2026

SRHR IN NEPAL

A Feminist Analysis of Lived Realities

WOREC

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Published Date:
2026

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We also extend our sincere appreciation to the Local government, WLOs, community members, local representatives, and district-level stakeholders for their valuable support and contributions.

Designed by:

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Acknowledgement

Women’s Rehabilitation Center (WOREC) sincerely acknowledge all the women and girls who generously shared their experiences, perspectives, and voices through the Sayapatri Kurakani. Their trust, courage, and willingness to engage in open dialogue made this study possible and form the foundation of this paper.

We are especially grateful to Ms. Renu Adhikari and team for initiating the Sayapatri Kurakani concept and analysis process.

We sincerely appreciate the dedication and hard work of the district teams in Udayapur, Kavre, Kailali, Dang, Morang, Sarlahi, Mahottari, and Siraha, whose efforts in facilitating the Sayapatri Kurakani sessions and supporting data collection were essential to the successful completion of this study.

Our special thanks go to Ms. Sunita Mainali, Executive Director of WOREC, for her visionary leadership and unwavering commitment to promoting feminist research, women's rights, and community-based approaches to health and empowerment. Her support has been instrumental in enabling this study.

We also acknowledge the counselors, facilitators, health workers, and all WOREC staff members who contributed their time, expertise, and commitment to the implementation of the integrated women's health camps and the Sayapatri Kurakani process. Their dedication ensured that women's voices were documented with dignity, care, and respect.

Finally, we express our sincere gratitude to everyone who contributed, directly or indirectly, to the completion of this paper. We hope that the findings will contribute to strengthening evidence-based, feminist, and rights-based approaches to advancing sexual and reproductive health and rights in Nepal.

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Women's Sexual and Reproductive Health and Rights in Nepal: A Feminist Analysis of Lived Realities

Abstract

This paper presents a feminist analysis of women's sexual and reproductive health and rights (SRHR) in Nepal, drawing on participatory evidence from *Sayapatri Kurakani* and integrated women's health camps implemented by the Women's Rehabilitation Center (WOREC) between 2023 and 2025. Based on responses from 1,182 women across eight districts of Nepal, the study examines how structural inequalities shape reproductive health outcomes beyond biomedical indicators.

Grounded in feminist epistemology and participatory knowledge production, the paper challenges conventional SRHR approaches that prioritize service delivery and quantitative outcomes while overlooking lived realities. Instead, it foregrounds women's narratives to explore how patriarchy, caste and class hierarchies, economic dependency, and limited access to education intersect to shape bodily autonomy and reproductive decision-making.

Findings reveal persistent menstrual stigma, early marriage and pregnancy, disproportionate female responsibility in family planning, high prevalence of home births, and significant reproductive morbidity. While national indicators suggest improvements in SRHR services, the analysis highlights deep inequities between policy-level progress and grassroots realities, particularly among rural and marginalized women. These conditions reflect not individual behavioral deficits but structural constraints embedded in social norms, household power relations, and weak health system responsiveness.

The study argues that women's bodies remain sites of social regulation, where reproduction, sexuality, and mobility are governed by patriarchal norms and institutional neglect. By centering participatory dialogue through *Sayapatri Kurakani*, the research demonstrates the value of feminist methodologies in capturing stigma, coercion, and emotional dimensions of SRHR that are often absent in conventional surveys.

The paper concludes that meaningful advancement of SRHR in Nepal requires structural transformation that goes beyond service provision to address gender inequality, redistribute decision-making power, and strengthen women's economic and social autonomy. SRHR is thus positioned not only as a health issue but as a question of justice, dignity, and bodily sovereignty.

Introduction

Established in 1991, Women's Rehabilitation Center (WOREC) is a national, movement-based organization committed to advancing women's human rights and social justice through a feminist lens. With a vision of a society where feminist aspirations are realized, WOREC works to dismantle structural discrimination by centering bodily integrity, decent work, and identity. Through its initiative *Sayapatri Kurakani*, WOREC has created a vital safe space for psychosocial support and open conversation on sexual and reproductive health, grounding its work in the lived realities of women, it serves as a community-based platform for interactive discussions on health, rights, social issues, and empowerment.

Sayapatri reflects WOREC's ongoing commitment to challenging harmful traditional practices, promoting gender equality, and improving women's overall health and well-being through community-centered awareness.

In practice, *Sayapatri Kurakani* involves:

- Group discussions among women at the community level
- Sharing experiences related to health, gender-based violence, and social issues
- Raising awareness about rights, health practices, and harmful traditions
- Encouraging collective thinking and local solutions

Overall, *Sayapatri Kurakani* represents a participatory and empowering process that strengthens women's voices, builds solidarity, and supports social transformation from the grassroots level. Sayapatri Kurakani is a participatory, bilateral communication platform between a counselor and a woman or girl from the community that aims to amplify women's voices and create a safe space for discussing sensitive sexual and reproductive health and rights (SRHR) issues. Unlike conventional survey methods, which often position women as passive respondents, this approach captures lived experiences shaped by cultural norms, gender relations, and power structures. It therefore allows for a more nuanced understanding of women's health that goes beyond numerical representation.

From a feminist methodological perspective, Sayapatri Kurakani challenges extractive research traditions that treat women as data sources rather than knowledge producers. Instead, it recognizes women as active agents who interpret, reflect on, and articulate their own experiences. This shift is important because quantitative-only approaches often reduce complex realities such as menstruation, reproductive health, and bodily autonomy to measurable indicators, without capturing the social meanings attached to them.

In contrast, Sayapatri Kurakani enables the exploration of how social norms, stigma, and power relations influence women's health decisions and experiences. For example, issues such as menstrual restriction, early pregnancy, and limited healthcare access are not only statistical trends but also deeply embedded lived realities shaped by patriarchy and social expectations. By creating a dialogical space, this method allows women to express concerns that may not emerge in structured questionnaires due to shame, fear, or normalization of inequality.

The approach is also aligned with feminist participatory research principles, which emphasize empowerment, reflexivity, and co-production of knowledge. As highlighted by Paulo Freire, meaningful knowledge production occurs through dialogue rather than one-way extraction. Similarly, feminist researchers argue that participatory methods help redistribute power in research processes by validating women's voices and experiences.

Therefore, while quantitative data provides important patterns and trends, it often frames women as passive respondents within predefined categories. Sayapatri Kurakani complements this by foregrounding agency, lived experience, and context, making it a more holistic and ethically grounded approach to understanding women's sexual and reproductive health.

Overall, this method not only enriches data quality but also contributes to awareness-raising and empowerment at the community level by enabling women to articulate their own realities and challenge existing gendered norms.

This paper presents analysis of women's sexual and reproductive health and rights (SRHR) in Nepal using data from the Sayapatri Kurakani implemented by WOREC. Based on responses from 1,182 women from integrated women's health camp (2023-2025) across 8 districts of Nepal (Udayapur, Kavre, Kailali, Dang, Morang, Sarlahi, Mahottari, and Siraha) the study foregrounds lived experiences and applies a feminist lens to examine how patriarchy, socio-economic inequality, and institutional structures shape women's bodily autonomy and reproductive decision-making. By situating quantitative trends alongside participatory narratives, the paper aims to move beyond biomedical indicators and highlight SRHR as a deeply social and political issue embedded in power relations, gender norms, and structural inequalities.[1]

Literature Review

Sexual and reproductive health and rights (SRHR) are widely recognized within global public health and feminist scholarship as fundamental human rights and essential components of gender equality. The World Health Organization (WHO, 2021) defines SRHR not only as access to health

WOREC Nepal organizes integrated women's health camps as a central component of their community health program, aimed at providing accessible reproductive and general health services to marginalized women in rural Nepal. These camps follow a rights-based approach, combining medical care with counseling on Violence Against Women (VAW) and reproductive health rights.

services but as the realization of bodily autonomy, informed choice, and freedom from coercion and discrimination. Feminist scholars argue that reproductive health outcomes cannot be understood in isolation from structural inequalities. Sen (1999) conceptualizes development as freedom, emphasizing that health and reproductive choices are shaped by broader capabilities such as education, economic security, and social agency. Similarly, Kabeer (1999) highlights that empowerment is grounded in women's ability to make strategic life choices within constraining social structures. In the context of Nepal, SRHR outcomes are shaped by intersecting systems of patriarchy, caste hierarchy, poverty, and geographic marginalization. These structural conditions determine not only access to services but also the extent of autonomy women have over their bodies and reproductive decisions.

Research in Nepal consistently shows increasing contraceptive prevalence alongside persistent unmet need and inequities in access and choice. The Guttmacher Institute and Sundaram et al. (2019) note that nearly half of women who wish to avoid pregnancy are not using modern contraception, reflecting gaps in access, information, and agency. Studies also highlight that contraceptive use is often shaped by provider bias, limited method choice, and male-dominated decision-making within households (Rogers et al., 2019). While national policies promote family planning, implementation often fails to address the social conditions that restrict women's independent decision-making. Importantly, feminist critiques argue that focusing solely on contraceptive uptake without addressing autonomy risks reinforcing medicalized control over women's bodies rather than expanding their freedom of choice.

Adolescent pregnancy remains a significant public health and social concern in Nepal. WHO (2018) identifies early marriage and early childbearing as key drivers of maternal and neonatal health risks. However, feminist analyses emphasize that adolescent pregnancy is not merely a behavioral issue but a structural outcome of poverty, gender norms, and limited educational opportunities. Subedi et al. (2018) highlight that adolescents in rural and marginalized communities face limited access to sexual health information and services. Early marriage is often socially normalized and economically driven, particularly in agrarian and low-income households. From an intersectional feminist perspective (Crenshaw, 1989), early pregnancy must be understood as a product of overlapping inequalities that include gender, class, caste, and geography.

A growing body of literature highlights menstrual health as a key yet often neglected dimension of SRHR. In South Asia, menstruation is frequently governed by cultural taboos that regulate women's mobility, diet, and participation in daily life. WHO (2021) and feminist public health scholars argue that menstrual stigma functions as a mechanism of social control over women's bodies. Practices such as isolation during menstruation, dietary restrictions, and exclusion from religious or household spaces reflect deeply embedded notions of purity and impurity. In Nepal, studies show that menstrual stigma persists despite policy-level improvements in menstrual

hygiene awareness. This gap between knowledge and practice illustrates the strength of entrenched patriarchal norms that continue to shape bodily autonomy.

While Nepal has made significant progress in increasing institutional delivery rates, disparities remain between urban and rural populations. NDHS data shows national improvements; however, rural women continue to rely heavily on home births due to geographic, financial, and cultural barriers (MoHP et al., 2023). WHO (2019) emphasizes that maternal mortality and morbidity are strongly linked to health system responsiveness, including respectful care, accessibility, and quality of services. In Nepal, studies reveal persistent issues such as disrespectful maternity care, lack of privacy, and inadequate referral systems, which discourage institutional delivery even when services are available (Rogers et al., 2019). Feminist health scholarship argues that maternal health must be understood not only as a clinical issue but also as a matter of dignity, rights, and institutional accountability.

Feminist political economy approaches emphasize that women's health outcomes are deeply embedded in economic and social structures. Women's disproportionate involvement in unpaid domestic and agricultural labor limits their financial independence and reinforces dependency within patriarchal households. Marmot (2005) identifies social determinants of health as key drivers of inequality, including income, education, and power relations. In Nepal, women's limited access to paid employment and education constrains their ability to make autonomous health decisions, including those related to contraception, childbirth, and healthcare utilization. Moreover, male-dominated household decision-making structures continue to shape reproductive choices, reinforcing gendered hierarchies in both private and public spheres.

Traditional SRHR research often relies on quantitative surveys that capture measurable indicators but fail to reflect lived experiences. Feminist scholars such as Haraway (1988) critique this "view from nowhere" and argue for situated knowledge that recognizes the role of context, power, and subjectivity in knowledge production. Participatory approaches, such as those advocated by Cornwall and Jewkes (1995), emphasize dialogue, co-production of knowledge, and empowerment. These methods allow for the inclusion of experiences such as stigma, coercion, and emotional distress that are often excluded from structured surveys.

In this context, Sayapatri Kurakani represents a feminist participatory intervention that contributes to both knowledge generation and empowerment by centering women's voices and lived realities.

Legal and Policy Framework on Women's SRHR in Nepal

SRHR in Nepal is supported by a robust legal and policy framework aligned with international human rights standards, including commitments under CEDAW, ICESCR, and the ICPD Program of Action. The Constitution of Nepal (2015) and the Safe Motherhood and Reproductive Health Rights Act (2018) explicitly guarantee women's reproductive rights and access to healthcare

services. However, the findings of this study reveal a persistent gap between formal legal provisions and lived realities. Despite progressive policies, women's reproductive autonomy remains constrained by entrenched patriarchal norms, economic dependency, and limited access to education and healthcare. This disjuncture highlights that SRHR is not merely a matter of legal recognition or service provision but is deeply embedded within social power relations. A feminist analysis therefore underscores the need to move beyond policy compliance toward structural transformation that addresses gender inequality, redistributes decision-making power, and ensures substantive realization of rights.

Objective:

General Objective

To explore the structural and gendered dimensions of women's sexual and reproductive health and rights in Nepal using participatory feminist methodologies.

Specific Objectives

- To assess the socio-demographic and economic conditions shaping women's SRHR outcomes.
- To examine the influence of patriarchal norms on bodily autonomy, and reproductive decision-making.
- To analyze women's access to maternal healthcare and family planning services.
- To investigate how economic dependency and gendered labor affect reproductive autonomy.
- To document lived experiences of stigma, coercion, and reproductive health challenges through Sayapatri Kurakani.
- To explore the gap between SRHR policies and grassroots realities in Nepal.

Methodological Approach: Feminist Knowledge Production

The study employs a mixed qualitative-quantitative design, combining descriptive statistical analysis with feminist participatory methods. While quantitative data provides trends and distribution patterns, qualitative narratives generated through Sayapatri Kurakani enable deeper interpretation of lived experiences. This integrated approach strengthens the validity of findings by situating numerical data within social and cultural contexts.

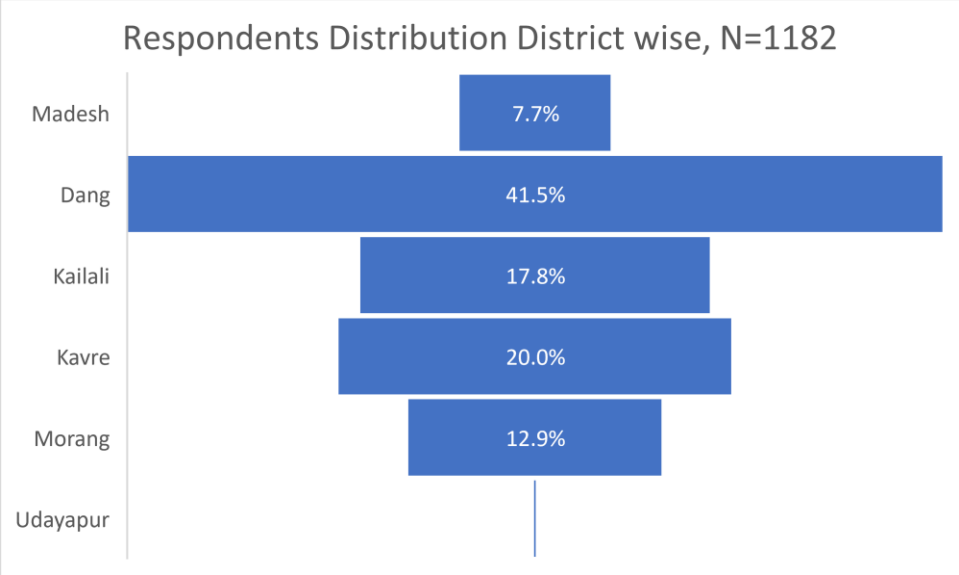
Sayapatri Kurakani represents a feminist methodological approach grounded in participation, dialogue, and lived experience. Unlike conventional surveys, it positions women as active agents in knowledge production rather than passive respondents.

This aligns with feminist epistemologies that critique extractive research practices and emphasize situated knowledge (Haraway, 1988). By creating safe spaces for sharing experiences, the approach captures dimensions of SRHR such as stigma, coercion, and emotional distress that are often absent in quantitative datasets like NDHS.

Sayapatri Kurakani: Results and Analysis

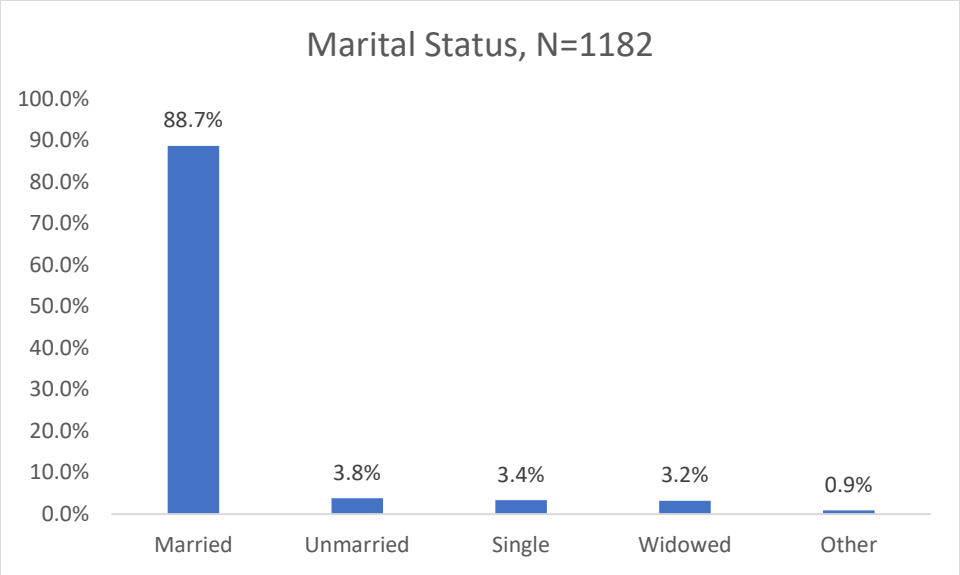
Socio-Demographic Profile and Structural Inequality

Figure 1. Distribution of Respondents by District



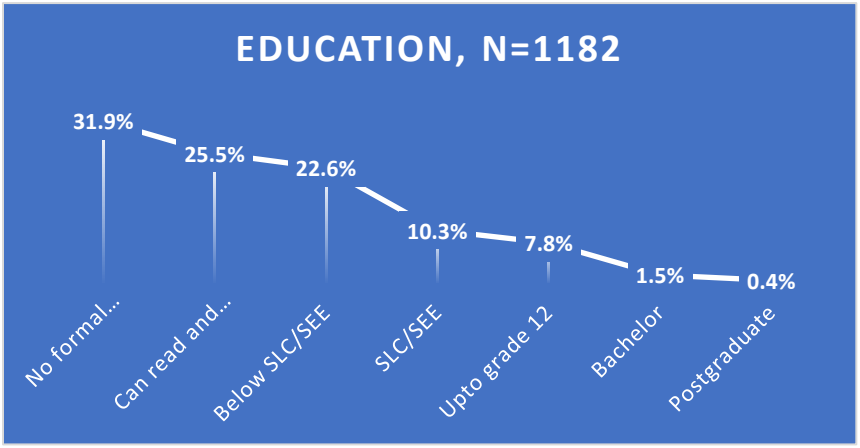
As shown in Figure 1, The respondents are unevenly distributed across districts, with the highest proportion from Dang (41.5%), followed by Kavre (20 %), Kailali (17.8%), and Morang (12.9%). The remaining districts of Madesh 7.7%, Udayapur (0.1%) have minimal representation.

Figure 2 Marital Status of Respondents



As shown in Figure 2, The majority of respondents are married (88.7%), while smaller proportions are unmarried (3.8%), single (3.4%), widowed (3.2%), and others (0.9%). This indicates that most participants are engaged in family life, and their responses are likely influenced by marital responsibilities and household roles.

Figure 3 Educational level of respondents



As shown in Figure 3, The educational level of respondents is generally low. A significant portion (31.9%) has no formal education, while 25.5% have basic literacy skills (can read and write). Additionally, 22.6% have education below SLC/SEE level, and 10.3% have completed SLC/SEE. Only 7.8% have studied up to grade 12, and a very small proportion have higher education (1.5% bachelor's and 0.4% postgraduate). Overall, about 57.4% fall into the low education category, and only 9.7% have higher education, indicating limited access to advanced learning opportunities.

Education and Women's Health-An Interrelated Perspective: This unequal distribution of education has direct implications for women's health. Education and health are deeply interconnected, not only because education increases knowledge but also because it enhances women's capacity to make informed decisions about their bodies. Women with higher levels of education are generally more aware of menstrual hygiene, nutrition, contraception, and the importance of institutional healthcare services. In contrast, limited education often restricts access to such knowledge, contributing to the continuation of harmful practices such as menstrual taboos, poor hygiene management, and delayed healthcare seeking.

From a broader perspective, education also shapes women's autonomy and decision-making power. As argued by Amartya Sen, education expands capabilities; in this study, low educational attainment directly limits women's ability to delay pregnancy and access reproductive health services, demonstrating how capability deprivation translates into health inequality. In the context of women's health, this means that educated women are more likely to exercise choice regarding marriage, timing of pregnancy, and use of healthcare services. Conversely, women with little or no education are more likely to experience early marriage and early pregnancy, as seen in your data, which increases health risks for both mothers and children.

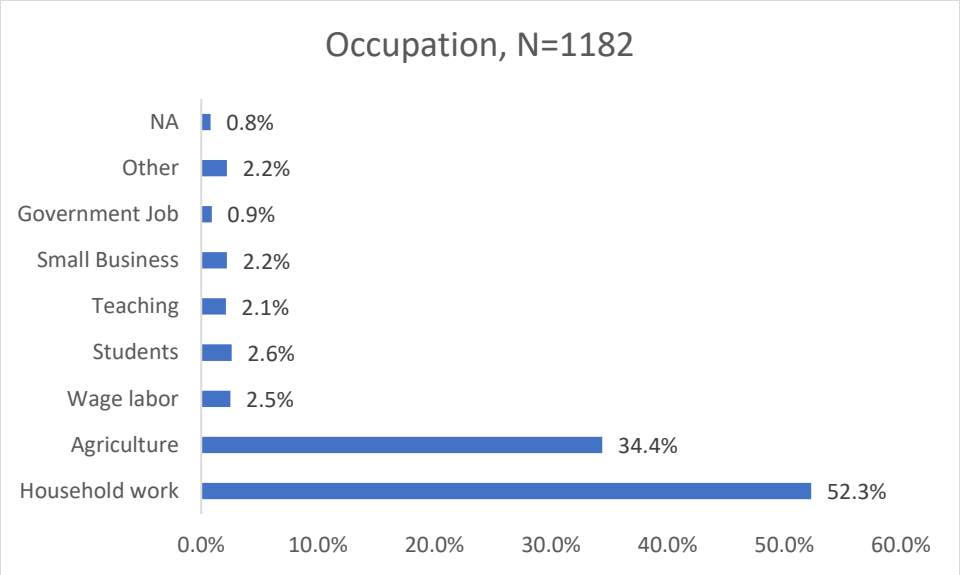
Similarly, Naila Kabeer highlights that education is a critical resource for empowerment, as it strengthens women's agency the ability to define goals and act upon them. Without education, women may have limited bargaining power within households, making it difficult to challenge restrictions such as food taboos during menstruation or to seek institutional delivery care.

At the structural level, the WHO identifies education as a key social determinant of health. Lower educational attainment is strongly associated with poorer health outcomes, reduced access to healthcare services, and higher vulnerability to reproductive health risks. This helps explain why populations with lower education levels often have higher rates of home births, inadequate maternal care, and limited use of reproductive health services.

In contrast, higher education tends to delay early marriage and childbearing, improve economic opportunities, and increase awareness of rights related to sexual and reproductive health. Educated women are more likely to question harmful social norms, seek medical assistance, and assert control over their own bodies.

Overall, the data demonstrates a clear contrast: while low levels of education are associated with restricted knowledge, limited autonomy, and poorer health outcomes, higher education enables women to make informed decisions, access healthcare, and exercise greater control over their reproductive and bodily rights. Therefore, improving women's education is not only an educational goal but also a critical strategy for enhancing women's health and overall well-being.

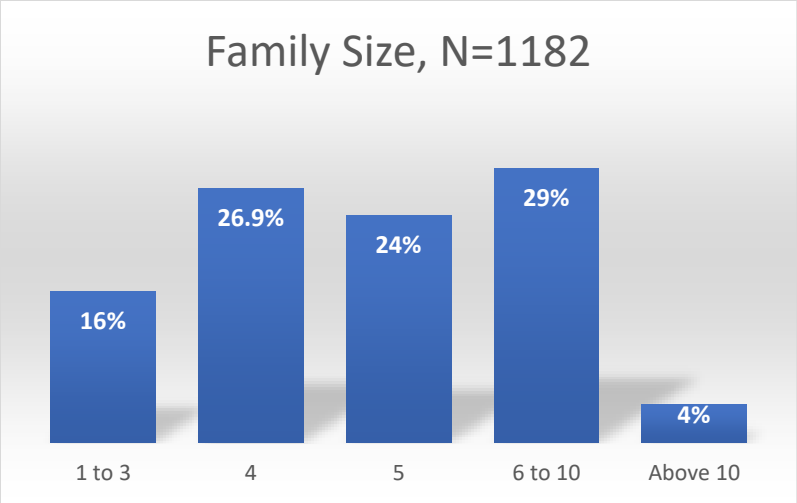
Figure 4 Occupations of respondents



As shown in Figure 4, The occupations of respondents are diverse but concentrated in a few key areas. The largest proportion are engaged in household work or domestic responsibilities (52.3%) and agriculture (34.4%). Other occupations, such as wage labor (2.5%), students (2.6%), teaching (2.1%), small business (2.2%), or government jobs (0.9%), are much less common. A very small number work in sewing, parlor, insurance, or NGO roles (2.2%). Notably, 0.8% reported "N/A" for occupation. This indicates that the majority of respondents are primarily involved in unpaid or low-income domestic and agricultural work, reflecting limited formal employment opportunities.

Whereas, Husband occupations are also diverse but primarily concentrated in agriculture (34.1%), wage labor (13.4%), foreign employment (15.9%), and household work (9.2%). Smaller proportions work in private sector jobs, government roles, teaching, or craftsmanship. About 9% reported "Not Applicable" or situations such as husband disability. This indicates that respondents' families largely rely on agriculture, wage labor, or remittance income, which may affect household financial stability and decision-making capacity. These patterns highlight how women's health issues are deeply intertwined with broader socio-economic and political contexts. Women's health is not only a medical concern but also a political issue, as it is shaped by social norms, gender roles, and unequal access to economic opportunities and resources (e.g., Sen, 1999; Marmot, 2005).

Figure 5 Family size of Respondents



As shown in Figure 5, Family size varies, with 29% of respondents reporting 6-10 members, 26.9% having 4 members, 24% having 5 members, and 16.1% having 1-3 members. A small proportion (4%) reported more than 10 members. This suggests that most families are moderate to large in size, which may influence household responsibilities, economic pressures, and caregiving burdens for women.

The socio-demographic characteristics of the respondents reveal deep structural inequalities, with the majority being married (88.7%), engaged in unpaid household or agricultural labor, and belonging to low-income households with limited education. These intersecting disadvantages illustrate how gender inequality is compounded by poverty, rural location, and restricted access to education. From an intersectional feminist perspective, such conditions systematically constrain women's agency, limit access to health information and services, and reinforce dependency within patriarchal household structures, thereby shaping their overall reproductive health outcomes.

Control Over Women's Bodies, Sexuality, and Bodily Autonomy

Most respondents experienced menarche at age 15 or older (32.7%), followed by 14 years (24.1%), 13 years (22.3%), and 12 years (13.2%). A smaller number experienced menarche at age 9-10 (1.2%) or 11 (4.1%). This indicates a gradual onset of menstruation for the majority, mostly between ages 12-15, which is consistent with general adolescent development patterns.

A substantial proportion of respondents reported experiencing some form of restriction or discrimination during menstruation. The most common form was being required to stay in a separate place or restricted due to cultural taboos (11.0%) and restricted access to nutritious food (11.8%). About 32.3% reported that the question was not applicable to them, possibly because they did not experience or did not face harmful practice and restrictions. Smaller percentages reported combinations of restrictions, such as exclusion from school, lack of rest, or inability to

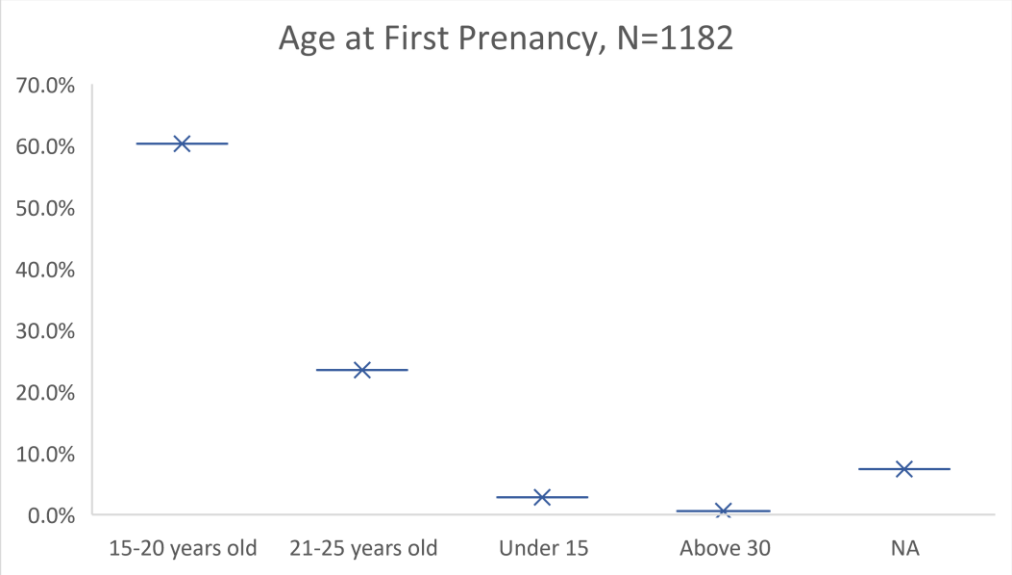
access clean cloths/pads. This shows that menstrual taboos, social stigma, and practical barriers remain significant issues, affecting women's health, comfort, and educational opportunities.

Many respondents reported experiencing discrimination or restrictions during menstruation. About 9.4% hid themselves during their first period, while 11% had to sit separately or stay in a secluded room, reflecting social taboos around menstruation. Other restrictions included being deprived of nutritious food like milk, yogurt, and fruits (11.8%), not being able to rest (2.6%), or lacking clean clothes and sanitary pads (1.5%). Some respondents faced multiple restrictions simultaneously, including school absenteeism, lack of hygiene materials, and dietary limitations. About 32.3% indicated that this question did not apply to them. Overall, menstrual discrimination often combined physical, social, and nutritional restrictions.

Regarding menstrual health issues, 21.3% reported no significant problems. However, a substantial proportion experienced discomfort: 13.8% had severe abdominal pain, 2.7% reported heavy bleeding, and 5.8% had irregular cycles. Other issues included dizziness or weakness (2%) and uncertainty about how to manage menstruation during the first period (1.7%). Many respondents experienced multiple symptoms at once, highlighting that menstrual challenges were often compounded.

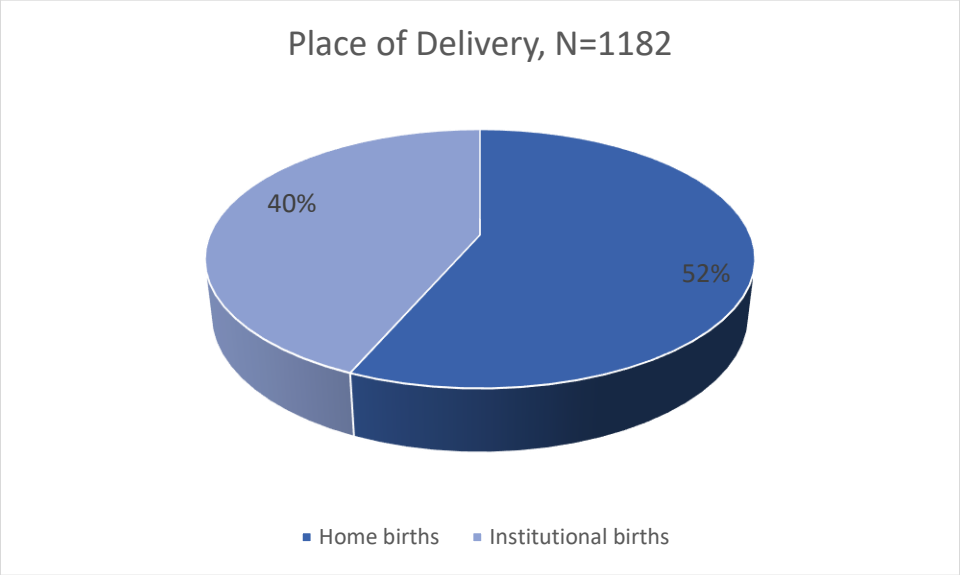
The data demonstrates that women's bodies are subject to both cultural regulation and social control, particularly through menstrual practices and reproductive expectations. Menstrual restrictions, including isolation and deprivation of nutritious food, reflect deeply embedded beliefs that construct women's bodies as impure, thereby legitimizing exclusion and limiting mobility. Simultaneously, the high prevalence of early pregnancy significantly higher than national averages indicates that reproductive roles are socially enforced rather than individually chosen. Together, these practices illustrate how patriarchal systems exert control over women's biological processes, reinforcing gendered norms that restrict autonomy and normalize reproductive obligation.

Figure 6 Age of respondents at first pregnancy



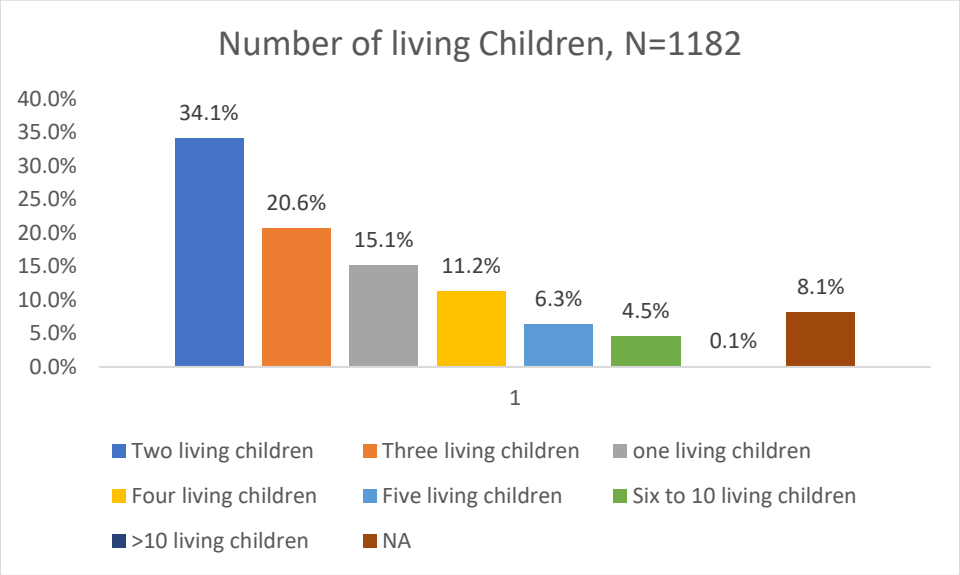
As shown in Figure 6, Most respondents (60.3%) reported their first pregnancy occurred between ages 15–20, while 23.5% were 21–25 years old. A small proportion were under 15 (2.8%) or above 30 (0.6%) at first pregnancy. About 7.4% indicated this question was not applicable. This suggests early pregnancies are common among the surveyed population. Overall, the data illustrates that women's bodies are governed through a continuum of control—from the onset of menstruation to early motherhood. These practices reflect not only cultural beliefs but also systemic denial of sexual rights and bodily autonomy. Addressing these issues therefore requires not only improving health services but also challenging the social norms and power relations that regulate women's sexuality and limit their freedom to make choices about their own bodies.

Figure 7 Place of Delivery



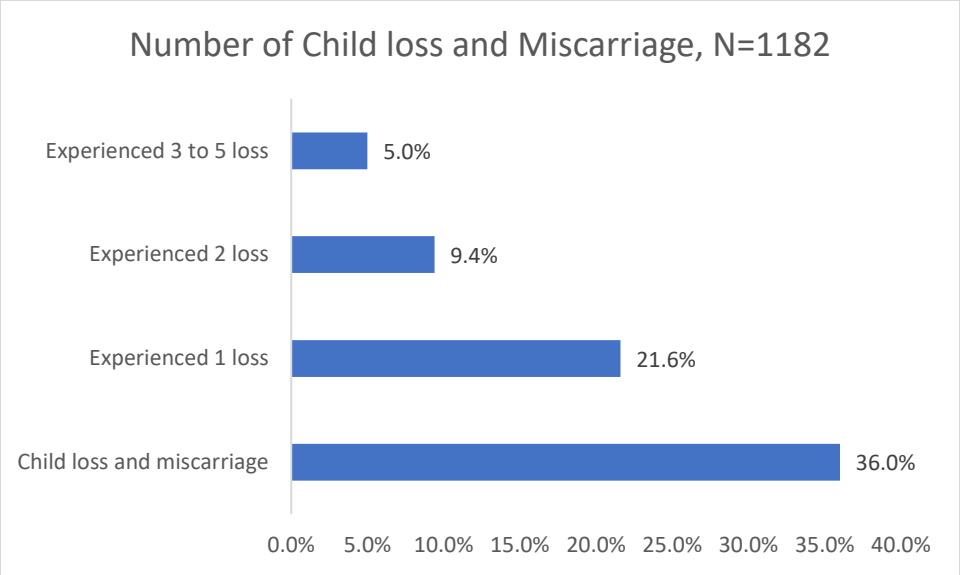
As shown in the figure 7 shows that a majority of births 52% occur at home, while 40% take place in health institutions and 8% N/A. This indicates that more than half of the population still relies on home deliveries, which may reflect cultural preferences, limited access to healthcare facilities, or financial constraints. The relatively lower proportion of institutional births suggests that many women may not be benefiting from skilled medical care during childbirth, which is important for reducing maternal and neonatal risks. Overall, the data highlights a need to improve access to and utilization of healthcare facilities for safer delivery outcomes. Overall, the high rate of home births illustrates how women's health is often negotiated within unequal power structures. It reflects not only gaps in healthcare systems but also deeper societal attitudes that normalize risk in women's reproductive lives. Addressing this issue therefore requires not only improving healthcare access but also challenging the gender norms and power relations that limit women's ability to make autonomous decisions about their bodies.

Figure 8 Number of living children



As shown in Figure 8, Among respondents, 34.1% had two living children, 20.6% had three, and 15.1% had one. Fewer respondents had four (11.2%), five (6.3%), or six to ten children (4.5%). Only 0.1% reported having more than ten children, and 8.1% indicated the question was not applicable.

Figure 9 Child loss or miscarriage of respondents



As shown in Figure 9, Child loss or miscarriage was reported by 36% of respondents. Among them, 21.6% had experienced one loss, 9.4% had two, 2.7% had three, and 2.3% had three to five losses. A majority, 64%, reported this question did not apply to them.

In most households, the wife primarily used family planning methods (53.1%). In 8% of households, the husband used family planning, and 0.6-0.2% reported shared responsibility. About 37.9% indicated that family planning did not apply to them.

Among those using family planning, the most common methods were Depo-Provera injections (23.4%) and permanent sterilization by women (12.9%). Other methods included condoms (5%), pills (5.8%), implants (8.2%), and natural methods (2.8%). About 39.9% reported that this question did not apply.

Table 1: Health Effects of Family Planning Methods

Response Category	**Percentage (%)N=1182**
Reported health effects	39.1%
No health effects	16.5%
Did not respond (N/A)	16.0%
Not using / Unsure	28.4%

As shown in Table 1 data on health effects of family planning methods indicates a diverse range of experiences among respondents. A significant proportion (39.1%) reported experiencing some form of health impact, with commonly mentioned issues including irregular menstruation, heavy bleeding, lower abdominal pain, back pain, nausea, and weight changes. Despite these concerns, many of the reported effects appear to be minor or manageable rather than severe. Meanwhile,

16.5% of respondents stated that they experienced no health effects, suggesting that family planning methods can be well-tolerated for a considerable group. A further 16% did not provide a response, and 28.4% reported either not using any method or being unsure. Overall, the variation in responses highlights differences in individual experiences and perceptions, emphasizing the importance of comprehensive counseling on potential side effects, as well as regular follow-up to support users in managing any health concerns and improving confidence in family planning methods.

The data highlights a broad spectrum of experiences with family planning methods, where although many women report some health effects, these are generally minor or manageable, and a notable proportion experience no adverse effects at all. However, the findings also reveal deeper structural and social challenges that go beyond medical outcomes. Women's bodily autonomy remains constrained, with limited control over their own reproductive health, including decisions about menstruation and contraception. This is further compounded by restricted access to education and information, particularly among adolescent girls, who often lack awareness of their health rights and available services. Male dominance and family pressure play a significant role in decision-making, influencing choices related to family planning, childbirth, and healthcare utilization. Additionally, economic dependency, driven by women's primary involvement in unpaid household or agricultural labor, reduces their financial independence and ability to seek healthcare services. Together, these factors underline the urgent need for comprehensive interventions, including improved counseling on family planning methods, community-based education, gender-sensitive policies, and consistent follow-up care to support women's health and autonomy.

Economic Dependency and Gendered Labor

Women's concentration in unpaid domestic and agricultural labor underscores the gendered division of labor that sustains economic dependency and limits autonomy. Despite their substantial contributions to household and subsistence economies, this work remains undervalued and invisible, reducing women's access to financial resources and decision-making power. From a feminist political economy perspective, such economic structures reinforce patriarchal dominance by tying women's survival and healthcare access to male-controlled resources, thereby constraining their ability to make independent reproductive and health-related decisions.

Health Access and Institutional Barriers

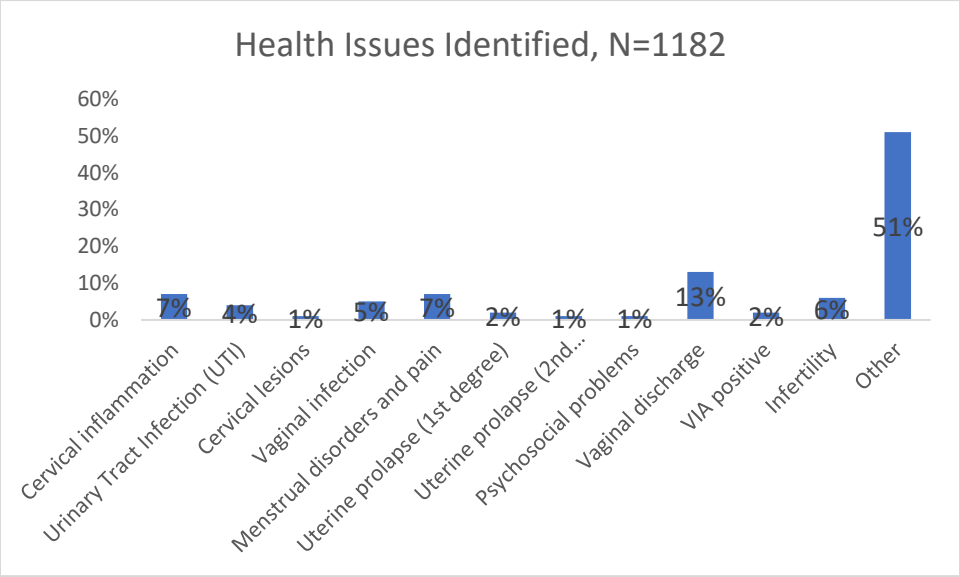
The findings reveal significant disparities in access to maternal healthcare, with institutional delivery rates considerably lower than national averages and a majority of women either not referred or unaware of referral pathways. These gaps point to systemic barriers including geographic inaccessibility, cultural norms favoring home births, and male-dominated decision-making processes. These findings indicate a failure of health systems to adequately respond to

women's needs, particularly in rural areas, where inadequate communication, weak service coordination, and lack of gender-sensitive care contribute to continued marginalization.

Family Planning and Gender Power Dynamics

The disproportionate burden of family planning placed on women highlights entrenched gender norms that assign reproductive responsibility primarily to females, while male participation remains minimal. Although over half of the women reported using contraceptive methods, many experienced adverse side effects, emphasizing the physical toll of this imbalance. At the same time, decision-making around contraception is often influenced by husbands or family members, revealing a contradiction in which women bear the health burden without full autonomy. This dynamic exemplifies how reproductive health systems reproduce patriarchal power relations rather than challenge them.

Figure 10 Health Issues Identified among respondents



The Figure 10 shows that the largest proportion of cases falls under "Other" at 51%, indicating a wide range of conditions like high Blood Pressure, Joint pain, gastritis etc. Among the issues, vaginal discharge is the most common at 13%, suggesting a notable prevalence of reproductive health concerns. Cervical inflammation and uterine prolapse (1st degree) each account for 7%, while infertility represents 6% and vaginal infection 5%. Urinary tract infections (UTIs) make up 4% of the cases. Less common conditions include VIA positive and uterine prolapse (2nd degree) at 2% each, and cervical lesions and psychosocial problems at 1% each. Overall, the data highlights that while specific reproductive health issues are present at varying levels.

Health Burden and Lived Experiences

The prevalence of untreated reproductive health conditions, including infections, menstrual disorders, and high rates of miscarriage or child loss, indicates significant gaps in preventive care and health literacy. These health issues are compounded by delayed care-seeking behavior, often driven by stigma, limited awareness, and financial constraints. This suggests, These findings indicate systemic neglect, where women's health concerns are normalized or deprioritized, leading to cumulative physical and psychological burdens that remain largely invisible within formal healthcare frameworks.

Gender Norms and Social Control

The data highlights how everyday social norms function as mechanisms of control over women's bodies and labor, including restrictions during menstruation, deprivation of nutrition and rest, and heavy domestic workloads. These practices are deeply embedded within patriarchal systems that normalize inequality and shape women's roles and expectations from an early age. Such norms not only limit women's physical well-being but also reinforce internalized subordination, perpetuating cycles of inequality across generations.

Discussion:

The findings collectively demonstrate that SRHR inequalities in Nepal are structurally reproduced through the interaction of social norms, economic dependency, and institutional gaps. Rather than functioning independently, these factors reinforce one another for instance, limited education constrains economic opportunities, which in turn restricts healthcare access and decision-making autonomy. This interconnected system reflects what Kimberlé Crenshaw conceptualizes as intersectionality, where overlapping inequalities produce compounded disadvantage.

A key area of divergence is menstrual health and related social restrictions. While national surveys often emphasize improved menstrual hygiene awareness and practices, the Sayapatri data reveals persistent forms of menstrual discrimination, including social isolation, dietary restrictions, and exclusion from daily activities. These practices reflect the continued normalization of menstrual stigma within household and community structures. Importantly, such restrictions are not merely cultural residues but function as mechanisms of social control over women's bodies, reinforcing gendered notions of purity and impurity (WHO, 2021; WOREC, 2009). The persistence of these practices over time suggests that policy-level progress in SRHR has not adequately translated into shifts in deeply embedded social norms.

Early pregnancy and reproductive timing further highlight structural inequalities. In the study population, a majority of women experienced their first pregnancy between ages 15–20, with a notable proportion reporting childbirth during adolescence. This is substantially higher than national averages reported in NDHS, indicating that early marriage and early childbearing remain concentrated among disadvantaged groups (MoHP et al., 2023; WHO, 2018). These findings

underscore that reproductive timing is not a matter of individual choice but is shaped by social expectations, economic dependency, and limited educational opportunities. This suggests, early motherhood must therefore be understood as a socially structured outcome rather than a personal life event (Sen, 1999; Kabeer, 1999).

Childbirth practices also reflect deep inequities in access to maternal healthcare. More than half of deliveries in the study were conducted at home, in contrast to NDHS data showing significantly higher institutional delivery rates nationally (MoHP et al., 2023). This discrepancy highlights uneven distribution of maternal health improvements, with rural and marginalized women continuing to face barriers such as geographic isolation, financial constraints, and culturally embedded preferences for home births. These factors are further reinforced by gendered household decision-making structures, where women's mobility and healthcare choices are often mediated by male family members or elders. Such patterns reflect structural exclusion from formal health systems rather than individual preference (World Bank, 2022).

Family planning practices reveal both progress and persistent gender imbalances. While a majority of women reported using contraceptive methods, responsibility for contraception remains disproportionately placed on women, with minimal male involvement. Moreover, a significant proportion of women reported experiencing side effects such as menstrual irregularities, pain, and other health complications. These findings highlight a contradiction within reproductive health programming: while contraceptive uptake may be increasing, the burden of use remains feminized, and decision-making authority is not equally shared (UNFPA, 2022; Sundaram et al., 2019). These findings indicate broader patriarchal norms in which reproductive responsibility is assigned to women while control over fertility decisions remains socially constrained.

Reproductive morbidity further exposes hidden dimensions of inequality. The prevalence of conditions such as vaginal infections, uterine prolapse, infertility, and miscarriage indicates significant gaps in preventive care, early diagnosis, and treatment. These health issues are often compounded by delayed healthcare seeking, driven by stigma, lack of awareness, and financial dependency. Such conditions are frequently normalized within communities, contributing to the invisibilization of women's suffering within formal health systems (WHO, 2019; Rogers et al., 2019). This demonstrates that reproductive health challenges are not solely biomedical but are deeply shaped by social and institutional neglect.

Underlying these outcomes are broader socio-economic structures that shape women's everyday lives. The majority of respondents are engaged in unpaid domestic or agricultural labor, with limited access to formal employment and economic resources. This economic dependency significantly constrains women's autonomy, particularly in relation to healthcare decisions and reproductive choices. Education levels remain low among the study population, further limiting access to health information and reinforcing cycles of early marriage and early childbearing. From

a structural perspective, these intersecting disadvantages reflect the reinforcement of patriarchal systems through both economic and educational inequality (Marmot, 2005; World Bank, 2022).

When compared with NDHS findings, the Sayapatri data highlights a consistent pattern: national averages tend to mask significant intra-country disparities. While Nepal has made measurable progress in indicators such as contraceptive prevalence and institutional delivery rates, these improvements are not evenly distributed. Marginalized rural women continue to experience disproportionately high levels of reproductive health risk and limited access to quality services. Earlier WOREC-supported studies similarly indicate that structural barriers including weak health system responsiveness, gender norms, and geographic inaccessibility remain largely unchanged over time (WOREC, 2009).

Overall, the findings suggest that improvements in SRHR outcomes cannot be fully achieved through service delivery alone. Instead, they require a comprehensive approach that addresses underlying power relations, gender norms, and socio-economic inequalities. A feminist analysis therefore shifts the focus from individual behavior change to structural transformation, emphasizing that reproductive health is fundamentally a question of justice, autonomy, and social equity (Crenshaw, 1989; Haraway, 1988)

Conclusion

This study demonstrates that women's SRHR in rural Nepal are shaped by deeply embedded structural inequalities rather than individual health behaviors alone. Drawing on participatory evidence from Sayapatri Kurakani (2023-2025), the findings highlight how patriarchal norms, economic dependency, limited education, and uneven access to health services collectively constrain women's bodily autonomy and reproductive decision-making.

Although national-level data such as the NDHS indicates improvements in indicators like contraceptive use and institutional delivery, this analysis reveals that such progress is unevenly distributed. Marginalized women in rural districts continue to experience early pregnancy, high rates of home births, reproductive morbidity, and restricted autonomy over contraception and menstrual health. These disparities underscore the limitations of aggregate national indicators in capturing lived realities.

This suggests, the study shows that women's bodies remain sites of social regulation, where reproductive roles are shaped by family expectations, cultural norms, and institutional constraints. Menstrual restrictions, son preference, and the gendered burden of contraception further illustrate how SRHR outcomes are embedded within broader systems of power.

Overall, the study concludes that meaningful improvements in SRHR cannot be achieved through service delivery alone. Instead, they require structural transformation that addresses gender

inequality, redistributes decision-making power, and strengthens women's social and economic autonomy. Reclaiming bodily autonomy in this context is fundamentally a question of justice and equity, not only health access.

Ultimately, achieving SRHR in Nepal requires rethinking health not merely as service provision, but as a question of power, justice, and social transformation.

Recommendations

Addressing the identified challenges requires a multi-dimensional approach that includes transforming harmful gender norms through community dialogue, expanding access to comprehensive SRHR education and services, and actively engaging men in reproductive health responsibilities. Economic empowerment initiatives are essential to reduce dependency and enhance women's decision-making capacity, while health system reforms must focus on improving accessibility, strengthening referral mechanisms, and ensuring respectful, gender-sensitive care. At the policy level, stronger alignment with national strategies and increased accountability are necessary to ensure that commitments to women's health translate into tangible outcomes.

1. Transform harmful gender norms through community engagement

Sustained community-based dialogue is needed to challenge entrenched practices such as menstrual restrictions, son preference, and early marriage. Engaging families, religious leaders, and local influencers is essential to shift social norms that regulate women's bodies and reproductive choices.

2. Strengthen comprehensive SRHR education

Age-appropriate and context-specific SRHR education should be integrated into schools and community programs. Special focus should be given to adolescents, who face early marriage and limited access to accurate reproductive health information. Education should also address consent, bodily autonomy, and menstrual health without stigma.

3. Promote male involvement through targeted community programs, couple-based counseling, and inclusion of men in SRHR education initiatives.

4. Improve accessibility and quality of health services

Health systems must be strengthened to ensure equitable access in rural areas. This includes improving geographic reach, affordability, privacy, and respectful maternity care. Referral systems should be made more efficient, and outreach services should prioritize marginalized populations.

5. Address women's economic dependency

Economic empowerment initiatives, including skills development, income-generating activities, and recognition of unpaid labor, are critical to enhancing women's decision-making power. Reducing financial dependency is essential for improving autonomy in health-related choices.

6. Ensure gender-sensitive health system reforms

Healthcare providers should be trained in gender-sensitive and rights-based approaches to SRHR. This includes addressing stigma, improving communication, and ensuring that women's experiences of pain, side effects, and reproductive health concerns are taken seriously.

Limitations of the Study

This study has several limitations that should be considered when interpreting the findings.

First, the data is drawn from women who participated in Sayapatri Kurakani and integrated women's health camps across eight districts. As a result, the sample is not fully representative of all women in Nepal, particularly those outside the reach of such programs or those not accessing health services.

Second, the data is self-reported and may be subject to recall bias, especially in relation to reproductive history, age at events, and health experiences. Sensitive topics such as violence, abortion, and reproductive coercion may also be underreported due to stigma or social desirability bias.

Third, the cross-sectional nature of the data limits the ability to assess long-term trends or causal relationships between socio-economic conditions and SRHR outcomes. The study captures lived experiences at a specific point in time rather than changes over time.

Fourth, while the participatory methodology provides rich qualitative insights, it also means that responses may vary based on facilitation context, group dynamics, and individual willingness to disclose personal experiences.

Finally, the study focuses on selected districts and may not capture regional diversity across all ecological and socio-cultural contexts of Nepal, particularly urban populations and hard-to-reach areas.

Despite these limitations, the study provides important insights into the lived realities of marginalized women and highlights structural dimensions of SRHR that are often underrepresented in national surveys.

The Hidden Violence: What Remains Unspoken

Case Story 1

Son Preference as Psychological Violence

"Society makes me feel incomplete."

35-year-old woman living in a family of four, including her husband and two daughters. She was married at 20 through a traditional arrangement. Initially, family relationships were good, as she was the youngest daughter-in-law and her husband the youngest son. She has two daughters, and both she and her husband are happy with them. Her husband frequently works abroad.

However, over time, her mother-in-law repeatedly expressed a desire for a grandson. Since her father-in-law passed away five years ago, the mother-in-law often complains that there are no grandsons in the family, sharing this with visitors and on phone calls. Hearing this daily causes the client emotional pain, sadness, and distress. Neighbors and others also comment on having sons, which adds to her discomfort.

She has tried treatments to conceive a son, but pregnancy has not occurred, which increases her emotional suffering. Although she and her husband are completely content with their daughters, societal pressure makes her feel that having a son is necessary. She recognizes that her daughters are capable, her husband supports her, and she is aware of her family's help, but she struggles with societal expectations. She seeks counseling on how to cope with these pressures and how to navigate societal expectations while staying emotionally healthy.

"This is not preference it is gendered devaluation, where women's worth is tied to producing male heirs."

Case Story 2

Invisible Suffering as Structural Neglect

"I could not rest because household work never stops."

35 years old women comes from a family of 18 members. She studied up to grade 5 and, growing up in a tribal family, did not have regular menstrual education or nutritious food during her early years. She experienced her first menstruation at age 10 but had no significant problems at that time.

She married at 16 by her own choice. Two years after marriage, she gave birth to her first child, and she now has two children (a son and a daughter), one born at home and one in a health facility.

Following her second delivery, she and her husband opted for Depo-Provera for family planning. She experienced heavy bleeding after the first injection, which improved with medication. After the second dose, bleeding reduced but continued intermittently.

During pregnancy and postpartum, she experienced poor nutrition, lack of rest, domestic violence, verbal abuse, and economic hardship, leading to physical weakness, pelvic discomfort, back pain, limb tingling, and abnormal white discharge. She recently underwent a ring pessary insertion at a private hospital in Kailali for pelvic support, which was supposed to be removed after three months. Due to household work and financial issues, the pessary remained for 3 years, causing stress. She came to a health camp for counseling and check-up. And was replaced by new ring pessary after the observation and counselling was done regarding its change frequency and management.

These findings indicate a brutal reality:
Women are denied rest even in illness, their bodies treated as endlessly extractable resources.
This represents a form of structural violence embedded in everyday life.

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