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Health, Gender, and Growth: Women-Centered Strategies for Rural Development

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ABSTRACT

Background: Women's health is a critical determinant of household well-being and community development, yet its role as a mediating mechanism between gender norms and development outcomes remains underexplored in the Islamabad Capital Territory (ICT), Pakistan.

Objective: This study investigates how gendered social structures, household dynamics, and institutional factors shape women's health experiences and influence broader developmental outcomes in ICT.

Methods: A qualitative multiple-case study design was employed, including in-depth interviews, focus group discussions, and key informant interviews with women, men, and community health providers. Data were analyzed thematically using Kabeer's Agency–Resources–Achievements (A–R–A) framework and the Social Determinants of Health perspective.

Results: Women's health mediates the effects of gender norms on household productivity, caregiving, children's education, and community participation. Key findings include: (i) negotiated but contingent agency in health-seeking, (ii) systematic prioritization of men's health over women's, (iii) normalization of chronic and untreated illness, (iv) intergenerational impacts, particularly on girls' schooling, and (v) variable institutional mediation through the Lady Health Worker programme. Structural and institutional constraints limit women's sustained agency and engagement in broader development initiatives.

Conclusions: Women's health functions as a foundational driver of household and community development. Addressing intra-household inequities, strengthening institutional support, and implementing integrated, gender-responsive interventions are critical to enhancing women's well-being and advancing equitable development outcomes in ICT.

Introduction

Women's health is a critical dimension of development, reflective not only of individual biological needs but also of broader social structures that allocate power, resources, and opportunities inequitably across gendered lines. Globally, gender norms significantly shape access to health services, autonomy in care-seeking, and the prioritization of health within households (WHO, 2021). The World Health Organization's Social Determinants of Health framework posits that health outcomes are embedded within social, economic, and institutional structures rather than merely individual behaviour (WHO, 2022). In this framework, gender emerges as a central determinant, shaping how risk factors, structural constraints, and access to resources intersect to influence women's health trajectories across diverse contexts. Despite extensive global attention on maternal and reproductive health, there remains a gap in understanding how women's health functions as a mediating mechanism between entrenched gender norms and broader development outcomes within specific territorial contexts such as the Islamabad Capital Territory (ICT) of Pakistan.

In Pakistan, deeply embedded patriarchal norms influence women's autonomy, mobility, and decision-making power, significantly constraining their access to health services (Riaz et al., 2024b). National and regional studies consistently highlight that women face restricted independence in household decision-making, limited control over financial resources, and social surveillance that curtails unaccompanied mobility barriers that are reinforced by gendered cultural expectations (Habib et al., 2021; Raza et al., 2022; Naz et al., 2025). For example, research on barriers to healthcare access in rural Pakistan identifies limited financial autonomy, disapproval of unassisted travel, and inadequate availability of female health providers as persistent obstacles for women (Habib et al., 2021; Naz et al., 2022a; Naz et al., 2022b; Ishtiaq et al., 2025). These barriers are emblematic of broader patterns of gender inequity in the region, reflecting how structural and normative conditions intersect to limiting women's health-seeking behaviour.

Empirical evidence from Pakistan also suggests that gender norms profoundly shape maternal healthcare utilization (Naz et al., 2023a). A large-scale demographic study documented that women's decision-making authority in mobility, health, and household expenditures significantly predicts antenatal care use and skilled birth attendance, implying that gender inequality negatively impacts maternal health outcomes (Aslam et al., 2025). Similarly, investigations into gendered social determinants of health in Khyber Pakhtunkhwa underscore that socio-cultural barriers, literacy disparities, and domestic expectations disproportionately burden women's health and wellbeing (Ali et al., 2024; Naz et al., 2023b). These findings reinforce broader patterns observed in low- and middle-income countries, where social determinants such as education, economic status, and social norms account for a substantial portion of health inequities (Marmot et al., 2008). Within Pakistan, these intersecting factors are particularly salient in rural and peri-urban populations where institutional support is uneven, and gendered expectations endure.

The literature on women's empowerment in Pakistan further highlights the centrality of gendered social structures in shaping health outcomes (Riaz et al., 2025). Quantitative analyses of nationally representative data show that women's empowerment is associated with improvements in health service utilization yet is constrained by socio-demographic factors including education, wealth status, and labour force participation (Baqutayan, 2021). These determinants influence not only access to formal services but also the conditions under which women negotiate care within households. Such findings suggest that empowerment must be conceptualized not solely

as individual autonomy but as relational and contextual, influenced by multiple intersecting axes of disadvantage that mediate women's health behaviours and outcomes.

Despite these insights, much of the existing research on gender and health in Pakistan has been limited to describing barriers or measuring associations between gendered constraints and health outcomes. There is comparatively less work that explicitly examines how women's health functions as a mediating mechanism linking gender norms to broader developmental dimensions such as household productivity, caregiving dynamics, children's education, and community participation. In other words, there remains a need to understand not just whether women face barriers to health services, but how these barriers reverberate through household and community structures to shape development outcomes. Such analyses are vital for informing policy frameworks that move beyond health access indicators to consider systemic and structural determinants of women's health and wellbeing.

ICT, Pakistan's administrative capital region, presents a compelling context for examining these dynamics. Although ICT is often considered better resourced in terms of infrastructure and service availability compared to other provinces, socio-cultural constraints and intra-territorial inequalities persist, particularly in rural and peri-urban localities. Studies in urban poor settings across Pakistan reveal that shortages of female health workforce, low female literacy, and limited autonomy in health decision-making coalesce with broader structural inequities to restrict women's utilization of health services (Hashmi et al., 2022). These findings suggest that resource availability alone does not guarantee equitable health outcomes; rather, the interaction of gender norms and institutional capacity is a crucial determinant of realized access. ICT's mixed rural-peri-urban profile thus allows an examination of how contextually embedded gender norms intersect with institutional presence to shape women's health experiences.

Furthermore, women's health outcomes have implications that extend well beyond the health sector. Maternal ill health can impose caregiving burdens that alter children's school attendance and engagement especially for daughters who may be required to compensate for reduced maternal labour thereby influencing intergenerational human capital formation. Research in comparable low-income settings suggests that maternal health constraints are associated with lower educational attainment among children and constrained future opportunities, particularly for girls (Mensch, Singh, & Casterline, 2005). These intergenerational pathways illustrate how health inequities reinforce broader patterns of social and economic disadvantages.

The analytic framework of this study draws on Kabeer's (1999) Agency–Resources–Achievements (A–R–A) framework, which conceptualizes empowerment as a dynamic interplay between individuals' agency, the resources available to them, and the achievements they are able to realize. Within the context of Pakistani gender norms, agency is often negotiated and relational rather than autonomous, shaped by household structures, economic constraints, and social expectations; resources include material inputs as well as institutional support systems; and achievements encompass realized health outcomes, mobility gains, and participation in economic and social life. Integrating the A–R–A framework with the SDH perspective enables a nuanced understanding of how structural constraints persist even where services nominally exist, and how these constraints shape developmental pathways.

In sum, this study addresses a gap in the literature by examining how women's health in ICT is shaped by gender norms and social determinants, and how it, in turn, influences broader household and community development outcomes. By situating women's health as a mediating mechanism, the research contributes to both theoretical and policy debates on gender, health, and

development, offering insights that can inform integrated, gender- responsive interventions aimed at enhancing women's wellbeing and enabling equitable development outcomes.

Methodology

Study Design

This study adopted a qualitative case study design (Riaz et al., 2024a; Amin et al., 2025) to examine how gendered social structures and health systems interact to shape women lived health experiences and development outcomes in ICT, Pakistan. Islamabad was conceptualized as an analytically bounded case, defined by its administrative jurisdiction, the coexistence of urban, peri-urban, and rural settlements, entrenched patriarchal gender norms shaped by Pashtun, Punjabi, and migrant communities, and reliance on public primary healthcare systems, including the Lady Health Worker (LHW) programme.

The selection of Islamabad was purposive and theoretically informed. Although Islamabad is often portrayed as a relatively well-resourced and urbanized capital territory, significant intra-territorial disparities persist, particularly in rural and peri-urban union councils. These areas exhibit constrained healthcare access, uneven service delivery, gendered mobility restrictions, and limited reproductive health outreach. Examining women's health experiences in this context enabled the study to interrogate how structural gender constraints persist even in settings characterized by relatively higher institutional capacity. This approach strengthens analytical generalization by highlighting how gendered health inequalities are reproduced across developmentally advantaged contexts.

3.2 Conceptual and Analytical Framework

The study was guided by an integrated analytical framework drawing on Gender and Development (GAD) theory, Kabeer's (1999) Agency–Resources–Achievements (A–R–A) framework, and the Social Determinants of Health (SDH) framework. These frameworks were operationalized analytically rather than applied descriptively and informed all stages of data coding, analysis, and interpretation.

Agency was examined as negotiated and relational rather than purely autonomous, particularly within contexts of male guardianship, family surveillance, and moral expectations surrounding women's endurance of illness. Resources were conceptualized to include both material inputs such as income, healthcare services, and transport and institutional mediators, including LHWs, Basic Health Units, and non-governmental organizations. Analytical attention was paid to understanding why the presence of services in Islamabad often failed to translate into effective access for women. Achievements were traced through realized health outcomes, mobility gains, and participation in household and community life, revealing persistent disconnects between available resources and meaningful outcomes.

Deductive codes were derived from the A–R–A and SDH domains, including gender norms, health system access, and intra-household power relations, while inductive coding captured emergent processes such as psychosocial distress, moral obligations to priorities family needs over personal health, and informal negotiation strategies employed by women. This integrated framework enabled the study to move beyond behavioural explanations and instead foreground structural determinants of women's health.

3.3 Study Site

The research was conducted in selected rural and peri-urban union councils of Islamabad Capital Territory. While Islamabad hosts relatively advanced tertiary healthcare facilities, women residing in peripheral settlements face significant barriers related to distance, transport costs, overcrowding of public facilities, and limited outreach of reproductive and preventive health

services. Gendered mobility norms, particularly within conservative households, further restrict women's ability to independently seek care.

Despite the territory's administrative prominence, rural Islamabad exhibits characteristics common to other underserved regions, including reliance on LHWs for primary care, informal healthcare-seeking practices, and strong patriarchal household structures. These contextual features provided a critical setting for examining how gender norms intersect with institutional arrangements to shape women's health experiences, thereby enhancing the study's transferability through thick contextualization.

3.4 Sampling Strategy

A criterion-based purposive sampling strategy was employed to capture diverse perspectives shaping women's health experiences in Islamabad (Naz et al., 2024a; Naz et al., 2024b). Participants included adult women with recent experiences of seeking, delaying, or foregoing healthcare; men involved in household decision-making; and community-level healthcare providers, including LHWs, Lady Health Visitors, and supervisory personnel.

The final sample comprised 24 in-depth interviews with women, 12 in-depth interviews with men, four (04) focus group discussions with married and unmarried women, and 10 key informant interviews with healthcare providers and community leaders. Sampling continued until thematic redundancy was achieved. Structural barriers to participation were documented; notably, several women declined participation due to family restrictions, underscoring the gendered constraints that formed the core analytical focus of the study.

3.5 Data Collection

Data were collected between April and July 2025 using semi-structured interview and focus group discussion guides tailored to participant categories. Individual interviews lasted between 45 and 75 minutes, while FGDs ranged from 90 to 120 minutes. All interactions were conducted in Urdu and Pashto by trained female and male researchers, with interviewer selection guided by cultural appropriateness and participant comfort.

Interview locations were carefully negotiated to ensure privacy, safety, and confidentiality, often requiring mediation by LHWs or community intermediaries. With informed consent, interviews were audio-recorded; in cases where recording was declined, detailed contemporaneous notes were maintained. All transcripts were translated into English through a bilingual verification process to preserve semantic accuracy and contextual meaning.

3.6 Data Analysis

Data were analyzed using thematic analysis supported by NVivo 12 software (Afridi et al., 2025; Naz et al., 2025). The analytical process involved iterative reading, reflexive memo-writing, and systematic code refinement. Both deductive and inductive codes were applied across the dataset.

To enhance analytic rigor, 20 per cent of transcripts were double-coded, and discrepancies were resolved through collective analytic discussion. Themes were refined to capture both structural constraints and context-specific mechanisms shaping women's health experiences in Islamabad, with particular attention to institutional mediation and household power dynamics.

3.7 Ensuring Rigor

Rigor was ensured using established qualitative trustworthiness criteria. Credibility was strengthened through prolonged engagement, triangulation across interviews and FGDs, and member checks with selected participants. Dependability was supported through a detailed audit trail documenting methodological and analytic decisions. Confirmability was addressed through reflexive journaling on researcher positionality. Transferability was enhanced through thick contextual description rather than claims of representativeness.

3.8 Ethical Considerations

Informed consent procedures accommodated literacy constraints and emphasized voluntariness and confidentiality. Given the sensitivity of health-related discussions, referral pathways to LHWs and public health facilities were maintained for participants who exhibited distress or expressed unmet healthcare needs.

Results

The findings demonstrate that women's health in rural and peri-urban ICT functions not merely as an individual welfare concern, but as a mediating mechanism through which gender norms shape household stability, livelihood productivity, and community-level development outcomes. While women across ICT experienced broadly similar structural constraints including patriarchal decision-making, restricted mobility, and resource scarcity the intensity and consequences of these constraints varied across localities within the territory. These variations reflected differences in household composition, male labour migration patterns, and the density and functionality of institutional support.

Across ICT, women's health-related decisions were embedded within negotiated household processes rather than being entirely absent. However, the scope for negotiation was uneven, contingent, and context-dependent, producing distinct trajectories of vulnerability and limited resilience. Three major themes emerged, aligned with the study objectives and interpreted through Kabeer's Agency–Resources–Achievements (A–R–A) framework and the Social Determinants of Health perspective.

Theme 1: Gendered Health Experiences and Unequal Access to Care

1.1 Negotiated, rather than Absent, Agency in Health-Seeking

Women across ICT reported limited autonomy in seeking healthcare; however, their narratives revealed negotiated forms of agency operating within patriarchal household structures. Decisions regarding care-seeking were typically mediated through husbands, elders, or senior women, with women carefully weighing the perceived severity of illness against anticipated household resistance.

In some localities within ICT, delays in seeking care were frequently attributed to institutional and logistical barriers, including overcrowded public facilities, long waiting times, and transport costs. Women described situations in which permission to seek care was eventually granted, yet practical constraints delayed action:

"My husband does not stop me, but the hospital is far and always crowded. By the time we arrange transport, the day is gone." *(IDI – Woman)*

In other areas, women emphasized heightened social surveillance within extended households, where multiple family members monitored women's movements. Even when health facilities were geographically accessible, seeking care required repeated justification and prolonged negotiation:

"Here, many eyes are watching. Even if the clinic is near, I must explain again and again why I need to go." *(IDI – Woman)*

These contrasts within ICT illustrate how similar gender norms are enacted differently depending on household structure and institutional context, shaping women's ability to translate nominal permission into actual access to care.

1.2 Gendered Resource Allocation as Structural Prioritizations of Men's Health

Across ICT, household financial resources were systematically prioritized for men's healthcare, reflecting deeply embedded assumptions about men's economic indispensability. Women's health

needs were frequently deferred until conditions became severe, reinforcing cycles of delayed diagnosis and incomplete treatment.

As one woman explained:

"If money is limited, treatment for men comes first. They earn for the family, so their health is considered more important." *(IDI – Woman)*

This pattern was particularly pronounced in households reliant on male wage labour or migration, where maintaining men's physical capacity for income generation was viewed as essential. Health workers noted that women often discontinued medication prematurely to conserve household resources:

"Women stop medicines halfway because the family says the money is needed elsewhere." *(KII – LHW)*

Within Kabeer's framework, this reflects unequal access to resources, whereby financial capital is systematically channeled towards men's health, constraining women's ability to achieve sustained health outcomes.

1.3 Normalization of Chronic and Untreated Illness

A striking finding across ICT was the normalization of women's chronic illness. Conditions such as musculoskeletal pain, reproductive tract infections, anaemia, and postpartum complications were commonly described as routine aspects of women's lives rather than health problems warranting medical attention.

One participant stated:

"After my last delivery, I had pain for months, but this is normal for women. Work does not stop."

(IDI – Woman)

This framing of endurance as moral responsibility legitimized neglect and masked the cumulative toll of untreated illness. Women frequently continued heavy domestic, caregiving, and income-related labour despite declining health, undermining both household productivity and their own long-term well-being. Although contact with Lady Health Workers was reported in several areas, access to medicines, diagnostics, and referrals remained inconsistent, limiting the translation of contact into effective treatment. The normalization of illness thus represents a critical pathway through which structural and cultural constraints suppress women's health achievements.

Theme 2: Women's Health as a Driver of Household and Community Development

Women's health emerged not merely as an individual concern but as a central determinant of household functionality, intergenerational well-being, and community-level development outcomes. The findings demonstrate that women's physical and reproductive health status directly shapes productive capacity, caregiving arrangements, and social participation. These effects were cumulative rather than episodic, revealing how chronic or recurrent ill health among women generates long-term developmental constraints within households.

Sub-Theme 2.1: Women's Health and Household Productive Capacity

Participants consistently linked women's declining physical strength, chronic illness, and reproductive health complications to reduced household productivity. Women played a critical yet largely unrecognized role in food preparation, caregiving, home-based economic activities, and, in some settings, informal agricultural or livestock-related labour. When women experienced prolonged illness, these tasks were either inadequately performed or redistributed in ways that disrupted household functioning.

As one participant noted:

"When a woman becomes weak, everything is affected the animals, the work, the children." *(FGD – Women)*

These narratives highlight women's health as a productive asset essential to sustaining household livelihoods, rather than a secondary or private concern.

Sub-Theme 2.2: Intergenerational Consequences of Maternal Ill Health

Maternal ill health produced significant intergenerational trade-offs, particularly affecting girls' education. In households where women were chronically ill or recovering from reproductive health complications, daughters were frequently withdrawn from school to compensate for reduced maternal labour.

One woman explained:

"If I am sick, my daughter stays home. Who else will help?" *(IDI – Woman)*

These accounts were corroborated by community stakeholders, who observed that girls' school absenteeism and dropout were closely linked to maternal health rather than lack of interest in education:

"Girls leave school not because they do not want to study, but because their mothers are unwell." *(KII – Community Representative)*

This sub-theme underscores how women's health mediates the intergenerational transmission of disadvantage, reinforcing gendered educational inequalities.

Sub-Theme 2.3: Women's Health and Community Participation

At the community level, women's health significantly influenced their ability to engage in collective activities, including savings groups, training sessions, health committees, and development programmes. Ill health restricted women's mobility, visibility, and sustained participation, weakening social cohesion and limiting the reach of community-based interventions.

Women who experienced frequent illness reported withdrawing from group activities, while organizers noted irregular attendance and drop-out among women facing health challenges. This limited women's access to information, skills development, and social support networks, reinforcing marginalization within local development processes.

Theme 3: Structural and Institutional Barriers to Women-Centered Development

3.1 Health Systems as Mediators of Gender Norms

The presence and functionality of health systems, particularly the Lady Health Worker programme emerged as a key mediating factor shaping how gender norms were experienced. In areas with consistent LHW engagement, women reported modest expansions in negotiated agency:

"If the LHW comes with me, my family allows the visit." *(IDI – Woman)*

Conversely, where LHW coverage was irregular or poorly resourced, restrictive norms intensified, leaving women with little leverage to negotiate care.

3.2 Siloed Development Programming and Gender Blindness

Participants highlighted the fragmentation of health, livelihood, and skills-development interventions, noting that women were systematically excluded from non-health development initiatives:

"Health programmes talk about mothers, but other programmes do not involve women at all." *(KII – NGO Representative).*

This exclusion was described as institutional neglect rather than cultural inevitability, reinforcing women's invisibility in development planning.

3.3 Community-Identified Pathways for Improvement

Participants articulated contextually grounded strategies for improvement, including expanding female health staffing, improving emergency transport, strengthening women's collectives, and engaging men in health awareness:

"If men understand women's health, half the problems will be solved." *(FGD – Women)*

Taken together, the results demonstrate that women's health operates as a developmental hinge, linking gender norms to household productivity, educational continuity, and community participation within ICT. While constraints were widely shared, their developmental consequences diverged across local contexts, shaped by institutional mediation and household composition. These findings move beyond descriptive accounts by explaining why similar gender norms produce different development outcomes, thereby advancing gender–health–development scholarship.

Table 1: Summary of Key Themes on Women's Health, Gender Norms, and Development Outcomes in ICT

Theme	Sub-Theme	Core Findings	Illustrative Evidence
Theme 1: Gendered Health Experiences and Unequal Access to Care	1.1 Negotiated, rather than absent, agency in health-seeking	Women's health decisions were mediated through husbands, elders, or senior women. Agency existed but was contingent, negotiated, and context-dependent. Institutional and social barriers delayed care even when permission was granted.	Women described delays due to transport costs, overcrowded facilities, and household surveillance limiting mobility.
	1.2 Gendered resource allocation prioritizing men's health	Household financial resources were systematically prioritized for men's healthcare due to their perceived role as breadwinners. Women's treatment was delayed or discontinued.	Women reported stopping medicines early; health workers confirmed premature discontinuation due to financial pressures.
	1.3 Normalization of chronic and untreated illness	Chronic pain, reproductive morbidities, and postpartum complications were normalized as routine aspects of women's lives, legitimizing neglect.	Women described enduring illness while continuing domestic and income-related labour.
Theme 2: Women's Health as a Driver of Household and Community Development	2.1 Women's health and household productive capacity	Women's ill health reduced household productivity, disrupted caregiving, and undermined livelihood activities.	Participants linked women's weakness to declines in household functioning and food security.

Theme	Sub-Theme	Core Findings	Illustrative Evidence
	2.2 Intergenerational consequences of maternal ill health	Maternal illness led to girls' school absenteeism and dropout to compensate for reduced maternal labour.	Women and community members reported daughters staying home during maternal illness.
	2.3 Women's health and community participation	Ill health restricted women's participation in community groups, training, and development programmes.	Women withdrew from savings groups and collective activities due to poor health.
Theme 3: Structural and Institutional Barriers to Women-Centered Development	3.1 Health systems as mediators of gender norms	Effective LHW engagement modestly expanded women negotiated agency; weak coverage intensified restrictions.	Women reported increased permission when accompanied by LHWs.
	3.2 Siloed development programming and gender blindness	Women were largely excluded from non-health development initiatives, reinforcing invisibility in planning.	NGO representatives highlighted lack of women's inclusion beyond health programmes.
	3.3 Community-identified pathways for improvement	Participants proposed expanding female health staffing, emergency transport, women's collectives, and male engagement.	FGDs emphasized men's awareness as critical to change.

Discussion

This study contributes to the literature on gender, health, and development by demonstrating that women's health in rural and peri-urban Islamabad Capital Territory (ICT) operates as a structural mediating mechanism through which gender norms shape household stability, livelihood productivity, and community-level development outcomes. Rather than conceptualizing women's health solely as an individual welfare indicator, the findings show that it is foundational to the functioning of households and the sustainability of local development processes. By foregrounding intra-territorial variation within ICT, this study advances existing scholarship by explaining how similar gender norms generate divergent development outcomes depending on household composition, livelihood arrangements, and the presence and functionality of institutional support.

Consistent with prior research in Pakistan and South Asia, women in ICT experienced constrained autonomy in health-seeking due to entrenched patriarchal decision-making, financial dependency, and mobility restrictions (Kabeer, 1999; Mumtaz et al., 2014). However, the

findings move beyond documenting barriers by revealing that women's agency in health-seeking was not absent but negotiated, contingent, and relational. Women frequently required permission from husbands, elders, or senior women, and such permission did not automatically translate into access to care. Institutional and logistical barriers including overcrowded public facilities, transport costs, and long waiting times often delayed or neutralized women's ability to act on granted permission. These findings align with feminist critiques of empowerment frameworks that caution against equating nominal autonomy with substantive choice or outcomes.

The results are strongly aligned with the Social Determinants of Health (SDH) framework, which conceptualizes health outcomes as embedded within social, economic, and institutional structures rather than individual behaviours (World Health Organization [WHO], 2022). In ICT, gender norms governing resource allocation, care-seeking, and mobility interacted with health system limitations to shape women's health trajectories. Women's illnesses were frequently normalized and deprioritized until they reached crisis points, reflecting structural rather than individual neglect. This underscores that women's health outcomes cannot be understood independently of household power relations and institutional capacity.

A central finding of the study is the systematic prioritization of men's health over women's health within households, reflecting what has been described as a "productivity bias" in intra-household resource allocation (Duflo, 2012; Quisumbing & Maluccio, 2020). Across ICT, limited financial resources were channeled towards men's healthcare due to their perceived role as primary income earners. Women's treatment was delayed, interrupted, or discontinued altogether, particularly in households reliant on male wage labour. Health workers' accounts of women discontinuing medication prematurely further illustrate how unequal access to resources constrains women's ability to achieve sustained health outcomes within Kabeer's Agency–Resources–Achievements framework.

The widespread normalization of women's chronic and reproductive ill health represents a critical pathway through which gender norms translate into long-term developmental consequences. Conditions such as musculoskeletal pain, anaemia, reproductive tract infections, and postpartum complications were framed as routine aspects of womanhood rather than health problems requiring care. This moralization of endurance legitimized neglect and masked the cumulative toll of untreated illness. Women's continued engagement in domestic labour, caregiving, and home-based economic activities despite declining health undermined both household productivity and women's long-term well-being. These findings corroborate with regional evidence showing that women's health needs are frequently deprioritized unless illness becomes severe (Das Gupta, 2015; Mumtaz & Salway, 2009).

Importantly, the study documents the intergenerational consequences of women's ill health, particularly for girls' education. Maternal illness frequently resulted in daughters being withdrawn from school to compensate for reduced maternal labour. This finding aligns with global evidence linking maternal health to children's educational participation, nutrition, and long-term socioeconomic outcomes (Victora et al., 2021; WHO & UNICEF, 2023). The gendered nature of this substitution, whereby daughters rather than sons absorb caregiving and domestic responsibilities, reinforces cycles of disadvantage and constrains progress toward gender equality in education (UNESCO, 2023). Women's health thus emerges as a critical yet under-recognized determinant of human capital formation within ICT.

At the community level, women's health significantly shaped participation in collective activities, including savings groups, training programmes, health committees, and development initiatives. Ill health restricted women's mobility and sustained engagement, leading to irregular attendance

and withdrawal from community groups. This weakened women's access to information, skills development, and social support networks, thereby limiting the effectiveness and inclusivity of community-based development interventions. These findings reinforce the argument that women's health is not only a private concern but a collective good essential to social cohesion and participatory development.

The findings further highlight the role of health systems as mediators of gender norms. In areas of ICT where Lady Health Worker (LHW) engagement was consistent, women reported modest expansions in negotiated agency, with LHWs sometimes acting as social legitimizers for healthcare visits. However, inconsistent coverage, shortages of medicines, and limited referral capacity constrained the translation of contact into effective treatment. This supports the argument that institutions do not merely operate within cultural constraints but actively shape how norms are enacted and contested (Cornwall, 2016; Rao & Kelleher, 2020). Service availability alone, without quality and integration, is insufficient to disrupt entrenched gendered health inequalities.

Beyond the health sector, the exclusion of women from livelihood programmes, skills training, and community decision-making spaces reflects institutional blind spots rather than cultural inevitability. Participants consistently described development programming as siloed, with women engaged primarily as mothers within health initiatives but largely absent from broader development interventions. Similar critiques in the gender and development literature highlight how sectoral fragmentation limits the transformative potential of programmes and reproduces gendered inequalities (Kabeer, 2016; UN Women, 2022). By failing to account for women's health constraints, development initiatives inadvertently undermine women's ability to participate meaningfully in community life.

Community-identified pathways for improvement including expanding female health staffing, improving emergency transport, strengthening women's collectives, and engaging men in health awareness underscore the importance of contextually grounded, integrated approaches. These pathways recognize women's health as foundational to inclusive development rather than a peripheral concern. Engaging men emerged as particularly critical, reflecting participants' recognition that shifting gender norms requires collective rather than individual change.

Finally, the findings extend Kabeer's (1999) Agency–Resources–Achievements framework by illustrating how achievements remain structurally constrained even when limited agency and resources are present. Women in ICT exercised negotiated agency, yet institutional fragmentation and inequitable resource allocation prevented this agency from translating into sustained health and development gains. This underscores the need to conceptualize empowerment not as an individual attribute but as a relational and institutional process embedded within broader development systems.

Conclusion

This study demonstrates that women's health in the ICT functions as a critical mediating mechanism linking gender norms to household and community development outcomes. Women's health is not merely an individual welfare concern; it shapes household productivity, caregiving capacity, children's educational trajectories, and participation in community development processes. Structural constraints including patriarchal decision-making, restricted mobility, and unequal resource allocation persist across ICT, yet their intensity and consequences vary across localities depending on household composition, male labour migration patterns, and the density and functionality of institutional support.

Women's negotiated agency in health-seeking was found to be contingent, uneven, and heavily mediated by household and institutional dynamics. Chronic and untreated illnesses were normalized, limiting women's ability to sustain their own health and contribute fully to household and community activities. The study also highlights intergenerational effects, with maternal ill health driving daughters' school absenteeism and dropout, reinforcing cycles of disadvantage and gendered inequalities.

The findings underscore the importance of conceptualizing empowerment as a relational and institutional process rather than solely an individual attribute. While women exercised negotiated agency, the absence of integrated and equitable support systems prevented this agency from translating into sustained health and development gains. Institutions, including health systems, NGOs, and community-based programmes, play a pivotal role in mediating gender norms and shaping outcomes, yet sectoral silos and service gaps limit their transformative potential.

Recommendations

Based on the study findings, the following contextually grounded recommendations are proposed to strengthen women's health and its developmental impact in ICT:

- **Strengthen Community Health Systems:** Ensure consistent LHW coverage, female staffing, and access to medicines, diagnostics, and emergency transport.
- **Promote Integrated Development Programming:** Coordinate health, education, livelihood, and skills initiatives while including women in decision-making.
- **Enhance Intra-Household Equity:** Raise awareness to reduce preferential allocation of resources to men and support shared caregiving responsibilities.
- **Support Women's Agency and Collective Action:** Strengthen women's collectives, peer networks, and health literacy for improved resilience and decision-making.
- **Mitigate Intergenerational Impacts:** Link maternal health programmes with educational support to prevent daughters' school absenteeism.

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