Reproductive Health: Concept and Determining Factors

Shivani Katara*

This paper intends to provide an introduction to the issue of reproductive health through secondary analysis of research papers and articles from peer-reviewed journals. Some studies present a conceptual overview, while others deal in greater depth with specific aspects of reproductive health. While all views and perspectives are not equally represented, this paper seeks to provide as broad a spectrum as possible, particularly in terms of thematic perspectives.

[Keywords: Reproductive health, multi-sectoral approach, reproductive and sexual rights, reproductive choices, socio-structural factors]

1. Introduction

Within the framework of WHO’s definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. There had been development and struggles around women’s health before International Conference on Population and Development, held in Cairo, Egypt from 5th to 13th September 1994.

Prior to International Conference on Population and Development, 1994 the global priorities related to women’s reproductive health were focused on medical outcomes i.e. maternal and child health services and limiting population growth by

* Delhi School of Economics, University of Delhi, New Delhi (A-306, Supertech Apartments, Moradabad-244102, UP (India) E-mail: <shivanikatara83@gmail.com>
expanding family planning services. This linear and divided approach didn’t capture in their entirety the social, economic and cultural factors that underlies poor or improved women’s health.

In 1993, Women’s Voices- a loose coalition of women’s group from around the world called for a multi-sectoral approach to address reproductive health in a more holistic way. In their proposed new models they stressed on understanding the relation of women’s health needs to a wider set of social, economic familiar circumstances in which they live. This led to an emerging focus on women’s rights as human rights (Gittelsohn. J, M.E. Bentley, P.J. Pelto, M. Nag, S. Pachauri, A.D. Harrison and L. Landman (eds.), 2011).

Emerging from the narrow focus on women’s reproductive health of United Nations-led International Population Conferences of Bucharest 1974 and Mexico 1984 the year 1994 happened to be a watershed year for women’s health and in particular women’s reproductive and sexual health and rights. The Cairo programme of action along with reproductive health addressed broader issues of gender equity and sexual rights. An year later, at the 1995, United Nations Fourth World Conference on Women in Beijing, powerful statement on reproductive and sexual health and rights was issued:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (Gittelsohn. J, M.E. Bentley, P.J. Pelto, M. Nag, S. Pachauri, A.D. Harrison and L. Landman (eds.)., 2011).

However, after years of post Cairo activism, we see pockets of progress. Still, there is enormous need to take into account realities of women’s life for not just effective policy making and programming also to get an in-depth understanding of women’s health.

Majority of women don’t have a full say in their sexual life. There are many unspeakable community norms regarding the behaviour of women and girls which dictate what is and is not an acceptable behaviour for her. Her decisions regarding use of contraception, protection from HIV and other sexually transmitted diseases, sexual activity, childbearing and access to reproductive health services are profoundly influenced not just by her own expectations and autonomy but also by her spousal and family relationships.

In the light of sexual and reproductive health and rights there was a subsequent revision of Millennium Development Goals between the years 1990 to 2015. The Millennium Development Goals set a target “to reduce by three quarters, between 1990 and 2015, maternal mortality ratio,” in part by increasing “the
proportions of birth by a skilled health professional.” One can read the full set of goals - which include poverty reduction, education, and women equality and empowerment - as fundamental to achieving improved sexual and reproductive health and rights outcomes. Yet the absence of specific reproductive goals or indicator was notable - and not an accident (J. Gittelsohn, M.E. Bentley, P. J. Pelto, M. Nag, S. Pachauri, A.D. Harrison and L. Landman (eds.), 2011).

Also, the Millennium summit in September, 2000 set the United Nations agenda for the 21st century by producing the visionary and far reaching Millennium Declaration. The Millennium Summit produced an offspring of International Conference on Population and Development with many similar elements. But if the Millennium Summit was the offspring, it spurned its parent by excluding sexual and reproductive health from the Millennium Development Goals (Bernstein, 2005).

Though, in 2000, women’s health was addressed only in terms of maternal health and sexual & reproductive health and rights were again marginalized. In 2004, the reproductive health was added to Millennium Development Goals but missed out on the fact that without promoting sexual rights as core values we cannot possibly achieve the goal of “universal access to reproductive health.” With their emphasis on demographics and focusing on only one aspect of women’s health- whether women survive while giving birth- the Millennium Development Goals again evoked a pre-Cairo approach ignoring the broader questions of women’s agency in matters relating to their sexual and reproductive choice, there was an absence of holistic approach.

Finally in September 2006, United Nations General Assembly, as a Goal 5B of the Millennium Development Goals adopted the target of universal access to reproductive health. In order to meet the different needs of all individuals, universal access means availability, accessibility and acceptability of reproductive health information and service.

2. Understanding the New Concept of Reproductive Health


There is no denying of the fact that reproductive health constitutes an important aspect of women’s health. However, the challenge is to define priorities within it according to the objective and subjective definitions of women’s needs. The subjective definition of reproductive health depends upon women’s life experiences and is reflected in their perceptions and what they themselves say. Also, it depends upon the status and social position of women (Qadeer 1998).
According to Dixon- Muller (1993) the new paradigm of reproductive health refers to a woman’s capability to: (1) understand and enjoy her sexuality by gaining full knowledge of it; (2) regulate her fertility through access to services and information; (3) remain free of reproductive morbidity (and death); and (4) bear and raise healthy children.

Makhlouf Obermeyer considers that the concept of reproductive health is culturally constructed, that is, a product of specific historical, ethical and legal transformations (Obermeyer, 1999). Reproductive Health Working Group (RHWG), an independent regional network comprising researchers mainly from Egypt, Lebanon, Palestine, Syria and Turkey, emphasizes dignity as a component of reproductive health. This is a concept which is absent from the ICPD definition.

Thus, reproductive health covers all aspects of women’s health. It is an umbrella concept, consisting of several distinct, yet related issues such as abortion, childbirth, sexuality, contraception, and maternal mortality. Biological, social, cultural, economical, and behavioral factors play an important role in determination of reproductive health. Hence, reproductive health addresses women’s health, rights, and empowerment.

3. Issues within the Concept of Reproductive Health

The concept of reproductive health has derived heavily from the notion of ‘biological vulnerability’ of women [Das Gupta et al 1995] (who are in fact, biologically the stronger sex!), and the concept of ‘life cycle’. This life cycle approach has transformed the social process of bearing and rearing children into an essentially biological event and by using reproduction as the criterion for defining stages of women’s life, denounce social tragedies like child marriages, deaths of young women in child birth, malnourishment and sexual exploitation or gynaecological suffering of widows and unmarried women. Exploitative processes begun in childhood which in fact, add on to the problems of various age groups. It is the ill-fed malnourished girl who becomes a sick, overworked, self-denying mother (Qadeer, 1998).

Gender and reproductive roles are projected as purely intra-household events (Das Gupta et al, 1995), and therefore, further dissociated from the macro socio-economic process. Hence, by focusing the discussion on reproductive health in its “medicalised” garb, the issues of socio-economic influences and the links between general health and reproductive health are often missed. The United Nations Fund Population Activities, in a less commercial fashion, places reproductive health of women centre stage and links population, development, and environment to it (UNFPA, 1992). A clear example is the Bhopal gas disaster, where women’s reproductive health was badly affected (Sathyamala, 1993), as they bore the brunt of a callous industrial policy. But the problem of under nutrition is more fundamentally linked to agricultural policy, pricing and the public distribution system.
Thus, expanding the domain of reproductive health on the basis of only symptomatology will lead to a superficial and medicalised interventive strategy as a result underplaying the importance of industrial and agricultural policy shifts for health.

4. Determinants of Reproductive Health

Women bear by far the greatest burden of reproductive health problems. They are at risk of complications from pregnancy, childbirth and unsafe abortion. Among women of reproductive age, 36% of all healthy years of life lost are due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity (Gupta, 2014).

In general, two broad schemes of analysis have been used recently in the social sciences literature to examine reproductive health: (1) social-structural characteristics (2) reproductive rights explanation (Guang-zhen Wang and Vijayan K. Pillai, 2001).

4.1 Socio-structural Factors


- **Demographic and background variables**: Caste, socio-economic status, education of the husband and wife, occupation of the husband and wife, household income, standard of living, age at marriage, duration of married life, perception of infant and child mortality.
- **Family action possibilities**: Family type and participation of wife in decision-making, the custom of child marriage (emotional aspects of early sexual initiation are equally important) and female infanticide.
- **Family size attitudes**: Value of children, ideal number of children preferred (Fertility) and son-preference.
- **Informational and attitudinal attributes**: Political awareness, knowledge of family planning methods and attitude towards family planning.

The control of women’s fertility was thus considered necessary for both economic and social reasons. Studies of the 19th and early 20th century show how the institutions of religion (Chakravarti, 1989), law and education (Desai and Krishnaraj, 1990) perfected the instruments of control (Qadeer, 1998). Also, various seclusion practices and other behavioural norms further reinforce women’s lack of freedom of movement, self-confidence and their acceptance of self-denial, including in matters relating to health seeking and food intake (Jejeebhoy, 1997).

Afamia Kaddour, Ragda Hafez and Huda Zurayk in their study “Women’s Perceptions of Reproductive Health in Three Communities around Beirut and
Lebanon” explores how women attach meaning to the concept within specific socio-economic, familial and cultural contexts. Economic problems prevented them from meeting their needs and wants, including getting medical care during childbirth, and carrying out their responsibilities as mothers.

Sharma and Niranjana (2001) further argued that the concept of social structure also covers social relationships expressed either through the role relationships and levels of interaction, amount of power and authority they exercise in relation to each other and privileges they enjoy by virtue of their respective position in the social hierarchy of the society. All these factors have an important impact on reproductive health of women.

4.2 Reproductive Rights

Women’s reproductive rights include the right to determine the starting, spacing, and terminating of pregnancy or births (Cook 1993; Dixon-Mueller 1993; Correa & Petchesky, 1994). Four indicators of women’s reproductive rights are: right to legal abortion, personal right to interracial, interreligious, or civil marriages, right to equality of sexes during marriage and for divorce proceedings, and the personal right to use contraceptive pills and devices. The right to legal abortion is divided into eight categories based on the grounds on which abortion is permitted: illegal with no exception, to save the woman’s life, to preserve physical health, to preserve mental health, rape or incest, fetal impairment, economic or social reasons, or on request (United Nations, 1994).

According to the 1994 Cairo Conference, reproductive rights are inseparable from reproductive health. This view is supported by the empirical findings from the study on developing nations titled “Women’s Reproductive Health: A Gender-Sensitive Human Rights Approach” by Guang-zhen Wang and Vijayan K. Pillai (2001). In this study it was found that the total fertility rate is negatively related to reproductive health and no empirical support was found for the expected relationship between reproductive health and social inequality. This study indicates an inverse direct relationship between women’s reproductive health and women’s economic status possibly because women tend to engage in low-paid and burdensome work thus exposing them to reproductive as well as overall health problems. Hence, women’s control over their reproductive health cannot be achieved by increasing economic gains alone. However, the hazardous effects of the organization and poor working conditions have not been adequately investigated.

According to Dreze and Sen (2002), women’s education in general and higher education in particular is the most important factor towards restoration of reproductive health rights which makes the horizon of vision broader and helps to disseminate the knowledge of family planning.

One of the most important correlates of reproductive rights is social inequality. There are glaring inequalities in the distribution of land, income, power
and social positions in developing countries (Crenshaw & Ameen, 1993). The power arrangement involved in societal relations can leave women’s right to reproductive health care stunted. For e.g side effects of contraceptives and the disapproval by male partners; inability to control husbands’ sexual conduct and to refuse unwanted intercourse; women’s low social status and economic dependence on men made it difficult for women to negotiate for safe sex.

5. Conclusion

The concept of reproductive health is not new but is a product of a process and is conditioned by the level of socio-economic development, the women’s status in the society, awareness and their access to medical services. International Conference on Population and Development (ICPD), 1994 has been marked in history as one of the most significant global conferences ever on women’s health. For the first time in a UN setting, the concept of reproductive health was adopted. It drastically transformed the views and perceptions about reproductive health and brought the issues of reproductive rights and women’s empowerment to attention of millions of men and women around the world. The international community accepted it’s concept of linking family planning with the treatment and provision of sexually transmitted diseases (STDs), the promotion of maternal health and reduction of maternal mortality, and addressed the broader issues of sexual and reproductive health, gender equity and sexual rights for both men and women. However, in their struggle to minimize life tensions, women are left with no choice except to choose between risks and adversities, where these risks are a mix of social, reproductive, economic, physiological and health factors. The denial of women’s autonomy in making reproductive choices and de-legitimization of their context-bound concerns, are in fact, counterproductive and disempowering (Qadeer, 1998).

References


