

Factors Influencing Women's Reproductive Health

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ABSTRACT

Women in the developing countries are often found in poor health and overburdened with work; most are anemic, many suffer from malnutrition and parasitism. Especially during pregnancy and childbirth they suffer from iron and adequate health care services. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed. Mainly women's health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner. Reproductive health is determined not only by the quality and availability of health care, but also by socio-economic development levels and women's position in society. In its 1994 World Report on Women's Health, the Federation states that women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights.

Keywords: Women's health, PHC (Primary Health Care), NGO clinics, SHOUJAR HASHI Clinics, RTIs, STDs, HIV and AIDS, WHO (World Health Organization. The National Institutes for Population Research and Training (NIPORT), CEDAW

10/10/2014

Source of Support: Nil, No Conflict of Interest: Declared.

How to Cite: Zahan N. 2014. **Factors Influencing Women's Reproductive Health** *ABC Journal of Advanced Research*, 3, 105-114.

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INTRODUCTION

Bangladesh is a developing country. It has the highest population density in the World. Most of them are poor and illiterate, and they are not conscious to their health. Further, they are much neglected. It is known to all that most of the members of the household are not interested about the health of their female member unless her condition is near to death. But women's good health is the pivotal factor in many of the circular relationships with development.

OBJECTIVE OF THE STUDY

- To gather knowledge about women's health and consciousness of people in Bangladesh.
- To analyse the factors that influence women's reproductive health behavior in different ways.
- To know how gender inequality affects women's reproductive health.

METHODOLOGY

The data of the present study has been collected from various sources. Mainly-

- a) Primary sources, and
- b) Secondary sources

Primary sources of data have been collected from the respondent directly, considering individuals and Households as a unit of the study.

For the secondary sources of information, present study has relied on various books, journals, articles, statistical information etc.

STATEMENT OF THE PROBLEM

Reproductive Health in Rural Bangladesh: policy and Programmatic Implications, is a study by journal Thomas T. Kane, Barkat-e-Khuda & James F. Philips (1997). The result of the study indicates that there is a strong need to focus strategic measures upon the increased use of health care facilities.

Bangladesh Demographic and Health Survey (2007) was the fifth nation-level demographic and health survey designed to provide information on demographic and maternal and child health in Bangladesh. The 2007 BDHS was conducted under the authority of the National Institute for Population Research and Training (NIPORT) of the Ministry of Health and Family welfare. It concludes with suggestions for maximizing WHO's use of the CEDAW monitoring process.

Several NGOs, such as Access to Voluntary safe contraception (AVSC), voluntary Health Services Society (VHSS), family planning Association of Bangladesh (FPAB), Paricharja, CARE, Nari Maitree, and Marie Stopes, have programmers of male involvement initiatives. These organizations have been working towards prevention and managing RTIs/STDs among males through offering services in the evening from specialized clinics run by male doctors; offering counseling with the use of both male and female counselors working with male and female clients in separate rooms; introducing cards for men to strengthen partner management; distributing reading materials on the prevention of STDs/AIDS for the purpose of creating awareness among the male and female college and university students; and developing a system of referral and linkage using local drug shops to refer customer to the clinic to RTIs/STDs. (ICDDR'B special publication No. 94 and published 1999.

WOMEN'S HEALTH

The issue of women's health cannot be understood without a board definition of health related to Women's role and position in society, particularly in the institution of the family. Women in the Asia and Pacific Region active in the area of health have adopted a broad approach to women's health problems and issues. It is recognized that the roots of disease and health hazards are in the social and economic structures of our society and until and unless the social – economic condition changes, women will continue to suffer. The state of women's health in the region is maximum poor. The actual health status varies from country to country, and within countries, according to class, race, occupation and location of women at different level. The length of

life of women as an overall indicator of health, for example, varies enormously. The average Japanese woman now lives to 80 years, almost the same as the life expectancy for Australian women of 79 years. Women of Nepal, Bhutan, Bangladesh and Democratic Kampuchea, however, die by their late forties. Women in Pakistan reach 50 years of age only, compared to China where women live to 76 years on an average. (Asian and Pacific Women's Resource and Action Series Health, 1989)

FACTOR INFLUENCING WOMEN'S REPRODUCTIVE HEALTH

In this study an attempt has been made to find out the major factors which are influence women's health. The factors are economic, demographic, cultural, political, environment etc. These factors effects on everyone's health, but particularly repercussions for women:

Biological Factors

Although human sexuality has come to many functions in addition to reproduction, its biological basis remains fundamental to the sexual experience. Sexual response involves psychological processing of information, which is influenced by learning, physiological responses and brain mechanisms which link the information processing to the physiological response. Although there is much that is not well understood about this complex sequence, it is understand that individuals vary considerably in their capacity for physical, sexual response. This variability can be explained only in part by cultural factors.

Poverty

Poverty of course affects the health of maximum, not just woman. Especially those people who live at slum area have not enough food or the right kinds of food, no decent house, water supply and sanitation. Not being able to get health care when needed, it will operate with deadly efficiency to make the situation mere difficult for women. Because the poor women spend more time and energy for cooking food or preparing for food .Usually they are unskilled and uneducated, so they are obliged to accept whatever work they can get. As a result, their health and families are severely affected.

Demographic Factors

Demographic factors affect women's health in two ways. One is "macro" level impact that refers the whole society, and the other is "micro" level impact that indicates the individual or family.

At the macro level the continuing population growth strains on the environment that makes our life more difficult, because the member of the population is gradually increasing. But there is no increase in food, water, sanitation, education and employment opportunities. So, the consequences of these are affecting on the poor women.

At the micro level, the decision about family size is made by each couple. And the opportunities what they have for the education, employment and others

can be one of the notable determinations of a woman's and her family's lifelong chances for good health.

Community

When a community-defined by its culture--also has minority status, its members are potential objects of economic or social bias which can have a negative impact on sexual health. Economic inequities, in the form of reduced educational and employment opportunities, and the poverty that often results, has obvious implications for accessing and receiving necessary health education and care. In addition, some cases, led to distrust and suspicion of public health efforts in some minority communities (Tafoya, 1989; Thomas and Quinn, 1991; Wyatt, 1997).

Culture

A shared culture based on and practices is another form of community. Each of these communities possesses norms and values about sexuality, and these norms and values can influence the sexual health and sexual behavior of community members. For example, strong prohibitions against sex outside of marriage can have protective effects with respect to STD/HIV infection and adolescent pregnancy (Comas-Diaz, 1987; Kulig, 1994; Sudarkasa, 1997; Amaro, 2001).

Political Factors

For a long time, there was no recognition to women's role in development activities. Especially their household works including preparing food and child minders as there are not for paid. But Now-a-days, policy makers realize that paid or unpaid work of women has a great contribution to the development. Different policies have an impact on women's status and their health directly.

Environmental Factors

Environmental factors have a direct impact on women's health. Patricia Smyke (2001) identified that, if PHC is carried out as intended, women's involvement in the process can lead them to new awareness of their health needs and give them new confidence in their own abilities. Poor women do not get available necessary facilities that indirectly impacts on women's health. Because of the scarcity of arrangement they cannot cook food properly and so often is not possible to boil drinking water. At this result ,women face various problem of diseases. Illness and disease in the developing world can be attributed to unsafe water and inadequate sanitation.

Besides this many poor women who work in the factories and industrial establishments may be exposed to harmful chemicals or radiation, with grave health risks for themselves and their unborn children. In developing countries, as we have seen, good nutrition or malnutrition is the pivotal factor in many of the circular relationships among women, health and development. In many rural communities women participate of the work to produce the family's food, as well as carrying the water and fuel needed to prepare it.

HEALTH CARE PROFESSIONALS AND AVAILABLE REPRODUCTIVE HEALTH SERVICES

Physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behavior of their patients.

In Bangladesh, contraceptive and reproductive health services are provided to women and men by a wide range of health care professionals. These services are offered by the variety of settings-private practice offices, NGO clinics, SHOUJAR HASHI Clinics, publicly funded family planning, private clinics, Union based health centers, and private hospitals. In addition to medical care, counseling or education related to sexual and reproductive family health may be provided.

FINDINGS AND ANALYSIS

The findings of the study and its analysis are given in the following discussions and data presentation.

Table-1 Age of the respondent when gave birth to her first child

Age (in year)	No	%
15 -17	60	60
18 - 20	31	31
21 -23	09	09
Total	100	100

Source: Field work, 2011

Table-1 show a woman the birth to her first child and age of the last child for 60% of the female respondents have given birth to their first child during the age 15-17. 31% and 09% respectively have given birth to their first child in the year 18-20 and 21-23 respectively.

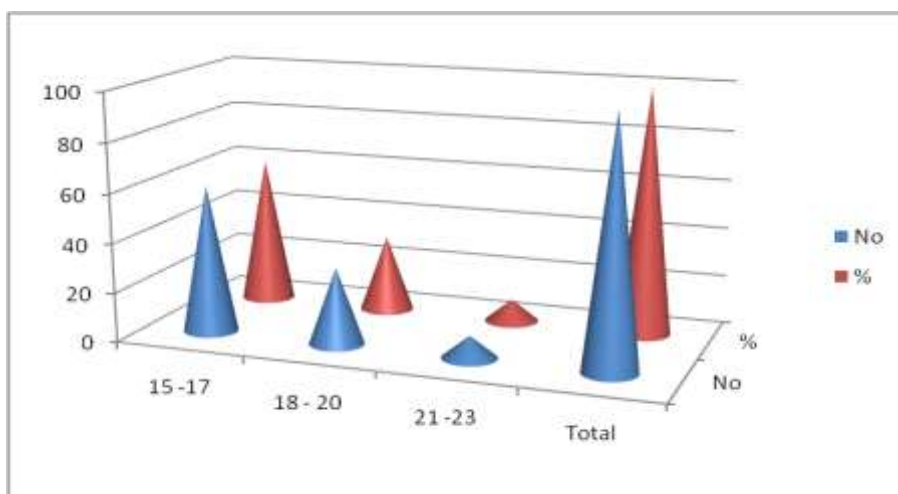


Figure 1

Table-2 Reasons for not using the contraceptive method

Reasons	No	%
Physical discomfort	20	23.51
To have baby	10	11.76
Husband opposed	20	23.55
Postpartum amenorrhea	25	29.42
Breast feeding, No contract	10	11.76
Total	85	100

Source: Field work, 2011

Table-2: The family respondents said the following causes for non-adoption of a contraception in 24% of the mothers are not using FP methods , postpartum amenorrhea is 30%, opposition of husband is 24%, physical discomforts associated with the use of the contraception is 24%, and breastfeeding is about 12%.

Table-3 Additional food during pregnancy

Status	No	%
Yes	35	35
No	65	65
Total	100	100

Source: Field work, 2011

In the state of pregnancy requires additional intake of food than what is consumed in natural condition. It is necessary for proper development of the baby in the womb needs to be nourished from mother's nutritional intake. Table-3, reveals that the majority of the pregnant women depended on natural foods during pregnancy. Around 65% believed that there is no need to intake protein-rich food during pregnancy. However, the emphasis is given on the casual consumption of vegetables, seasonal fruits and eggs by the respondents.

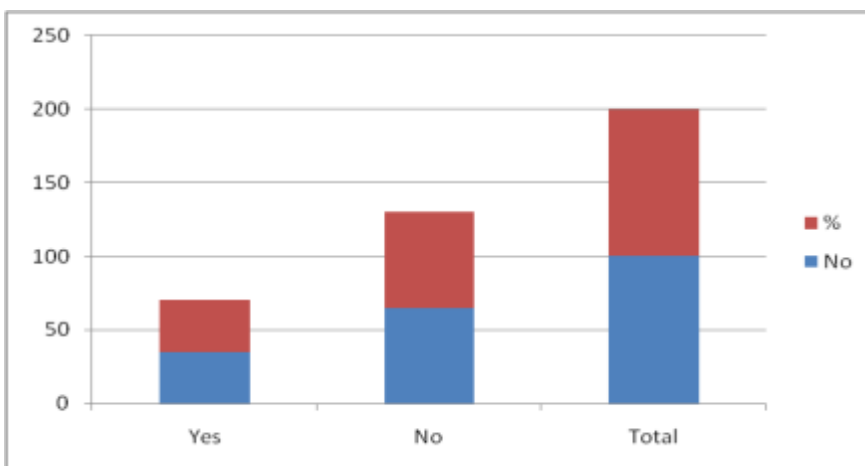


Figure 2

Table-4 pattern of utilization of adequate rest during pregnancy

Pattern	No	%
After mid-day meal	26	26
Whenever felt discomfort	25	25
whenever felt fatigue	49	49
Total	100	100

Source: Field work, 2011

Table-4, shows that in survey area 26% of the pregnant women took rest after mid-day meal, 25% hold that the resting hour when they felt discomfort and 49% of pregnant woman rest whenever they felt fatigue and which forced them to take rest. The behavioral pattern regarding restriction of movements during pregnancy reflects their own explanation based on perceptions, belief system of human reproduction and relates it with a body mechanism to nature.

Table-5 sharing the households activities by the husband at wife's pregnancy

Response	No.	%
Yes	11	11
No	89	89
Total	100	100

Source: Field work, 2011

Table-5, Shows that 89% husbands did not share the burden of household work during this critical stage of their wives. The study revealed that female respondents are aware of their situation and take measures according to their ability than male.

Table-6 types of complications faced during pregnancy

Complications	No.	%
Bleeding during pregnancy	3	10
Edema	10	34
Severe Vomiting	9	31
Convulsion	2	7
Leaking membrane before delivery	2	7
Anemia	3	10

Source: Field work, 2011

Table-6 (see figure-3) shows that following symptoms appear to be important in the study area: bleeding during pregnancy, edema, leaking membrane before delivery, convulsion, severe vomiting and anemia. During pregnancy, about 10% females have affected bleeding, about 34% affected edema, 31% affected severe vomiting and 10% female have suffered anemia.

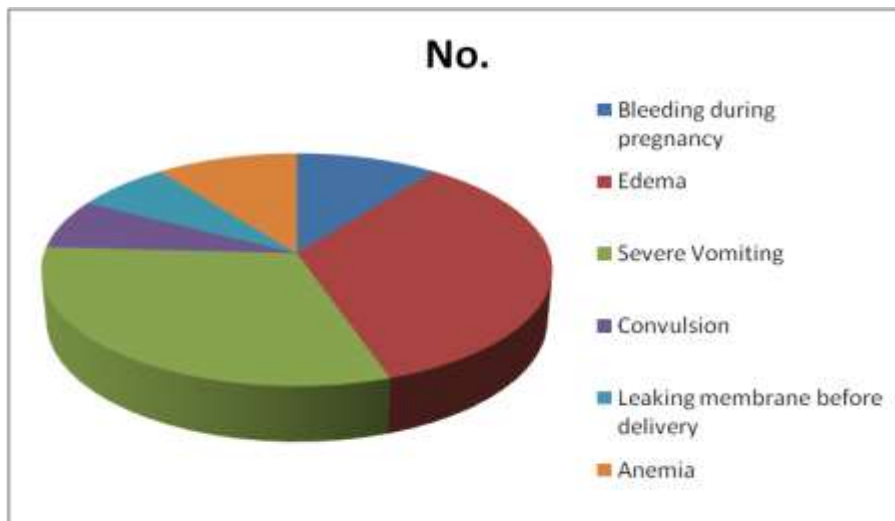


Figure-3

CONCLUSION AND RECOMMENDATION

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and much preventable suffering and deaths. Many of the women and girls who die each year during pregnancy and childbirth could have been saved by relatively low-cost improvements in reproductive healthcare; yet high levels of maternal mortality persists. And a large proportion of abortions, some resulting in death and injury would be avoided if women and men had access to safe, affordable and effective Means of contraception. Women face discrimination in nearly every culture. Gender inequality exacerbates the harmful effects of poverty and lack of education on women's health, hampering the ability of women worldwide to access health care and achieve the best possible level of health. Following are the recommendations:

- Eliminate disparities in sexual health status that arise from social and economic disadvantage diminished access to information and health care services.
- Target interventions to the most socio-economically vulnerable communities where community members have less access to health education and services.
- Improve access to health and reproductive health care services.
- Encourage the implementation of health and social interventions to improve sexual health that have been adequately evaluated and shown to be effective.

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ISSN Online: 2312-203X