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Socio-Cultural Barriers to Reproductive Health and Their Impact on Mental Health: A Case of Young Married Women

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Abstract

This qualitative study investigates the mental health impact of sociocultural barriers to reproductive health among young married women of the Madhesh community in Harion, Sarlahi, Nepal. Reproductive health, a fundamental human right essential for social, emotional, and physical well-being, is constrained by entrenched patriarchal norms, gender discrimination, and cultural traditions in this community. Through in-depth interviews with three purposively selected married women under 24 years, the study identifies four key themes: gender and social inequality manifested in son preference, dowry, educational discrimination, and enforced silence; marriage-related factors including child marriage, early pregnancy, unpaid labor, and reproductive pressure; nutrition and health access influenced by food hierarchies, poverty, and limited healthcare use; and challenges in natal and postnatal stages characterized by neglect, overwork, malnutrition, and postnatal depression. These issues cause anxiety and low self-esteem, showing that reproductive and mental health are shaped by social and cultural, not just medical, factors. The study calls for integrated health policies and programs addressing gender inequity to improve women's autonomy and well-being.

Keywords: reproductive health, socio-cultural barriers, mental health, young married women, patriarchal norms, gender inequality

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Introduction

Madhesh Province exhibits significant cultural complexity for women, which profoundly influences the high prevalence of early marriage in the region. According to Mishra and Mishra (2024), women in Madhesh face entrenched patriarchal norms where their primary value is linked to domestic responsibilities and motherhood, exacerbated by strong son preference, dowry practices, and limited decision-making power within families. These factors contribute to early marriage being a socially accepted norm, as families often marry off daughters young to reduce economic burdens, notably dowry costs, and conform to cultural expectations. Educational and economic disparities further restrict women's autonomy, leaving many young girls married before legal age, with limited access to health, education, and empowerment opportunities (Mishra & Mishra, 2024). National and local data indicate child marriage rates in Madhesh districts as high as 47.5%, driven by poverty, low literacy, and cultural traditions (Kafle, 2024). This early marriage prevalence has severe consequences: increased maternal and infant mortality, restricted reproductive autonomy, and amplified mental health risks due to social pressure and limited agency.

Despite legal prohibitions, lack of awareness and weak enforcement persist (Karki et al., 2024). Addressing early marriage in Madhesh thus requires culturally sensitive, intersectional approaches that challenge gender norms, promote female education, and enhance women's empowerment within the province's unique socio-cultural fabric (Adhikari, 2020).

The World Health Organization defines reproductive health as a state of complete physical, mental, and social well-being, recognizing it as a fundamental human right that includes the ability to make informed decisions about childbearing. The United Nations Population Fund (UNFPA, 1994) further emphasizes women's right to reproductive autonomy. Women's health outcomes are influenced by social determinants such as education, wealth, cultural attitudes, and gender roles (Hosseinpoor et al., 2012; El-Sayed et al., 2012; Galea & Link, 2013). In Nepal, the health of young married women is shaped by entrenched sociocultural norms, particularly in the Madhesh community (Jafarey et al., 2020). Although national data show improvements in reproductive health indicators such as maternal mortality and contraception use (MoHP, 2017), significant disparities persist in Madhesh, a region marked by strict patriarchy and cultural ties with India.

In this context, women's value is closely linked to bearing sons, while daughters face discrimination through limited access to nutrition, healthcare, and education (Bhattacharjee & Goswami, 2020; Fuller, 2020; Shrestha et al., 2024). After marriage, women's autonomy is further constrained by household decision-makers, increasing risks of unintended pregnancies and health complications (Khatri & Pokhrel, 2023; MoHP, 2017). The persistent pressure to produce male heirs contributes to social stigma, domestic violence, and mental health issues such as anxiety and depression (Ghimire & Samuels, 2017; WHO, 2021). Mental health remains a taboo subject with minimal access to care in these communities (Subba et al., 2017). During pregnancy and postpartum, women face additional challenges including overwork, malnutrition, and restricted healthcare access, compounding their physical and psychological vulnerability (Shrestha et al., 2024; Saud, 2024). While physical health effects have been studied extensively, there is limited research on how these intersecting stressors impact mental health among young married women in Madhesh.

Problem Statement

The rationale for this research stems from the urgent need to address the complex interplay of sociocultural barriers and their detrimental effects on the reproductive and mental health of young married women in the Madhesh community. Despite improvements in national reproductive health indicators in Nepal, significant disparities persist in marginalized regions where patriarchal norms, gender discrimination, and traditional practices severely limit women's autonomy. These restrictions not only compromise physical health outcomes but also contribute to profound mental health challenges that remain largely unrecognized and untreated due to cultural stigma. By exploring how these social and cultural factors intersect and impact mental well-being, this research aims to fill critical knowledge gaps. The findings will support the development of targeted public health policies and culturally sensitive interventions that integrate mental health support with reproductive health services. Ultimately, this study seeks to promote holistic health and empower women in this vulnerable population to exercise greater control over their reproductive lives and mental health.

Research Objective

This study aims to investigate the socio-cultural barriers to reproductive health and their impact on the mental health of young married women from the Madhesi community in Harion, Sarlahi, Nepal.

Methodology

This study used case study design within a qualitative methodological framework with in-depth interviews as the major tool to analyse the

realities of young married women in Harion, Sarlahi. The study is philosophically grounded in interpretivism paradigm that concerned with comprehending the intricate nature of social reality as it is intrinsically constructed through the meanings individuals assign to their experiences (Scotland, 2012; Thapaliya & Pathak, 2022). This approach is a good for studying the complex social and cultural barriers that affect reproductive health and learning how these barriers impact mental health from the perspectives of young married women of Madhesh community. In-depth interviews were chosen for this study because they are a good way to carefully explore each unique point of view of person. This method is very effective for collecting detailed story like information about personal and complicated topics (Brinkmann & Kvale, 2015).

Research Site and Participant

This study chooses Harion Municipality as a research site, which was selected due to its central location within Madhesh Province. This area is characterized by a mixed societal structure, where the Madhesh community coexists with other caste groups. The context shows a progressive erosion of strong social and cultural norms. Studying this specific context provides for a study of the real-life experiences of married Madheshi women in a possibly changing social environment. The insights acquired here are critical for portraying an accurate picture of their situation, which can then be utilized to drive broader discussions about all Madheshi women.

Aligning with the qualitative case study research design, purposive sampling was used to select participants who could provide detailed, relevant information based on their direct experiences. This non-probability strategy is best for qualitative research because it allows researchers to deliberately choose the participants who are knowledgeable about the topic of interest (Palinkas et al., 2015). Participants were chosen based on criteria such as being a married women under the age of 24 of Madhesh community, living in the Harion municipality, and having been subjected to fertility and son preferences. This criteria was chosen because strong preference for sons in the Madheshi community comes from deep-rooted patriarchal traditions and economic realities. Sons are expected to care their parents in old-age security, bring dowry when they get marriage and serving as successors to the family heritage (Devkota & Mishra, 2024; Mishra & Mihra, 2024). As a result, this son-centric mind-set frequently lowers the women to the role of "production machines," Women societal value is determined by their capacity to deliver male children.

The final sample size for this study was three participants. Due to the high level of homogeneity found in the community, this study used a small sample size of three participants. Due to the consistent and repeated reporting of the same experiences, data saturation was achieved rapidly.

Economic backgrounds of participants were varied. Two of the three young married women were from middle-class families. These families typically owned 6 to 8 Kattha of land, lived in a small wooden house, and owned two or three cows. The third participant came from a family with less financial stability. Her family did not own land and relied on daily wage labour as their main source of income. After taking interviews from three participants, it was observed that the narratives were yielding thematic repetition, which indicating that a sufficient depth of understanding had been achieved for this specific context.

Data Collection Methods

Qualitative information was collected through personal, in-depth conversations using a flexible interview guideline. This provides participants to share their stories freely while covering important subjects. First of all purpose of study was explained and got verbal consent from each person. To ensure comfort and privacy, we held the interviews in a location chosen by the participant. We recorded each conversation with their permission these recordings were later transcripts. Interview

transcripts were given to participants for member checking, feedback and revisions.

Data Analysis

Thematic analysis, following the inductive approach outlined by Braun & Clarke (2022), was used to analyse the data. The analysis started by carefully reading the interview transcripts multiple times to become familiar with the content. Significant statements were then identified and labeled with concise codes. Next, these codes were examined and sorted into groups based on shared characteristics, forming broader categories. Finally, these categories were combined to produce broad themes that captured the essential experiences shared by participant. This study made four main themes that describe the participants' experiences

Rigor and trustworthiness

Some strategies were used in this qualitative research to assure the credibility and reliability of this research's findings.

First, credibility was strengthened by member checking. This included sending the participants their written interview transcripts to them for their approval. This stage allowed young Madhesi women to certify their experiences and opinions had been correctly recorded, which ensure that the data accurately reflected their views.

Second, transferability was achieved by giving a thick, detailed description of the research context. The backgrounds of participants, the study location in Harion Municipality and the specific socio-cultural setting of the Madhesh community were all described in depth. This detail allows others to determine whether the findings are applicable to other similar scenarios.

Third, dependability was established by using a clear and systematic process for data analysis. The study followed the standard steps of thematic analysis, which includes familiarizing with the data, generating codes, grouping codes into categories and finally developing the main themes. This structured method makes the research process transparent and repeatable.

Finally, conformability was secured by connecting the findings directly to the participants' own voices. Using direct quotations in the results connects the themes and conclusions to the basic information. This shows that the conclusions are based on the experiences of participants rather than the researcher's personal biases, which ensures that the data shapes the results.

Together, strategies such as member checking, thick description, a systematic analytical procedure and the use of verbatim quotes, all contribute to the confidence that the findings of study are a legitimate and trustworthy which represent the real-life experiences of participants.

Ethical Considerations and Approval

This research was carried out in full compliance with established ethical guidelines for studies involving human subjects. The fundamental principles of voluntary informed consent, protection of participant confidentiality and ensuring the well-being of those involved formed the foundation of all research procedures.

Before participating, each woman was thoroughly informed about the aims of study, the voluntary nature of her involvement and her right to withdraw at any time without consequence. Verbal consent was obtained. To protect participant privacy, all identifying information was removed from the transcripts. Pseudonyms are used throughout the research to ensure anonymity. Audio recordings were recorded on a password-protected device and would be completely erased after study is completed. The transcribed material is kept secure and secret.

Results and Discussion

Social factors like social, economic and political condition affect the women health during different life stage. How these factors affect women physical and mental health are described developing four themes based on literatures and in-

depth interview with local young married women belongs to Madhesh community are described below.

Effect of Gender and Social Inequality on Mental Health

Our communities are well aware that women have a lower role and status than men. Because women's reproductive journeys in our community are influenced by a variety of socio-cultural elements, such as wealth, education, women's social and family position, beliefs, conventions, traditions, and taboos.

The widespread social and gender inequities create an unhealthy environment that affects mental health of married young women. Girls are systemically devalued from an early age to daughter-in-law due to practices such as son preference, which causes significant mental distress. One participant noted, "male can get more appreciation from society… People want to know whether their child is boy or girl…if there is already baby girl in their house, they do not need same gender child again …. mental torture has been seen because of this reason.. created mental stress" (P1). This is made worse by educational disparity, where "Parents prioritize sons' education… Daughters discouraged from pursuing school… expected to marry and leave" (P2). This systemic bias reinforces the view that "Girls [are a] burden to family… Investment in boys [is] seen as family asset" (P3), which girls internalize, resulting in persistent depression, anxiety and a distorted sense of self.

The patriarchal control, particularly in the Madhesh community, where women are controlled and denied autonomy and constitute a sort of on-going mental health oppression. One participant confirmed that "Madhesh community women are highly dominated… not allow to take their own decision… dowry system is still prevalence" (P2). This imposed silence and lack of control in personal issues, especially reproductive health, turns women to objects. This is clear from reports that "Health decisions are made by husbands/elders… women rarely consulted in family planning… lack of autonomy in reproductive health…they think female is like baby production machine" (P3), undermining their dignity and creating emotions of powerlessness and despair.

Neglect during pregnancy manifesting as the denial of nutritious sustenance and essential healthcare serves as a powerful mental health problem. One woman shared her experience: "During her pregnancy she cannot get support from family members… not getting nutritious food and health care services…feel like second class people. Created lots of tension and stress" (P1). This deprivation transcends physical maltreatment. It acts as a clear signal to the woman that she is devalued, thereby reinforcing feelings of inferiority and social marginalization.

This, combined with the enormous pressure to produce a male heir, causes severe mental suffering and stress, making her feel like a second-class citizen in her own family. In addition, the expectation of additional hard work without equal rights causes chronic stress and injustice, as women "involve to do more hardworking compare to male… does not get equal right on their property" (P3). The high rate of violence, as "violence rate is also high compare to the male and violence cases are high especially in Madhesh community" (P3), as well as cultural norms that restrict self-expression, increase this trauma. This is especially true for young brides, where "younger brides silenced by in-laws… cultural obedience discourages self-expression… no dignity in daughter-in-law feel depression" (P1).

The combination of societal oppression, economic disparities and legalized abuse produces an environment in which suicidal thought is not just a personal issue, but a rational, albeit tragic response to an unbearable condition. For some, the relentless pressure and violence leads to being "motivated to do suicide" (P3) as a final escape from a life lacking hope, dignity, and escape.

Effect of Marriage and Reproductive Health on Mental Well-being

Marriage and reproductive health are intimately linked particularly in traditional societies. Early marriage frequently leads to early pregnancy, endangering physical and emotional health of the women. Reproductive health promotes informed choice, safe motherhood and gender equality. Lack of autonomy, son preference, and unpaid labour add to stress and vulnerability of women.

Mental health of young married women of Madhesh community suffers greatly due to the socio-cultural challenges they are facing. Child marriage and early pregnancy are not separate events; rather, they are severe stresses that set off a long cycle of psychological suffering. Being forced to quit school and marry young frequently as a teenager, breaks relationship of young girls to her education, social friends, and personal goals. This is common, as "marriage at 16–20 is common… stops to go to school" (P1), often driven by the fact that "social pressure to marry early… social stigma for unmarried older girls" leads families to "prioritize marriage over personal growth" (P3). This rapid transition into marriage and motherhood creates serious emotional suffering because she is thrust into adult tasks for which she is emotionally and psychologically unprepared. This lack of preparedness is compounded by the physical toll of "early pregnancies before physical maturity" (P1). This combination creates feeling of worry, isolation and a loss of her identity, establishing the groundwork for her mental health.

Furthermore, the expectation of having sons adds another layer of psychological pressure for young married women. In a situation where male children are desired, failure to perform this social responsibility can result in profound internalized shame, chronic anxiety, and despair. This reproductive pressure adds to the already high physical health risks associated with early and multiple pregnancies. Participants said that "early pregnancy causes malnutrition… weak physical condition due to early childbirth… increased maternal mortality risk," which create "mental stress due to unprepared motherhood" (P3). The knowledge of these health risks, along with a lack of control over reproductive decisions, creates a continual mood of dread that is profoundly adverse to mental health.

Perhaps the most pervasive mental health stressor is the crushing burden of unpaid labour. Young married women typically face a double, and often triple, burden of work. They are responsible for all domestic chores, child-rearing, and frequently extensive agricultural labour. As one participant explained, "We are responsible for both reproductive roles, like childbearing and childcare… productive roles, like farming, but men are completely free from childbearing responsibilities" (P2). This immense workload is socially normalized as their inherent duty, as "society normalizes it as our cultural duty" (P3). This constant unpaid work makes women always busy with their household works. As one woman said "recognized as unpaid labour… always occupied in household works, which creates chronic fatigue, and affects our health" (P1). This persistent physical tiredness is directly linked to adverse mental health effects. The work is demanding, recurrent, and, most importantly, ignored as economically productive labour, a "double burden of work inside and outside the home that leaves women exhausted" and ultimately affects their "mental well-being" (P3).

Effect of Nutrition and Health Access on Mental Health

Nutrition and health care access are critical for general well-being, particularly for women during the reproductive cycle. In many communities, cultural food hierarchies and poverty that limit the access of women to healthy diets which result malnutrition. Limited healthcare facilities distance and economic constraints exacerbate maternal health issues, raising stress, anxiety and poor mental health.

The socio-cultural barriers that limit access to reproductive healthcare for young married women have a profound and detrimental impact on their mental well-being. These barriers create a cycle of stress, anxiety, and powerlessness that directly affects mental health. One participant said that middle and low class "families cannot afford balanced diets," leaving pregnant women without proper nutrition (P1)" due to economic hardship, and cultural norms dictate that "men eat first… women eat last," young wives experience food insecurity and specific nutrient deficiencies (P2). This food insecurity is not just a bodily concern; it is also a constant mental health stressor. The anxiety of not being able to properly nourish them, particularly during pregnancy causes significant concern for their own and their unborn child's health, contributing to prenatal sadness and chronic stress.

Furthermore, being unable to receive essential healthcare services causes feelings of isolation and neglect. An awareness gap exists, as "some women attend antenatal check-ups… many unaware" of their importance (P3). Even for those who are aware, significant obstacles prevent access. Participants noted that "economic issues limit visits," and "long distance to health center" creates a geographic access problem (P2). This situation is worsened when women are being lacked formal support, "rely on traditional healers" instead of medical professionals, which can increase fears about the adequacy of care (P2). The irregular intake of needed supplements is also a problem, as "immunization services exist but are underused… iron/vitamin supplements are irregular" due to a mix of economic and social restrictions (P1). Being aware of available services but being physically or financially prevented from attending them fosters a deep sense of frustration and helplessness.

This combination of dietary neglect and limited access to care fosters an atmosphere in which mental health of a young woman is constantly jeopardized. As one participant stated, "poverty is root cause" of these challenges (P3). This "root cause" is more than just an economic issue; it is also a major generator of mental health issues. Ultimately, this creates a feeling of being trapped in circumstances beyond their control. The persistent uncertainty regarding their own bodies and reproductive lives fosters chronic grief, anxiety and diminished self-esteem. These mental health issues are a direct consequence of the linked social and economic obstacles they face.

Effect of Natal and Post-Natal Stage on Mental Health

The postnatal period is a risky time because it is when the majority of maternal and new-born deaths occur, especially right after childbirth. The vast majority of these deaths may be avoided if postnatal care is provided in the initial hours and days following childbirth.

The natal and post-natal stage for women is often defined by profound neglect, leading to a severe decline in health. One participant described a critical situation: "After the birth of the baby her health condition is critical…they did not have time for rest…forced to work outside as well inside too… uterine prolapse, anaemia and weakness may occur" (P1). This physical toll is compounded by a lack of essential support, as women are "involve in breast feeding… but not getting nitrous food and proper health care support from family member" (P1). This deprivation occurs because, according to traditional norms, the daughter-in-law is responsible for all home responsibilities without respite.

This relentless workload and physical neglect directly fuel psychological distress. Participants reported experiencing not just backache but also "feeling irritation and depression" after delivery (P2). The combination of these factors creates a deep sense of isolation and hopelessness. This deprivation is part of a broad trend of marginalization. As one respondent critically said, "the intersection of poverty, distance to health centres and social restrictions does not merely limit access to postnatal care… it actively

constructs a landscape of isolation where feelings of hopelessness and despair can thrive" (P3).

The rationale for this suffering is deeply embedded in social structures. Daily routine of a women is "[c]arrying water, caring for cattle, cleaning, washing clothes, cooking, agricultural work and so on" continues unabated, even after childbirth. Even though they continue these duties, many "do not get appropriate nutrition," which is crucial for recovery, especially while breastfeeding. Consequently, the health condition of women is directly and severely affected during the natal and post-natal stage by these social determinant factors, that creating a cycle of physical deterioration and profound despair.

Discussion

This research examined how socio-cultural barriers to reproductive health affect the mental health of young married women in Madhesh community of Nepal. The findings demonstrated that structural inequities, cultural practices, and gendered norms combine to create conditions that undermine women's autonomy, dignity, and mental health well-being. Four major themes emerged: gender and social inequality, marriage and reproductive health, nutrition and health access, and natal/postnatal experiences. Each theme is analysed below with reference to prior literature.

The findings show that gender bias, patriarchal control, son preference and silencing mechanisms deeply affected women's mental health. Women's reproductive journeys in this community are influenced by a variety of socio-cultural elements, such as wealth, education, women's social and family position, beliefs, conventions, traditions, and taboos (Baral et al., 2012; Gupta et al., 2023). Gender discrimination which may begin in the womb and it goes on till their adult reproductive years and beyond because of our social structure (Ydav, 2024).

Respondents talked about violence, lack of property rights, dowry-related dominance, and discrimination in education, which frequently led to anxiety, depression and even suicidal thoughts. Such findings are consistent with Previous research confirms that patriarchal systems in South Asia enforce gender hierarchies by valuing women primarily for their reproductive roles, "particularly male heirs (Khatri & Pokhrel, 2023).

Dowry systems and enforced obedience still exist, reflecting what Kandiyoti (1988) calls "patriarchal bargains," in which women accept subordinate positions for survival, frequently at the cost of their mental health. Educational inequality in which males are emphasized while girls are deemed "temporary members" of the household which reinforces systemic marginalization that result in low self-esteem and lasting mental health issues (Adhikari, 2013). Neglect during pregnancy, including denial of healthy food and health care, is not only a physical deprivation but also a mental health indicator of women's devaluation, worsening stress and promoting inferiority. Thus, gender inequality in this community operates as a structural violence (Galtung, 1969), producing chronic stressors that erode women's mental resilience and autonomy.

The second theme focuses on child marriage, early pregnancy and reproductive duties which heighten mental distress of Madhesi young married women. Respondents said that marriage between the ages of 16 and 20 disrupts education and stresses parenting above emotional and physical maturation. This is consistent with UNICEF (2021), which states that Nepal has one of the highest rates of child marriage in South Asia which resulted in increased maternal health risks, limited opportunities, and lifelong mental health issues.

The finding of this research is that early pregnancy not only increases maternal mortality risk but also creates emotional unpreparedness and isolation. Similar findings by (Sütlü & Kutlu, 2024) show that adolescent mothers had greater rates of sadness and anxiety due to the lack of preparation and social support. Furthermore, the cultural

expectation of son preference adds an extra mental burden for young married Madhesi women. There is a preference of sons over daughters in large parts of South Asia especially in Nepal (Vickery & Teijlingen, 2018). When a woman in Nepal gives birth to a girl child, she faces social stigma. (Mahato et al., 2018). Another research find out that failure to birth a male child frequently causes internalized guilt, shame and marital conflict and male threat to leave their wives if they do not give birth to a son in Nepal (Wasti et al., 2017).

For many married women in Madhesh, the heavy burden of unpaid work at home and on farms is seen as their "cultural duty." This continuous workload causes fatigue, low self-esteem and sadness. As researchers like Hochschild and Machung (2012) and Sharma (2024) point out, this "second shift" of work falls mostly on women, that lead to tiredness and long-term mental health problems. Because this work is a normal routine daily life in Madhesh, women often suffer in silence and their struggles are never acknowledged by society.

The findings demonstrated that cultural food hierarchies in which males eat first and women eat last, combined with poverty-driven food insecurity cause chronic stress and anxiety in young married women. Malnutrition during pregnancy was reported as a major psychological burden, where women constantly feared for their own and their unborn child's health. Research has indicated that maternal malnutrition plays a substantial role in perinatal anxiety and sadness. (Black et al., 2013; Naaz & Muneshwar, 2023).

Access to reproductive healthcare was further limited by long distances, economic constraints and social restrictions, forcing women to depend on traditional health care system rather than modern health care system. This not only reduces health outcomes but also heightens uncertainty and fear which further eroding mental well-being. Previous research in rural Nepal shows that prenatal services are underutilized due to economic and cultural limitations (Van Teijlingen et al., 2015).

The irregular usage of iron and vitamin supplements demonstrates the how socioeconomic and gender factors interact to generate a vulnerable environment. This is consistent with the report of World Health Organization (2018) that poverty, gender discrimination and inadequate healthcare access create "triple barriers" to maternal health and emotional well-being.

Under this last theme, young married Madhesi women described being denied rest and support shortly after childbirth which forced to continue their regular duty both at home and agricultural tasks, and denied nutritious food. Such diseases frequently resulted in uterine prolapse, anaemia, weakness, and sadness. Respondents experienced feelings of frustration, pain in their backs, and hopelessness, which were exacerbated by a lack of family support and limited access to health facilities.

Postnatal depression is a well-known condition, but in poor areas like Madhesh, its rate is made worse by official neglect and local customs. According to this study, maternal health is affected by social conventions of gender that force daughters-in-law to perform excessive domestic and agricultural work even during and after pregnancy in Madhesh province of Nepal. This prevents them from getting enough sleep and eating a healthy diet properly which is essential for breastfeeding and postpartum recovery. Fisher et al. (2012) and Southard & Randell, (2024) found that women with little money are more likely to get this depression because they are financial weak, lack of food security and social support.

Proper natal and post-natal care have been still lacking because of lacking of health services, poverty, illiterate society, socio-economical condition of society and. women's unwillingness to seek treatment for uterine prolapse as a result of a lack of family support, poor treatment, and excessive travel, food, and housing costs (Simkhada et al., 2006; Sharma et al., 2007; Langlois et al., 2015; Subedi, 2020). National Nutritional Policy

of Nepal (2017), has also recognized that cultural attitudes and practices about food intake have a significant impact on perinatal women's nutritional status and welfare, particularly among the postnatal group (Bista et al., 2020). So, inadequate utilization of postnatal care, different physical difficulties have been observed after the delivery such as uterine prolapse, backache, anaemia etc. which may directly affect the women health (Dhakal et al., 2007; Subedi, 2020). This result of this study agrees, showing that pressures to do all chores right after birth create a strong feeling of hopelessness. Thus, the natal and postnatal stage represents a critical point where reproductive health intersects with cultural oppression to exacerbate mental illness.

Conclusion

This study explored how socio-cultural barriers to reproductive health affect the mental health of young married women in Nepal's Madhesh population. It discovered that mental health of these young married women is intimately linked to established cultural norms, gendered expectations and institutional injustices.

Patriarchal control, a strong son preference and enforced silence place women in a position of subordination that promotes anxiety, sadness, and feelings of worthlessness. Furthermore, child marriage and early motherhood affect education of young married women, autonomy and emotional maturity. This thrusts them into roles for which they are unprepared, thereby creating a cycle of mental health distress. Feelings of helplessness and chronic stress are intensified by nutritional deprivation and barriers to healthcare access. Meanwhile, the double burden of unpaid domestic and agricultural labour reduces the self-esteem and contributes to tiredness and hopelessness. Finally, the natal and postnatal stages which are characterized by neglect and a lack of care expose women to serious health difficulties and postnatal depression.

This study found that socio-cultural limitations such as patriarchal norms, son preference, dowry practices and limited autonomy have a negative impact on the reproductive and mental health of young married women in the Madhesh community. This study shows that impact on mental health is more than just biological or medical issues. Effect of mental health is strongly influenced by sociocultural structures and power relations. Therefore, Interventions must include cultural sensitivity, gender equality, mental health assistance and community awareness programs to empower women and improve their general well-being in similar marginalized situations.

Limitations of Study

This study has several limitations. The findings are based on a small number of participants from one specific location. These stories provide deep insight, but the results may not be broadly applied to all young married women in the Madhesh community or other regions of Nepal. The personal nature of the topics may have also affected the data. Due to cultural stigma, some participants might not have shared all of their experiences related to mental health or family conflict. Additionally, only the young women's perspectives were included in this study. Their husbands, in-laws and community leaders who have a significant impact on their lives were not consulted. This incomplete background prevents a full understanding of the dynamics of society depicted. Finally, as a qualitative study, its significance is in capturing deep personal narratives rather than giving statistical data. The findings highlight key issues that must now be examined on a greater scale to determine their full depth and prevalence.

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