socio-economic factors

Theme	Subthemes
Socio-Cultural and Patriarchal Influence on Women's Health Cultural Practices	- Gender roles in Pakistani society - Women's primary role as caregivers - Influence of Islamic traditions on gender inequality - Women's economic dependency on men - Practice of "Pardah" (seclusion) - Men as decision-makers in healthcare - Impact of gendered norms on communication and interactions
Regional and Socio-Economic Variations	- Differences in women's freedoms across regions (e.g., Punjabi high caste women vs. others) - Influence of socio-economic status, ethnicity, and local cultural practices on healthcare access
Barriers in Healthcare Policy and Professional Representation	- Lack of female representation in healthcare policymaking - Gender-segregated norms in healthcare services - Women's limited role in health-related decision-making
Women's Autonomy and Mobility	- Impact of autonomy and financial independence on healthcare access - Cultural expectations and family constraints on healthcare decisions
Economic Dependency and Healthcare Access	- Barriers due to lack of education and financial independence - Women's preference for female doctors and its effect on healthcare access
Social Costs of Seeking Healthcare	- Financial and social costs associated with mobility and healthcare access - Barriers women face in making independent healthcare decisions

Gender in sociological scope service the character of stratification based on classification by the surgical face and limbs of an individual. It influences nigh all facets of life, social values concerning what men and women do as well as how they are supposed to do it are imparted to children at school and kindergarten through family and neighborhood.¹⁰ Gender is not the same everywhere rather gender becomes the core of relations shaped by different historical, social and cultural factors and varies by class, construction, ethnicity, and age¹¹. In a broad sense, gender inequality is the difference in rights and responsibilities and the power relations between men and women.¹²

Gender norms have been shown to impact the distribution of material resources and affect health outcomes. Gender socialization contributes to inequality in the provision of healthcare services, with women disproportionately more disadvantaged in accessing the care they require.¹³ Numerous developing countries are known to have women suffering from poor health, inadequate healthcare services, and neglect from a superficial healthcare system.¹⁴ Such disparities reveal a deep-rooted problem of how women are treated because they are deemed sub-citizens with lesser privileges than men. The neglect of women's health in developing countries still remains an issue because of the lack of living and reproductive health standards, which is an apparent indicator of gender discrimination and inequality in these regions.¹⁵ Imperialistic power structures and their subordinate policies at various

levels straddle the bureaucratic and sociocultural domains which transcend the micro health system engagement and planning choreography mechanisms. Feminist scholars have expressed their frustration over the lack of focusing on women and gender in health policies and programming¹⁶, but more recent literature seems to suggest there is an emerging uncritical acceptance of this idea.¹⁷ Outdated paradigms describing women's health in developing countries still persist which indicates that the need for gender theory to design women's health services goes beyond what is presently offered to them.

Socio-cultural and patriarchal influence on women's health

In Pakistan, cultural practices profoundly affect women's health seeking behavior due to rigid gender expectations. Traditionally, women are relegated to the role of caregivers, and they bear the responsibility of attending to familial and childcare duties. These roles hinder their chances to pursue educational and career ventures because they are mostly housebound. Their confinement to the house is rationalized through "Pardah,"¹⁸ an honor-based cultural construct that circumscribes female mobility in public spaces, particularly in the company of men, as a mark of family respect.¹⁹

The socio-cultural system of Pakistan is markedly patriarchal, with men serving as economic providers and decision makers within families.

Women are required to rely on male family members for access to material resources. Such financial dependency limits women's freedom to make choices, including those related to their health.²⁰ Often, women face discriminatory sexual division of resource distribution within families, and unequal access to health becomes available on the borders of family income, with men exercising control over necessary financial resources while women require permission to use them. Similarly, Islamic customs have been known to perpetuate some forms of social gender imbalance as it seeks to provide some order to social interaction. Although Islam recognizes the contributions of both men and women in society, women's health is neglected due to cultural undertones. Women's status in Pakistan is a product of culture and religion which tends to disrespect their self-determination and personal development.²¹

Such a system of patriarchy profoundly influences women's access to maternal care services. Often women in Pakistan are required to obtain approval from a male member of the family before they seek healthcare, which may prolong or completely hinder access to timely treatment.²² Women in rural regions are subject to more stringent traditional standards and therefore encounter a greater number of obstacles to obtaining health care services. These factors contribute to the extremely high rate of maternal mortality in Pakistan which is currently pegged at one hundred seventy-eight maternal deaths per one hundred thousand live births.^{21, 22} Moreover, women's health needs are often left unaddressed as they have little awareness of their legal rights and are bound by social norms to fulfill a wide range of other responsibilities. Such ignorance alongside poverty creates an even more serious situation regarding awareness of maternal health²³. Health-seeking behavior, influenced by socio-cultural factors and a dominance of patriarchal governance, greatly constrains women's choices and access to care, particularly for maternal health.

To encapsulate, chronic issues affecting women's health, include their defined gender roles, economic dependency, and the hierarchical order prevalent in Pakistan. The system where women solely function as caregivers economically depends on men; this model fails to compete with the rising indiscriminate health access barrier, which ends in suboptimal maternal health. All the socio-cultural and patriarchal fingers need to be lifted off the

women in order to grant adequate services necessary to improve their health.²⁴

Cultural practices

In Pakistan, sociocultural structures strongly determine women's utilization of healthcare, particularly maternal health services. One of the most important sociocultural barriers is the custom of female seclusion, or *Pardah*. As per PDHS 2017-18, approximately 60% of women in rural Pakistan practice *Pardah*, reducing their ability to independently access healthcare. Women who observe *Pardah* are expected to remain at home, and are thus unable to attend health facilities or consult for doctor's appointments without male guardian permissions.²⁵ This results in inefficient maternal healthcare seeking behaviors, leading to severe health complications accumulated over time. Due to these factors, the maternal mortality ratio in Pakistan remains critical at 178 deaths per 100,000 live births in 2018.²⁶

Wider societal context where women are subordinate to men, and expected to be housewives is reflective of the power imbalance over women's autonomy. It is evident that norms empower men to single-handedly control women's decisions. Healthcare, particularly women's healthcare, is greatly impacted by the sociocultural milieu.²⁶ For instance, a woman may forgo receiving life-saving surgical intervention due to her husband's permission being a prerequisite. Dependency like this can otherwise be prevented in women, if husbands allowed them unrestricted autonomy leading to independent decision-making.²⁶

In many rural and traditional households, men assume full control of the household, making all the decisions and leaving little to no power to women which further leads to their healthcare neglect. A good representation of this notion is shown in the PDHS 2017-18. It demonstrates that there is an astounding amount of 41% of women who seek permission from their husbands in order to access a healthcare facility. This often means that there is a delay in treatment due to permission being needed, either hypothetically wanting to be treated or actually being willing to receive necessary treatment.²⁷ A prime example that illustrates this point well is a pregnant woman. If her husband is postponing or outright denying permission, she may not receive necessary care during critical and time

sensitive phases. Such scenarios may be detrimental for women's health, consequentially needing grave and life threatening interventions.²⁷

The consequences of gendered norms are more pronounced in the manner health-related communication is conducted. In numerous instances, women are not encouraged to communicate their health concerns, particularly matters of reproductive health, in a straightforward manner. WHO reports that 38% of women from Pakistan feel uneasy talking about their health issues with a doctor, especially if he is male.²⁸ This reluctance stems from having to observe women's ceaseless cultural restrictions of silence and supposed modesty. Most women remain reluctant to seek medical assistance, or are quite simply reluctant to seek help, even when suffering dire health complications, such as pregnancy complications or reproductive tract infections. As some women are too unwell to speak for themselves, it is their male relatives who somewhat 'help' women deal with their health issues, which far too often leads to gaps in understanding and misdiagnoses.²⁹

In addition, the gendered divisions of labor within healthcare institutions make it more difficult for women to receive care. An ICDDR Study found that only 28% of rural Pakistani women are supported by female healthcare practitioners during childbirth, which starkly contrasts with the desire to be attended by female doctors. Culturally, there is supporting rationale in "Pardah" and modesty that underlies women's discomfort with seeking care from males.³⁰ Yet, because of the overwhelming lack of female healthcare providers, particularly in the countryside, women are often left with the last option of either seeing a male doctor or stalling their visit indefinitely.

As a cultural barrier, Pardah, alongside men's dominating control over decision-making, and gendered socio norms, bring about profound challenges related to healthcare access for women in Pakistan. These conditions foster late healthcare access, inadequate maternal health indicators, and fragility of proactively controlling one's health. Societal transformation towards these practices, coupled with giving women primary decision-making authority regarding their pregnancy care services, is paramount to improving healthcare standards and minimizing maternal deaths in Pakistan.

Regional and socio-economic variations in women's healthcare access

In Pakistan, the "socio-economic" and geographical region have a significant influence on the woman's healthcare access and use, more so in the rural areas compared to the urban areas. For example, in Pakistan cultural and social practices influenced regionally pose one of the greatest challenges to healthcare access. For example, the majority of Punjabi high caste women enjoy greater degree of freedom in comparison to women from other backward areas such as rural Sindh or Balochistan.³¹ Quite a good number of women in Punjab especially urban areas have a greater freedom of choice concerning their medical care and do not observe cultural practices such as Pardah (seclusion). In any case, the situation tend to be better in Punjab compared to the rest of the country but even in Punjab low socio-economic women are often more deeply entrenched in poverty and lack of education, which creates significant barriers. Conversely, women living in the countryside or from conservative cultures experience harsher discrimination in relation to gender, which limits their autonomy and an access to medical services. For instance, Sindhi or Baloch women are frequently viewed as housebound, while their medical choices are greatly controlled by the males in their households.³² In these cultures, women are often hampered in their mobility, as well as their ability to decisively act within their social sphere, most notably concerning maternal health. There is a heavily patriarchal structure within a family, where married women are obliged to consult their mother-in-law or other elders prior to making any healthcare decisions, thereby prolonging, or even making unavailable, essential treatment.³³

One woman gave a detailed case of how her mother-in-law's controlling nature led her to prolong a dangerous delivery: the baby's head was stuck and could not be delivered. A cesarean was recommended, but the mother-in-law insisted on a natural delivery and things became severely complicated³⁴. This illustrates the terrible impact older women have on female decision making. The young wife's health options remain at the mercy of other women patriachs devoid of any regard for her wellbeing and autonomy. Frequently, the younger women who are expected to act are step-mothers or

older sisters-in-law, considered wise and knowing the secrets that come with these battles, thus rendering them is the ultimate call to “surgically” bypass all these family matters.³⁴ It is clear that the cultural conditions are dangerous and catastrophic when exercised upon younger women, such as not providing medical attention and care in a timely fashion.

In many families, husbands assume that issues pertaining to reproductive health are of the domain of “women work,” and as such do not participate in conversations regarding pregnancy care. This lack of engagement can further limit women's access to timely health care services because women may ultimately lack the necessary support when attempting to access medical services.

For instance, numerous husbands refuse to engage in discussions around pregnancy complications because such issues are perceived as unclean or shameful within some cultures, particularly among older relatives. A woman who recently gave birth is, in most cultures, considered postpartum, which adds a level of seclusion from male family members. Culturally, men are expected to have little to no contact with their wives, thus retiring from all responsibilities concerning childbirth and post-natal care.³⁴

Socio-economic status further exacerbates these regional differences. Wealthy women living in urban regions tend to have superior healthcare facilities, specialist doctors, and maternal health services compared to their rural counterparts.³⁵ On the other hand, women from poorer backgrounds or rural areas face numerous challenges accessing medical care due to cost, a shortage of nearby healthcare providers, and cultural norms. Some rural areas are devoid of basic healthcare services such as antenatal consultations and skilled birth attendant which put women at greater risks during child birth.³⁶

Barriers in healthcare policy and professional representation

Cultural misconceptions about women's health, along with gender role expectations, restrict women's mobility which delays the healthcare services they may seek. Women's access to care is largely limited by health system factors, with patriarchal socio-cultural barriers remaining fundamental obstacles to women's participation and

decision-making in health matters. Because of these barriers, the advancement of maternal and reproductive care is systematically undermined.³⁷

Pakistan's healthcare structure is a clear representation of set policies and practices that tend to disadvantage women, thus leaving them to suffer the consequences of unresponsive healthcare policies. To a large extent, this is due to lack of female representation in healthcare decision-making at upper echelons. Gendered social structures also significantly propagate the idea that medical practice is a technical field dominated only by men.³⁸ As a result, there are very few women in decision-making positions and even fewer women in health policy or administrative positions to attend to women's needs and address their concerns. As a result, healthcare policies particularly with respect to menarche, menstruation and even childbirth is dominantly adult-centric. For instance, regarding maternal mortality, Pakistan has one of the highest maternal mortality rates in the country estimated at 178 deaths per 100,000 live births³⁹, which signifies the policies are not directed towards aiding women in conservative rural areas where these cultures plus barriers to healthcare are pronounced.⁴⁰

Women's healthcare needs go unmet due to the lack of intersectional healthcare frameworks catering to their unique requirements. In Pakistan, as a matter of custom, a significant proportion of women prefer to be treated by female doctors due to concerns of privacy and modesty.⁴¹ Unfortunately, this custom is not easy to fulfill given the lack of female healthcare practitioners, especially within the more remote rural regions. This gap in the employment of feminine practitioners means that a lot of women have to rely on male practitioners which poses a great psychological burden, making women reluctant or uncomfortable seeking treatment. Findings from PDHS 2017-18 indicate a striking 28% of females who underwent childbirth in rural areas get attended to by qualified gynaecologists and obstetricians which does not recognize to the prevailing cultural demand for female doctors. Such a gap among rural health service providers profoundly undermines the chances of women obtaining prompt and culturally sensitive care, leading to adverse health implications.⁴²

An additional equally essential challenge is the limited participation of women in making health-

related decisions. Healthcare choices, ranging from antenatal care to delivery and post-natal care, are defined at the household level by some male relatives and elder women (mothers in-law). Subsequently, women have a restricted ability to make choices regarding their health. As Mumtaz and Salway (2005) indicate, 41% of women in Pakistan require their husband's consent to seek medical attention. This power imbalance inhibits many women from accessing adequate and timely healthcare, particularly in relation to pregnancy and childbirth.⁴²

Economic dependency and healthcare access

Educational neglect combined with economic dependency critically understaffs maternal healthcare services in Pakistan. A considerable number of women remain mostly financially dependent on their husbands or male family members which curtails their ability to independently make considerations regarding their health. This dependency results in care seeking delays or avoidance of care altogether.⁴³ Limited financial autonomy serves as one of the greatest impediments to maternal healthcare in Pakistan. According to PDHS 2017-18, a meager 28% of women in Pakistan are employed outside the home. The remaining women depend financially on their husbands or other male family relatives. Consequently, women in such dire need of advanced healthcare services often have to rely on their male family members to authorize the payment for healthcare services or even suitable insurance coverage. In situations where timeliness is crucial, such as in the case of pregnancy complications, sensitive maternal issues, or chronic ailments, women can be easily left unattended. Women devoid of financial dependency often face difficulty affording antenatal care, delivery, and post-natal care services which are essential for their well-being as well as that of their infants.⁴³

Besides the economic dependency, the lack of education is a prominent barrier for women's healthcare access.⁴⁴ Many females in Pakistan, especially those who live in rural areas, do not possess adequate information concerning maternal health or reproductive health. As stated in Mumtaz and Salway's (2005) study, less educated women tend to have lower rates of utilizing antenatal care services and are more likely to depend on traditional

birth attendants (TBAs) rather than qualified medical practitioners. Moreover, the lack of education means that these women do not understand the risks they might face during childbirth, e.g. eclampsia or hemorrhaging, and will only seek assistance when it is already too late. This lack of understanding is part of the reason for the high maternal mortality rate in Pakistan which is 178 deaths per 100,000 live births.³⁹

Women's healthcare access is significantly impacted by their preference for female practitioners. In conservative, rural regions of Pakistan, women are more comfortable receiving medical care from female practitioners due to sociocultural perceptions of privacy and modesty. As cited in the PDHS 2017-18 report, in Pakistan, 75% of women prefer to visit female doctors for gynecological and obstetric care.⁴⁵ Unfortunately, due to a lack of female physicians and general practitioners in rural areas, many women are forced to attend medical consultations with male doctors—this is especially true for obstetric services. This situation may increase the chances of women's delaying medical attention during sensitive cases like pregnancy or childbirth. Women in rural areas can potentially avoid medical treatment for long periods, only seeking assistance when the situation deteriorates to an emergency.⁴⁶

Social costs of seeking healthcare

Healthcare services both socially and economically burden women in Pakistan, which greatly impacts their ability to utilize medical services. This significantly affects health, primarily in rural, conservative societies where women are expected to be submissive and do not possess autonomy.

Healthcare is one of the many services women use but is often restricted due to the sheer financial burden that accompanies it. A large population of women in Pakistan, around 71% according to the PDHS 2017-18 report, is financially reliant on fathers, husbands, or brothers, which makes it difficult for them to seek healthcare.⁴⁷ For many women, the costs of antenatal care, delivery services, or post-natal care can be out of reach, especially in low-income families. Women require family support, which is often delayed and, in some cases, non-existent. The unavailability of funds can lead to a delay in treatment or a dependency on untrained birthing attendants.⁴⁸

In addition to the financial burden, the social cost is equally important in understanding why women lack access to healthcare provide in Pakistan. In certain regions of Pakistan, social customs require that women acquire consent from their male kin such as their husbands or fathers before they can go for healthcare. These customs form a mobility barrier whereby women are restricted from traveling alone to see a doctor or health facility. For instance, 41% of women in Pakistan state that they require permission from their husbands to access health care services²⁹ Such restricted mobility combined with the lack of autonomy in a woman's social setting makes it difficult for women to procure medical assistance in a timely manner during any medical emergencies⁴⁸.

Cultural customs such as Pardah further restrict mobility which is practiced by a few women.⁴⁹ Women who practice this form of seclusion are supposed to remain indoors and shun public area rendering them immobile in terms of reaching health facilities. Because basic health needs are often neglected, Pardah also puts women at risk of more serious health issues. Additionally, women may also feel social pressure and the need to seek approval from male relatives before visiting a healthcare professional which creates social stigma that hinders women from acquiring basic healthcare.⁵⁰

Women have been subjected to a myriad of discriminations and lower standards of living, and a major contributory factor is the lack of freedom and control over one's own body. In many societies, an intricate network of traditions culturally or religiously subordinates women. For example, female what many women refer to as an unspecified status or role, where some women might prefer to be defined as Nationals or Lifestyles – that is defined in relation to the male figure who effectively has control over other women only when it comes to practicing self-restraint. What is worse is that In Pakistan mere financial dependency is bad enough wherein uncontrolled women whose cultural mobility and decision are bound within the four wall of their house. Furthermore, conditioning such women ethnocentric, geocentric, or any other centric thoughts rm as mere creates consequences that are dire at both personal and collective fronts⁵¹.

For Pakistani women, these challenges cumulatively mean, limited access to affordable

health and care services that eventually equate to low-grade maternal health resulting in underwhelming achievement and understated mortality rates. Thus, it goes without saying further needless to explain that needs to Overcome socio-economic challenges by multidiscipline pre and post pregnancy care necessitate a revitalized strategic approach to both individual and pioneering framework attuned to the goals empower women. Empowering women through means of educating them about bolstered with convincing funding and supportive policies dealing of family, maternity, health, and exercise alongside legal barriers over with would experience unerring sickness. Gaining tangible impact over devising frameworks will enable healing dare all set the tide that aid elevating maternal health to the wellness level well above bare necessity modulo

Discussion

The theory of intersectionality, developed by Kimberlé Crenshaw, offers a comprehensive framework for understanding how various aspects of identity—such as gender, socio-economic status, caste, and class—intersect to create unique and compounded disadvantages. In the context of Pakistan, this theoretical lens is crucial for analyzing the barriers women face in accessing maternal healthcare. These barriers are not solely due to gender hierarchies but are exacerbated by the overlapping influences of class, caste, and cultural practices, which collectively reinforce the challenges to healthcare access.

In Pakistan, the intricate web of socio-cultural, economic, and patriarchal elements plays a central role in shaping women's access to healthcare. The deeply ingrained societal norms regarding women's roles, particularly in relation to their family and household responsibilities, significantly restrict their autonomy. These restrictions directly affect their ability to seek education or employment, and consequently, limit their ability to make independent health decisions. The 2017-18 Pakistan Demographic and Health Survey (PDHS) reveals that 71% of women in Pakistan are financially dependent on male relatives, which highlights the pervasive economic subordination that constrains women's autonomy over their healthcare decisions. This financial dependency often results in women

being required to seek permission from male family members before accessing healthcare, which delays timely medical intervention—particularly in critical situations like pregnancy or childbirth where prompt medical attention is vital.

Cultural practices such as *Pardah* (seclusion) further compound these barriers by limiting women's mobility and access to healthcare. In many parts of Pakistan, women are expected to remain confined to their homes and avoid public spaces, significantly hindering their ability to visit healthcare facilities without male guardians' consent. Decisions regarding healthcare, including maternal care and childbirth, are often made by male relatives or older women, which can lead to delayed or insufficient care, posing serious risks to maternal health. A study by the World Health Organization (WHO) highlights that only 24% of healthcare workers in Pakistan are women, a stark representation of gender inequality in the healthcare sector. This gender disparity in the healthcare workforce further limits women's ability to access care from female practitioners, exacerbating their struggles in obtaining the necessary medical attention.

Moreover, the patriarchal nature of healthcare in Pakistan often results in gender-segregated practices that overlook women's specific needs. Healthcare policies and decision-making processes are frequently dominated by male leaders, who may lack the understanding or consideration of women's distinct health requirements. This disconnect between healthcare providers and the realities of women's healthcare needs contributes to the persistent barriers to healthcare access. The lack of female healthcare practitioners in both rural and urban areas further compounds these challenges, as women may be reluctant to seek care from male doctors, particularly for reproductive health issues, which are often viewed as private and sensitive.

The intersectionality of gender, caste, and socio-economic status creates a multi-layered system of exclusion that not only restricts women's access to healthcare but also perpetuates their social marginalization. This compounded discrimination is particularly severe for women from lower socio-economic backgrounds or marginalized castes, who face both societal and systemic barriers to healthcare. In rural areas, the lack of infrastructure

and healthcare facilities, coupled with entrenched cultural norms, means that these women are often unable to access even basic maternal care.

A woman's access to healthcare services are determined by her geographical location alongside her socio-economic status. In urban settings such as Punjab, women enjoy greater mobility, sophisticated education amenities, and even access to healthcare. On the contrary, women in rural parts like Sindh or Balochistan have more limited mobility and power to make decisions. Women with less education and from poorer backgrounds face significant hurdles in meeting healthcare services. Such women are more likely to utilize the services of traditional birth attendants instead of professional health care services which increases the chances of complications during pregnancy and childbirth.²⁵

A woman's autonomy—or ability to make decisions for herself—and her financial independence are key factors in her ability to access healthcare. Women who earn their own income tend to utilize healthcare services without having to rely on someone else's discretion. But for a lot of women in several families, they can only visit a doctor when given consent by their husband or any man in the household. Mumtaz and Salway (2005) note that for about 41% of women in Pakistan, visiting a healthcare facility remains a decision made by husbands.²⁹ The dependence on someone else for such a basic service invariably makes them receive from medical attention when they want to, worsening their health in the long run.

Women also incur social and financial difficulties when attempting to obtain medical care. Women, in particular, face barriers to healthcare access, including most services' lack of affordability coupled with insufficient male financial support. Additionally, seeking medical care is often challenging due to cultural constraints. For example, reproduction and gynecology are among the fields of medicine that are dominated by female physicians. However, in many locations, there is a shortage of female medical practitioners. This gap in the supply of female doctors in rural areas compels women to consult with male doctors whom they find uncomfortable. This phenomenon causes women to delay or completely avoid seeking necessary medical attention, which poses a danger to their health.

Strengths of the review

This review provides a comprehensive and insightful exploration of the intersectionality of gender, caste, and socio-economic status in accessing maternal healthcare services in Pakistan. One of its key strengths is its qualitative focus, capturing a diverse range of studies that highlight the multi-dimensional barriers faced by marginalized women. The review effectively synthesizes literature from various sectors, including academic articles, policy reports, and intergovernmental publications, providing a well-rounded perspective. Additionally, the thematic synthesis approach allows for the identification of key barriers—such as caste, economic inequality, and geographic isolation—that impede access to care. The intersectional lens applied adds depth to the analysis, drawing attention to the compounded vulnerabilities of marginalized women. By focusing on these critical social determinants, the review contributes significantly to policy discussions on improving maternal healthcare access and addressing systemic exclusion in Pakistan.

Limitations of the review

Despite its strengths, this review has several limitations. One key limitation is the inclusion of only studies published in English, which could have excluded valuable insights from research published in local languages or regions. This limits the scope of the review and may omit relevant cultural and contextual factors affecting healthcare access. Additionally, the review did not include a formal meta-analysis, which could have strengthened the statistical evidence and enhanced the overall rigor of the findings. The heterogeneity of study designs, including both qualitative and quantitative studies, could lead to inconsistencies in data interpretation. While the thematic synthesis approach was appropriate for capturing broad patterns, the absence of a more structured, quantitative synthesis limits the ability to generalize findings. Lastly, the review is constrained by its focus on secondary data; primary research would have further enriched the findings with firsthand experiences from marginalized women.

Conclusion and recommendations

In conclusion, it is evident that women in Pakistan face significant challenges in accessing healthcare services. The barriers they encounter are deeply rooted in societal and cultural factors, including restrictive gender norms, economic dependency, practices such as *Pardah*, and the absence of a woman's voice within the healthcare system. These factors severely limit women's autonomy over their health decisions. For example, women are often required to obtain permission from male guardians before consulting healthcare providers, and rural areas, in particular, suffer from a severe shortage of female doctors. These obstacles delay access to timely and essential medical care, especially during pregnancy and childbirth.

To address these issues and improve access to healthcare, several key revisions are necessary. A crucial first step is the need for more female physicians, particularly in rural areas, to encourage women to seek medical assistance without fear or stigma. Additionally, increasing women's access to education and employment will empower them to make informed health decisions, fostering greater self-reliance. This empowerment will also help challenge societal perceptions of *Pardah* as a cultural practice that limits women's ability to access essential healthcare services.

By addressing these systemic issues, healthcare providers can offer more effective reproductive healthcare services, ensuring that women have the necessary resources to make decisions about their health and well-being.

References

1. Rai and RK. Utilization of maternal health-care services by Muslim women in India, Bangladesh, and Pakistan, 2005–2007. *Journal of Public Health*. 2015;23:37-48.
2. Naz S, Muhammad D, Ali P and Ahmad A. qualitative study exploring pregnant women perceptions regarding their husbands and in-laws'support during pregnancy. *Rehman Journal of Health Sciences*. 2023;5(1):9-16.
3. Litva A, Coast J, Donovan J and et al. 'The public is too subjective': public involvement at different levels of health-care decision making. *Social science & medicine*. 2002;54(12):1825-1837.

4. McTavish S, Moore S, Harper S and Lynch J. National female literacy, individual socio-economic status, and maternal health care use in sub-Saharan Africa. *Social science & medicine*. 2010;71(11):1958-1963.
5. Begum A, Amin R, Nath H, Nath D, Paul M and Khatun M. Intersectionality of Gender with Race, Class and Ethnicity and its Impact on Economic Development: A Complex and Multi-Layered Framework. *Library of Progress-Library Science, Information Technology & Computer*. 2024;44(3).
6. Kapulula PK. The role of men in promoting women's reproductive and maternal health in a matrilineal marriage system in Malawi: the case of Ntchisi District. 2015.
7. Timyan J, Brechin SJG, Measham DM and Ogunleye B. Access to care: more than a problem of distance. *The health of women*: Routledge; 2018:217-234.
8. Odia LO. primary health care services administration and challenges in Uhumwode Local Government Area, Edo State–Nigeria.
9. Chen L, Chen T, Lan T, Chen C and Pan J. The contributions of population distribution, healthcare resourcing, and transportation infrastructure to spatial accessibility of health care. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*. 2023;60:00469580221146041.
10. Alsager A, McCann JK, Bhojani A and et al. "Good fathers": Community perceptions of idealized fatherhood and reported fathering behaviors in Mwanza, Tanzania. *PLOS global public health*. 2024;4(7):e0002587.
11. Wiesner-Hanks and ME. *Gender in history: Global perspectives*: John Wiley & Sons; 2021.
12. Larasati NPA. Gender inequality in Indonesia: Facts and legal analysis. *Law Research Review Quarterly*. 2021;7(4):445-458.
13. Smith SG and Sinkford JC. Gender equality in the 21st century: Overcoming barriers to women's leadership in global health. *Journal of Dental Education*. 2022;86(9):1144-1173.
14. Rapp KS, Volpe VV, Hale TL and Quartararo DF. State-level sexism and gender disparities in health care access and quality in the United States. *Journal of Health and Social Behavior*. 2022;63(1):2-18.
15. Wei W, Sarker T, Żukiewicz-Sobczak W and et al. The influence of women's empowerment on poverty reduction in the rural areas of Bangladesh: Focus on health, education and living standard. *International journal of environmental research and public health*. 2021;18(13):6909.
16. Thorpe H, Bekker S, Fullagar S and et al. Advancing feminist innovation in sport studies: a transdisciplinary dialogue on gender, health and wellbeing. *Frontiers in Sports and Active living*. 2023;4:1060851.
17. Wright A and Michailova S. Critical literature reviews: A critique and actionable advice. *Management Learning*. 2023;54(2):177-197.
18. Basu A and Tripathi P. Poetics and Politics of Seclusion: Approaching Purdah Through Intersectionality in Select Works of Indian Female Authors. *Lit: Literature Interpretation Theory*. 2024;35(3):229-252.
19. Kagawa E. Veil and Gaze: The Practice of Pardah Among Urban Female College Students in Contemporary Pakistan. *Created and Contested*. 2022:27-49.
20. Brannen J and Wilson G. *Give and take in families: Studies in resource distribution*: Taylor & Francis; 2023.
21. Noorani I and Shakir K. Pakistani Women and Traditional Values: The Role of Culture in Work-Life Balance. *Work-Life interface: Non-western Perspectives*. 2021:343-378.
22. Khalid MA. Assessment of gender-role attitudes among people of Pakistan. *Open Journal of Social Sciences*. 2021;9(12):338-350.
23. Omer S, Zakar R, Zakar MZ and Fischer F. The influence of social and cultural practices on maternal mortality: a qualitative study from South Punjab, Pakistan. *Reproductive health*. 2021;18(1):97.
24. Chaudhary N and Dutt A. Women as agents of change: Exploring women leaders' resistance and shaping of gender ideologies in Pakistan. *Frontiers in Psychology*. 2022;13:800334.
25. Agha N and Agha N. *Kinship, patriarchal structure and women's bargaining with patriarchy in rural Sindh, Pakistan*: Springer; 2021.
26. MacQuarrie KL and Aziz A. Women's decision-making and contraceptive use in Pakistan: an analysis of Demographic and Health Survey data. *Sexual and reproductive health matters*. 2022;29(2):2020953.
27. Ahmad D, Shah SZA and Bashir F. Women Empowerment in Punjab: dimensions, determinants, and implications for access to healthcare. *Pakistan Journal of Humanities and Social Sciences*. 2021;9(3):505-514.
28. Nazir H, Rowther AA, Rauf N and et al. 'Those whom I have to talk to, I can't talk to': Perceived social isolation in the context of anxiety symptoms among pregnant women in Pakistan. *Health & social care in the community*. 2022;30(6):e5885-e5896.
29. Habib SS, Jamal WZ, Zaidi SMA and et al. Barriers to access of healthcare services for rural women—applying gender lens on TB in a rural district of Sindh, Pakistan. *International journal of environmental research and public health*. 2021;18(19):10102.
30. Maheen H, Hoban E and Bennett C. Factors affecting rural women's utilisation of continuum of care services in remote or isolated villages or Pakistan—A mixed-methods study. *Women and Birth*. 2021;34(3):257-265.
31. Akhter N, Haq A, Akhtar S and Manj MS. The Status Of Women In Pakistan: A Case Of The Socio-Political And Economic Role Of Women In Rural & Tribal Area Of Dera Ghazi Khan. *Webology*. 2022;19(2).
32. Towghi F. *Baloch Midwives: Contesting Global Perceptions of Midwifery in Balochistan, Pakistan*: Taylor & Francis; 2024.
33. Ahsan C. Where Girls Rule the World: Lessons for Pakistan in the Bangladeshi Educational Phenomenon. 2022.
34. Yarrow A. *Birth control: The insidious power of men over motherhood*: Seal Press; 2023.
35. Banerjee S. Determinants of rural-urban differential in

- healthcare utilization among the elderly population in India. *BMC Public Health*. 2021;21:1-18.
36. Shen Y and Tao Y. Associations between spatial access to medical facilities and health-seeking behaviors: A mixed geographically weighted regression analysis in Shanghai, China. *Applied Geography*. 2022;139:102644.
 37. Midhet F, Khalid SN, Baqai S and Khan SA. Trends in the levels, causes, and risk factors of maternal mortality in Pakistan: A comparative analysis of national surveys of 2007 and 2019. *PLoS One*. 2025;20(1):e0311730.
 38. Williams CL. *Still a man's world: Men who do women's work*. Vol 1: Univ of California Press; 2023.
 39. Anwar J, Torvaldsen S and Morrell S, Taylor R. Maternal mortality in a rural district of Pakistan and Contributing Factors. *Maternal and Child Health Journal*. 2023;27(5):902-915.
 40. Shaheen SK, Tharwani ZH, Bilal W, Islam Z and Essar MY. Maternal mortality in Pakistan: challenges, efforts, and recommendations. *Annals of Medicine and Surgery*. 2022;81.
 41. Shabbir A, Asif H and Kabir M. Magnitude Of Sudden Infants Deaths, Maternal Mortality And Still Births In Pakistan. *MARKHOR (The Journal of Zoology)*. 2021:05-14.
 42. Ahmed F, Malik NI, Bashir S, Noureen N, Ullah S, Ahmed JB, Mansoor T, Tang K. "An obedient wife never says "no" to her virtual god." High fertility conceptions and barriers to contraceptive use among mothers of Southern Pakistan: a qualitative study. *BMC Public Health*. 2024;24(1):2157.
 43. Khan S. The impact of gendered experiences on female medical students' specialty choice: A systematic review. *The American Journal of Surgery*. 2023;225(1):33-39.
 44. Zegeye B, El-Khatib Z, Ameyaw EK, Seidu AA, Ahinkorah BO, Keetile M, Yaya S.. Breaking barriers to healthcare access: a multilevel analysis of individual- and community-level factors affecting women's access to healthcare services in Benin. *International journal of environmental research and public health*. 2021;18(2):750.
 45. Ilyas A. Maternal health services in Pakistan. *Pakistan Journal of Medical & Health Sciences*. 2023;17(05):2-2.
 46. Asif N, Adnan F, Ali SS, Memon Z and Ali TS. Maternal mortality and morbidity in Pakistan: a situational analysis. *British Journal of Midwifery*. 2023;31(11):623-632.
 47. Ain QU, Farooq N, Kashif S, Aslam S, Ashraf B and Siraj N. Analysis of Three Delays of Maternal Mortality in Federal Government Polyclinic Islamabad. *Annals of Punjab Medical College*. 2023;17(3):361-366.
 48. Okeke CI, Agwu P, Etiaba E and Onwujekwe O. Demand and supply side factors that drive delayed referrals from traditional birth attendants to public primary healthcare facilities: Insights from three states in Nigeria. *PLOS Global Public Health*. 2024;4(12):e0003886.
 49. Asif M. Breaking barriers: Empowering women's mobility in Pakistan through Women on Wheels. *Riding to Freedom: Women Cyclists Reclaiming Public Space in Muslims Contexts*. 2024:42.
 50. Shahbaz S, Ashraf MZ, Zakar R and Fischer F. Psychosocial, emotional and professional challenges faced by female healthcare professionals during the COVID-19 outbreak in Lahore, Pakistan: a qualitative study. *BMC Women's Health*. 2021;21(1):197-51. Crawford R. A cultural account of "health": Control, release, and the social body. *Issues in the political economy of health care*: Routledge; 2022:60-104.