THE GENDER PROJECT
THE GENDER EQUITY AND DEMOGRAPHIC RESEARCH PROJECT

UC San Diego
CENTER ON GENDER EQUITY AND HEALTH

Advancing Sexual and Reproductive Health through Innovative Research on Gender Equity, Norms, and Agency

Insights from the GENDER Project

This brief synthesizes findings from peer-reviewed studies emerging from the GENDER Project, offering key insights on sexual and reproductive health (SRH) in India and broader South Asia. It outlines evidence-based opportunities for advancing SRH outcomes, policies, and research through the lenses of gender equity and agency.

Introduction

Sexual and Reproductive Health (SRH) has been recognized as a key pillar of global public health and an important individual human right for more than 30 years.[1] A substantial body of evidence has consistently demonstrated widespread benefits of improved SRH to both individuals and broader society, including reduced maternal and infant mortality, increased educational attainment, greater economic participation, and accelerated development.[2,3] In light of these benefits, SRH has remained a primary research and policy priority in major multinational efforts such as the Sustainable Development Goals, FP2030, and others.

Despite this well-established and widespread recognition of the importance of SRH, gaps and inequalities in SRH care remain present globally. This is especially salient in South Asia broadly and India specifically, where large gender gaps in healthcare access, utilization, and outcomes persist despite major equity-oriented efforts and improvements. Though SRH care is inherently gendered — intertwined with individuals' autonomy, power, access to services, and decision-making capabilities – broader gender systems, norms, and agency which affect SRH access and utilization remain understudied as determinants, correlates, and influences of SRH care.

This brief synthesizes peer-reviewed research on SRH from the Gender Equity and Demographic Research (GENDER) Project, a collaboration between the Center on Gender Equity and Health (GEH) at the University of California, San Diego and the International Institute of Population Sciences (IIPS), Mumbai. The first phase of the GENDER Project (2017–2022) sought to document and explain lagging progress in gender equity and Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India. The second phase (2022–2026) expanded this research by explicitly considering how gender systems, norms, and individual agency influence SRH outcomes.

In this report, we highlight key insights and opportunities for SRH drawn from both phases of the GENDER Project. We summarize findings from three cross-cutting themes of determinants, correlates, or contextual environments for SRH: SRH and experiences of violence, SRH and women's economic empowerment, and SRH and other gendered contexts. We also share implications from the methodological aspects of the work. Collectively, these insights can be used to support advocacy, programming, and future research that seeks to strengthen SRH and promote gender equity in India and beyond.

SRH and Violence

Work from the GENDER Project consistently demonstrated a meaningful bidirectional relationship between violence and SRH, as measured by contraceptive use and discontinuation, and abortion access. Women facing IPV during pregnancy were more likely to use methods they could control themselves (like pills or injectables) and less likely to use methods controlled by their male partner (like condoms) after birth, suggesting that IPV impacts contraceptive choice.[4] Emotional IPV was linked to greater likelihood of condom discontinuation and physical IPV was linked to greater likelihood of IUD discontinuation, suggesting that IPV is differentially associated with stopping use of certain forms of contraception.[5] Women experiencing physical or sexual IPV were more likely to obtain abortions, both from facilities and self-managed.[6] GENDER Project research also suggested that the relationship between violence and SRH differs based on context; for example, in Sri Lanka, the association between violence and contraceptive utilization differed meaningfully depending on proximity to conflict zones within the country.[7] Broadly, these studies consistently suggest that negative SRH outcomes and violence may be driven in part by the same root cause of gendered norms which deny women's agency and bodily autonomy.

- ***SRH and violence counseling services should co-occur.*** Due to the interrelatedness of SRH and violence, SRH health system contacts like FP counseling and provision could provide valuable opportunities for screening for violence, connecting individuals to IPV services, and discussing and providing methods which can be used covertly in the face of opposition. SRH healthcare encounters should address individuals' broader safety and autonomy and provide counseling and method choices suited to the unique situation of each client.
- ***Male engagement is key.*** Men are most commonly the perpetrators of gender-based violence, and male support for the use of SRH services, particularly contraceptive use, is an important determinant of utilization. Greater integration of male engagement components within policy initiatives and public health interventions can serve to both reduce violence and improve SRH outcomes.
- ***Norms change is imperative.*** Addressing the underlying gendered norms which underscore women's agency and autonomy can work to address common root causes of both violence and adverse SRH outcomes.

SRH and Women's Economic Empowerment (WEE)

Work from the GENDER project demonstrated that financial inclusion was linked to improved SRH service uptake, and that economic engagement was associated with patterns of SRH utilization. Women who were aware of or participated in microcredit programs were more likely to have antenatal care (ANC), postnatal check-ups, and postpartum modern contraceptive use, though these associations were present only for the poorest women.[8] Women who owned a bank account had higher rates of ANC and contraceptive use, especially in states with below-average utilization rates.[9] A study of the relationship between employment and current contraceptive use found differing associations across methods and employment sectors, suggesting divergent pathways for family planning across different fields of work.[10] These studies broadly concluded that indicators of economic engagement may reflect women's increased autonomy and control over important decisions affecting them and their families, as well as their mobility and self-efficacy to act upon their decisions, leading to improved economic

empowerment and subsequent SRH behaviors. However, political and economic context such as family leave policies may also be a key influencer of SRH outcomes, and economic engagement should therefore not be conflated with economic empowerment.

- ***WEE efforts should consider integration with SRH services and downstream SRH benefits***. Financial inclusion and economic programs can enhance SRH outcomes, especially among disadvantaged women (such as those with the lowest wealth or those in states with below-average SRH care). Explicit consideration of these downstream effects, including discussion of SRH topics or linkages to SRH care, could offer complementary additional benefits for WEE interventions.
- ***Economic engagement alone is insufficient to draw conclusions about WEE and SRH***. The relationship between SRH and economic engagement is not a monolith, and important differentials in goals and subsequent trajectories exist among women who are considered engaged (e.g. by sector of employment). Additionally, economic engagement is not necessarily reflective of economic empowerment; research in this space should consider the broader policy and normative context and utilize empowerment-specific measures where feasible and appropriate.

SRH and Other Gender-Related Power Dynamics

Multiple analyses suggested that agency, especially agency earlier in the life course, shaped subsequent SRH behaviors. For example, child marriage is associated with reduced contraceptive use and poor SRH outcomes.[7,11] A commentary on pregnant adolescents highlighted that this population frequently experiences a lack of agency and restrictive norms around SRH behaviors despite a need for SRH care and should be explicitly considered in interventions and research.[12] An examination of postpartum family planning use concluded that postpartum women often lacked agency in contraceptive decision-making both within their relationships and within the broader healthcare context, needing their husband's approval to access services, and receiving prescriptive rather than person-centered counseling.[13] Other analyses examined measures of gender equity more broadly and collectively found that gender equity matters significantly for SRH outcomes. For example, lower gender equity at the district level (assessed as higher levels of patriarchy) was linked with higher total fertility rate and excess female child mortality,[14] while greater gender equity in the healthcare workforce (captured as female provider availability) increased maternal health service use.[15]

- ***Interventions to improve agency and/or gender equity may have downstream positive effects on SRH***. As with WEE, efforts to address gender-related power dynamics should explicitly consider potential impacts on SRH outcomes, including addressing these topics as part of interventions, providing warm referrals or linkages to SRH care, and measuring SRH outcomes in research.
- ***SRH interventions which do not examine and address broader gender norms, attitudes, agency, and contexts will be less effective***. Work from the GENDER Project underscores the interrelatedness of broader gender systems, norms, and agency with SRH care and outcomes. Targeting the outcomes of SRH service uptake without considering and addressing the underlying gender-related power dynamics at play will limit the potential impact of programs and policies.

Methodological Insights and Implications



Disaggregation is key. Analyses from the GENDER project consistently demonstrated important differences in findings across disaggregated SRH indicators (such as female-controlled versus male- controlled contraceptive methods[4]), correlates of SRH (such as sector of work[10] or location of SRH services[16]), and population subgroups (such as adolescents and first-time mothers[17]). Collection and reporting systems should be designed to ensure availability of disaggregated information as much as possible. Analyses which utilize disaggregated data should consider specific outcomes, predictors, and correlates where possible to ensure the most accurate and actionable findings.



Measurement of contraceptive use should be person-centered and dynamic. Several analyses of contraceptive utilization expanded upon the standard measure of current modern contraceptive use, considering both traditional and modern forms of contraception, as well as dynamic patterns of use including concurrent method use and method initiation, switching, and discontinuation.[17,18] These more detailed considerations of contraception demonstrated important nuances in use and highlighted the need for person-centered utilization measures that reflect the contraception women want to use and the ways in which they actually use it, rather than simple standalone uptake as a target.



There is continued opportunity for innovation in analysis. Novel analytic methods, such as machine learning[11,19] and spatial approaches like Local Indicators of Spatial Association (LISA)[14], are promising tools for deepening understanding of SRH outcomes and contexts.



The quantitative measurement of agency and related concepts requires further development. There is a need for continued measurement innovation in agency, empowerment, and equity. Where measures exist, there is a need for greater inclusion in large-scale surveys, and for adaptation and validation[20] to specific subpopulations.

Conclusions

The findings synthesized in this brief underscore the reality that SRH outcomes do not exist in a vacuum. To move the needle in India and beyond, the sector must embrace an intersectional and methodologically sound framework for policy and research, and engage more deeply with gender as a structural determinant of health. The GENDER Project's work highlights the indispensable value of this kind of evidence—not just for academic record, but as a tool to design responsive programs, reduce health disparities, improve health outcomes, and ultimately achieve a future where all individuals can exercise their reproductive rights and access quality SRH care.

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For more information and additional GENDER Project resources, please visit geh.ucsd.edu/the-gender-project or explore our resources page.

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