

FEMINIST GLOBAL HEALTH DIPLOMACY: GENDER, POWER, AND HEALTH INEQUITIES IN PAKISTAN - A COMPREHENSIVE REVIEW

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Abstract

This comprehensive review examined feminist global health diplomacy through the critical lens of Pakistan's health governance landscape, where profound gender inequities manifest in alarming statistics: 186 maternal deaths per 100,000 live births, 34% of women experiencing spousal violence, and only 22.6% female labor force participation. Through systematic literature review methodology analyzing peer-reviewed articles, national health surveys, and policy documents from 2012-2024, it has been investigated that the intersections of gender, power, and health inequities within Pakistan's patriarchal social structures. The analysis revealed that traditional global health diplomacy frameworks systematically marginalize women's health priorities, with devastating consequences for maternal health (lifetime risk of maternal death 1 in 89), reproductive rights (48.5% unmet family planning needs), and gender-based violence prevention (conviction rates below 2%). Using feminist political ecology and intersectionality frameworks, it presented comprehensive data documenting provincial variations in health indicators, gender-based violence statistics, healthcare access barriers, and policy implementation gaps across Pakistan's diverse regions. The paper demonstrates how feminist global health diplomacy, emphasizing local agency, intersectional analysis, and structural inequality transformation, provides essential frameworks for achieving health equity in contexts where gender discrimination intersects with class, ethnicity, and geographic marginalization to produce devastating health outcomes for women and marginalized populations.

Introduction

Global health diplomacy, defined as the strategic negotiations and collaborations among states, international organizations, civil society, and private sector entities to improve health outcomes worldwide, has emerged as a critical mechanism for addressing transnational health challenges (Kickbusch et al., 2013). However, despite its expanding scope and influence, traditional global

health diplomacy frameworks have systematically failed to address the gendered dimensions of health crises and inequities (Bambra et al., 2014). This oversight is particularly consequential in contexts such as Pakistan, where gender-based power asymmetries fundamentally shape health access, outcomes, and policy formulation. Pakistan presents a compelling and urgent case study for examining how feminist perspectives can

transform global health diplomacy to address deeply entrenched gender inequities that conventional approaches have persistently neglected.

Pakistan ranks 164th among 193 countries on the World Economic Forum's Global Gender Gap Index, reflecting profound disparities across economic participation, educational attainment, health and survival, and political empowerment dimensions (World Economic Forum, 2024). These aggregate indicators mask even more alarming health-specific inequities. The maternal mortality ratio stands at 186 deaths per 100,000 live births, translating to a lifetime risk of maternal death of one in 89 for Pakistani women compared to one in 17,400 in Sweden (Pakistan Maternal Mortality Survey, 2019; WHO, 2023). This 195-fold disparity is not merely a function of economic development differentials but reflects systematic devaluation of women's lives and health within patriarchal governance structures that prioritize male-centered health concerns and exclude women from decision-making processes affecting their own bodies and wellbeing (Mumtaz & Salway, 2009).

The manifestations of gender-based health inequities in Pakistan are multifaceted and severe. Only 69% of births are attended by skilled health personnel nationally, declining to 60% in rural areas where the majority of Pakistan's population resides (Pakistan DHS, 2017-18). Modern contraceptive prevalence remains stagnantly low at 25%, with an alarming 51.5% unmet need for family planning, indicating that over half of married women who wish to avoid or delay pregnancy cannot access contraceptive services (UNFPA, 2024). Critically, less than one-third of women can make autonomous decisions regarding their own sexual and reproductive health, with most decisions controlled by husbands or male family members—a stark indicator of systematic denial of bodily autonomy (Sathar et al., 2016). Beyond reproductive health, gender-based violence constitutes a public health emergency of catastrophic proportions. Recent data indicate that 34% of ever-married women in Pakistan have experienced physical, sexual, or emotional violence from their spouses (Pakistan DHS, 2017-

18). In 2024 alone, over 32,000 gender-based violence cases were officially reported, including 5,339 rapes, 24,439 abductions, 547 honor killings, and 2,238 domestic violence cases (Sustainable Social Development Organisation, 2024). These staggering figures represent only documented cases; the actual prevalence is substantially higher due to pervasive social stigma, fear of reprisal, and systematic barriers to reporting embedded within patriarchal family structures and complicit justice systems (Human Rights Commission of Pakistan, 2024).

Perhaps most disturbing is the near-total impunity characterizing responses to gender-based violence. Overall conviction rates for GBV crimes hover around 1.2%, with specific rates of merely 0.5% for rape and honor killings, and 0.1% for abduction (Aurat Foundation, 2024). This systemic failure to hold perpetrators accountable reflects not weak law enforcement capacity but deliberate normalization of violence against women, embedded within patriarchal ideologies that construct women as male property, justify violence as discipline, and prioritize family honor over women's fundamental rights to safety, dignity, and bodily integrity (Ali & Gavey, 2022). Between 2021 and 2024, more than 7,500 women were killed in Pakistan, including 1,553 victims of honor crimes killings perpetrated by family members to preserve perceived family honor, often for exercising autonomy in marriage choices or alleged sexual impropriety (Human Rights Watch, 2024).

Traditional global health diplomacy has proven inadequate for addressing these gendered health crises because it operates within frameworks that treat health issues as gender-neutral technical problems amenable to universalized interventions (Harman, 2016). This approach obscures how health inequities are fundamentally produced and sustained through gendered power relations operating at multiple scales from household decision-making dynamics to national policy formulation to international development paradigms (Molyneux & Samuels, 2009). Feminist global health diplomacy offers a transformative alternative by centering gender analysis, intersectionality, and structural power critique as

essential components of health policy and practice (Harrison, 2016).

Feminist scholars have long argued that global health policies systematically fail to consider unique challenges confronting women and gender minorities, including limited maternal health service access, reproductive rights constraints, gender-based violence, and social determinants such as income inequality, educational deficits, and restrictive cultural norms (Kabeer, 2018; Tobin, 2018). By integrating feminist perspectives into health diplomacy, it becomes possible to create more inclusive, intersectional, and responsive approaches that recognize health as fundamentally shaped by power relations rather than merely biological or environmental factors (Sultana, 2014).

Intersectionality, conceptualized by Crenshaw (1989) and expanded by Indigenous and transnational feminist scholars, provides crucial analytical tools for understanding how multiple systems of oppression based on gender, race, class, caste, religion, sexuality, disability, and geography interact to produce unique patterns of health vulnerability and marginalization. In Pakistan's context, intersectional analysis illuminates how gender discrimination intersects with class inequality, ethnic marginalization, religious minority status, rural isolation, and disability to create compounded health disadvantages for particular groups of women (Bambra et al., 2014). For instance, rural women in Balochistan face maternal mortality rates three times higher than urban women in Punjab, reflecting not merely geographic variation but systematic state neglect of ethnic minority regions and deliberate resource concentration in politically dominant areas (Provincial Health Departments, 2023).

This review employs feminist global health diplomacy frameworks to critically examine how gender, power, and health inequities intersect within Pakistan's health governance systems. We argue that addressing Pakistan's profound health disparities requires not merely technical interventions building more hospitals, training more health workers, distributing more medicines but fundamental transformation of patriarchal power structures governing health policy

formulation, resource allocation, service delivery, and accountability mechanisms. Through systematic analysis of empirical evidence, policy documents, and theoretical literature, we demonstrate how feminist approaches emphasizing intersectionality, local agency, and structural inequality transformation can reshape Pakistan's health landscape toward greater equity and justice. The paper proceeds as follows: first, we review relevant theoretical and empirical literature on feminist global health diplomacy and Pakistan's gendered health landscape; second, we detail our systematic review methodology; third, we present comprehensive data on gender health inequities through four detailed tables; fourth, we discuss findings and policy implications; finally, we conclude with recommendations for feminist-informed health diplomacy in Pakistan and similar contexts.

Literature Review

Feminist Political Ecology and Health Governance

Feminist political ecology (FPE) provides essential analytical frameworks for understanding how gender intersects with environmental change, resource access, and power relations in health contexts (Sultana, 2014). Unlike gender-neutral approaches that obscure differential vulnerabilities, FPE recognizes that health outcomes are mediated by social hierarchies including gender, class, ethnicity, religion, and geography. In Pakistan, where 67% of employed women work in agriculture and rural women bear primary responsibility for water collection, food production, and household maintenance, environmental degradation and climate change directly amplify gendered labor burdens and health risks (International Water Management Institute, 2024). Feminist political ecology illuminates how these seemingly natural arrangements are actually produced through patriarchal power relations that assign women disproportionate care responsibilities while denying them decision-making authority and resource control.

Intersectionality and Multiple Marginalization in Pakistan

Intersectionality reveals how multiple oppression systems interact to produce unique experiences of marginalization that cannot be understood by examining single identity categories in isolation (Crenshaw, 1989). For Pakistani women, health experiences reflect complex intersections of patriarchal gender norms, economic marginalization, religious discrimination, caste-based hierarchies, and geographic isolation. Kalash women in Chitral, for example, experience discrimination as religious minorities practicing animism within an Islamic state, as ethnic minorities in Pashtun-dominated regions, as women within patriarchal societies, and as impoverished communities with minimal state services (National Commission on Human Rights Pakistan, 2023). These intersecting marginalization forms produce maternal mortality rates of 350-450 per 100,000 in mountain regions more than double national averages reflecting systematic state neglect of Indigenous and minority populations.

Gender-Based Violence as Structural Violence

Critical public health scholarship conceptualizes gender-based violence not merely as individual acts of aggression but as structural violence systematic ways that social structures harm people by preventing basic needs from being met (Farmer et al., 2013). In Pakistan, GBV manifests through multiple interconnected forms: intimate partner violence affecting 34% of married women; honor killings claiming over 500 lives annually; forced marriage affecting millions of girls; workplace sexual harassment that excludes women from economic participation; and state violence through discriminatory laws and inadequate protection (Sikkink, 2011). The 1.2% overall conviction rate for GBV crimes demonstrates systematic judicial complicity in normalizing violence, transforming GBV from individual crime into state-sanctioned terror maintaining patriarchal control over women's mobility, sexuality, and autonomy.

Reproductive Rights and Bodily Autonomy

Reproductive health and rights constitute fundamental components of women's overall health and wellbeing, yet remain among the most contested areas in global health policy (Molyneux & Samuels, 2009). Feminist approaches emphasize that reproductive health extends beyond biological aspects to encompass broader social, economic, and political dimensions affecting women's reproductive autonomy. In Pakistan, only 25% modern contraceptive prevalence despite 51.5% unmet need reflects not supply-chain failures but systematic denial of women's reproductive autonomy through male-dominated decision-making, provider bias against unmarried women, and inadequate comprehensive sexuality education (Sathar et al., 2016). The 186 maternal mortality ratio requiring 122 years to reach SDG targets at current pace represents not technical deficits but deliberate policy choices deprioritizing women's lives.

Health Systems and Patriarchal Barriers

Women's healthcare access in Pakistan is constrained by multiple interconnected barriers embedded within patriarchal social structures. Permission requirements from male family members affect 65% of women seeking healthcare, while distance to facilities (average 12km in rural areas), lack of female providers (only 38% availability rurally), unaffordable costs (64% out-of-pocket expenditure), and cultural restrictions (purdah norms limiting 28% of women) create nearly insurmountable obstacles (Pakistan DHS, 2017-18). These barriers are not natural or inevitable but result from conscious policy choices: underinvestment in rural health infrastructure, failure to train and deploy female health workers, absence of subsidized services, and refusal to challenge patriarchal norms restricting women's mobility and autonomy (Mumtaz & Salway, 2009). Addressing these barriers requires not merely building facilities but fundamentally reimagining health systems to respect women's agency and autonomy.

Methodology

Research Design

This study employs a comprehensive systematic literature review methodology with critical qualitative synthesis, specifically designed to examine feminist global health diplomacy within Pakistan's socio-political context. The research integrates multiple methodological approaches including feminist political ecology, intersectionality analysis, and critical policy analysis to understand complex interrelationships between gender, power structures, and health outcomes in Pakistan. Unlike conventional systematic reviews that prioritize quantitative meta-analysis, our approach emphasizes critical interpretation of how power relations shape knowledge production, policy formulation, and health outcomes recognizing that seemingly objective health data reflect underlying political choices about what is measured, how, and for whom.

Data Sources and Search Strategy

The literature search encompassed multiple databases including PubMed, Google Scholar, Web of Science, Scopus, JSTOR, and Pakistani institutional repositories. Additional materials were sourced from governmental agencies including Pakistan Bureau of Statistics, National Institute of Population Studies, Ministry of National Health Services, and provincial health departments. International organization sources included World Health Organization, United Nations Population Fund, UN Women, World Bank, and World Economic Forum publications. The search covered publications from January 2012 to December 2024, focusing on peer-reviewed articles, governmental statistical reports, NGO advocacy documents, and policy frameworks published in English and Urdu languages.

Search terms included combinations employing Boolean operators (AND, OR, NOT): 'Pakistan' AND ('women's health' OR 'maternal health' OR 'reproductive health'); 'gender inequities' OR 'gender disparities'; 'maternal mortality' OR 'maternal morbidity'; 'gender-based violence' OR 'domestic violence' OR 'intimate partner violence';

'feminist health diplomacy' OR 'global health governance'; 'intersectionality'; 'health policy' AND 'gender'; 'patriarchy' AND 'health'; 'social exclusion'; and related concepts in English and Urdu. Reference tracking from key articles identified additional relevant literature not captured through database searches.

Inclusion and Exclusion Criteria

Inclusion criteria prioritized: (1) empirical studies from Pakistani contexts examining gender dimensions of health, healthcare access, or health policy; (2) comparative analyses from South Asian countries (India, Bangladesh, Afghanistan, Nepal, Sri Lanka) with similar socio-economic and cultural profiles; (3) theoretical frameworks addressing intersectionality, feminist political ecology, colonialism, patriarchy, and health governance; (4) national health surveys and demographic data specific to Pakistan or disaggregated by gender; (5) policy documents, legislative frameworks, and governmental reports addressing women's health; and (6) studies published between 2012-2024 to capture contemporary health governance landscapes, with exceptions for seminal theoretical works establishing foundational concepts.

Exclusion criteria included: (1) studies focused exclusively on clinical interventions or biomedical mechanisms without analysis of social, political, or structural determinants; (2) literature not addressing gender dimensions of health or treating gender as peripheral variable rather than central analytical category; (3) publications prior to 2012 unless establishing seminal theoretical frameworks; (4) studies from contexts with limited applicability to Pakistan's socio-cultural environment (high-income Western countries); and (5) grey literature without verifiable methodological rigor or institutional credibility.

Data Extraction and Synthesis

Data extraction employed systematic coding procedures, organizing findings according to: (1) health domains (maternal health, reproductive health, mental health, physical health, healthcare access); (2) structural determinants (patriarchy, colonialism, poverty, social exclusion,

discrimination); (3) geographic variations (provincial differences, urban-rural disparities); (4) policy frameworks (national legislation, provincial regulations, international commitments); and (5) resistance strategies (grassroots organizing, traditional knowledge, advocacy). Extracted data included quantitative health indicators, qualitative descriptions of barriers and experiences, policy content, and theoretical insights.

Thematic analysis was conducted using feminist political ecology frameworks, identifying patterns, contradictions, and gaps in existing literature. Analysis focused on: how health inequities are produced and sustained through gendered power relations; which populations experience compounded vulnerabilities through intersecting marginalization; what policy responses exist and why they succeed or fail; and how feminist approaches can transform health governance. Critical reflexivity guided the review process, acknowledging that academic knowledge production systems have historically excluded and misrepresented marginalized populations, particularly women from Global South contexts. We remained attentive to whose voices appear in literature, whose experiences are documented, and whose perspectives shape interpretation.

Quality Assessment and Ethical Considerations

Quality assessment criteria included methodological rigor, data reliability, peer-review status, sample representativeness, and theoretical grounding. National surveys conducted by governmental agencies (Pakistan Demographic and Health Survey, Pakistan Maternal Mortality Survey) were considered highly reliable for

quantitative indicators. NGO reports were critically evaluated for potential advocacy biases while recognizing their value in documenting experiences often invisible in official statistics. Limitations acknowledged include: (1) systematic underreporting of gender-based violence and maternal mortality, particularly in rural and marginalized communities where social stigma and limited documentation capacity obscure actual prevalence; (2) limited disaggregated data by ethnicity, class, disability, and sub-provincial geographic location; (3) potential publication bias favoring studies showing positive intervention outcomes; and (4) researcher positionality influencing interpretation. Ethical considerations include commitment to centering marginalized voices, avoiding extractive research practices, ensuring representation of diverse perspectives, and orienting findings toward advocacy supporting communities studied rather than merely advancing academic careers.

Results and Discussion

The following section presents comprehensive data analysis through four detailed tables documenting various dimensions of gender inequities, health disparities, and policy gaps in Pakistan. These tables synthesize data from national surveys, governmental reports, international organizations, and academic research to provide evidence-based understanding of feminist global health diplomacy's relevance to Pakistan's context. Each table is followed by critical discussion interpreting findings through feminist political ecology and intersectionality frameworks.

Table 1: Pakistan's Gender Inequality and Health Indicators (2023-2024)

Indicator	Value	Comparison
Global Gender Gap Rank	164 out of 193 countries	Second lowest in South Asia
Maternal Mortality Ratio (per 100,000)	186	Target: <70 by 2030
Lifetime Risk of Maternal Death	1 in 89	Sweden: 1 in 17,400

Female Labor Force Participation	22.6%	Male: 84.3%
Women Experiencing Spousal Violence	34%	Physical, sexual, or emotional
Skilled Birth Attendance	69%	Rural: 60%, Urban: 85%
Modern Contraceptive Prevalence	25%	Unmet need: 51.5%
Women in Parliament	20.5%	Mostly reserved seats
Secondary School Enrollment (girls)	40.2%	Boys: 50.8%
Gender Pay Gap	Women earn 34% less	Higher than global average

Source: World Economic Forum Global Gender Gap Report 2024; Pakistan Bureau of Statistics; Pakistan DHS 2017-18; UNFPA 2024

Table 1 reveals systematic patterns of gender inequality across all measured dimensions in Pakistan. The 164th global ranking on gender equality second-lowest in South Asia surpassed only by Afghanistan reflects not merely cultural difference but systematic state failure to guarantee women's fundamental rights. The maternal mortality ratio of 186 per 100,000 births, translating to lifetime risk of 1 in 89, is particularly alarming when compared to Sweden's 1 in 17,400 a 195-fold disparity indicating not natural

variation but political choices prioritizing certain lives over others. At current rates of progress, Pakistan requires 122 years to achieve SDG maternal mortality targets an unconscionable timeline reflecting inadequate political will and resource commitment. The 34% spousal violence prevalence, affecting approximately 16 million married women, coupled with 1.2% conviction rates, demonstrates how violence functions as systematic terror maintaining patriarchal control rather than isolated individual crimes.

Table 2: Provincial Variations in Maternal Health and Gender-Based Violence

Province	MMR (per 100,000)	Skilled Birth Attendance	GBV Cases (2024)	Key Barriers
Punjab	145	75%	Highest absolute	Cultural norms
Sindh	175	68%	High	Rural-urban divide
Khyber Pakhtunkhwa	268	58%	High per capita	Geography, patriarchy
Balochistan	298	42%	Moderate	Extreme isolation
Gilgit-Baltistan	350-450	38%	Underreported	No facilities
National Average	186	69%	32,617 total	Wide disparities

Source: Pakistan Maternal Mortality Survey 2019; Provincial Health Departments; Sustainable Social Development Organisation 2024; MMR = Maternal Mortality Ratio

Table 2's provincial disaggregation illuminates critical geographic inequities often obscured in national averages. Maternal mortality ranges from 145 per 100,000 in Punjab to 350-450 in Gilgit-Baltistan representing a three-fold disparity that reflects systematic state neglect of mountain communities, ethnic minorities, and politically marginalized regions rather than natural geographic variation. Similarly, skilled birth attendance varies from 75% in Punjab to 38% in Gilgit-Baltistan, demonstrating how intersecting marginalization geography, ethnicity, poverty,

political exclusion—compounds to create catastrophic health outcomes. These disparities reveal that Pakistan's health crisis is fundamentally a crisis of unequal power and resource distribution rather than uniform underdevelopment. Feminist health diplomacy must address these subnational inequities through targeted resource allocation prioritizing most marginalized provinces, community-led interventions respecting local contexts, and political representation ensuring marginalized regions influence national policy.

Table 3: Gender-Based Violence Statistics and Justice System Failures

Type of Violence/Indicator	Cases/Prevalence	Conviction Rate
Total GBV Cases Reported (2024)	32,617	1.2% overall
Rape Cases	5,339	0.5%
Abductions	24,439	0.1%
Honor Killings	547	0.5%
Domestic Violence Cases	2,238 reported	1.3%
Ever-Married Women Experiencing Violence	34% (prevalence)	Most unreported
Women Killed (2021-2024)	7,500+	Including 1,553 honor crimes
Women (15-49) Physical Violence	28% lifetime	Systematic impunity
Sexual Violence Prevalence	6%	Severe underreporting

Source: Sustainable Social Development Organisation 2024; Human Rights Commission Pakistan; UNFPA Pakistan; Pakistan DHS 2017-18

Table 3 documents Pakistan's gender-based violence emergency and near-total judicial impunity. Over 32,000 documented GBV cases in 2024 with overall conviction rates of 1.2% dropping to 0.5% for rape and honor killings, 0.1% for abduction reveal systematic normalization of violence against women embedded within patriarchal structures. This impunity is not accidental but reflects deliberate state complicity: inadequate investigation resources, police bias dismissing women's complaints, judicial prejudice blaming victims, and societal pressure on women to withdraw cases

to preserve family honor. The 34% spousal violence prevalence represents approximately 16 million married women experiencing physical, sexual, or emotional violence—constituting a public health emergency requiring comprehensive policy responses integrating legal reform, healthcare provider training in trauma-informed care, survivor support services including shelters and economic assistance, and fundamental cultural transformation challenging patriarchal norms justifying violence as male prerogative. Feminist health diplomacy must recognize GBV not as private family matter but as systematic

human rights violation and public health crisis demanding urgent state accountability.

Table 4: Barriers to Women's Healthcare Access in Pakistan

Barrier Type	Prevalence/Impact
Permission from Male Family Member Required	65% of women need male permission for healthcare
Distance to Health Facility (Rural)	56% rural women report as major barrier; average 12km
Lack of Female Healthcare Providers	42% cite as barrier; rural areas only 38% availability
Cost of Healthcare Services	38% cannot afford; 64% out-of-pocket expenditure
Lack of Transportation/Mobility	34% lack independent mobility; cultural restrictions
Cultural/Religious Restrictions (Purdah)	28% limited by purdah norms and gender segregation
Language Barriers	22% in ethnic minority areas cannot communicate
Lack of Awareness of Health Rights	45% unaware of health entitlements and services
Quality of Care Concerns	Poor service quality deters 32% from seeking care
Decision-Making Autonomy	<33% can make own sexual/reproductive health decisions

Source: Pakistan DHS 2017-18; National Health Survey 2021; UNFPA Pakistan 2024

Table 4 documents multifaceted barriers preventing women from accessing healthcare even when services theoretically exist. The requirement for male permission affecting 65% of women combined with distance barriers (average 12km rural), lack of female providers (only 38% rural availability), unaffordable costs (64% out-of-pocket), and cultural restrictions (purdah limiting 28%) creates nearly insurmountable obstacles for rural and marginalized women. Critically, these barriers are not natural or inevitable but result from conscious policy choices prioritizing patriarchal control over women's health autonomy: underinvestment in rural infrastructure, failure to train and deploy female health workers, absence of subsidized universal health coverage, and refusal to challenge restrictive gender norms. The finding that less than 33% of women can make autonomous sexual and

reproductive health decisions reveals systematic denial of bodily autonomy women cannot decide whether, when, or how many children to have, whether to seek healthcare during pregnancy, or whether to use contraception. Addressing these barriers requires not merely building more facilities but fundamentally reimagining health systems to respect women's agency, autonomy, and rights to make decisions about their own bodies and lives.

Conclusion

This comprehensive review demonstrates that Pakistan's profound health inequities are not accidental outcomes of underdevelopment but systematic results of patriarchal power structures governing health policy formulation, resource allocation, and service delivery. Feminist global health diplomacy provides essential frameworks

for addressing these inequities by centering intersectionality, local agency, and structural transformation rather than treating health as gender-neutral technical domain. The evidence presented reveals urgent need for comprehensive policy interventions fundamentally reimagining health governance to respect women's rights, autonomy, and dignity.

First, Pakistan must dramatically increase investment in maternal and reproductive health services, recognizing that current maternal mortality levels requiring 122 years to reach SDG targets at present pace represent moral emergency demanding urgent action. This requires not merely expanding facility infrastructure but addressing systematic barriers including permission requirements, distance, cost, and cultural restrictions preventing women from accessing existing services. Universal health coverage eliminating financial barriers, deployment of female health workers to rural and underserved areas, and community-based service delivery respecting women's mobility constraints constitute essential interventions.

Second, comprehensive gender-based violence prevention and response systems with meaningful judicial accountability must be established. Current 1.2% conviction rates demonstrate systematic state complicity in normalizing violence against women. Required interventions include: legal reform eliminating discriminatory provisions and strengthening penalties; adequately resourced police investigation and prosecution; judicial training challenging victim-blaming attitudes; survivor support services including emergency shelters, economic assistance, and trauma counseling; and public education campaigns challenging patriarchal norms justifying violence as male prerogative. GBV must be recognized not as private family matter but as systematic human rights violation and public health crisis demanding state accountability.

Third, targeted resource allocation must address provincial and class-based disparities illuminated in Table 2. The three-fold maternal mortality differential between Punjab and Gilgit-Baltistan reflects systematic state neglect requiring deliberate resource redistribution to historically

marginalized regions. Equity-oriented financing mechanisms ensuring adequate per-capita health expenditure in all provinces, infrastructure development in underserved areas, and community-based delivery models adapted to local contexts constitute essential interventions.

Fourth, fundamental transformation of health governance ensuring women's meaningful participation in policy formulation is imperative. Current systems exclude women from decision-making affecting their own bodies and lives reflected in findings that less than 33% can make autonomous reproductive health decisions. Transformative governance requires: quotas ensuring women's representation in health leadership at all levels; participatory policy processes centering affected communities' voices; accountability mechanisms making policymakers responsive to women's needs; and elimination of permission requirements and other patriarchal controls over women's healthcare access.

Finally, achieving health equity in Pakistan requires not merely technical interventions but fundamental challenge to patriarchal structures denying women's rights to health, bodily autonomy, and full social participation. Feminist global health diplomacy, emphasizing women's leadership, intersectional analysis recognizing how multiple marginalization forms compound, and structural inequality transformation addressing root causes rather than symptoms, offers crucial pathways toward building health systems truly serving all populations. The 122-year timeline to end preventable maternal deaths at current pace is morally unconscionable; urgent, sustained, feminist-informed action prioritizing women's lives, autonomy, and dignity is imperative. Only through centering gender justice within health diplomacy can Pakistan achieve the Sustainable Development Goal commitments to leave no one behind and ensure health and wellbeing for all.

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