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Knowledge and Practices of Reproductive Rights among Women in Chandragiri Municipality

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Abstract

This study was conducted with an aim to identify the knowledge and practices of reproductive rights among women of reproductive age. Descriptive and cross-sectional methods under the quantitative research design were adopted. About 160 women from Chandragiri Municipality were selected using lottery methods. Both structured and semi-structured questionnaires were administered as the tools of data collection. The collected data were analysed and interpreted using statistical tools. A high level of awareness among the sample population was demonstrated by the fact that 84.9 % of respondents were aware of reproductive health and rights, whereas 15.1 % had never heard of them. Respondents' perceptions of reproductive rights like making decisions which was achieved by 28.0 % and health care right was achieved by 25.1 % of respondents. Similarly, the right to information was practiced by only 19.4 % of respondents. It indicates that there are gaps in the knowledge of women's reproductive health and access to health services in Chandragiri Municipality, which are driven by socio-economic, cultural, and gender barriers. So, accessible health services and comprehensive education in reproductive health with legal aspects should be managed both in community outreach and in school curricula effectively.

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Introduction

Reproductive rights constitute an essential dimension of human rights, ensuring that individuals can make informed and autonomous decisions regarding their reproductive health without discrimination, coercion or violence. These rights encompass access to comprehensive and accurate reproductive health information, family planning services, safe pregnancy and child birth care, and the freedom to determine whether and when to have children (UNFPA, 2022; WHO, 2020). For women of reproductive age, understanding and exercising these rights are crucial for safe guarding overall health, enhancing social empowerment and promoting economic well-being (UNFPA, 2022). This right is the attainment of the highest standard of physical and mental health possible for women. The enjoyment of reproductive right is essential to their life, well-being, and to their ability to participate in all areas of public and private life. A humanistic approach is built on seven fundamental principles: availability, accessibility, acceptability, quality of facilities and services, participation, equality, and accountability. According to World Health Organization (WHO), (2013), reproductive rights can be realised, respected and met if the sexual and reproductive health results are going to be enhanced, especially for the providers and the poor. Socio-economic and demographic characteristics have equally played a key role in the growth of knowledge about human rights to reproductive health. Economic and democratic developments have key positive effects on levels of gender equality (Pillai & Gupta, 2011).

Reproductive health is central to individual well-being and self-determination; thus, identification of the gaps in knowledge and practices is a priority. Most of the relatively underdeveloped areas face low literacy rates. Poor utilisation of health services and deeply rooted beliefs in culture are negative factors for reproductive health outcomes. This study hereby illustrates the gaps, providing useful insights to develop proper interventions and educational programs. The steps have been deemed crucial for the improvement of reproductive health and rights to ensure progress in the general quality of life and increased equality between genders in life. So, this study aimed to identify the knowledge and practices of reproductive rights among women of reproductive age in Nepal.

Literature Review

Reproductive rights among women of reproductive age remain uneven across many low- and middle-income countries. Although women may be aware of concepts such as family planning and safe motherhood, the understanding of reproductive rights as entitlements,

such as the right to access information, make autonomous decisions, and receive non-discriminatory reproductive health services, remains limited. Limited formal education and restricted access to accurate health information are common barriers that diminish women's ability to understand their reproductive rights (Kariuki & Muthoni, 2022).

Digital tools offer anonymity and convenience, enabling women, especially younger and unmarried individuals, to seek information without fear of judgment. These technologies have been linked with improved contraceptive uptake and increased self-advocacy in reproductive decision-making (Fernandez & Malik, 2024).

Sharma and Awasthi (2018) attempted to evaluate the effect of some socio-demographic factors on women's knowledge in regards to reproductive health in Nepal. The finding presents the education level and income as the two basic parameters affecting the management and understanding of reproductive health problems by women.

Nepal and Thapa (2020) highlighted the effectiveness of the role of health education programs in strengthening the feeling of reproductive rights among Nepalese women. Their results showed that focused education programs greatly increased knowledge, thereby increasing the practice of reproductive rights.

Although existing studies highlight factors influencing women's knowledge and practice of reproductive rights, there remains limited evidence specifically focused on women of reproductive age in Chandragiri Municipality. General awareness, but gaps persist in understanding how education, socioeconomic status, and access to services interact at the local level (Kaphle, 2013). In this way there is disconnection between knowledge and practical utilisation of reproductive rights in Nepal's semi-urban settings.

Methods

The constraints of the study area were deliberately set for an in-depth investigation of reproductive rights awareness and practices in the selected community without expanding the scope to other areas with potentially different socio-cultural and economic conditions. Under the quantitative method, the lottery sampling technique was used to select the participants. The population of reproductive age women in Chandragiri Municipality is not readily available. Since the population of the study was unknown, the researcher followed the statistical formula invented by William G. Cochran in 1963: n=Z2pq/d2 to calculate the actual sample size.

Z2 = 6.6536 derived from the Z-score for a 99% confidence interval)

d= signifies the degree of freedom

In this case, the values are set as follows:

p= 60 % = 0.6; q = 1- 0.6 =0.4; d= 10 % = 0.1 (Margin of error)

Using the formula, the calculation yields:

n = Z2 pq/d2, where n=desired sample size

= 6.6536* 0.24 /0.01= n=159.6864; n =160 (Nearly)

Therefore, the calculated sample size for the study was 160, with respondents representing the study area.

Results and Discussion

The collected data were reviewed for completeness, accuracy and consistency, and transferred into Statistical Package for Social Science (SPSS) for further analysis. Descriptive statistics (frequency and percentage) were used to describe the socio-demographic information of respondents, knowledge on reproductive rights, and practices in managing reproductive health.

Socio-demographic Information of Respondents

The socio-demographic information, including number, religion, caste, education and occupation of the respondents as per survey is mentioned below.

Table 1. *Socio-demographic informations of the respondents*

Age group	Frequencies (N)	Percentage (%)
18–30 years	55	34.37
31–40 years	70	43.75
41–49 years	35	21.87
Religion	Frequencies (N)	Percentage (%)
Hindu	130	81.12
Buddhist	15	9.37
Muslim	8	4.97
Christians	7	3.79
Caste	Frequencies (N)	Percentage (%)
Chhetri	49	30.55
Brahman	36	20.37
Janajati	60	37.81
Dalits	9	5.73
Muslims	2	1.01
Others	4	4.53
Total	160	100

Source: Field data, 2024

The residence of Chandragiri Municipality is culturally mixed which is reflected in the data given in table 1. The age composition analysis of the respondents shows that a bigger

proportion, which is 43.75%, of the respondents fall in the age bracket of (31-40) years. Second age group is of (18-30) years, which composes 34.37%. Following this the age group with the least proportion, which is the 41-49 years age group, with only 21.87 % of the respondents. These groups indicate that the dominant membership comes from the age group of (31-40) years, while the age group of (41-49) years holds a comparatively lesser proportion.

The table 1 also indicates that among the overall number of respondents, which is 160, the greatest number of respondents are Hindus, constituting people or 81.12%. The Buddhist community is the second-leading respondent, constituting 9.37% as the total of respondents. Likewise, there are also Muslim respondents, accounting for 4.97% and a total of 12 respondents. Then, the Christian community represents the final position, accounting for the lowest percentage of 3.79% and a total of 10 respondents. This indicates the overall respondents belong to a predominately Hindu community, followed by the Buddhist, Muslim, and Christian communities.

Table 2. *Level of education and ccupation of respondent (n=160)*

Education Level	Frequencies (N)	Percentage (%)
No formal education	16	0.101
Primary school	48	29.9
Secondary school	53	33.4
High school	34	21
Higher education	9	5.6
Occupation	Frequencies (N)	Percentage (%)
Housewife	62	38.5
Farmer	43	27.1
Laborer	35	21.6
Teacher	9	5.6
Students	11	7.2
Total	160	100

Source: Field data, 2024

The educational background of the respondents indicates a diversified trend among the levels of education attained. Notably, an impressive 33.4% of all the respondents attained their last educational level by completing secondary education, followed by 29.9% who attained their last educational level by completing primary education.

According to the data, 21.0 % of the respondents completed high school, while 5.6 % of the respondents had higher education. This is quite remarkable, considering that 10.1% of the respondents had no schooling at all. Based on the distribution, it is clear that the

number of secondary and primary schools is prevalent among the respondents, as opposed to the meager level of higher education.

Similarly, occupational status reveals that a large number of respondents are housewives at 38.5 percent and 62 in number; then farmers at 27.1 percent and 43 in number; followed by laborers at 21.6 percent and 35 in number. Teachers and students followed closely at 5.6 percent and 9 respectively; and 7.2 percent and 11 respectively. Clearly, from this information, it is evident that a large number of respondents are housewives and farmers, although there is a fair proportion of laborers and so forth. The knowledge of respondents on reproductive rights ispresented in the following tables:

Table 3. *Knowledge and understanding on reproductive rights*

Response	Frequencies (N)	Percentage (%)
Yes	136	84.9
No	24	15.1
Understanding	Frequencies (N)	Percentage (%)
Right to access health services	40	25.1
Right to make decisions	45	28
Right to receive information	31	19.4
Uncertain	44	27.5
Total	160	100

A high level of awareness among the sample population was demonstrated by the fact that 84.9 % of respondents were aware of reproductive health and rights, whereas 15.1% had never heard of them. Respondents' perceptions of reproductive rights include the right to make decisions (28.0%) and the right to health care (25.1%). The right to information, which has the lowest percentage of responses (19.4%), is referred to as reproductive rights. A sizable portion of respondents about 27.5% remained unsure and may require more education and awareness around reproductive rights. The descriptions of the respondents' reproductive health management practices is given below:

Table 4. *Practices Followed (n=160)*

Practice	Frequencies (N)	Percentage (%)
Regular check-ups	3	2
Use of contraceptives	75	46.7
Seeking info from health professionals	74	46.2
Self-care practices	8	5.1
Total	160	100

Table 4 lists the methods used by the respondents to manage their reproductive health. Contraception and consulting medical professionals were the most common practices among the 160 respondents, accounting for 46.7 % and 46.2 %, respectively. Just 2.0 %

have sought routine checkups, compared to 5.1 % who exercise self-care. According to the data, the sample's most popular behaviors include using contraceptives and consulting with medical professionals; regular checkups and self-care are far less common.

Table 5. *Education level affects knowledge of reproductive rights (n=160)*

Impact	Frequencies (N)	Percentage (%)
Significantly affects	82	51.0
Somewhat affects	43	27.0
No effect	35	22.0
Total	160	100

The table above highlights the role of education level in influencing the respondents' awareness about reproductive rights. A higher percentage, 51.0 %, perceived education to have a substantial effect on them, while 27.0 % agreed that education has some effect on them, but 22.0 % perceived it as having no effect on them. It is very notable that education is an ideal tool for creating reproductive rights awareness, as more of its respondents agreed to the substantial effect of education on them.

Discussion

The study reveals that a majority of the respondents fall in the age group of 31-40 years, and a greater number of them follow Hinduism. The caste representation in the population is varied, and same in educational background. The majority of respondents completed secondary school. In the occupation, the largest groups are housewives and farmers. Regarding awareness, most of the respondents were aware of reproductive rights, and their major source of information came from community health workers and health professionals. The Respondents who believed that reproductive rights include decision-making comprise 28.0%, and health service access is 25.1%. There was good awareness of maternal health and FP services among the respondents; however, awareness about certain reproductive health services was quite varied, such as sexual health education or prenatal care.

The findings of the study have also highlighted that knowledge of reproductive health is widely present in the surveyed population. 84.9% of the respondents reported knowing about reproductive rights, but knowledge concerning what the concept entails is limited. The most frequent responses were the right to decide and the right to health services, although a significant percentage (27.5%) did not know what reproductive rights meant. This means that profound education in reproductive rights is needed, explaining the concepts in their broader perspective, sexual and reproductive health, and entitlements that accrue to persons from healthcare systems.

Similarly, the study also elicited information on practices about reproductive health, where the use of contraceptives and seeking professional health advice were the most 37 common practices. Although awareness in most of aspects is high, barriers to access, especially financial constraints, lack of information, and stigma, are still reported by many respondents. This study has established that the influence of education and income levels was high on the knowledge about reproductive rights and accessibility of services. Moreover, a large number of respondents stated that their communities did not provide sufficient help with problems arising from reproductive health. Results of the research reveal significant awareness among respondents on issues of reproductive rights, specifically about health services accessibility and the right to individual decision-making. At the same time, health services on reproductive issues turn out to be inaccessible for financial, informational, and social reasons. General education and income are crucial factors in knowledge and access to services. Besides, community support is found lacking and increases the need for more vigilant efforts towards improvement in reproductive health services and their awareness, especially in the less privileged areas. Better education, community support, and accessibility to reproductive health services all call for equated health care.

The study also found that although the respondents were familiar with services such as family planning and maternal health care, practices related to the management of reproductive health were not common. It is further supported that routine health check-ups were as low as 2.0%. This is because awareness cannot always be translated into action, or services may be inaccessible or unaffordable, or cultural beliefs and gender expectations influence them from seeking care or being openly communicative about reproductive health issues. Finally, socio-demographic factors include education and income, which are important factors in the knowledge of reproductive rights and the accessibility of services. Awareness is better for people with higher education, and similarly, income levels determine access to the services.

Conclusion

This study points out a significant gap in knowledge and practices regarding reproductive health rights among women of reproductive age in Chandragiri Municipality of Kathmandu district. Despite some level of awareness about family planning and maternal health services, various barriers, including economic barriers, stigma, and deeply ingrained cultural norms, hinder women's ability to fully access and utilise reproductive health services. These challenges are compounded by socio-economic factors such as

education and income, which have been shown to play an important role in improving knowledge and access to reproductive health services. The findings suggest that addressing these socio-economic inequalities through targeted policies could help improve reproductive health outcomes in the region. Furthermore, misconceptions about reproductive rights and a general lack of awareness of legal protections contribute to the continued under-utilisation of reproductive health services. This underscores the need for more accessible, comprehensive education in reproductive health, including a focus on legal aspects, both in community outreach and in school curricula. In addition, addressing gender- based barriers and ensuring women receive adequate support from health care providers and community organisations are important steps in building a more inclusive environment where reproductive rights are respected and supported.

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