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Reproductive Autonomy Across Legal Systems: Comparing Pakistan and the United States

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Abstract

Reproductive autonomy, which refers to the right to make independent, informed, and free choices about reproductive life, is a contentious issue in legal discourse, raising significant questions about constitutional structure, legal interpretation, and gender equality. Most people agree that reproductive rights are essential, yet local legislation translates them inconsistently. Different constitutional and cultural traditions, sociocultural norms, political viewpoints, and institutional resources affect reproductive rights in municipal law. The paper compares Pakistan and the US's constitutional and rights-based analyses of reproductive autonomy, taking into account their drastically different legal structures, developmental settings, and rights recognition experiences. Though neglected in contemporary studies, this comparative lens is important in understanding how legal regimes define, regulate, and preserve reproductive autonomy. To determine how judicial systems, support or hinder reproductive decision-making, the study examines law provisions, major court judgments, international human rights obligations, and real health records. Pakistan's constitution partially protects reproductive rights under sections 9, 14, and 25. They also face gender inequity, massive health care disparities, and abortion legal ambiguity. Since the Supreme Court's 2022 decision in Dobbs v. Jackson Women's Health Organization, the US Constitution has changed, creating a patchwork of uneven abortion regulation powers and deep racial and socioeconomic inequalities. Both have different development and legal systems, but both exhibit a gap between the law and women's lives, especially poor, rural, young, and culturally excluded women. The paper claims that both nations' legislative safeguards are ineffective without changes in structures, organizations, and social norms. The most rational and consistent approach to reproductive choice-making is a rights-based regulation based on reproductive justice theory, which views reproductive autonomy as a positive right necessitating state involvement in healthcare, education, and economic independence.

Keywords: Reproductive Autonomy, Pakistan Constitutional Law, United States Abortion Law

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Introduction

Reproductive rights are basic human rights that enable people to make decisions about their reproductive health in relation to if, when, and how they want to have children; access to safe, effective, and affordable contraception; access to quality maternal health care; and freedom from forced, discriminatory, or gender-based abuse. This understanding was acknowledged by the United Nations (1994) at the 1994 International Conference on Population and Development, where reproductive rights were defined as the "basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so." Thirty years later, the implementation of these commitments remains very uneven, both across and within countries.

In this skewed global setting, Pakistan and the United States are two of the most educationally advanced countries, and they share several similarities. Pakistan is an Islamic lower-middle-income country with a population of more than 255 million and the 5th most populous country in the world (UNFPA Pakistan 2026). The country faces structural challenges that have resulted in a nearly 20-year plateau in its modern contraceptive prevalence rate (CPR) at around 34% and one of the highest maternal mortality ratios (MMR) in Asia (Ahmad et al., 2025; Kamal et al., 2026). The U.S. is a wealthy liberal democracy with the most litigated body of reproductive rights jurisprudence in the world and has experienced the erosion of constitutional protections for abortion rights since the Supreme Court's decision in Dobbs v. Jackson Women's Health Organization (2022). This erosion has had immediate and measurable consequences, including impacts on maternal health (Lewis et al., 2025; Gender Equity Policy Institute, 2026).

Both countries have domestic legislation recognizing autonomy in reproduction and have signed agreements with international organizations, including the ICPD Program of Action (1994) and the Sustainable Development Goals (2015). However, the gap between law in writing and legitimacy in practice remains major. The reproductive rights context is a prominent and worrisome aspect. Saleem et al. (2026) view this gap as a consequence of the complex dynamics of legislation design, health care systems, economic disparities, cultural and religious convictions, and political debates. This article is an extension of that thesis, including the latest empirical literature, and provides a well-contextualized and data-based comparison.

Review of the Literature

Both Pakistan and the United States have developed a substantial body of academic literature on reproductive rights, but the scholarship in both countries has been largely disjointed. Pakistani literature, particularly since 2022, has focused heavily on the use of contraceptives, maternal mortality, and the gender gap within the specific cultural and legal context of Pakistan. American literature has largely focused on the effects of Dobbs, especially since the ruling. Comparative studies between the two systems are scarce, and the present article aims to fill that gap. The following review summarizes the major contributions of five thematic clusters. In this section, we will examine the nature and content of reproductive rights and the international context for reproductive rights.

❖ Defining Reproductive Rights and the Global Framework

The fundamental concept of reproductive rights was articulated in the United Nations ICPD Programme of Action (1994) on the recognition of the right of every couple and every individual to freely and responsibly determine the number and spacing of their children. In a call for reproductive rights to be used to address reproductive health in developing countries, Pillai and Gupta (2011) emphasized structural determinants of reproductive health, such as poverty, gender inequality, and education, over service provision. In The Lancet, Glasier et al. (2006) state that sexual and reproductive health is a matter of life and death and that poor reproductive health has a significant impact on women in low and middle-income countries. In international development, Temmerman, Khosla, and Say (2014) argued that progress in sexual and reproductive health and rights was inextricably linked to success in reaching the Millennium Development Goals, emphasizing the importance of reproductive rights. Saleem et al. (2026) provide the most up-to-date, detailed legal analysis for Pakistan, noting that while Pakistan has a relatively broad legal framework for reproductive rights, implementation problems, cultural opposition, and unequal access to healthcare mean that formal rights do not readily translate into de facto autonomy.

❖ Contraceptive Access and Family Planning in Pakistan

The phenomenon of contraceptive stagnation in Pakistan has been the subject of in-depth research. Similar conclusions have emerged that the country's investments in the field of contraceptive use, both public and donor, have not been able to translate into any significant changes in the prevalence of contraceptive use. Abdullah et al. (2023) identified as a national goal the need to increase CPR from 34% to 50% by

2025 and found that the targets for the number of people using contraceptives, the number of service delivery channels, and the level of community engagement needed were feasible in principle but would likely require drastic changes to governance. Target not reached. Kamal et al. (2026) in a study published in PLOS One found that based on four waves of the Pakistan Demographic and Health Survey data, CPR has slightly declined from 2012-13 to 2017-18, and community-level contextual factors, particularly rural residence and spousal disapproval, are shown to be better predictors of non-use than individual-level factors. Naz et al. (2024) found in their study published in Reproductive Health that the effect of spousal age differences and sociocultural norms in suppressing contraceptive uptake is synergistic. A facility-based study published by Ishaque et al. in IJERPH showed that son preference—the preference to continue childbearing until a desired number of male children are realized—has a significant impact on curbing modern contraceptive adoption, highlighting the robustness of gender norms in family planning practices.

Ahmad et al. (2025) estimated that Pakistan could reduce its MMR by about 30 percent based on the Pakistan Maternal Deaths Survey 2019. The solution is simple, requiring meeting the unmet need for family planning services (FP) (17 percent) and increasing CPR from 34 percent to 51 percent, a compelling evidence-based policy goal. Although there have been many family planning campaigns in the region, the 2019 PDHS shows that there is a significant gap in contraceptive use between urban and rural communities, and this gap is larger if the overall unmet need is low. Rural and Remote Health journal (2024).

- **Maternal Mortality in Pakistan and the USA**

In Pakistan, Midhet et al. (2025) compared the national surveys of 2007 and 2019 and showed that the MMR decreased from 276 in 2007 to 186 in 2019, which is a significant improvement but still not the 70-target set by SDGs. The factors identified to influence the risk were low level of education of mothers, poverty of household, rural residence, and poor antenatal care. However, the quality of care at health facilities is now a critical challenge. Awan et al. (2025) reported a nationally representative sample published in Cureus that most deaths among women occurred within facilities. However, Raza et al. (2026) reported the PMR was 70.1 per 1000 live births, which is concerning as it suggests the momentum towards improving perinatal mortality has been lost.

In a comparison-based study with a discontinuous time sequence design, Lewis et al. (2025) published a paper in BMC Public Health noting a large increase in adverse birth outcomes and maternal deaths and complications in the U.S. following Dobbs. Nuss et al. (2025) analyzed the CDC WONDER database from 2018 to 2024 and reported increased maternal mortality rates for up to 365 days after birth in "abortion-prohibited" states. The Gender Equity Policy Institute (2026) found that in states that banned abortion, maternal deaths increased 21% since Dobbs. Texas saw a 56% increase. Black mothers were 3.3 times more likely than white mothers to die in states that banned abortion. Health Affairs Scholar conducted a broad scoping review and discovered a systematic link between restrictive abortion laws and worse maternal health outcomes. Srinivasulu and Heiland (2025) estimated that, under hypothetical national ban scenarios, maternal mortality would increase by 39% for non-Hispanic Black people across 14 states (Guttmacher Institute, 2024).

- **Legal and Constitutional Frameworks Compared**

Shahbaz (2020) explored the impact of religion, culture, and politics on reproductive rights in Pakistan and found that conservative religious mobilization and patriarchal governance are systematic processes of undermining women's autonomy in reproductive rights. Ali (2012) studied the domestication of CEDAW in Pakistan to document the political and cultural obstacles to the implementation of the treaty. In the American context, Saleem et al. (2026) discuss the progression of reproductive rights case law from Griswold v. Connecticut (1965) to Roe v. Wade (1973), Planned Parenthood v. Casey (1992), Whole Woman's Health v. Hellerstedt (2016), and the devastating overturn of Dobbs (2022). In a palpable public health crisis, Lau et al. (2026) describe the post-Dobbs environment as one where abortion care training is massively reduced in ban states. The idea of contraceptive conflation was introduced by Roth (2026) in the New England Journal of Medicine, meaning that state legislation making life at fertilization could make emergency contraception legally vulnerable. The Guttmacher Institute (2023) found that Black and Latina women are over-represented among those living in states with abortion bans, and they are also at an additional geographic and economic disadvantage.

- **Socio-Cultural, Religious, and Gender Dimensions**

Farooq et al. (2025) in BMJ Public Health reported that "societal taboos, political inaction, and sociocultural and socioeconomic factors continue to normalize the suppression of reproductive and sexual health education in Pakistan." They also reported that there is high community opposition to even basic sexuality education

in the three provinces studied. BMC Women's Health (2022), in a scoping review, confirms that the main structural causes for gender discrimination in reproductive health are male dominance and patriarchy. A study by the European Student Think Tank (2025) on child marriage in Pakistan shows that even though child marriage is legally prohibited, it is still widespread. This points to the failure of law-only strategies to promote gender rights in Pakistan. According to Burke and Lindberg (2024), power dynamics in intimate relationships in the United States lead to non-preferred contraceptive use, showing how gender inequality is manifesting through interpersonal coercion and systemic economic barriers to non-preferred use of contraceptives. Abortion access is an essential factor to women's socioeconomic achievement, Everett and Taylor (2024) showed. However, a recent study by Bossick et al. (2023) finds that greater state-level reproductive autonomy correlates with a larger decrease in Black-white disparities in low birth weight and preterm birth. More than 1.3 million women and girls around the world were denied contraceptives by the Trump administration's 10-day ban on reproductive health assistance, the Harvard Human Rights Journal noted in 2025.

Historical Development of Reproductive Rights

❖ Pakistan: From Colonial Inheritance to Post-Zia Reforms

The trajectory of reproductive rights in Pakistan has five periods that carry forward institutional and normative inheritance. Saleem (2024) provides the most comprehensive and up-to-date account. In the pre-Partition era (before 1947), child marriage was prevalent, access to healthcare was limited, especially for those living in rural areas, and extended families had a major influence over women's reproductive rights. In the first few years of the period (1947-1970s), the focus was on nation-building, not on reproductive health. Reproductive health received minimal policy attention, and urban and rural regions exhibited significant disparities. The most significant halt was during the Zia period (1977–1988), when family planning budgets were allocated to religious education, the Islamization of family laws diminished women's legal capacity, and conservative readings of Islamic precepts made their way into policy (Saleem, 2024; Butt et al., 2020). We are still dealing with the effects of these changes on the population. In the 1990s and early 2000s, there were some improvements, such as more women getting an education and civil society speaking up and advocating for the use of contraceptives and better access to them (Saleem, 2024). According to UNFPA Pakistan (2026), institutional progress has been real but insufficient, with the Family Planning Act 2000, the Lady

Health Worker Program, and the Punjab RMNCH&N Program 2014, and the time is ripe for decisive governance reform.

❖ United States: From Comstock to Post-Dobbs Fragmentation

The story in the United States runs from the constricting Comstock Laws of 1873, which banned the dissemination of information about contraceptives, through the mid-twentieth-century legal and jurisprudential watershed that delineated the legality of contraceptives, and back to deep fragmentation today. The modern advocacy movement began with the opening of the first birth control clinic by Margaret Sanger in 1916 and the introduction of the oral contraceptive in 1960, a structural revolution in family planning (Saleem, 2024). Griswold v. Connecticut (1965) established the constitutional right to marital privacy, including contraception. Roe v. Wade (1973) extended the privacy protections of the Due Process Clause to include abortion. Planned Parenthood v. Casey (1992) created the undue burden standard. Whole Woman's Health v. Hellerstedt (2016) struck down onerous TRAP laws under the undue burden standard. The standard changed with the Dobbs v. Jackson Women's Health Organization (2022) decision. In 2026, approximately 62.7 million women and girls will live in states where abortion is illegal (Gender Equity Policy Institute, 2026). The next wave of restrictions is being led by the May 2026 Louisiana v. FDA case, which the Supreme Court put on hold, and the Center for Reproductive Rights expects to be the next battleground.

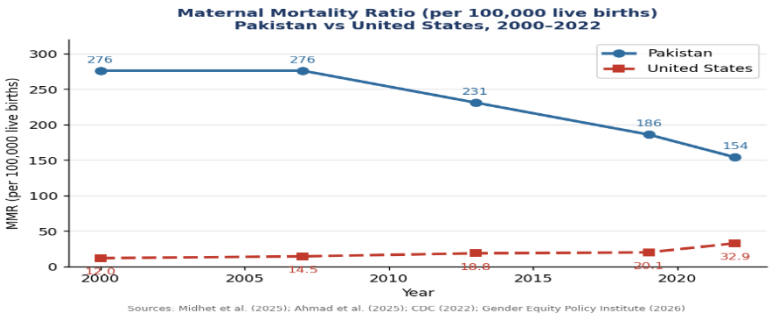

Figure 1: Maternal mortality rate (per 100,000 live births) in Pakistan and the United States, 2000–2022. Sources: Midhet et al. (2025); Ahmad et al. (2025); CDC (2022); Gender Equity Policy Institute (2026).

Constitutional and Legislative Frameworks

❖ Pakistan: Constitutional Provisions and Key Legislation

Pakistan's law on reproductive rights is built on three constitutional provisions. Article 9 of the Constitution of Pakistan 1973 (Right to Life and Liberty) provides a legal interpretation of the protection of individuals' health and their right to make reproductive decisions. Article 14 guarantees respect for the right to reproductive freedom and provides a normative framework for reproductive freedom and protection from reproductive coercion and prejudice in reproductive health services. Article 35 places a direct constitutional obligation on the state to ensure marriage, family, and the rights of women and children (Saleem et al., 2026). Article 34 provides for the active participation of women in all aspects of national life. It directly bears upon the reproductive role of women.

The Family Planning and Reproductive Health Services Act of 2000 has a legislative mandate to promote family planning services and to provide contraceptives. The Maternity Benefits Ordinance, 1958, protects women workers against the financial burden during their pregnancy and after their operation. The Punjab Province of the 2014 Provincial Structure of the RMNCH&N Program has adequate maternal, neonatal, and child health facilities. National Health Policy 2009 includes reproductive health as a part of overall health policy (Saleem, 2026). But there are big implementation gaps in this formally comprehensive architecture. The law is very restrictive, permitting only surgical abortions to save a woman's life, resulting in unsafe abortions. The modern CPR has struggled to achieve the national target of 50% set for 2025, remaining at approximately 34% since 2007 (Kamal et al., 2026; Abdullah et al., 2023). The unmet need for family planning is about 21%, and the estimated number of unintended pregnancies per year is 3.8 million (UNFPA Pakistan, 2026).

❖ United States: Constitutional Doctrine and Federal-State Fragmentation

American law has always been about reading the Constitution. Marital privacy was established in Griswold v. Connecticut (1965); the Fourteenth Amendment's Due Process Clause was applied to abortion in Roe v. Wade (1973); the undue burden standard was introduced in Planned Parenthood v. Casey (1992) and applied to TRAP laws in Whole Woman's Health v. Hellerstedt (2016) (Saleem, 2024). Dobbs rejected this doctrinal structure and returned control over abortion to the states. California, New York, and Colorado have established constitutional abortion rights,

while Texas, Alabama, and Mississippi have enacted near-total abortion bans that criminalize abortion providers (Lau et al., 2026). Health Affairs Scholar (2025) conducted a scoping review that directly associates this variability with variations in maternal health outcomes.

Roth (2026) highlighted the issue of state legislation defining fertilized life, which, alongside abortion bans, affected millions of women. The ACA mandated contraception coverage without out-of-pocket costs in 2010, significantly increasing access for millions. The Hyde Amendment (1976) continues today, restricting federal Medicaid coverage of abortion services to women in cases of rape, incest, or life endangerment, disproportionately impacting women of color and low-income women (Guttmacher Institute, 2023).

Table 1: Comparative Framework — Reproductive Autonomy in Pakistan and the United States

Dimension	Pakistan	United States
Constitutional basis	Arts. 9, 14, 35; Family Planning Act 2000	14th Amendment Due Process; Roe (1973); Dobbs (2022)
Abortion access	Restricted — life of the mother only	Varies by state; 22+ near-total bans post-Dobbs
MMR (latest)	~154–186 per 100,000 (2019–2022)	~32.9 per 100,000 (2021); rising in ban states
Modern CPR (%)	~34% (stagnant since 2007)	~65–70%
Sex education	Largely absent; no standardised curriculum	Varies by state; abstinence-only vs. comprehensive
Religious influence	High — Islamic law directly informs legislation	Significant; mediated by church–state separation
CEDAW status	Ratified 1996	Signed; not ratified
TFR (latest)	3.6 (2017–18 PDHS)	1.7 (2022, CDC)
Skilled birth attendant.	~69% nationally; lower in rural areas	~99% (national)

Sources: Saleem (2024); Kamal et al. (2026); Midhet et al. (2025); Lau et al. (2026); Gender Equity Policy Institute (2026); UNFPA Pakistan (2026).

Access to Reproductive Healthcare

❖ **Maternal Mortality**

Pakistan has seen a significant decrease in the MMR, from 276 per 100,000 in 2006-07 to 186 in 2019 and about 154 in 2020. A recent study (Awan et al., 2025) using the Three Delays Model in 2025 showed that most maternal deaths occur in health facilities, suggesting that the quality of care on arrival is the main problem, not just the lack of access. The neonatal death rate remained high at 70.1 per 1000 live births, also much higher than the DHS figures for 2017-18, indicating that there was no real progress. Ahmad et al. (2025) found that meeting the current demand for family planning, which stands at 17%, would prevent about 4,000 maternal deaths per year.

The U.S. is in a structural paradox: the richest country in the world has a steady rise in MMR, while most comparable countries have steadily improved. The Gender Equity Policy Institute (2026) found that maternal mortality dropped 21% in states that banned abortions after Dobbs but rose 56% in Texas during the first full year of the ban. Black mothers in abortion ban states were 3.3 times more likely to die than white mothers. Lewis et al. (2025), in a BMC Public Health comparative interrupted time series study, confirmed significant rises in maternal morbidities in abortion-ban states after Dobbs. The results confirm that access to abortion is a maternal health care problem, with definite mortality implications.

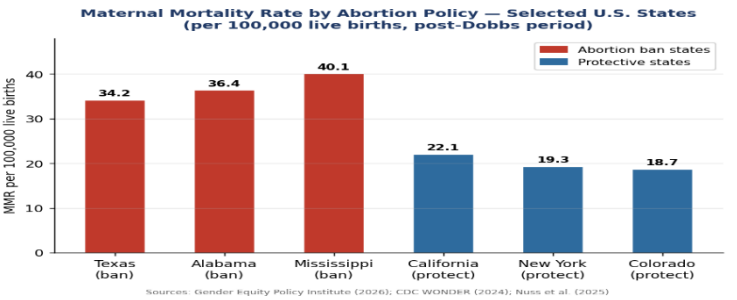

Figure 2: Maternal Mortality Rate by Abortion Policy — Selected U.S. States (per 100,000 live births). Sources: Gender Equity Policy Institute (2026); CDC WONDER (2024); Nuss et al. (2025).

❖ **Contraceptive Prevalence and Family Planning**

The contraceptive prevalence rate (CPR) in Pakistan has remained stagnant at around 34% since 2007, and total family planning demand is at 52% with a significant and structurally persistent gap in unmet need for family planning (Kamal et al., 2026). Naz et al. (2024) found in Reproductive Health that the interaction between sociocultural norms, spousal age differences, and low levels of

contraceptive knowledge is more likely to influence uptake than individual factors and that community-level factors have a greater influence than other factors. Imbedded gender norms have been reflected in son preference, which was identified as a major factor influencing non-use of modern contraception, by Ishaque et al. (2025). Rural and Remote Health (2024) found that the gap between women in rural and urban areas in contraceptive use is significant and enduring, and women living in rural areas are exposed to additional barriers to accessing contraceptives, including distance, awareness, and social permission.

In the United States, current CPR rates are around 65–70%. Even within the context of the United States, there are interpersonal coercive dynamics and systemic economic obstacles that limit reproductive autonomy—and Burke and Lindberg (2024) document reproductive autonomy as power dynamics in intimate relationships produce non-preferred contraceptive use. In a 2023 study, the Guttmacher Institute found Black and low-income women are at much greater risk of being pressured by their clinicians about contraceptive choice. Roth (2026) discussed the potential for the post-Dobbs legislative misnaming of fertilization as the beginning of life to become a legal risk to access to emergency contraception and some hormonal contraceptive methods.

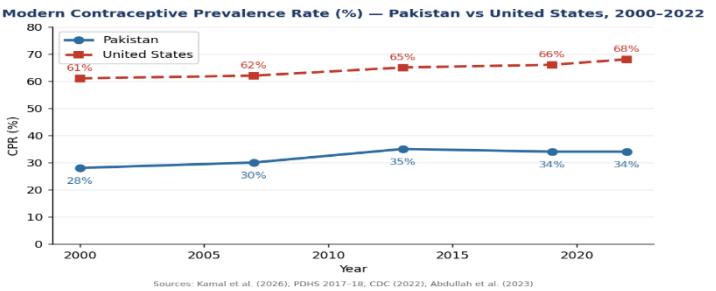

Figure 3: Contraceptive Prevalence Rate (Modern Methods, %) — Pakistan and United States, 2000–2022. Sources: Kamal et al. (2026); PDHS 2017–18; CDC (2022); Abdullah et al. (2023).

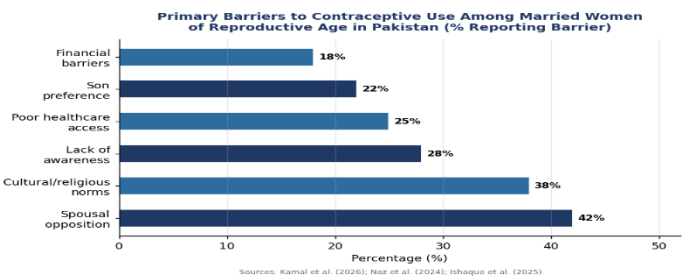

Figure 4: Primary Barriers to Contraceptive Use Among Married Women of Reproductive Age in Pakistan. Sources: Kamal et al. (2026); Naz et al. (2024); Ishaque et al. (2025)

❖ Sex Education and Adolescent Reproductive Health

Conventional socio-cultural and religious taboos in Pakistan limit the scope of sex education to a significant extent. Comprehensiveness and evidence-based content on sexual and reproductive health, contraception, STIs, and relationships were low in the curriculum, while structured opposition from the community to sexuality education measures still played a major role, even though social conventions were normalizing the denial of sexual and reproductive health education across various provinces, as revealed by Saleem et al (2026) and Farooq et al. (2025) in BMJ Public Health. Specific mechanisms of community resistance were reported by Ahmad et al. (2022), which included misinformation and conflation of CSE with threats to Islamic values, and they recommended strategies, including community sensitization and digital platform strategies, to counter it. Sex education policy in the United States is decentralized and widely varied, including a focus on abstinence in some states, where there is little evidence-based information (Saleem, 2024).

In addition to the reproductive rights restrictions that have contributed to a geographic divide in the landscape of reproductive rights since Dobbs, the variability adds further compound disadvantages to adolescent reproductive health in conservative states.

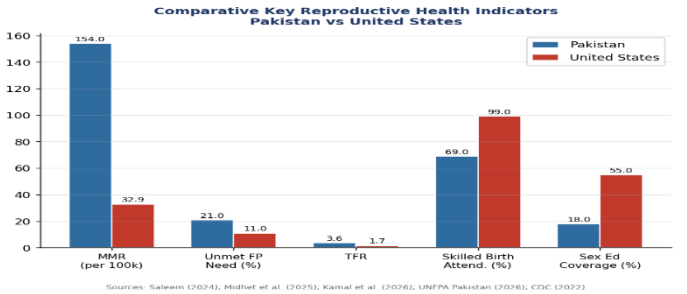

Figure 5: Comparative Key Reproductive Health Indicators — Pakistan and the United States. Sources: Saleem (2024); Midhet et al. (2025); Kamal et al. (2026); UNFPA Pakistan (2026); CDC (2022); WHO (2022)

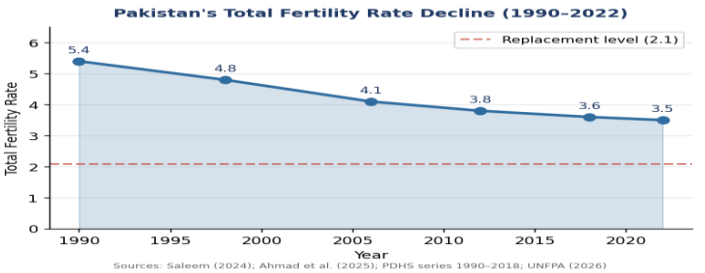

Figure 6: Pakistan's Total Fertility Rate Decline (1990–2022). Sources: Saleem et at (2026); Ahmad et al. (2025); PDHS series 1990–2018; UNFPA Pakistan (2026). Note: SDG replacement-level fertility target = 2.1

Socio-Cultural, Religious, and Political Dimensions

❖ Religious Influence on Reproductive Policy

The legitimacy of Islam as a state religion in Pakistan translates to religious knowledge being explicitly embedded in laws and policies, as well as in social norms and practices, especially those with a conservative bent (Saleem, 2024). This religious-normative complex serves as a basis for the preference for bigger families; stigmatization of contraception, particularly for unmarried women; the restrictive laws on abortions; and the authority of religious leaders and patriarchs to supersede women's preferences about their reproductive options. In response, BMC Health Services Research (2025) reported that almost 28% of females aged 15–49 face physical violence and 6% face sexual violence, highlighting the extent to which Pakistani women do not enjoy reproductive security due to the lack of norms of patriarchy and religious connotations. In a recent study, Farooq et al. (2025) revealed that Islamic conservatism acts as a dynamic obstacle to the normalization of sexual and reproductive health education even in the context of legal mandates.

The primary political driver of reproductive rights restrictions in the United States since the Supreme Court's Roe decision has been conservative religious mobilization. The Dobbs majority consisted of judicial appointments closely linked to conservative Protestant, Evangelical, and Roman Catholic organizations (Saleem et al., 2026). In its 2025 edition of the Harvard Human Rights Journal, it reported that the Trump administration's religiously motivated attack on global reproductive health funding had been a direct threat to millions of women and girls around the world, as more than 1.3 million women received no contraceptive care within ten days of the foreign aid freeze.

❖ Gender Inequality and Structural Determinants

Gender inequality is both a contributor and an outcome of gaps in reproductive rights in both countries. In Pakistan, women's reproductive choices were limited even when they had formal rights because of patriarchal social structures that restricted women's mobility and male-dominated decision-making in the household (Saleem et al. 2026). In the American Journal of Human Biology, Ibupoto et al. (2026) concluded that gender norms and son preference, as well as women's less autonomy in reproductive decision-making, not only predict fertility behavior but also more strongly predict child health outcomes than economic variables do. UNFPA Pakistan (2026) defines true progress as "transformations in gender norms, access to education, and women's economic participation.

Structural racism, in conjunction with gender inequality, upholds persistent inequities in reproductive health in the United States. Everett and Taylor (2024) found that abortion services availability is important in determining women's socioeconomic outcomes. For example, Bossick et al. (2023) found that higher state-level reproductive independence indices were significantly associated with reductions in Black-white disparities in low birth weight and preterm birth, providing evidence that reproductive laws directly affect racial health disparities. According to the Guttmacher Institute (2023), in states that have not expanded Medicaid, nearly two-thirds of ineligible women are women of color, contributing to geographic inequities.

❖ Political Contestation

Conservative religious and political parties in Pakistan organize opposition, undermining legislation, especially in rural areas where these groups influence reproductive health policy (Saleem, 2026). Meanwhile, in the US, reproductive rights are a partisan battleground. Supreme Court decisions now hinge more on political alignment than democratic discourse (Saleem et al., 2026; Lau et al., 2026). Several 2026 state ballot measures may affect abortion access (Reproductive Freedom for All, 2025).

Pakistan and the US face unique but similar issues. Both have legal reproductive rights but struggle with access. Political debates are intensifying in both. Vulnerable groups are most affected: in Pakistan, rural and low-income women; in the US, Black and low-income women.

Conclusion and Recommendations

To address these challenges, Pakistan should strengthen abortion law, invest in rural health systems, provide evidence-based sex education, engage religious leaders to support family planning, and improve enforcement of reproductive health laws (Saleem et al. 2026; UNFPA Pakistan, 2026). Evidence of impact is strong: Ahmad et al. (2025) showed meeting current family planning needs could save 4,000 lives annually, making family planning an urgent, evidence-backed investment.

In the US, the key recommendations are: (1) create a federal law for national minimum abortion access; (2) address structural racism in health care and economic barriers that cause maternal health disparities (Gender Equity Policy Institute, 2026); (3) keep contraceptives and reproductive health care separate in legislation, as seen in the mifepristone litigation and Roth's (2026) analysis; (4) make national standardized sex education to reduce knowledge gaps and regional differences in reproductive health knowledge.

In summary, reproductive autonomy is not only a health problem. It is a challenge of gender equality, a constitutional issue, and a question of dignity in society. This comparative analysis shows two urgent problems: a structural deficit in one nation and a recent, fast decline in the other.

References

Abdullah, M., et al. (2023). Raising the contraceptive prevalence rate to 50% by 2025 in Pakistan: An analysis of number of users and service delivery channels. Health Research Policy and Systems, 21, 4. https://doi.org/10.1186/s12961-023-00953-y

Ahmad, F., et al. (2022). Understanding community resistance to sexuality education and exploring prospective implementation strategies in Pakistan. Frontiers in Psychology, 13, 864465. https://doi.org/10.3389/fpsyg.2022.864465

Ahmad, A. M., Shah, I. H., Mir, A. M., Sadiq, M., Bosan, M. A., & Mersha, A. (2025). Demographic, social and health system factors associated with maternal mortality in Pakistan: A nested case-control study. PLOS One, 20(1), e0290492. https://doi.org/10.1371/journal.pone.0290492

Ali, S. S. (2012). Navigating religion, politics and cultural norms: The arduous journey toward domestication of CEDAW in Pakistan. Journal of Peace, Conflict & Development, 19, 43.

Awan, T., Asif, N., Miraj, M. A., Khalid, H., Khan, M. A., & Khalid, N. (2025). Maternal mortality in Pakistan: Demographic, temporal, and contextual insights from the three delays model. Cureus, e98424. https://doi.org/10.7759/cureus.98424

BMC Health Services Research. (2025). Enhancing health workforce capacity through life skills-based interventions: Evidence from Pakistan on reducing gender-based violence. BMC Health Services Research, 25, 1044. https://doi.org/10.1186/s12913-025-13041-9

BMC Women's Health. (2022). Perpetuation of gender discrimination in Pakistani society: Results from a scoping review and qualitative study. BMC Women's Health, 22, 540. https://doi.org/10.1186/s12905-022-02011-6

Bossick, A. S., Williams, E. C., Painter, I., & Katon, J. G. (2023). Association of reproductive autonomy and rates of state-level racialized disparities in preterm birth and low birthweight. Health Equity, 7(1), 638–646. https://doi.org/10.1089/heq.2023.0060

Burke, K. L., & Lindberg, L. D. (2024). Gender, power, and nonpreferred contraceptive use in the United States: Results from a national survey. Socius, 10. https://doi.org/10.1177/23780231241282641

Butt, S., Jaffar, S., & Mehmood, K. (2020). An overview of Islamisation during Zia regime. Al-Sharq (Journal of Religious Studies), 1, 01.

Center for Reproductive Rights. (2026). After Roe fell: U.S. abortion laws by state. Retrieved from https://reproductiverights.org/maps/abortion-laws-by-state/

Centers for Disease Control and Prevention. (2022). Maternal mortality rates in the United States, 2020. National Center for Health Statistics. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2022.htm

Centers for Disease Control and Prevention, National Center for Health Statistics. (2024). CDC WONDER online database: Linked birth/infant deaths, 2018–2024. https://wonder.cdc.gov/

Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

European Student Think Tank. (2025, December 2). From paper to practice: How grassroots norms undermine gender rights in Pakistan. Retrieved from https://esthinktank.com/2025/12/02/from-paper-to-practice-how-grassroots-norms-undermine-gender-rights-in-pakistan/

Everett, B. G., & Taylor, C. J. (2024). Abortion and women's future socioeconomic attainment. American Sociological Review, 89(6). https://doi.org/10.1177/00031224241292058

Farooq, S., et al. (2025). Sexual and reproductive health in Pakistan: A qualitative exploratory study of gender roles, family planning and adolescent health in Chitral, Gilgit-Baltistan and Sindh. BMJ Public Health, 3(1), e000870. https://doi.org/10.1136/bmjph-2023-000870

Gender Equity Policy Institute. (2026). Maternal mortality in the United States after abortion bans. https://doi.org/10.5281/zenodo.14713213

Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2006). Sexual and reproductive health: A matter of life and death. The Lancet, 368(9547), 1595–1607. https://doi.org/10.1016/S0140-6736(06)69478-6

Griswold v. Connecticut, 381 U.S. 479 (1965).

Guttmacher Institute. (2023). Inequity in US abortion rights and access: The end of Roe is deepening existing divides. Retrieved from https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides

Guttmacher Institute. (2024). Clear and growing evidence that Dobbs is harming reproductive health and freedom. Retrieved from https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom

Harvard Human Rights Journal. (2025, February 13). The US administration's assault on global reproductive health and autonomy. Retrieved from https://www.hhrjournal.org/2025/02/13/the-us-administration-assault-on-global-reproductive-health-and-autonomy/

Health Affairs Scholar. (2025). Relationship between state-level abortion policy and maternal mortality in the United States: A scoping review. Health Affairs Scholar, 3(8), qxaf146. https://doi.org/10.1093/haschl/qxaf146

Human Rights Watch. (2026, February 4). World report 2026: Pakistan. Retrieved from https://www.hrw.org/world-report/2026/country-chapters/pakistan

Ibupoto, Z. A., et al. (2026). Exploration of household socioeconomic factors related to fertility and child mortality in Pakistan. American Journal of Human Biology, 38(3), e70246. https://doi.org/10.1002/ajhb.70246

Ishaque, M., Hazerjian, J., Brooks, M. I., Sarosh, T., Latif, M., & Ali, M. (2025). The effect of offspring gender composition on modern contraceptive uptake among married women of reproductive age in Pakistan. International Journal of Environmental Research and Public Health, 22(1), 118. https://doi.org/10.3390/ijerph22010118

Kamal, A., Alyami, L., Malik, S., Siddiqa, M., Ijaz, M., & Rasul, A. (2026). Understanding contraceptive use in Pakistan: The role of individual and community contextual factors. PLOS One, 21(2), e0342157. https://doi.org/10.1371/journal.pone.0342157

Lau, D. T., Liu, J., & Jones, M. M. (2026). Post-Dobbs era: Evolving abortion care restrictions and public health impact. American Journal of Public Health, 116(3), 317–320. https://doi.org/10.2105/AJPH.2025.308394

Lewis, K., et al. (2025). Changes in maternal morbidity and infant outcomes following state-level abortion bans post-Dobbs: A comparative interrupted time series study. BMC Public Health, 25(1), 2265. https://doi.org/10.1186/s12889-025-23468-8

Midhet, F., Khalid, S. N., Baqai, S., & Khan, S. A. (2025). 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, 20(1), e0311730. https://doi.org/10.1371/journal.pone.0311730

National Institute of Population Studies (NIPS) & ICF. (2019). Pakistan Demographic and Health Survey 2017–18. NIPS and ICF. https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf

Naz, S., et al. (2024). Examining contraceptive utilization behavior in Pakistani women. Reproductive Health, 21, 100. https://doi.org/10.1186/s12978-024-01857-3

Nuss, M., et al. (2025). Maternal mortality according to state abortion legislative climate following the US Supreme Court's Dobbs v. Jackson Women's Health Organization ruling. Pregnancy, e70128. https://doi.org/10.1002/pmf2.70128

Pillai, V. K., & Gupta, R. (2011). Reproductive rights approach to reproductive health in developing countries. Global Health Action, 4, 8423. https://doi.org/10.3402/gha.v4i0.8423

Planned Parenthood v. Casey, 505 U.S. 833 (1992).

Raza, S., et al. (2026). Why and where perinatal deaths: Trends and determinants in Pakistan. Maternal Health, Neonatology and Perinatology, 12, 2. https://doi.org/10.1186/s40748-025-00246-3

Reproductive Freedom for All. (2025, December 30). Six reproductive freedom storylines to watch in 2026. Retrieved from https://reproductivefreedomforall.org/news/six-reproductive-freedom-storylines-to-watch-in-2026/

Roe v. Wade, 410 U.S. 113 (1973).

Roth, S. (2026, January 17). Conflation of contraception and abortion: Implications for access to contraceptives. New England Journal of Medicine. https://doi.org/10.1056/NEJMp2514218

Rural and Remote Health. (2024). Fertility patterns in Pakistan: A comparative analysis of family planning trends across different geographic regions. Rural and Remote Health, 24, 8835. https://doi.org/10.22605/RRH8835

Saleem, H., Urooj, A., & Lodhi, N. H. (2026). Reproductive rights in Pakistan: A constitutional and human rights analysis. The Critical Review of Social Sciences Studies, 4(1), 5649–5656. https://thecrsss.com/index.php/Journal/about

Shahbaz, S. (2020). Caught in the cross-fire of religion, culture, and politics: Women's sexual and reproductive health and rights in Pakistan. In Gender mainstreaming in politics, administration and development in South Asia (p. 231).

Srinivasulu, S., & Heiland, F. W. (2025). How will abortion bans affect maternal health? Forecasting the maternal mortality and morbidity consequences of banning abortion in 14 U.S. states. Journal of Women's Health, 34. https://doi.org/10.1089/jwh.2024.0544

Temmerman, M., Khosla, R., & Say, L. (2014). Sexual and reproductive health and rights: A global development, health, and human rights priority. The Lancet, 384(9941), e30–e31. https://doi.org/10.1016/S0140-6736(14)61190-9

UNFPA Pakistan. (2026, January). Pakistan 2026: Walking the talk on population and reproductive rights. Retrieved from https://pakistan.unfpa.org/en/news/pakistan-2026-walking-talk-population-and-reproductive-rights

United Nations. (1994). International Conference on Population and Development: Programme of action. United Nations Population Fund.

United Nations. (2015). Transforming our world: The 2030 agenda for sustainable development (A/RES/70/1). https://sdgs.un.org/2030agenda

Whole Woman's Health v. Hellerstedt, 579 U.S. 582 (2016).

World Health Organization. (2022). [Title of specific report — PLACEHOLDER: replace with actual report title and URL]. World Health Organization.

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