American Journal of Health Research
2026, Vol. 14, No. 6, pp. 280–286
https://doi.org/10.11648/j.ajhr.20261406.13

Research Article

Exploring Lived Experiences of Sexual and Reproductive Health Among Newly Married Women: A Transcendental Phenomenological Study

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Abstract

Sexual and reproductive health (SRH) is central to women's well-being, autonomy, and dignity, yet newly married women in rural Nepal may encounter substantial social, cultural, economic, and household barriers to accessing information and participating in reproductive health decisions. This qualitative exploratory study examined the lived experiences of newly married women in Rajdevi Municipality, Rautahat District, Nepal, with particular attention to SRH awareness, decision-making, and the influence of social and cultural expectations. The study used a transcendental phenomenological approach. Participants were currently married women aged 18-30 years who were within the first five years of marriage. Data were generated through six in-depth interviews (IDIs) and one focus group discussion (FGD) involving eight participants; six women participated in both methods and two additional women participated in the FGD. Data were transcribed, translated where necessary and analyzed thematically using Braun and Clarke's six-step approach. Four interconnected themes emerged: (1) understanding of SRH, (2) women's role in SRH decision-making, (3) influence of social expectations and gender roles, and (4) support systems and possibilities for change. Participants commonly described learning about SRH after marriage, often around pregnancy and motherhood, with Female Community Health Volunteers (FCHVs) and mothers' groups serving as important information sources. However, knowledge did not consistently translate into autonomy. Husbands and in-laws, particularly in joint families, often retained authority over contraception, pregnancy timing, and health-care decisions. Women in nuclear households or with supportive and educated spouses described greater participation. Economic dependence, restricted mobility, and lack of legal documentation further constrained agency. The findings indicate that improving SRH outcomes requires more than information dissemination; interventions should address household power relations, engage men and elders, strengthen women's community networks, and promote economic and legal empowerment.

Keywords

Sexual and Reproductive Health, Newly Married Women, Reproductive Autonomy, Feminism, Intersectionality, Transcendental Phenomenology, Nepal

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Received: 27 September 2026; **Accepted:** 9 November 2026; **Published:** 27 November 2026

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1. Introduction

Sexual and reproductive health (SRH) is fundamental to women's physical well-being, dignity, autonomy, and ability to make informed decisions about contraception, pregnancy, childbirth, and other aspects of reproductive life. SRH is therefore not only a clinical concern but also a matter of gender equality, social inclusion, and human development. Evidence from low- and middle-income settings indicates that women's knowledge, access to services, and capacity to act on reproductive information are closely connected to maternal and child health outcomes and to women's broader empowerment [1, 2].

Despite policy and programmatic progress, women in rural and traditionally patriarchal settings continue to face barriers to SRH information and services. Socio-cultural norms, restrictive gender roles, stigma, limited mobility, and unequal household power relations can shape what women are able to know, discuss, and decide about their reproductive health [3, 4]. In South Asia, newly married women may enter households in which reproductive decisions are strongly influenced by husbands, mothers-in-law, and other senior family members, while topics such as contraception, menstruation, and abortion remain difficult to discuss openly [5].

Nepal has established a strong legal and policy foundation for reproductive health. The Constitution of Nepal recognizes women's right to safe motherhood and reproductive health, while national programs address family planning, maternal health, safe motherhood, and reproductive health information [6, 7]. Nevertheless, a gap can persist between formal rights and women's everyday capacity to exercise those rights, particularly in rural communities where household hierarchies, economic dependence, and social expectations remain influential [8, 9].

The theoretical perspectives informing this study emphasize that reproductive knowledge and autonomy are socially produced. Feminist scholarship has highlighted patriarchy and the regulation of women's sexuality and reproductive lives [10, 11], while Mies [12] drew attention to the undervaluation of women's reproductive and domestic labour. Intersectionality further recognizes that gender interacts with caste, class, education, age, and geographic location to produce different and sometimes compounded forms of disadvantage [13-15]. Reproductive justice perspectives similarly emphasize that reproductive autonomy depends on the social and structural conditions in which choices are made [16].

Although national surveys provide important information on reproductive health indicators, quantitative measures may not fully explain how newly married women acquire SRH knowledge, negotiate decisions, experience silence and stigma, or interpret household expectations. Qualitative inquiry is therefore valuable for examining the meanings women attach to their experiences. Transcendental phenomenology, associated with Husserl and developed methodologically by Moustakas [17], focuses on describing the essence of lived experience while encouraging the researcher to bracket preconceptions. This approach is particularly appropriate for a sensitive topic in which women's own voices and meanings are central.

This study consequently explored the lived experiences of newly married women in Rajdevi Municipality, Rautahat, focusing on how they understand SRH, participate in reproductive decision-making, and experience the influence of social and cultural expectations. By bringing feminist and phenomenological perspectives together, the study sought to illuminate the gap between awareness and agency in the everyday lives of newly married women.

1.1. Objectives

The general objective of this study was to explore the lived experiences of newly married women in Rautahat in relation to their awareness, decision-making, and the social factors that shape their sexual and reproductive health.

The specific objectives were to: (i) understand how newly married women perceive and experience SRH; (ii) examine their participation and perceived role in SRH decision-making; and (iii) identify how social and cultural expectations influence their awareness, choices, and involvement in SRH.

1.2. Significance of the Study

The study contributes context-specific qualitative evidence on SRH awareness and reproductive agency among newly married women in rural Nepal. Its findings are relevant to health workers, local governments, community organizations, and policymakers seeking to strengthen SRH information, women's participation in decision-making, and gender-responsive community interventions.

2. Methods

2.1. Study Design

A qualitative exploratory design informed by Moustakas's [17] transcendental phenomenological perspective was used to explore the lived experiences of newly married women concerning sexual and reproductive health (SRH). This perspective guided the study's focus on understanding how women experienced and interpreted SRH within their marital, household, and sociocultural contexts. The study explored participant's experiences of SRH awareness, reproductive decision-making, and the influence of social and cultural expectations. In keeping with the transcendental phenomenological perspective, the researcher consciously practised bracketing (epoché) by reflecting on and setting aside personal

assumptions and preconceptions about SRH, as far as possible, to remain attentive to participant's own accounts and interpretations. Data were collected through in-depth interviews (IDIs) and a focus group discussion (FGD) to capture both individual experiences and shared perspectives.

2.2. Participants and Sampling

The study universe consisted of currently married women aged 18-30 years residing in Rautahat District who were within the first five years of marriage. Non-probability purposive sampling was used to identify women whose experiences were relevant to the research questions. Eligibility was confirmed during the recruitment process based on participants' age, marital status, and duration of marriage. Although all participants met the criterion of being within the first five years of marriage, their exact duration of marriage was not recorded as a separate demographic variable. Eight unique participants were included. Six participants took part in both in-depth interviews (IDIs) and the focus group discussion (FGD), while two additional participants participated only in the FGD. This design provided both individual narratives and collective perspectives on social norms and reproductive decision-making.

2.3. Data Collection

Data were collected using a semi-structured in-depth interview guide and a focus group discussion guide. The interview guide covered SRH knowledge, sources of information, reproductive decision-making, household expectations, and barriers to accessing services. The FGD explored shared beliefs, gender norms, expectations after marriage, family planning decisions, community influences, women's groups, and the role of Female Community Health Volunteers (FCHVs).

Six IDIs were conducted in private and comfortable settings and lasted approximately 45-60 minutes. With participant's permission, conversations were audio-recorded and field notes were taken. One FGD with eight participants was conducted in a familiar community setting near the local health post and lasted approximately 90 minutes. FCHVs assisted in identifying potential participants. Informed consent was obtained before data collection.

2.4. Data Analysis

The collected data were analyzed using Braun and Clarke's [18] six-phase approach to thematic analysis. The process involved familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Interview and focus group transcripts were reviewed repeatedly to identify meaningful patterns related to participant's experiences of sexual and reproductive health. Initial codes were developed from the transcripts and organized into broader themes. The resulting themes reflected participant's understanding of SRH, their involvement in reproductive decision-making, the influence of social expectations and gender roles, and the support systems available to them.

2.5. Trustworthiness and Reflexivity

Trustworthiness was addressed using the criteria of credibility, dependability, confirmability, and transferability [19]. Credibility was supported through rapport-building with participants and triangulation of data from the IDIs and FGD, which provided opportunities to consider both individual experiences and shared perspectives. Dependability was supported through documentation of field procedures and methodological decisions, along with consultation with the academic supervisor. Confirmability was strengthened by grounding interpretations in participants narratives and illustrative quotations. The researcher also practised reflexivity throughout the study, acknowledging how her familiarity with the cultural and social context could influence the research process and reflecting on personal assumptions during data collection and interpretation. Rich descriptions of the study setting, participants, and their experiences were provided to support transferability. Participant verification of interview summaries was not conducted.

2.6. Ethical Considerations

Institutional permission to conduct the study was obtained from the Department of Gender Studies before data collection. No separate formal ethical review or approval was obtained. Participants were informed about the purpose, voluntary nature and procedures of the study and informed consent was obtained before data collection. They were also informed of their right to decline to answer any question or withdraw from participation. Privacy and confidentiality were maintained, and participant codes were used when reporting findings to protect participant's identities. Audio recordings, transcripts, and field notes were stored securely. Data collection was conducted sensitively, considering the personal nature of discussions concerning sexual and reproductive health.

3. Results

3.1. Participant Characteristics

Table 1. Participant Characteristics.

Participant	Age (years)	Family type	Education	Reproductive status
P1	20	Joint	No formal education	Lactating mother
P2	25	Joint	No formal education	Mother of child <2 years
P3	25	Joint	No formal education	Lactating mother
P4	21	Nuclear	Secondary education	Mother of child <2 years
P5	25	Joint; spouse abroad	No formal education	Mother of child <2 years
P6	24	Joint	Limited education	Pregnant
P7	25	Joint	Not specified	Pregnant
P8	30	Joint	Not specified	Mother of child <2 years

Note: Participant codes are used in place of names to protect confidentiality.

The eight participants were aged 20-30 years. Most lived in joint families and had limited or no formal education. Participants represented different reproductive circumstances, including pregnancy, lactation and motherhood. One participant lived in a nuclear family, while another lived in a joint household while her spouse was abroad. Individual participant characteristics are presented in Table 1.

3.2. Theme 1: Understanding of Sexual and Reproductive Health

For most participants, understanding of SRH developed after marriage and was often connected to pregnancy, childbirth, breastfeeding, and motherhood. FCHVs and mother's groups were important sources of information, particularly for maternal nutrition, breastfeeding, family planning, and related health topics. However, participants described a clear difference between topics considered socially acceptable and topics considered sensitive or taboo.

"Before marriage, I knew very little about sexual and reproductive health. After giving birth, I learned about exclusive breastfeeding and nutrition from the Health Mother group meetings through FCHV." (P1)

Participants also described discomfort in discussing SRH within the family. Women's groups and other women-only spaces were viewed as safer settings for asking questions and discussing sensitive issues. Participants with more education or supportive household relationships appeared more confident in expressing their health concerns.

"No, I feel shy. I don't feel comfortable discussing such things with family members. But when I meet with other women here, I can ask freely." (P3)

3.3. Theme 2: Women's Role in Sexual and Reproductive Decision-Making

Awareness did not consistently translate into decision-making power. Most participants reported that husbands, mothers-in-law, or other senior family members had substantial influence over family planning, pregnancy timing, antenatal care, and other health-related decisions. This pattern was particularly visible in joint households.

"I have heard about family planning, but I cannot use anything unless my husband agrees. There is nothing I can do on my own." (P2)

Another participant described the gap between knowing what was beneficial and being able to act on that knowledge: "I know what is good for my health, but at home, others decide. I cannot go for checkups or choose for myself." (P3)

In contrast, a participant living in a nuclear family with a supportive spouse described greater participation: "My husband listens to me. I don't have to ask others for small things now." (P4). These accounts suggest that education, spousal communication, and household composition can create enabling conditions for women's agency.

3.4. Theme 3: Influence of Social Expectations and Gender Roles

Social expectations surrounding marriage, motherhood, obedience, and fertility strongly shaped women's reproductive experiences. Participants described pressure to conceive

soon after marriage and expectations that younger women should defer to elders. Reproductive roles were closely linked to women's status and acceptance within the household.

"We learn here about spacing children, but at home, the elders say children should come soon after marriage." (P4)

The influence of gender norms extended beyond fertility to everyday decisions about food, rest, mobility, and health care. One participant explained: "I cannot even decide what food to cook without asking elder. Sometimes I wish I could manage small things on my own." (P1). Another participant, who was pregnant, expressed hope that motherhood would eventually increase her voice: "Right now, my words do not matter much. But once I become a mother, maybe they will listen to me more." (P6).

3.5. Theme 4: Support Systems and Possibilities for Change

Community-based spaces, including mothers' groups, local women's groups such as Radha Aama Samuha, and FCHV networks, were identified as important sources of information, encouragement, and solidarity. Participants described these settings as comparatively safe places to discuss SRH and gain confidence.

"These discussions give courage. Even if I cannot decide everything, at least I know what is right and wrong for my health." (P8)

Participants also emphasized that women-focused awareness activities alone were insufficient. They recommended involving men, husbands, in-laws, and community leaders so that the social environment surrounding women's reproductive choices could change. Economic dependence and lack of legal documentation were additionally identified as structural barriers to agency. The four themes and illustrative evidence are summarized in Table 2.

Table 2. *Themes and Key Findings.*

Theme	Key finding	Illustrative evidence
Understanding of SRH	SRH knowledge commonly developed after marriage, often through pregnancy, motherhood, FCHVs, and mothers' groups; sensitive topics remained difficult to discuss.	"Before marriage, I knew very little…" (P1)
Women's role in SRH decision-making	Husbands and in-laws often retained decision-making authority, particularly in joint families; supportive spouses and nuclear households enabled greater participation.	"I cannot use anything unless my husband agrees." (P2)
Social expectations and gender roles	Pressure for early childbearing, obedience, and deference constrained reproductive agency and everyday autonomy.	"Elders say children should come soon after marriage." (P4)
Support systems and possibilities for change	FCHVs and women's groups created safer spaces for learning and solidarity; participants called for male and elder engagement and broader structural support.	"These discussions give courage…" (P8)

4. Discussion

The findings reveal a persistent tension between growing SRH awareness and limited reproductive agency among newly married women in Rajdevi Municipality. Participants were increasingly exposed to information through FCHVs, mothers' groups, and women's community spaces, yet the ability to translate knowledge into decisions remained constrained by household power relations and social expectations. This supports feminist interpretations that reproductive knowledge and bodily autonomy are shaped by wider structures of power rather than by information alone [10, 11].

A prominent finding was that SRH learning often occurred after marriage and, for several women, around pregnancy or childbirth. This reactive pattern suggests that reproductive knowledge was frequently introduced through socially accepted roles of wife and mother rather than through an understanding of women as autonomous rights-bearing individuals. Similar concerns have been identified in research emphasizing that awareness without empowerment may not lead to meaningful reproductive autonomy [4, 8].

The findings also demonstrate that household structure matters. Women in joint families described greater involvement of husbands, mothers-in-law, and senior relatives in reproductive decisions, while the participant living in a nuclear household with a supportive spouse reported greater confidence and participation. These differences are consistent with household-level perspectives on women's autonomy and with intersectional approaches that recognize how education, economic

position, household composition, and gender interact to shape agency [13, 14].

Social expectations surrounding early childbearing further narrowed the space for reproductive choice. The pressure to demonstrate fertility soon after marriage illustrates how motherhood can become a condition for recognition and respect. From a reproductive justice perspective, meaningful choice requires not only access to information and services but also social conditions in which women can make decisions without coercive pressure [16].

The role of community-based support was an important positive finding. FCHVs, mothers' groups, and women's collectives provided opportunities for information exchange and peer solidarity. These spaces appeared to create a degree of privacy and confidence that was often unavailable within households. However, participants' recommendations to include men and in-laws highlight the limits of women-only information approaches when the broader decision-making environment remains unequal.

Finally, the experiences of participants facing economic dependence, restricted mobility, or lack of citizenship documentation show that reproductive autonomy is also connected to material and legal conditions. Knowledge can increase without producing agency when women lack control over resources or the ability to move and access services independently. The findings therefore support a multidimensional approach to SRH programming that combines information, gender-transformative engagement, community support, economic inclusion, and legal empowerment.

5. Conclusion

This study shows that newly married women in rural Rautahat are gaining SRH knowledge, particularly through FCHVs, mothers' groups, and community discussions, but awareness does not necessarily translate into reproductive autonomy. Decisions concerning contraception, pregnancy timing, antenatal care, and other health matters frequently remain influenced or controlled by husbands and in-laws, especially in joint families. Women living in nuclear households or with supportive and educated spouses described comparatively greater participation.

The findings further demonstrate that SRH experiences are shaped by gender norms, expectations of early childbearing, economic dependence, restricted mobility, and legal exclusion. Community-based groups provide valuable spaces for learning and solidarity, but sustainable change requires transformation of the household and community environments in which reproductive decisions are made.

5.1. Recommendations

1) Expand SRH education for newly married women to include family planning, menstrual health, reproductive rights and other sensitive topics in confidential and culturally appropriate formats.
2) Strengthen FCHV, mothers' group, and women's group platforms as safe spaces for discussion while linking them to referral and counseling services.
3) Engage husbands, in-laws, male community members, and local leaders in gender-responsive SRH initiatives to address household power imbalances.
4) Integrate negotiation, communication, and decision-making skills into community SRH programming so that women can translate knowledge into action.
5) Address structural barriers to reproductive autonomy through economic inclusion, access to resources, mobility support, and assistance with legal identity and documentation.

5.2. Limitations and Future Research

This study has several limitations. First, the findings are based on eight participants from a single municipality in Rautahat District, Nepal, and may not reflect the experiences of newly married women in other geographical and sociocultural settings. Second, the sensitive nature of sexual and reproductive health may have influenced participants' willingness to discuss certain experiences. This may have been particularly relevant during the focus group discussion, where the presence of other participants could have affected the extent to which women felt comfortable sharing personal experiences. Furthermore, differences between the individual interviews and the focus group discussion may have influenced the depth and nature of the information shared. Third, the findings are based on participants' self-reported experiences and perceptions within the specific context of the study. Additionally, six participants took part in both data collection methods, while two participated only in the FGD, meaning that individual interview accounts were not available for all participants. Participant verification of findings was also not conducted.

Future research should include women from diverse geographical, socioeconomic, and cultural backgrounds to examine how caste, education, economic status, migration, and household composition shape reproductive autonomy. Further studies could also explore the perspectives of husbands, in-laws, and community health workers to provide a broader understanding of reproductive decision-making and the social conditions that influence women's agency.

Abbreviations

FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
IDI	In-Depth Interview
SRH	Sexual and Reproductive Health

Acknowledgments

The authors express sincere gratitude to the study participants who shared their experiences and to the Female Community Health Volunteers and community groups who supported access to participants. Appreciation is also extended to Kanti & Kunja International College's department of Gender Studies and the academic supervisor for guidance throughout the research process.

Author Contributions

Simran Upadhayay: Conceptualization, Formal Analysis, Investigation, Methodology, Writing – original draft

Yashoda Dangi: Writing – review & editing

Bhishma Prasad Pokharel: Writing – review & editing

Dip Bahadur Singh: Formal Analysis, Writing – review & editing

Data Availability Statement

The qualitative data are not publicly available because of the sensitive nature of the subject and the need to protect participant's privacy and confidentiality.

Conflicts of Interest

The authors declare no conflicts of interest.

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