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The influence of gender norms on women's sexual and reproductive health outcomes: a systematic review

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Abstract

Background Despite progress toward gender equity, enduring societal norms continue to shape women's roles, particularly impacting their sexual and reproductive health, including fertility, maternal health, and family planning, all of which are influenced by traditional gender expectations.

Aim This review investigates how gender norms affect women's sexual and reproductive health outcomes.

Methods A systematic review was conducted on publications from 2013 to 2023, sourced from databases such as PubMed, Scopus, Web of Science, and Google Scholar, using keywords, MeSH terms, and Boolean operators. Of 1,500 articles identified, 38 peer-reviewed articles in English or French met the inclusion criteria. Data were extracted using a standardized form and evaluated with the mixed-methods appraisal tool. Findings from the selected studies were analyzed through a narrative synthesis approach.

Findings The review identified key themes from the 38 included studies results underscoring the lack of comprehensive sexual education and the challenges posed by cultural norms and social stigma. It highlighted how cultural and gender dynamics restrict women's autonomy in family planning and maternal healthcare, with impacts varying by context. Finding also highlight the importance of culturally competent healthcare that respects diverse cultural beliefs and tackles educational and economic barriers to enhance women's sexual and reproductive health outcomes.

Conclusion This review identifies gender norms as one of major obstacles to accessing sexual and reproductive health (SRH) education and services among women. It emphasizes the need for comprehensive SRH education, women's autonomy, and culturally competent healthcare services to address barriers and promote gender equity globally.

Keywords Sexual and reproductive health, Systematic review, Gender roles, Gender norms, Social norms, Access, Women's health

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Introduction

Gender roles have long been a fundamental aspect of societal norms, shaping the expectations, behaviors, and opportunities of individuals based on their gender. Historically, women have been assigned specific roles in many cultures, often centering around domestic responsibilities and caregiving [1]. While progress has been made towards gender equity in various aspects of life, deeply ingrained gender norms continue to influence the lives of women, particularly concerning their sexual and reproductive health [2].

Since the Beijing Declaration, it was asserted that the right of women to achieve the highest standard of health throughout their lives, on equal terms with men, is essential. This commitment highlighted the crucial importance of gender equity in health access [3]. However, despite international commitments, significant disparities persist, often exacerbated by traditional social structures and gender norms that perpetuate these inequalities, particularly in the realm of sexual and reproductive health [4].

Sexual and reproductive health is a critical aspect of overall well-being for women worldwide. It encompasses a range of issues related to the female reproductive system, including fertility, maternal health, access to family planning services, and the management of reproductive-related conditions [5]. However, the link between gender roles and women's sexual and reproductive health is complex and multifaceted, and understanding the dynamics between the two is crucial for promoting equitable healthcare and addressing potential disparities [6].

Universal access to reliable information and comprehensive sexual health care is crucial. This includes access to high-quality information about sex and sexuality, understanding the risks associated with unprotected sexual activity, the ability to access necessary sexual health care, and living in an environment that supports and promotes sexual health [7]. Moreover, ensuring adequate contraceptive methods, effective protection against sexually transmitted infections, and sufficient support during pregnancy to guarantee safe childbirth and the birth of a healthy child are essential. However, these necessities are often restricted by deeply entrenched gender norms [8, 9]. These limitations expose women to multiple risks such as sexually transmitted infections, unsafe abortions, and unwanted or risky pregnancies [10, 11].

The disparity in education, particularly in sexual and reproductive health education, is critical as approximately 132 million girls worldwide are deprived of education, limiting their ability to access essential information and make informed decisions about their health [12]. Economic inequalities, exacerbated by a lack of financial independence, further hinder women's access to quality care, reinforcing barriers to safe and informed health and reproduction [13].

Gender disparities in sexual and reproductive health (SRH) outcomes persist in many societies, affecting access to essential healthcare services and influencing health-seeking behaviors. These disparities can arise from unequal power dynamics, limited decision-making autonomy, and restrictive gender norms that may hinder women's ability to make informed choices about their reproductive well-being [14, 15]. To better understand these challenges, this systematic review seeks to answer the following question: What is the influence of gender norms on women's sexual and reproductive health (SRH) outcomes?.

Prior to conducting this systematic review, we performed a preliminary search to identify existing reviews on the influence of gender norms on women's SRH outcomes. Our search identified several key reviews, including one that highlighted the exclusion of older women in global health policies [16], another that examined gender norms and health behaviors [17], and a third that provided a methodological framework for gender analysis in health systems research [18]. However, these reviews did not systematically examine the influence of gender norms on SRH outcomes across diverse populations and regions, nor did they provide a comprehensive synthesis of both qualitative and quantitative evidence. Our review aims to fill these gaps by systematically analyzing the impact of gender norms on women's SRH outcomes globally, with a focus on both qualitative and quantitative studies.

This systematic review comprehensively examines and synthesizes the existing literature on the relationship between gender norms and women's SRH outcomes. The rationale for this review stems from the critical role that gender norms play in shaping women's access to and experiences with SRH services. By synthesizing findings from diverse studies, we aim to provide a deeper understanding of how societal expectations, norms, and roles influence women's SRH outcomes globally. This understanding has significant implications for the development of healthcare policies, programs, and interventions that address the specific needs of women and promote gender equity in SRH.

Methodology

Review question

What is the influence of gender norms on women's sexual and reproductive health (SRH) outcomes?

Review objective

To investigate how gender norms affect women's sexual and reproductive health (SRH) outcomes globally.

Review design

This study employs a systematic review design to synthesize global evidence on how gender norms influence women's sexual and reproductive health (SRH) outcomes. Given the complex and socially constructed nature of gender norms—and their varied impacts across cultures—this approach is particularly valuable because it:

✓ Identifies patterns in how normative frameworks affect SRH outcomes.
✓ Compares findings across diverse geographic and socio-demographic contexts.
✓ Critically assesses the methodological strengths and limitations of existing evidence.

Systematic reviews follow a structured, reproducible methodology, incorporating predefined eligibility criteria, systematic search strategies, and critical appraisal of included studies to minimize bias and enhance the reliability and generalizability of findings [19]. The design accommodates both qualitative and quantitative evidence, allowing for a comprehensive analysis of gender norms as both measurable outcomes and contextual social processes.

To ensure transparency and methodological rigor, this systematic review adheres to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [20]. While PRISMA standardizes the reporting of key processes (e.g., search strategy, study selection, and data extraction), the systematic review design governs the broader approach to evidence synthesis and interpretation. The completed PRISMA checklist is provided in [Table 3] (Supplementary Materials).

Literature search strategy

A comprehensive literature search was conducted to identify relevant studies published in electronic databases as PubMed, Scopus, Web of Science, and Google Scholar using a combination of relevant keywords, MeSH terms, and Boolean operators. We also performed a hand search of key journals and examined the reference lists of included studies to identify any additional studies that may have been missed in the database search. For keywords we use Gender Role, woman's roles, men's, sex roles, Gender norms, healthcare disparities, health care in equity, reproductive health, and sexual health. The search was limited to studies published between 2013 and 2023 to ensure the inclusion of recent and relevant evidence. This period aligns with key global developments, such as the adoption of the Sustainable Development Goals (SDGs) in 2015, which emphasize gender equality and universal access to SRH services. Specific search equations and filters applied, covering these publications, were detailed in the supplementary materials [Search equation] after the PRISMA item checklist.

Eligibility criteria

To ensure a focused and relevant analysis, our systematic review explicitly includes and excludes studies based on the following refined criteria:

Inclusion criteria

➢ Study Focus: Only studies that directly examine the relationship between gender roles and sexual and reproductive health outcomes in women are included. This encompasses studies that either primarily focus on this relationship or uncover it as a significant finding while investigating barriers to accessing sexual and reproductive health services for women.
➢ Type of Research: This review included qualitative, quantitative, and mixed-methods studies to ensure a comprehensive analysis of the influence of gender norms on women's sexual and reproductive health (SRH) outcomes. Qualitative studies provided in-depth insights into how gender norms shape women's experiences and decision-making, while quantitative studies offered measurable data on their impact. Mixed-methods studies combined the strengths of both approaches, enabling a nuanced understanding of the topic.
➢ Definitions and Operationalization: Studies must provide clear definitions or operational constructs of'gender roles'and'sexual and reproductive health.'
➢ Participant Demographics: All studies included must involve human participants, with data specifically analyzed for female subjects.
➢ Availability and access to full text.

Exclusion criteria

➢ Study Focus: Studies that exclusively focused on male participants or did not provide gender-differentiated results were excluded. This review specifically examines the influence of gender norms on women's sexual and reproductive health (SRH) outcomes. Since gender norms affect men and women differently, the exclusion of male-focused studies ensures a focused analysis of their impact on women's health.
➢ Type of Articles: Excludes review articles, editorials, commentaries, and other non-original research documents.

➢ Language: Studies not available in English or French are excluded to ensure the comprehensibility.

Studies selection

Our systematic review followed a rigorous selection process to identify and include peer-reviewed, full-text articles pertinent to our review objectives. We conducted a comprehensive search across major databases, which yielded 1,500 references. After removing 320 duplicates, we screened 1,180 titles for relevance, excluding 424 on the basis that the intervention was not relevant to this review.

We subsequently assessed 756 abstracts, further excluding 696 studies due to the intervention's irrelevance or lack of moderation or subgroup analysis. This refinement led us to a full-text review of 60 articles, from which 22 were excluded due to their limited availability as conference proceedings, irrelevance of the intervention, or absence of moderation or subgroup analysis.

Ultimately, 38 studies met our inclusion criteria and were incorporated into the review. These studies were selected based on their direct relevance to our review focus and their provision of sufficient detail for inclusion in our analysis. Our process was meticulous and systematic, ensuring a comprehensive and relevant evidence base for our review. The details of our study selection process are succinctly visualized in (Fig. 1) of the PRISMA flow chart.

Data extraction

A standardized data extraction form was developed to collect relevant information from the included studies. The data extraction form included details such as study characteristics author, year, country, study design, sample size, participants'characteristics, and key findings related to the review question (Table 1). To ensure the reliability and accuracy of the data extraction process, two independent reviewers conducted the data extraction. Both reviewers, independently to minimize bias, and enhance the thoroughness of the data collected, examined each article. Any discrepancies between the reviewers were resolved through discussion or, if necessary, by consulting a third, senior reviewer.

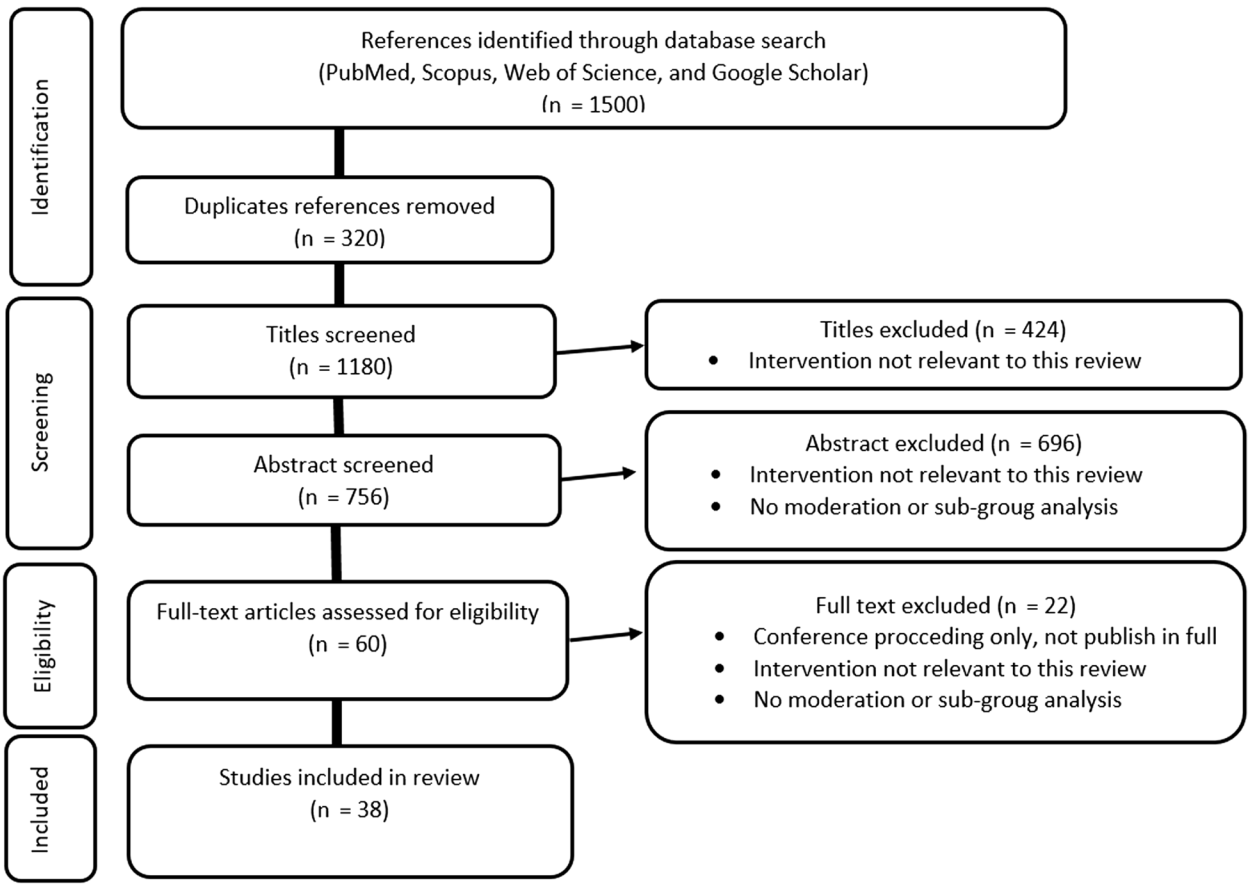

Fig. 1 PRISMA flow chart

Table 1 Characteristics of included studies

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
1	Janighorban, Mojgan et al. (2022) [21]	Iran	Qualitative: in-depth interviews	14–19-years-old vulnerable adolescent girls and twenty-two key informants and health professionals	To explore the barriers to the access of vulnerable adolescent girls to sexual and reproductive health	The study underscores the vital need for comprehensive sexual and reproductive health education in Iran to overcome cultural barriers, ensuring adolescents can make informed decisions about their sexual and reproductive health	100
2	Boaventura Manuel Cau [22]	Mozambique	Quantitative study: the 2011 Demographic and Health Survey (DHS)	Married (or in union) women aged 15–49 years	To examine the mechanisms through which community context influences women's use of modern contraception	In Mozambique, cultural norms and gender dynamics influence contraceptive use, with larger family desires and male dominance limiting women's choices, while community-level women's empowerment promotes modern contraceptive methods	80
3	Mardi, A (2018) [23]	Iran	qualitative study: in-depth semi-structured interviews	Married women aged 13–19 years who attended in urban–rural healthcare center in Ardabil	to explore factors influencing the use of contraceptives from the perspective of teenage women living in the city of Ardabil in Iran	In Iranian society, societal pressures and norms around fertility and adulthood drive teenage women to early pregnancies, exacerbated by limited knowledge of and access to contraception, leaving them without control over their reproductive choices	100
4	Rosemary Morgan 2017 [24]	Uganda	qualitative study: Group discussions	Three districts in Eastern Uganda were surveyed, covering women who recently gave birth, fathers of recent newborns	To identify key gender dynamics affecting maternal health and maternal health care	Gender power dynamics heavily influence maternal healthcare access and outcomes, affecting resource allocation, labor division, societal norms, and decision-making, amidst challenges like workload, male involvement, and healthcare provider attitudes	100

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
5	Kazaura, M. 2015 [25]	Tanzania	Quantitative study: a quasi-experimental study GEM Scale	A sample of 1,620 adult women and men	To assess how attitudes and beliefs respond to the spread of HIV and gender-based violence (GBV) in Tanzania	Findings reveal that changing gender dynamics, attitudes, and societal norms significantly mediate HIV transmission risks between genders, highlighting the need to address gender inequalities to mitigate differential HIV risks	70
6	Drioui, C. 2021 [26]	Morocco	Quantitative study: Survey	The data are from two surveys, the 2003–2004 Population and Family Health Survey and the 2011 National Population and Family Health Survey	To measure women's empowerment, particularly in the domestic sphere and in relation to spouses, and its effect on women's fertility preferences	Women's empowerment, marked by independence and improved bargaining power, decreases desired family size through enhanced couple communication and education access, simultaneously challenging male violence and influencing reproductive decisions broadly	80
7	Ouahid, H 2023 [27]	Morocco	A qualitative study: semi-structured interviews and focus groups	women and men aged over 18 years old, living in the urban and rural areas of the Marrakech-Safi region in Morocco	To explore how gender norms influence access to sexual and reproductive health services	The study highlights how entrenched gender norms stigmatize and restrict women's access to sexual and reproductive healthcare, demonstrating the need for interventions to dismantle these gender-based barriers and enhance women's healthcare autonomy	100
8	Delbiso, T.D. 2013 [28]	Ethiopia	Quantitative study: structured questionnaire	317 married couples	The objective of assessing gender power relations in reproductive decision-making (DM)	Younger women [15–20, 29–32] often have husbands controlling contraceptive and maternal health decisions, while women with one or two children tend to share decision-making, reflecting varied reproductive health participation across demographics	80

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
9	Rizvi, N. 2014 [33]	Pakistan	A qualitative study: group discussions	semi-structured group discussions with women, through snowballing from different age and socio-economic categories	The study identifies reasons for gender role repetition and examines their impact on women's reproductive health	In patriarchal systems, male dominance limits women's autonomy in sexual and reproductive health, leading to increased risks and reliance on abortion, particularly for female fetuses	100
10	Cerezo, A et al. 2023 [34]	U.S.A	an exploratory qualitative study: semi-structured interviews and focus groups	with twenty sexual minority gender expansive women of Latinx and African American descent	To explore participants'access to health services and the impact of cultural factors on their health decisions and behaviors	Participants face barriers to healthcare due to income disparities, provider discrimination, and familial discouragement, often leading to delayed medical care seeking influenced by early life experiences and family messages	100
11	Kingori, C. et al. 2018 [35]	U.S.A Ohio	A qualitative study: In-depth interviews	27 Somali young adults aged 18–25 years	To identify sexual health knowledge barriers among Somali young adults in Ohio	Cultural and religious norms significantly influence sexual health knowledge in the Somali immigrant youth community, where stigma and judgment are prevalent. Research supports a multi-level approach to address these barriers, involving individual, interpersonal, and community interventions	90
12	Chiweshe, M.,Macleod, C. 2017 [36]	**Zimbabwe**	Qualitative research: in-depth semi-structured interviews	Six health service providers working in different facilities in Harare, Zimbabwe	We utilise positioning theory to show how the ways in which Zimbabwean health service providers' position women and themselves are rooted in cultural and social power relations	The analysis reveals stigmatization of women who have abortions, portrayed as norm violators, while healthcare providers frame abortion as morally wrong and socially unacceptable, positioning themselves as experts and protectors of cultural values	80

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
13	Metusela, C. et al. 2017 [32]	**Sydney, Australia, and Vancouver, Canada**	Qualitative study: individual interviews, and focus groups	migrant and refugee women from Afghanistan, Iraq, Somalia, South Sudan, Sudan, India, Sri Lanka and South America participated in the study	to examine constructions and experiences of SRH in non-English-speaking migrant and refugee women, across a range of cultural groups	The study underscores the need for culturally safe sexual and reproductive health (SRH) education and services for migrant and refugee women post-resettlement to address barriers to access and adverse SRH outcomes influenced by taboos around menstruation and sexuality	90
14	Belay, A.D. et al. 2016 [37]	**South Ethiopia**	cross-sectional study: structured and pre-tested questioner	married women in the child bearing age. The women who were living in Mizan city were selected using the simple random sampling method	to assess the impact of women's decision making power on family planning use and its associated factors	The study found that a majority of married women (67.2%) reported increased autonomy in family planning decisions, with key contributing factors including secondary education, government employment, spouses with higher education, and younger age	100
15	Miani, C. 2021 [38]	**23 European countries**	An ecological correlation study	The study utilizes various gender equality indices as the Gender Equity Index, Gender Inequality Index, and Social Institutions and Gender Index	To explore the association between medical abortion ratios and gender equality in Europe	In countries with higher gender equality, medical abortion is more prevalent than surgical, indicating potential influence of women's engagement on abortion methods, emphasizing feminist perspectives in shaping reproductive health policies	70

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
16	Farmer, D.B. et al. 2015 [39]	**Rwanda**	qualitative study interviews	Interviews with randomly selected male and female community members, community health workers, and health facility nurses	To investigate factors that contribute to family planning use, barriers to care, and quality of services from the community perspective	Study participants valued family planning benefits but leaned towards larger families due to cultural influences, while young, unmarried women faced stigma and lacked decision-making power, revealing a misunderstanding of family planning as primarily a woman's responsibility	90
17	Msoka, A.C. et al. 2019 [40]	**Tanzania**	Qualitative descriptive approach drawing on four group discussions	20 purposively selected married women with two or more children	To investigate rural Tanzanian women's perceptions and cultural beliefs of the barriers to family planning services utilization	The study revealed factors impacting family planning, including method usage, cultural beliefs, and male dominance in decision-making, emphasizing the need for educational interventions to challenge myths and religious barriers	100
18	Amini, E., McCormack, M. 2021 [41]	**Iran**	a biographical life course approach,	interviews with 30 older Muslim women living in Tehran and Karaj	This article will show concepts of shame, stigma, and pollution are powerful ways of understanding the regulation of cathexis within a patriarchal gender order	In Iran, patriarchal and religious norms restrict women's rights, linking sexuality to shame and stigma, fostering silence and shame in puberty, with severe consequences for deviation from cultural emphasis on virginity and lack of sexual education	60
19	Kwambai, T.K. et al. 2013 [42]	**Kenya**	**A qualitative study**	Eight focus group discussions were conducted with 68 married men between 20–65 years of age in May 2011	To explore men's perceptions of antenatal and delivery care services and identified factors that facilitated or constrained their involvement	Traditional gender roles often assign pregnancy support to women, viewing men primarily as providers, limiting their participation in reproductive healthcare processes, exacerbated by negative attitudes from healthcare workers and facilities ill equipped for couple involvement	100

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
20	Noge, S. et al. 2020 [43]	**South Africa**	**A qualitative descriptive study/interviews/focus group**	Mothers who gave birth to a stillborn and midwives	to describe the sociocultural norms contributing to the high number of stillbirths	Traditional norms and the involvement of figures like healers and mother-in-law, combined with social oppression and abusive behaviors, contribute to stillbirths and hinder pregnant women's autonomy in healthcare decisions	90
21	Bukuluki, P. et al. 2021 [44]	**Uganda**	**cross-sectional survey**	individuals from six districts (Amudat, Kaberamaido, Kasese, Moroto, Tororo and Pader) in Uganda	To investigate the factors that influence the social norm access to contraception by adolescent girls in six districts in Uganda	Social norms hinder adolescent girls'contraception access, but support rises with employment and positive attitudes, except in regions with low employment and reliance on less effective methods, barring respondents aged 30–34	100
22	Achen, S. et al. 2021 [45]	**Uganda**	**Qualitative methods. In-Depth Interviews, Focus Group Discussions, and Key Informant Interviews**	Involving married adolescent girls aged 15–19, elderly women, and key informants	To explore the socio-cultural perceptions of sexuality and their influence on SRH among adolescent Karamojong girls	In Karamoja, cultural norms dictate the sexual and reproductive health (SRH) of adolescent girls, allowing sexual activity both within and as a commitment to marriage. These traditions, combined with societal views of girls as sources of wealth and labor, pressure them into early marriages, negatively influencing their SRH outcomes	100

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
23	Mbarushimana, V. et al. 2022 [46]	**Rwanda**	**Qualitative study. semi-structured interviews**	16 purposively selected key informants from public and private institutions in Rwanda	To explore factors that enable or prevent young adolescents from accessing to SRHR information from the perspective of the key informants in Rwanda	The study explores factors affecting young adolescents'access to sexual and reproductive health information, including individual behaviors, parental communication, cultural norms, and societal factors like economic constraints and policy inadequacies, affecting availability and accessibility in both urban and rural settings	100
24	Sia, D. et al. 2020 [47]	**Sub-Saharan Africa**	**Quantitative study. Cross sectional study**	Using country-level panel data from 24 SSA countries. for the period between 2000 and 2016	To quantify the extent to which country-level trends in HIV incidence in Sub-Saharan Africa were influenced by gender inequalities	The study found a link: as the Gender Inequality Index (GII) improved, HIV incidence decreased in Sub-Saharan Africa. Yet, it noted a troubling association—a one percent increase in GII could mean a 1.6 percent rise in HIV cases, underlining the urgency of addressing gender inequalities in HIV/AIDS prevention	70
25	White, D.et al. 2013 [48]	**Mali**	**Quantitative study. Cross sectional study Survey**	317 households in two rural districts of central Mali, women who had given birth in the previous year, their husband and their mother-in-law	To understand how intra-familial power dynamics and the attitudes of women, their husband and their mother-in-law are associated with maternal health practices	Mothers-in-law significantly influenced daughters-in-law's maternal health behaviors, while individual factors like self-efficacy and societal valuation, along with perceptions of health facility quality, independently shaped health behaviors, with husbands'preferences having no notable effect	80

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
26	Chandrasekaran, S. et al. 2023 [49]	**USA**	**Qualitative study semi-structured interview**	People of reproductive age over 18 that self-identified as Asian American or mixed race including Asian American, Native Hawaiian, and/or Pacific Islander, and had a medication abortion in the US between January 2016 and March 2021	To fill gaps in research and understand how cultural and community views influence medication abortion access and experiences among AAs	Cultural and community factors deeply shaped participants'identities, especially second-generation individuals, as stigma surrounding sexual and reproductive health limited open family discussions, highlighting the need for culturally competent healthcare and community-centered mental health resources	100
27	Tesha, J. et al. 2023 [50]	**Tanzania**	**qualitative study in-depth interviews of key informants and Focus Group Discussions**	FGDs were conducted, comprised married women and men, unmarried women and men, and adolescent boys and girls aged 15 to 19 years	To explore gender-based enablers and/or barriers that influence women and girls'realization of their sexual and reproductive health and rights in the Simiyu Region of Tanzania	In the Simiyu region, patriarchal norms restrict women's access to reproductive health services, leading to adverse outcomes, exacerbated by male-dominated decision-making, economic disparities, and entrenched traditions, hindering women's autonomy and healthcare access	100
28	Garrison-Desany, H.M. et al. 2021[51]	**Tanzania**	**Quantitative study multi-stage cluster sampling, stratified by area of residence**	2528 women aged 15–49 in all the sampled households and 1000 men aged 15–49 in area of residence (urban, rural, mixed) within the Simiyu region	To investigate the role of gender power relations within households on women's health outcomes in Simiyu region, Tanzania	The study identifies significant associations between gender-related factors such as decision-making autonomy and health outcomes, stressing the importance of women's perceived autonomy and advocating for integrating gender considerations into maternal health interventions to address disparities and improve outcomes	100

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
29	Zinke-Allmang, A. et al. 2023 [52]	**Kenya**	**Qualitative study Interviews**	16 women, 10 men and 14 key influencers across 7 peri-urban wards in Nairobi, Kenya	to explore the role of key influencers (partners, parents and friends) in women's FP use and how women anticipate normative reactions or sanctions	Women rely on a network of trusted individuals including parents, partners, friends, and healthcare workers for family planning decisions, while viewing mothers as understanding social risks and offering discreet advice, and aunts as trusted sources for impartial information on family planning benefits and drawbacks	100
30	Rodrigues, P. et al. 2022 [53]	**Ethiopia**	**Mixed methods approach survey and in depth interview**	randomly selected women in four kebeles ($n = 120$), and key informant interviews with local health experts ($n = 5$)	To examine possible determinants of women's fertility preferences in rural southwestern Ethiopia	The study highlights how socio-economic, environmental, and cultural factors shape women's fertility preferences in southwest Ethiopia, noting increased contraceptive use despite challenges like religious constraints and male dominance	100
31	Yamin, A.E. et al. 2015 [54]	**Tanzania, Ethiopia, Malawi, and South Africa**	**Qualitative study Focus group discussions, and in depth interviews**	115 key informants and 83 stakeholders were interviewed, and 290 people participated in focus group discussions, across settings	Identify gender as a fundamental driver not only of maternal, but also child health, through manifestations of gender inequity in household decision making, labor and caregiving	In African countries like Tanzania, Ethiopia, Malawi, and South Africa, socio-economic challenges hinder women's financial decision-making due to cultural norms, while maternal orphans, particularly girls, face vulnerability, exacerbating gender disparities despite female caregivers'efforts to facilitate children's access to healthcare and education	100

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
32	Bazié, F. et al. 2022 [55]	**Burkina Faso**	**Qualitative study in depth interviews**	women who reported an abortion in the last 10 years in an initial quantitative survey	to classify women's abortion care-seeking experiences across the life course and social conditions into typologies using qualitative data	The study explores abortion experiences of 23 women in Burkina Faso, revealing distinct typologies and highlighting impacts of social stigma, economic constraints, and partner involvement across demographics	100
33	Jordal, M. et al. 2013 [56]	**Sri Lanka**	**Qualitative study semi-structured interviews**	unmarried pregnant women or single mothers	To explore and describe how unmarried women facing single motherhood in Sri Lanka handle their situation	The study unveils women's complex challenges with premarital pregnancies, navigating familial dependence, concealing pregnancies to avoid stigma, coping with societal stigma through various strategies, showcasing the interplay between societal expectations, individual agency, and survival instincts	100
34	Thatte, N. et al. 2016 [57]	**Ghana**	**Quantitative study cross sectional**	Ghanaian youth	To assess how perceived barriers differed depending on the service being sought between common services accessed by young people: HIV/STI testing, abortion, and contraception	Key barriers to accessing sexual and reproductive health services varied by type, with gender differences revealing nuanced challenges across demographics and communities, like boys facing religious prohibition for HIV testing and girls fearing social stigma for contraception	90

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
35	Tiruneh, F.N. et al. 2017 [58]	**Ethiopia**	**Quantitative study cross sectional**	Data from the 2005 and 2011 Ethiopia Demographic and Health Surveys	To assess whether women's autonomy, measured at both individual and community levels, is associated with maternal healthcare service utilization	Modest improvements in maternal healthcare utilization from 2005 to 2011, alongside positive shifts in attitudes like domestic violence, reflect changing demographic and socioeconomic characteristics, necessitating targeted interventions to address persistent disparities	70
36	Sougou, N.M. et al. 2020 [59]	**Senegal**	**Propensity score matching (PSM) is a quasi-experimental method**	Women aged 15–49	To analyze the effect of women's autonomy over decision-making regarding their health and access to family planning in Senegal in 2017	Only 6.26% of women had health-related decision-making autonomy, mostly relying on partners, yet autonomy correlated with a notable 1414.42% reduction in unmet family planning needs, despite no apparent change in modern contraceptive use, indicating a positive impact on family planning outcomes	60
37	Rizkianti, A. et al. 2020 [60]	**Indonesia**	**Quantitative study cross sectional**	Women of reproductive age (15–49 years) who had given birth within one year preceding the survey	To examine the influence of Indonesian women's decision-making within the household regarding the use of maternal health services	The Women's Participation Index correlated with higher antenatal care service utilization but didn't significantly affect skilled birth attendance or facility-based delivery, suggesting other factors. Older age, higher education, and wealth were associated with increased maternal healthcare service usage	80

Table 1 (continued)

N	Author/year	Country	Study Design and data collection method	study population/ participants	Study objectives	Outcomes of interest to the review	Quality assessment score(%)
38	Tesfa, D. et al. 2022 [61]	**Ethiopia**	**Quantitative study cross sectional**	currently married women aged (15–49 years)who are not pregnant and are currently not using family planning preceding five years the survey	To analyze women's independent decision-making power and determinants of not using contraceptives	Individual and community-level factors influence women's independent contraceptive decision-making, underscoring the need for policies empowering women at both individual and regional levels to enhance their autonomy in reproductive choices	100

Quality assessment

The quality of the 38 studies included studies was assessed using the Mixed Methods Appraisal Tool (MMAT), version 2018. The MMAT was chosen because it is specifically designed to appraise the methodological quality of qualitative, quantitative, and mixed-methods studies, making it highly suitable for evaluating the diverse study designs included in this review. For qualitative studies, we used the qualitative criteria to assess methodological coherence, data collection, analysis, and interpretation. For quantitative studies, we applied the relevant quantitative criteria to evaluate study design, sampling, measurement validity, and statistical analysis. For mixed-methods studies, we used the mixed-methods criteria to assess the integration and interpretation of qualitative and quantitative findings [29].

For the assessment, we adopted a descriptor-based scoring system as outlined in the MMAT guidelines, with scores ranging from 1 to 5 (corresponding to 20% to 100% of the criteria met). This scoring approach provided a precise and quantifiable measure of each study's methodological quality, ensuring a standardized, consistent, and transparent evaluation of methodological rigor across all included studies [30].

Data synthesis

Data from the included studies were synthesized using a narrative synthesis approach, which is particularly effective given the diversity of findings and the complex influence of societal gender norms on women's sexual and reproductive health. This approach involved developing a preliminary synthesis by organizing and summarizing findings, exploring relationships within and across studies to identify key patterns, and assessing the robustness of the synthesis through critical examination of consistency and validity. The process was collaborative and iterative, involving all review team members to ensure a rigorous and nuanced understanding of the data. By presenting the findings in a narrative format, we were able to provide a coherent and contextualized account of how gender norms influence women's SRH outcomes, highlighting inter-study relationships and key themes [31].

Ethical considerations

As this systematic review relies on published data, ethical approval is not required. However, proper handling of data was ensured throughout the review process.

Results

Study characteristics

Geographic spread

The reviewed studies encompass 38 separate research projects spread across diverse geographical regions, including Asia (Iran, Pakistan, Siri Lanka, Indonesia), Africa (Mozambique, Ethiopia, Tanzania, Uganda, Morocco, Zimbabwe, Rwanda, Kenya, South Africa, Mali, Malawi, Burkina Faso, Ghana, Senegal), North America (USA, Canada), Oceania (Australia), and a study that include 23 European countries (Belgium, Denmark, England, Estonia, Finland, France, Germany, among others). The diversity in locations underscores the universal relevance of gender norms and their impact on women's health, reflecting varied cultural, economic, and societal contexts (Table 2).

Methodological approaches

Methodologies varied across the studies, incorporating both qualitative and quantitative approaches to provide a rich, multi-dimensional understanding of the dynamics at play. Qualitative methods (e.g., in-depth interviews, focus groups) were employed in highlighting personal experiences and societal norms. The remaining studies used quantitative methods (e.g., surveys, cross-sectional analyses), which contributed robust statistical data to support broader trends observed in the qualitative research. This methodological diversity ensures a comprehensive analysis of the interplay between gender norms and health outcomes. [Table 1].

Study populations and objectives

Participants in these studies included adolescent girls, married women, sexual minorities (gender expansive women), and community members. Such variety allows the findings to be applicable to a broad spectrum of the female population and provides insights into the specific impacts of gender norms across different subgroups.

The primary objectives of these studies focused on a range of issues from exploring barriers to healthcare access to assessing the effects of community decision power on health behaviors. Common outcomes of interest included access to healthcare services, usage of contraception, and maternal health metrics. [Table 1].

Data synthesis

The results from analysis reveals several key themes and patterns related to sexual and reproductive health (SRH), gender dynamics, and healthcare access across various cultural contexts. The synthesis were centered on:

Table 2 Summary of included studies by country, income level, and region

Country/Region	Number of Studies	Income Level*	World Region
Africa			
Tanzania	5	LMIC	Africa
Ethiopia	4	LIC	Africa
Uganda	3	LIC	Africa
Morocco	2	LMIC	Africa
Rwanda	2	LIC	Africa
Kenya	2	LMIC	Africa
South Africa	2	UMIC	Africa
Mozambique	1	LIC	Africa
Zimbabwe	1	LMIC	Africa
Mali	1	LIC	Africa
Burkina Faso	1	LIC	Africa
Ghana	1	LMIC	Africa
Senegal	1	LMIC	Africa
Asia and Middle East			
Iran	3	UMIC	Middle East
Pakistan	1	LMIC	Asia
Sri Lanka	1	LMIC	Asia
Indonesia	1	UMIC	Asia
America			
United States of America	3	HIC	North America
Canada	1	HIC	North America
Oceania			
Australia	1	HIC	Oceania
Europe			
A study that include 23 European countries (Iceland, Sweden, Finland, Norway, Belgium, Denmark, England and wales, Estonia, France, Germany, Poland, Lithuania, Netherland, Scotland, Slovakia, Luxemburg, Czech Republic, Switzerland, Italy, Slovenia, Portugal, Spain, Hungary)	1	HIC	Europe
Total	38		

* LIC: Low-Income-Countries

** LMIC: Lower-Middle-Income-Countries

*** UMIC: Upper-Middle-Income-Countries

**** HIC: High-Income-Countries

➢ Lack of Comprehensive Sexual Education and Reproductive Health Information:

✓ There is a widespread lack of comprehensive sexual education across regions. This educational gap leads to misinformation and negative health outcomes, such as unplanned pregnancies and sexually transmitted infections [21, 32].

✓ In Iran, cultural norms and taboos significantly hinder discussions on sexual health, critically limiting adolescent access to necessary information and services, as it is stated in Janighorban et al. study "Our parents think their children are going astray. They're not taught or guided about sexuality. This causes them to be unaware of the dangers" (participant No.37) [41].

➢ Social Stigma and Barriers to Accessing SRH Services

✓ Women face significant social stigma and barriers when accessing sexual and reproductive health services. Societal attitudes, cultural norms, and healthcare provider biases contribute to the marginalization of certain populations, hindering their ability to seek and receive necessary care [33, 50]. In context like Morocco, study participants reported a social stigma especially for unmarried girl in accessing SRH services [27].

✓ In Iran and Mozambique, societal attitudes towards adolescent sexuality and reproductive health contribute to stigma and discrimination, particularly for unmarried individuals seeking contraceptive services or abortion care. This stigma may deter adolescents from seeking care or accessing accurate information about their sexual and reproductive health [21, 22].

➢ **Influence of Cultural Norms on Family Planning**:

✓ Cultural norms and values play a significant role in shaping family planning decisions. In communities where larger family sizes are desired, contraceptive usage may be lower due to cultural preferences for larger families and societal expectations surrounding fertility [53].

✓ The influence of male and familial control over women's contraceptive choices, as observed in Mozambique and Ethiopia, underscores the importance of addressing gender dynamics and promoting women's autonomy in reproductive decision-making [22, 28].

✓ Interventions aimed at promoting family planning should take into account cultural beliefs and norms surrounding fertility, contraception, and reproductive decision-making, while also addressing barriers to accessing contraceptive services and information [40].

➢ **Impact of Gender Dynamics on Maternal Healthcare:**

✓ Gender dynamics, including power imbalances and social norms, significantly affect maternal healthcare access and utilization [24, 36].

✓ In Eastern Uganda, these dynamics manifest through limited decision-making autonomy and restricted mobility for women, negatively influencing their healthcare access [24].

➢ **Women's autonomy and reproductive decision-making:**

✓ Autonomy is a key factor in improving reproductive health decisions. Studies show that educated and economically independent women are more likely to make informed reproductive choices. As demonstrated in Rizkianti et al. where women with more autonomy experienced 1.7 (95% confidence interval: 1.17–2.45) times higher odds of using adequate antenatal care services [26, 38, 47, 61].

✓ Enhancing women's agency involves addressing educational and economic barriers, as well as challenging gender norms that limit autonomy [26, 28, 37].

➢ **Cultural and Religious Influences on Health Perceptions:**

✓ Cultural and religious beliefs significantly shape attitudes and behaviors toward reproductive health, often leading to stigma and misinformation. Kingori et al. highlight how these norms critically influence community attitudes, substantially impacting access to sexual health knowledge through the mechanisms of stigma and fear of judgment [32, 34, 35, 49]

➢ **Need for Culturally Competent Healthcare Services:**

✓ The importance of culturally competent healthcare services cannot be overstated. Such services respect and recognize diverse cultural backgrounds and beliefs, facilitating better health outcomes. Healthcare providers must be trained to understand and address cultural, social, and religious factors that influence health behaviors and outcomes [49].

✓ Culturally competent care includes fostering open, nonjudgmental communication, addressing stigma and discrimination effectively, and tailoring healthcare services to meet the unique needs of diverse populations. Additionally, community-centered mental health resources are crucial for mitigating the psychosocial impacts of cultural stigma and discrimination [42, 57].

Quality assessment of included studies

The average quality assessment score across all studies was approximately 98.42%, indicating a generally high standard of research quality.

Discussion

Our systematic review highlights the complex interplay between gender norms and women's sexual and reproductive health (SRH) across diverse cultural contexts. The findings reveal consistent patterns, including a widespread lack of comprehensive sexual education, persistent stigma—especially affecting adolescents and unmarried women—and limited autonomy in reproductive decision-making due to entrenched gender power imbalances. Cultural and religious beliefs strongly shape perceptions of family planning and maternal care, while provider bias and systemic barriers further hinder access to SRH services.

This pattern is underscored by studies such as those by Janighorban et al. (2022) in Iran and Boaventura Manuel Cau [22] in Mozambique, which reveals the pervasive influence of societal attitudes and educational gaps on women's health [21, 22]. Our review extends these findings, emphasizing that such influences transcend cultural and geographical boundaries, as seen in the narratives from vulnerable adolescents in Iran, which reflect a global issue where restrictive gender norms significantly

contribute to barriers in sexual education and early uninformed pregnancies [23, 55].

Women's agency and education, as discussed by Drioui C. (2021) in Morocco, are pivotal in reshaping fertility preferences and improving intra-couple communication [26]. This review correlates with broader research indicating that autonomy is directly linked to improved reproductive health outcomes, as similarly highlighted in studies across various settings, including those by Mardi A. (2018) and Rosemary Morgan (2017), who suggest that community-level women's agency is crucial for enhancing maternal health care outcomes [23, 24]. Additionally, the concept of empowerment is central to understanding how gender norms influence women's SRH outcomes. Empowerment, agency, education, and system transformation are deeply interconnected, with each factor reinforcing the others. For example, education can enhance women's agency by providing them with the knowledge and skills to make informed decisions about their SRH, while system transformation can create an enabling environment that supports women's empowerment and agency [62].

Additionally, the findings emphasize the need for culturally sensitive healthcare provision to address the stigmatization and barriers women face in accessing sexual and reproductive health (SRH) services, a critical issue highlighted by Ouahid H (2023). The dominance of men in fertility decisions, as noted by Rizvi N. (2014) in Pakistan, and similar gender dynamics discussed in studies by Kazaura M. (2015) in Tanzania and Farmer (2015) in Rwanda, underscore the multifaceted nature of interventions required to tackle these issues effectively [25, 27, 33, 39].

This review supports the urgent call for educational and community-based interventions that challenge entrenched social norms and support equitable reproductive healthcare, particularly in regions like Sub-Saharan Africa and Rwanda, as explored by Sia D. et al. [47] and other similar studies [47]. The collective evidence underlines that while some progress has been made, significant efforts remain necessary. Targeted interventions that consider both practical and sociocultural factors are essential for advancing women's health outcomes.

The critical discourse on how gender norms shape and often impede women's access to SRH services informs our discussion on the potential for policy interventions, community education, and individual autonomy to transform the SRH landscape, making services more accessible and equitable across various cultural contexts [36]. However, the included studies largely focused on individual-level factors, with limited attention to systemic barriers and opportunities. Future research should explore how interventions targeting empowerment, agency, education, and system transformation can collectively improve women's SRH outcomes, particularly in low-resource settings.

While our review focused on the influence of gender norms on women's SRH outcomes, the underrepresentation of sexual and gender minorities (SGM) in the included studies limits our ability to draw conclusions about their experiences. SGM may face unique challenges and barriers to accessing SRH services, which could be exacerbated by restrictive gender norms. Future research should prioritize the inclusion of SGM to better understand these dynamics and develop targeted interventions.

Furthermore, considering the geographic diversity of the selected studies, our review reveals clear contextual differences in how gender norms influence sexual and reproductive health (SRH) outcomes across regions. Findings from the 38 studies reveal a notable distinction between low-, middle-, and high-income countries. In low- and middle-income countries (LMICs)—such as Tanzania, Morocco, and Pakistan—gender norms are often deeply rooted in traditional and patriarchal structures, restricting women's autonomy in SRH decision-making. This contributes to limited access to contraception, higher rates of early marriage, and ongoing stigma surrounding abortion and maternal care. In upper-middle-income countries (UMICs), such as Iran and Indonesia, religious and cultural values further constrain discussions around sexuality, particularly for adolescent girls. In contrast, studies from high-income countries (HICs)—including the United States, Canada, and several European nations—highlight more subtle yet persistent barriers, such as provider bias, cultural stigma, and socioeconomic disparities, especially impacting migrant and minority populations.

These findings underscore the need to tailor health interventions to specific cultural, economic, and social contexts. Mainstreaming gender into health strategies requires a nuanced understanding of each region's societal fabric and a commitment to context-specific policies and programs grounded in the lived realities of women worldwide.

Limitations

This systematic review has several limitations. It includes only English and French studies, which may introduce language bias. There is also a risk of publication bias, as studies with positive findings are more likely to be published. The exclusion of grey literature, such as reports and dissertations, may have limited additional insights. Access restrictions to paywalled full-text articles further constrained study selection. Lastly, the review protocol was not registered before commencement; however, we have ensured

transparency by thoroughly documenting our methodology, including the search strategy, inclusion/exclusion criteria, and data extraction process.

Conclusion

Our systematic review highlights the profound impact of cultural contexts and gender norms on womens sexual and reproductive health (SRH) outcomes. Key findings reveal a widespread lack of comprehensive sexual education, significant social stigma, and barriers to accessing SRH services, particularly for marginalized groups such as unmarried women and adolescents. Studies from Iran, Morocco, and Mozambique illustrate how cultural taboos and healthcare provider biases restrict access to essential SRH information and services, leading to misinformation and negative health outcomes. Additionally, gender dynamics and limited decision-making power significantly hinder maternal healthcare access, as seen in Eastern Uganda and Ethiopia.

The review also underscores the critical role of culturally competent healthcare services, as cultural and religious beliefs often shape health behaviors, contributing to stigma and misinformation. To address these challenges, we recommend targeted interventions such as early, culturally sensitive SRH education, stigma reduction programs, and healthcare provider training to ensure equitable and respectful care. Collaborative efforts involving governments, healthcare providers, and communities are essential to dismantle these barriers.

Future research should focus on evaluating the effectiveness of systemic interventions, such as policy changes and community-based programs, to further inform evidence-based strategies for improving womens SRH outcomes.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12905-025-03768-2.

Supplementary Material 1

Authors'contributions

H.O conceptualized and designed the review topic, developed the search strategy, collected data, performed the analysis, and wrote the original draft of the manuscript. L.A conception, methodology, analysis, review and editing the manuscript. M.S, M.C and M.A review of the manuscript, supervision.
All the authors approved the final version of the manuscript.

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Data availability

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

As this systematic review relies on published data, ethical approval is not required.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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