Exploration अन्वेषण
A Peer-Reviewed Multidisciplinary Journal
ISSN 2542-2944 (Print)
Published by the Research Management Cell
Darchula Multiple Campus, Khalanga, Darchula
Far Western University, Nepal

Sexual and Reproductive Health Among Women with Disabilities in Kailali District

Lal Singh Karki, Associate Professor
Tikapur Multiple Campus, Far Western University, Nepal
karkilstmc@gmail.com

Abstract

The study aims to identify the demographic and socio-economic characteristics of women with disabilities, assess their knowledge, attitudes and practices about sexual and reproductive health and examine their sexual and reproductive health-related problems. A descriptive research design was adopted for using primary and secondary data sources. Primary data were collected using structured interviews with 40 women with disabilities in Janaki Rural Municipality, Kailali District, and secondary data were collected from municipal records and reports of concerned NGOs. The findings reveal that most of the respondents were Hindus. They were also housewives, and more than half of them belonged to nuclear family units. Sexual and reproductive health knowledge of respondents came from school/college, training and other interpersonal communication. In terms of menstrual hygiene, 50 percent of respondents used cloth, and a few used sanitary pads, homemade pads, and other materials. Over 20 percent of respondents slept separately during the period of menstruation. Most respondents received antenatal check-up services. The main reasons for not accessing antenatal services are attributed to a lack of knowledge, a shortage of time, the absence of services, and fear. Concerning family planning, the majority of respondents used condoms, and some others used injectable and other methods. Concerning the vaccination and delivery practices, most of the respondents reported having received the T. T. vaccine and having taken iron tablets. The majority of respondents reported having given birth in a hospital. They reported several sexual and reproductive health problems. These included abdominal pain, vaginal bleeding, vomiting, headaches, irregular menstruation, difficulty keeping clean, postpartum depression, lack of health services and other health problems. The study recommends that improving literacy and income, and implementing community participatory health

programs, taking into account cultural beliefs, family support, and community the focus on promoting sexual and reproductive health for women with disabilities.

Keywords: *Delivery practice, disabled women, family planning, postpartum depression*

Introduction

It is important to note that a condition is not a disability because of being "defective", nor is it a punishment for something we have done wrong; rather, it is a trait of how one may engage with their surrounding environment. Public health and social research on the sexual and reproductive health of disabled women is primarily important, and oftentimes goes unexplored. Approximately 16 percent of the global population has some kind of disability, with women being some of the most disadvantaged because of a combination of the disability and social stigma, gender, and lack of available vital resources (WHO, 2023). One of the most difficult challenges that disabled women experience is physical inaccessibility to services. Numerous health facilities do not have any means of offering a wheelchair ramp, have no accessible washrooms, and do not have any trained personnel who have the physical and mental capacity to assist disabled human beings. Consequently, they cannot obtain health care services that are deemed vital, such as screening for health issues during pregnancy, planning a family, and gaining knowledge about the health issues surrounding reproduction. There are negatively compounded health issues, physical and social exclusion, and a lack of knowledge that cause the greatest victimisation of the disabled (Groce and Kett, 2014).

The attitudes and perceptions of health service providers play an equally important role in determining health-seeking behaviour (Shakespeare, 2006). Women with disabilities face negative attitudes, insensitivity, and a lack of knowledge about the specific needs of disabilities, which makes them less likely to seek health care. Women with disabilities also face social stigma, which adds feelings of shame, inferiority, and isolation. According to The Act Relating to Rights of Persons with Disabilities, 2074 (2017), disability is defined as a condition which can be physical, mental, intellectual, or sensory that results in the lack of ability to fully participate in everyday activities. The Act also includes types of disabilities such as physical, visual, hearing, deaf blind, speech, mental or psychosocial, intellectual, haemophilia, autism, and multiple disabilities. Based on the degree of severity of the condition, disability is classified as profound, severe, moderate, and mild (The Act Relating to Rights of Persons with Disabilities, 2074).

According to the National Census, 2078 (Central Bureau of Statistics, 2021), 647,744 persons in Nepal, representing 2.2 percent of the total population, live with disabilities. Among them, 54.2 percent are men and 45.8 per cent are women. The disabled live in every community and every age group; this is due to congenital, accidental, and disease-related causes. The government of Nepal, in the document of the national census 2078, recognises a total of 10 major and 12 minor disabilities, which include, but are not limited to, physical, low vision, total blindness, deaf, hard of hearing, deaf-blind, speech, mental/psychosocial, intellectual, haemophiliac, autism, and multisystem disabilities. No, a single type of disorder, however, describes the totality of the physical, mental, and

social conditions of a person when it comes to reproductive health. The International Conference on Population and Development, which was held in Cairo in 1994, was the first to affirm reproductive health as a right of every individual. The individual, it went on to explain, is entitled to choose when to marry, when to give birth, and how many children to have. Additionally, it detailed the right to access modern contraception and the right to protection from any sexual abuse and sexual coercion (Sherchan and Upreti, 2020). Moreover, reproductive health thus includes not only the prevention and treatment of reproductive diseases but also the promotion of dignity, gender equality, and bodily autonomy (Sharma, 2016).

A complex mix of culture where the Hindu religion and patriarchal society are strongly rooted, the desire for productivity makes the promotion of reproductive health among disabled women, including adolescents, a demanding task in Nepal. Historically suppressed and victimised groups, such as the Badi women and Devaki, the affected population faced sexual exploitation and sexually servicing their guests, while hidden sexual violence is still rampant in the poor, uneducated society. Sexual and reproductive health (SRH) includes more than the absence of disease but also rights to informed, safe, satisfying sexual lives as well as contraception and maternal care. Effective, developmentally- and age-appropriate sexual health education for adolescents is needed to prevent unsafe practices and unwanted pregnancy. Another priority of Nepal is the Adolescent Health and Development Strategy (2018) includes youth-friendly, inclusive SRH services that are accessible to all, including persons with disabilities. The connection between disability and poverty is cyclical, disability preventing employment and social inclusion, leading to increased risk of poverty; while poverty increases the risk of becoming disabled through malnutrition, hazardous work conditions, and lack of healthcare. Women and girls with disabilities account for higher levels of all forms of sexual abuse, including rape, domestic violence, and exploitation. Women with deafness, visual impairment, who are using a wheelchair, and intellectual disability face the violence camouflaged by the caring landslide itself due to communication barriers and vulnerability to violence that goes unreported (NDWA, 2014).

Despite the presence of progressive laws and international obligations, implementation is still problematic. The government of Nepal has implemented several programs, such as the Disability Protection and Welfare Act (1982), the UN Convention on the Rights of Persons with Disabilities,2006 (un. info. np). But obstacles and social discrimination remain strong. Schools, hospitals, roads and toilets are yet to become accessible for the disabled. The Family Planning Association of Nepal (FPAN) has been working on SRH rights and access for persons with disabilities since 2008, including in relation to equality, bodily integrity, freedom from discrimination, and access to health information and services. However, these domestic and international initiatives, women with disabilities in Nepal endure intersecting webs of discrimination due to gender inequality, poverty, social stigma and lack of access to services. As indicated by the National Census 2078, there were a total of 3,413 disabled persons in Janaki Rural Municipality of Kailali District. But there are only 545 who have been registered by the municipality. Among the registered persons, 56 have profound disabilities (red card), 229 have severe disabilities (blue card), 145 have moderate disabilities (yellow card), and 115

have mild disabilities (white card). Given this background, this study aims to provide a comprehensive understanding of women with disabilities by examining their demographic and socio-economic characteristics, assessing their knowledge, attitudes, and practices regarding sexual and reproductive health and identifying their health problems.

Literature Review

In general,the review of related literature serves as the basis for defining research problems, giving reasons for the study, choosing the right methods, and organising data collection and analysis. This research study, "Sexual and Reproductive Health Among Women with Disabilities," referenced different kinds of materials such as textbooks, journal articles, research reports, and audio-visual materials from a variety of national and international organisations. Sexual and reproductive health is one of the most basic elements of human rights, and it is accepted worldwide through the Universal Declaration of Human Rights (United Nations, 1948) as well as other international conventions. These frameworks emphasise that every individual, irrespective of their gender, has the right to enrol in health-related programs, make up their minds in a totally free way as to whether or not they will have children and when, and obtain the necessary knowledge and education built on giving care to themselves and their .

Karl Mannheim's sociocultural theory suggests that understanding the society's structure and its cultural practices, which influence individual behaviour, including reproductive practices and childbirth, is necessary for effective social reform (Sharma, 2066). Women, by tradition, are not allowed to do household activities or engage in the process of childbirth. A few communities isolate them in specific parts of the house during childbirth to avoid exposure to sunlight or social contact, showing that these are the areas of the house which are strictly forbidden for women (Sharma, 2066). Similarly, feminist theorist Betty Friedan asserts that even though there are biological differences between men and women, the latter's social roles, duties, and rights should be treated as the same (Dulal, 2011). Both genders gain from the family and the community, and the shared accountability for maternal and reproductive health is the key to the progression of women's lives.

The health of the mother during pregnancy is, therefore, the factor that determines whether the child will survive. Any kind of pregnancy that is early, late, or close together with malnutrition of the mother causes the death of infants and children, especially in places where the provision of healthcare is inadequate. The concept of safe motherhood comprises the various health services that extend to women for them to be able to have healthy pregnancies, safe deliveries, and receive proper postpartum care (Budha, 2015). The government, on the other hand, through a constitution, has to ensure that women with disabilities have the same rights as other women in respect of education, healthcare, employment, and social protection, besides the mutual rights for them to be free from discrimination and violence. In addition, through such community-based programs as well as advocacy networks, such as the Nepal Disabled Women's Association, which has been engaged in promoting empowerment, leadership, and inclusion among women with disabilities for over ten years, they should be encouraged.

The law of Nepal provides a lot of measures to ensure the safety of women with disabilities. The major legislations, including the Civil Code (2017), Safe Motherhood and Reproductive Health Rights Act (2018), and the Rights of Persons with Disabilities Act (2017), are the pillars that guarantee justice, protection, and the right to health services for those individuals. The laws prohibit sexual and gender-based violence; they also require the provision of rehabilitation and psychosocial support to those who have experienced such violence. Moreover, the instruments of the policy like the National Health Policy (1991), Gender Equality, and Social Inclusion Policy (2016), and Gender Equality, Disability, and Social Inclusion Policy (2023–2027) strongly advocate fair access to the health services, democratic decision-making, and health care that is both maternal and mental health-friendly (Ministry of Health and Population, 2018).

Empirical studies have consistently pointed out the difficulties that women with disabilities have to overcome when trying to get sexual and reproductive health care. Research conducted worldwide suggests that the main factors that impede their implementation of reproductive health programs are the lack of information, autonomy, and social acceptance, as well as structural and systemic challenges (Nguyen, 2020). Such a thorough investigation was done in the Kathmandu Valley aimed at persons with disabilities and the results were 422 individuals participated in the study and the conclusions drawn were only 32.7 percent were receiving sexual and reproductive health education; 47.6 percent were utilizing contraceptive services; 27.7 percent were going through antenatal care; 13 percent had access to safe abortion services; 3.6 percent were availing HIV services; and merely 16.8 percent were using STI management services (Journal of Women's Health, 2020). The results of these are instrumental in making clear the imperative of providing health education and delivering services that are inclusive of all people. Several activities, including the DEC Nepal project that took place in Banke (2023) and the awareness programs conducted by the Nepal Blind Welfare Association, Kailali Branch (2023), have recently endeavoured to fill these gaps through imparting education on menstrual hygiene, law, self-defence, and reproductive health. An investigation into these projects showed that the participating groups realised that their knowledge had been broadened, more health services were being used, and confidence levels had increased. Hence, it clearly demonstrates the significance of the presence of the targeted .

There have been very few studies that focus specifically on sexual and reproductive health and women with disabilities, particularly in rural and local areas. While there has been some progress made, Barriers such as physical inaccessibility, financial limitations, discriminatory attitudes, and inadequate availability of assistive devices continue to prevent people from using services. Likewise, women with disabilities in high-income countries often face barriers to accessing prenatal, delivery and postpartum care due to stigma and lack of training among health care providers (WHO., 2013). Whereas cultural norms, early marriage, low literacy rate and social stigmatisation contribute to reproductive health inequalities in developing countries like Nepal.

In Nepal, one of the most common oppressions of women with disabilities, particularly those living in rural and isolated areas, at the intersection between targeted initiatives and law frameworks, there exists a range of targeted legislation and policy

frameworks, but little to no research on the practice of sexual and reproductive health on the intersection of disability and rural epidemiology. Most of the literature and research, with a few exceptions, over the past fifty years, the majority of the literature and research focused on the urban adolescent population. Various literature and research studies on the sexual and reproductive health of various rural populations, especially women with disabilities, however, appear to be under-researched. There is limited integration of assistive devices to be used. In addition to these barriers, cultural attitudes, social stigmas, and inadequate training, health services are becoming more and more discriminatory. There are very few, if none, extensive studies to shed light and expand the policy framework to more inclusive and appropriate health sector reforms. It requires in-depth and very detailed studies to be able to address the issue more effectively. This is the gap in research, especially in the case of Janaki Rural Municipality. This is why the research is innovative, as it is the only one to focus on women with disabilities in all wards of Janaki Rural Municipality.

Methods and Procedures

Theresearch used a descriptive research design to explore the sexual and reproductive health of disabled women. The research was conducted in all the wards of Janaki Rural Municipality, Kailali District. As per the National Census 2021, the total number of persons with disabilities in the municipality is 3,413. However, only 545 have been officially registered. Among them, 56 people have a profound disability (red card), 229 severe disability (blue card), 145 moderate disability (yellow card), and 115 mild disability (white card). Not all of the registered individuals were willing to participate as respondents; hence, 40 married women with at least one child were chosen through a convenience sampling method. Both primary and secondary data were utilised. Primary data were gathered through structured interviews, and secondary data were taken from municipal records and reports of the relevant .

Results and Discussion

Demographic and Socio-economic Characteristics

The demographic data provide statistical insights into population characteristics, while socio-economic data reflect people's educational, economic, and social conditions. A community comprises individuals from diverse castes, religions, occupations, lifestyles, and cultures, and the development of a country largely depends on these human resources. This study examines the socio-economic characteristics of women with disabilities, including age, religion, family structure, education, occupation, housing, sanitation, cultural practices, access to health services, and disability-friendly infrastructure, along with their sexual and reproductive health issues and service accessibility, which is clarified in the following table.

Table 1
Demographic and Socio-economic Characteristics

Characteristics	Frequency (n=40)	Percentage (%)
Population Distribution by Age		
15–20 years	2	5
21–25 years	10	25
26–30 years	14	35
31–39 years	8	20
40 years and above	6	15
Population Distribution by Religion		
Hindu	30	75
Christian	8	20
Muslim	2	5
Educational Status of Respondents		
Illiterate	14	35
Literate (Basic)	12	30
Secondary Level	10	25
Higher Education	4	10
Family Structure of Respondents		
Nuclear Family	28	70
Joint Family	12	30
Occupational Status of Respondents		
Housewife	16	40
Agriculture	14	35
Business	8	20
Employment	2	5

The study included 40 women with disabilities, aged between 15 and 40 years. Aged 26–30 years were 35 percent, 21–25 years were 25 percent, 31–39 years were 20 percent, > 40 years were 15 percent, and the least age group was 15–20 years. They

were 5 per cent of the respondents. In terms of religion, most of the participants were Hindu (75%), followed by Christian (20%) and Muslim (5%), resembling the major religious composition of the population. Regarding family structure, within which the participants live, 70 percent of the respondents were living in a nuclear family, whereas 30 percent of the participants live in a joint family. Educational status of the participants revealed that 35 percent of the participants were illiterate, 30 percent were adults aged 18- 24 with primary education, whereas 25 percent of the participants had secondary, and only 10 percent completed higher education. Occupationally, great percentage of the participants were housewives (40%), 35 percent were involved in farming, 20 percent running business and 5 percent were in employed others, all business and employment were formamidine contrast to the high literacy and low dependence on agriculture and which infers that woman engaged in unpaid housework and self-employment was high, which might indicate higher dependency on household/ agricultural activities. These socio-economic data considerably helped to understand the practices of women living with significant disabilities' reproductive and sexual history, as well as knowledge and access to services were lived experiences from the study setting.

Sexual and Reproductive Health Knowledge, Perceptions and Practices

Women with disabilities have no better access to sexual and reproductive health. They face these challenges as a given reality, i.e., lack of health checkup, lack of reproductive health education, early marriage, menstrual and nutrition problems, and limitations associated with the mother. Moreover, pregnancy generates multiple risks such as hypertension, swelling, fetal suffering, and infection. Proper nutrition and care should be preserved for the child, and before dawn. This study aims to investigate knowledge, attitudes, and practices related to SRH among disabled women, focusing on marital status, age at first conception, prenatal care, nutrition, menstrual hygiene, nature of delivery, family planning, and being forced to get married.

Table 2

Knowledge about Sexual and Reproductive Health

Characteristics	Frequency (n=40)	Percentage (%)
Sources of SRH Information		
School/College	14	35
Training Programs	14	35
Health Institutions	4	10
Other Sources	8	20
Age at Marriage of Respondents		
10–15 years	10	25
16–20 years	18	45
21–25 years	8	20
26 years and above	4	10

Living Arrangement with Husband		
Living with Husband	22	55
Husband Not at Home	18	45
Sleeping During Menstruation		
In the Cowshed	5	12.5
On Own Bed	25	62.5
In a Separate Room	8	20
Other	2	5
Types of pads		
Commercially Purchased Pads	10	25
Cloth (Cotton)	20	50
Homemade Pads	8	20
Other	2	5
Age at First Pregnancy		
Below 15 years	2	5
16–20 years	20	50
21–25 years	13	32.5
26 years & above	5	12.5
Antenatal Health Check-up		
Received Antenatal Check-up	32	80
Did Not Receive Antenatal Check-up	8	20
Reasons for Not Having Check-ups During Pregnancy		
Lack of Time	12	30
Lack of Knowledge	14	35
Lack of Health Services	10	25
Fear or Anxiety	4	10
Additional Food Intake During Pregnancy		
Green Vegetables or Fruits	22	55
Eggs, Fish, and Meat	10	25
Milk, Yoghurt, and Ghee	8	20
Use of Family Planning		
Condom	16	40
3-month injection	2	5
Others	17	42.5

Do not use	5	12.5

In this study area, disabled women face broad sexual reproductive health and rights, literacy and poverty issues. The women with disabilities in the study area are confronted with enormous SRH challenges, and these combine with societal stigmatisation, poverty and low levels of education. Respondents' perception of knowledge was measured by enquiring their SRH awareness and ways of obtaining information. For the 40 women, information was provided by schools or colleges (35%), training programs (35 %), health agencies (10 %) and others (20 %). Early marriage was common, with 25 percent having been married at the age of 10–15 years; for 45 percent of women, their ages at first marriage were between 16–20 years, and between 21 - 25 years for 20 percent. Only about one out of ten women (11%) had attained a marriage age equal to or greater than that stipulated by law in Nepal (≥20 years). Underage marriage poses serious risks for maternal and child health, such as pregnancy complications, delivery complications, and stunted growth among the children born.

Health outcomes were also affected by marriage patterns. Among them, 55 percent of women were living with their husbands, and 45 percent were living apart for work and other reasons, and those living with their spouses enjoyed better health and nutrition. Menstrual hygiene management is heterogeneous, with 50 percent using cloth, 25 percent using commercial pads, 20 percent using homemade pads and 5 percent using other materials. When they menstruated, 62.5 percent of them slept in their own beds, 20 percent in a different room, and 12.5 percent in the cowshed; a consequence of what can be described as cultural beliefs, illiteracy, and social standards. Age at first pregnancy was a further issue. Among the total respondents, 50 percent were pregnant within the age group of 16–20 years, 32.5 percent within 21–25 years, 12.5 percent was at the age of 26 years or above, and 5 percent were below the age of 15 years, indicating the hazards of early pregnancy. Some 80 percent of respondents had made use of antenatal services, and 20 percent did not. Taste, dirty environment, toothache and 4 main reasons of ignorance, 35 percent, lack of time 30 percent, distance 25 percent of fear or anxiety, 10 percent, were reasons for not taking treatment. Nutrition during pregnancy was evaluated, showing 55 percent ate green vegetables and fruits, 25 percent eggs, fish and meat, and 20 percent drank milk, yogurt and ghee, indicating they had fairly balanced meals, often supplemented with family support.

Family planning methods revealed that 40 per cent used condoms, 5 percent used the three-month injectable, 42.5 percent used other methods like Norplant, Copper-T, and pills, and 12.5 percent did not use any method. These results show that women with disabilities have knowledge of SRH and make use of certain services, but their reproductive health outcomes are still affected by barriers such as early marriage, social stigma, inadequate knowledge, and limited access to health facilities. This study clearly demonstrates the requirements for focused awareness raising programs, health services that are disabled friendly and community support to secure the quality of life or life chances of women with disabilities and their children.

Table 3
Vaccination and Delivery Practices

Characteristics	Frequency (n=40)	Percentage (%)
Vaccination		
Vaccinated	34	85
Not vaccinated	6	15
Iron Tablet Consumption		
Took iron tablets	34	85
Did not take iron tablets	6	15
Place of Delivery		
Delivered in the hospital	24	60
Delivered at home	10	25
Delivered at the health post	6	15
Type of Delivery		
Normal Delivery	34	85
Cesarean (Operation) delivery	5	12.5
Vacuum-assisted delivery	1	2.5
Persons Assisting During Delivery		
Family members	21	52.5
Health workers	5	12.5
Neighbors	6	15
Traditional birth attendants (Sudeni)	8	20

Tetanus Toxoid (T.T.) vaccine is a mandatory part of pregnancy care to safeguard the life of mother and baby from fatal infections, which is one of the causes of death in neonates in Nepal. Two doses during pregnancy for pregnant women and five doses for life for other than pregnant women are recommended. Among the respondents, who had the T.T. vaccine, 85 percent were given two doses and 15 percent were not who citing time constraints, ignorance, traditional superstitions and cultural practices as reasons for not taking the vaccine. Likewise, the supplementation of iron is necessary to prevent anaemia and maintain the health of a mother and her fetus. Pregnant women should take the tablets from the fourth month of pregnancy up until seven weeks after delivery. In the study site, 85 per cent of the women took iron tablets, 15 per cent did not, mainly because of limited access to health services, and this emphasises the importance of awareness creation for women who are illiterate and not trained.

Safe birth is essential to maternal and newborn health. Nepal encourages hospital delivery by providing free services, cash incentives warm clothing to mothers who deliver at home. The study said 60 per cent of the women gave birth in hospitals, 25 per cent at

home and 15 per cent at health posts, noting traditional beliefs and transportation problems were some of the reasons many did not go to the hospital to deliver. Delivery was of a different category: 85 per cent had normal delivery, 12.5 per cent underwent caesarean section, and 2.5 per cent had vacuum-assisted delivery. The majority of deliveries were normal, with cesarean and assisted delivery capacity limited by poor local facilities. Support during labour is also imperative, as confirmed. The report revealed that half (52.5%) of the women were assisted by a family member, 12.5 per cent were attended to by health workers, 15 percent were helped by neighbours and 20 per cent by a traditional birth attendant (Sudeni). Family was the main social support, neighbours, and Sudeni came in as help when family assistance was not sufficient. These results emphasise the need for trained, accessible health personnel and a community-based support system to promote safe deliveries and maternal health for women with disabilities.

Table 4
Sexual and Reproductive Health Problem

Characteristics	Frequency (n=40)	Percentage (%)
Problems During Menstruation		
Stomach pain/Fever/Headache	19	47.5
Hygiene maintenance difficulty	7	17.5
Dependence on others	5	12.5
Irregular menstruation	9	22.5
Problems During Pregnancy		
Fever	9	22.5
Severe abdominal pain	7	17.5
Vaginal bleeding	5	12.5
Nausea / Vomiting	19	47.5
Problems During the Postpartum Period		
Excessive bleeding/High fever/ Fainting	6	15
Postpartum depression	4	10
Financial stress	21	52.5
Lack of health access	9	22.5
Sexual Abuse		
Yes	12	30
No	28	70

Disabled women encounter multiple challenges which are related to sexual and reproductive health. They include menstruation, pregnancy, postpartum periods, and risks of sexual abuse. In the menstruation period, they experience health problems like stomach pain, fever, headaches and so on. They have to depend on others for support

and proper care. In this study, a total of 47.5 per cent of respondents reported stomach pain, fever and headache, 17.5 per cent faced hygiene problems, 12.5 per cent relied on others, and 22.5 per cent experienced irregular menstruation. These findings show that menstruation poses greater challenges for women with disabilities compared to the general population. Similarly, pregnancy is a vital time when special attention is needed, such as adequate nutrition, hygiene, rest and avoidance of toxicants. Among the respondents with fever were 22.5 per cent, 17.5 per cent had severe abdominal pain, 12.5 per cent suffered from vaginal bleeding, and 47.5 per cent were experiencing nausea or vomiting. These obstacles are further compounded by physical disabilities, ignorance, poverty and traditional beliefs, which is why support from husband, family and community is vital.

The postnatal period, which lasts for almost 6 weeks, is as important for maternal well-being. In this study,15 per cent of women had severe bleeding, high fever or fainting, 10 per cent had postpartum depression, 52.5 per cent faced financial stress, and 22.5 per cent lacked access health care system. Financial hardship was the most common worry, especially among women who do not qualify for full social security benefits, pointing to a need for broader government assistance. Sexual abuse is a continuing problem for disabled women. The research revealed 30 per cent of those interviewed claimed to have been sexually abused, while 70 per cent stated they had not. This highlights the importance of awareness, protection and training programs to prevent abuse and to support the victims. In conclusion, the research suggests that Janaki Rural Municipality women with disabilities confronted multiple SRH barriers at all levels of reproductive life. The results signal the importance of specific actions, including health promotion, access to services, financial support and protection against abuse, that can contribute to ensuring their well-being and empowerment.

Conclusion

To conclude, women with disabilities face multiple barriers in sexual and reproductive health, mainly due the reasons such as a lack of information, cultural prohibitions and inadequate assistance. Their menstrual, pregnancy and family planning and postnatal care needs are frequently overlooked, and many also experience violence, financial hardship and postnatal depression. In this regard, the study findings show early marriage, lack of education, dependence on agriculture and household chores, and poor menstrual hygiene, pregnancy care and safe delivery of women with disabilities in Janaki Rural Municipality. Although most could receive antenatal care and vaccinations, many still face serious obstacles. Ignorance, social stigma and distance to health services have taken their toll, denying some women the treatment they need. Alarmingly, several women said that they had been sexually abused, which is an urgent reminder of the need for protection, robust support mechanisms and safe spaces that empower and protect them. This study adds important information to the national and international discussions on disability-inclusive health by focusing on the intersection of disability, gender, and access to health. It provides a firm basis for future research to improve SRH services, enhance policy implementation, and empower women with disabilities through context-specific awareness and support initiatives worldwide.

References

Brenna, E. A., & Santinele Martino, A. (2024). Disability is associated with sexually transmitted infection: Severity and female sex are important risk factors. *The Canadian Journal of Human Sexuality, 72*(2). 232-245.

Budha, R. (2015). *A study on safe motherhood*. Unpublished Master's Degree Thesis, Tikapur Multiple Campus.

Dhakal, S. (2010). *Population bases*. Vidyarthi Pustak Bhandar.

Dhulal, K. (2011). *Comprehensive maternal services*. Sunlight Publication.

Ghasemi, M., et al. (2022). Unmet need for sexual health services among women with disabilities: A systematic review. *Disability and Health Journal, 32*(2). 27-38.

Groce, N. E., & Kett, M. (2014). *Health of people with disabilities: A global perspective*. Oxford University Press.

Gurung, R. (2015). *A study on knowledge and practice regarding safe motherhood*. Unpublished Master's Degree Thesis, Morang Multiple Campus.

Karki, A. (2008). *Population, education base and reproductive health*. Pairavi Publication.

Khanal, C. (2016). *A study on knowledge and attitudes of adolescents regarding sexual and reproductive health*. Unpublished Master's thesis, Tribhuvan University.

Ministry of Health and Population (2018). *Nepal National Health Accounts, 2012/13 – 2015/16*. Government of Nepal. https://www.who.int/docs/default-source/nepal-documents/nepal-nha-2012-13-to-2015-16-ministry-of-health-and-population-june-2018.pdf?sfvrsn=64645c52_2&utm_source=chatgpt.com

National Census (2078). *National Census 2078.* Government of Nepal. http://censusnepal.cbs.gov.np/Home/Index/EN

National Guidelines for Disability Inclusive Health Services, 2019. Government of Nepal. https://www.nhssp.org.np/Resources/GESI/National_Guidelines_Disability_Inclusive_Health_Services2019.pdf

National Health Policy (1991). National Health Policy 1991.Government of Nepal. https://shisiradhikari.com.np/library/398/550

Nepal Blind Welfare Association, Kailali Branch. (2023). *Awareness program on sexual and reproductive health of disabled adolescents and women*.

Nepal Disabled Women Association. (n.d.). *Situation of women with disabilities in Nepal*. YouTube. https://www.youtube.com/watch?v=0QUCB6HzxTE&t=37s

Nepal Disabled Women's Association, *Invisible Realities* (2019), https://www.ndwa.org.np/wp content/uploads/2020/08/invisible_realities_ndwa_report-published-by-Womenkind_Reduced.pdf?utm_source=chatgpt.com

Nepal's Adolescent Health and Development Strategy 2075 (2018) https://shisiradhikari.com.np/library/112/1075

Nguyen, A. (2020). *Challenges for women with disabilities accessing reproductive health care around the world*: A scoping review. Sexuality and Disability. https://www.researchgate.net/publication/340571601_Challenges_for_Women_with_Disabilities_Accessing_Reproductive_Health_Care_Around_the_World_A_Scoping_Review

Safe Motherhood and Reproductive Health Rights Acts (2018). https://fwld.org/wp-content/uploads/2019/03/Safe-Motherhood-and-RHR-Act-2075.pdf

Shakespeare, T. (2006). *Disability rights and wrongs*. Routledge. https://books.google.com.np/books/about/Disability_Rights_and_Wrongs.html?id=8vHtAAAAMAAJ&redir_esc=y

Sharma, M. R. (2066 B.S). *Community health and safe motherhood*. Vidyarthi Pustak Bhandar.

Sherchan, L., & Upreti, Y. (2020). *Health and physical education*. Quest Publication.

WHO (2023). Disability. https://www.who.int/news-room/fact-sheets/detail/disability-and-health