ISSN: 2576-2842

Review Article

Journal of Gynecology & Reproductive Medicine

Reproductive Health

Siniša Franjić

Faculty of Law, International University of Brcko District, Brcko, Bosnia and Herzegovina, Europe

***Corresponding author**
Dr. Siniša Franjić, Faculty of Law, International University of Brcko District, Brcko, Bosnia and Herzegovina, Europe, Tel: +387-49-49-04-60. E-mail: sinisa.franjic@gmail.com

Submitted: 25 Jan 2019; **Accepted**: 02 Feb 2019; **Published**: 20 Feb 2019

Abstract

Reproductive health implies that people have a satisfying and safe sex life and the ability to have offspring as well as the freedom to decide whether to have it, when and how often. This means that men and women have the right to be informed and have access to safe, effective, accessible and acceptable methods of fertility regulation of their choice, as well as access to appropriate health care services that will enable women to have safe pregnancy and childbirth, and couples are the best chances for a healthy baby. Reproductive health also refers to diseases, disorders and conditions affecting the functioning of the male and female reproductive system at all stages of life.

Keywords: Woman, Birth, Health

Introduction

The concept of Reproductive Health has been afforded international prominence by its strong endorsement at two United Nations' conferences in the mid-1990s, namely the International Conference on Population and Development, held in Cairo, Egypt in 1994, and the International Conference on Women, held in Beijing, China in 1995 [1]. The full definition is that:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Laws are essential tools used to promote women's reproductive health, to facilitate their access to health services, and to protect their human rights as users of such services [2]. Laws, however, also can keep women from achieving optimal reproductive health. For example, laws may limit access to an individual's choice of contraceptive methods, impose restrictions on accessing abortion services, and discriminate against specific groups, such as adolescents, by denying them full access to reproductive health services. Laws that discriminate against women, or serve to define or value them primarily in terms of their reproductive capacities, undermine the right to reproductive self-determination and serve to legitimize unequal relations between men and women.

The absence of laws or procedures to enforce existing laws may also have a negative effect on the reproductive lives of women and men. For example, the absence of laws and policies regarding violence against women makes it difficult to obtain reliable documentation and to assess its overall impact on women's health,including reproductive health. The lack of anti-discrimination laws affects marginalized women in particular as it undermines their ability to access reproductive health services.

The field of reproductive health includes examples of almost every type of public health law [3]. Reproductive health has multiple dimensions, ranging from the biomedical to the social. At the biomedical level, it addresses a variety of exposures to physical, chemical, and biologic agents that may affect an entire human biologic system, with possible health outcomes that affect not only a woman but also her partner/spouse and her child. At the individual level, it addresses psychosocial, behavioral, and clinical issues that are often perceived as defining a human being and affect health and quality of life well beyond the spheres of sexuality and reproduction. Communication with a sex partner or a spouse is a key component of these behaviors, which often highlight interdependence within a couple rather than individual free will. At a broader societal level, sexuality and reproduction raise core moral questions that are the subject of intense debate in a free society. Public health laws and regulations are promulgated and enacted and exert their effects within such a complex web of relations.

One of the interesting areas of law that is debated at these scientific

meetings is the balance between special protections for women, such as those needed in the workplace to protect pregnant women and their fetuses from toxic substances, and the need to achieve equality of women and men that can be reached by not treating women differently from men [4]. However, just taking the issue of exposure to toxic substances as an example, it is mostly women who work in low-paying jobs, in either the formal or informal labor market, where they are exposed to tedious and unhealthy conditions. But, if women are to be reassigned to other jobs, and there are no other comparable jobs, then their status is not being improved. If employers are legally liable for protectionism, will they then favor hiring men and not women? In either case, women are not really being protected unless there are penalties for employers to create a safe workplace for both men and women, equally. This raises the issue of basic health protections versus special protections for women and the continuing argument that women will never be equal to men unless they control their own reproductive health issues. So, despite the success in the international arena, the future of women's access to acceptable health conditions will continue to be the responsibility of each country.

Physiological and genetic factors have long been known to influence reproductive outcome [5]. For example, children born to teenage parents or parents of advanced age are at risk of numerous adverse birth and health outcomes including well described disadvantages such as low birth weight and Down syndrome, prevalent in younger and older parents, respectively. However, advanced parental age has also been associated with positive characteristics, such as higher intelligence, in the children. More recent research has continued to explore the fascinating early findings of positive effects of parental age on the intellectual abilities of the offspring and alternative explanations have been sought. Influence of parental age on intelligence of the offspring does not seem to be mediated by confounding demographic or other socioeconomic factors. Instead, higher maternal age may be more important to superior intelligence test scores in offspring than paternal age. These inconsistent findings may be due to difficulties defining intelligence, or because testing for intelligence is not sufficiently broad (as it does not include accomplishments, creativity, personality variables and so on). In health or birth outcome terms, the optimum age to have children is 25 to 35 years, with increasing paternal age resulting in poor outcomes, such as more spontaneous abortions and older maternal age increasing the risks for miscarriage, stillbirth and ectopic pregnancy. Both also affect longevity in the offspring, a variable not yet conquered by researchers.

Reproductive Politics

Beginning in the mid-1960s, women's rights advocates known as "Second Wave feminists" (a name inspired by nineteenth-century "First Wave" feminists who focused on winning the right to vote and other reforms) coined the term "reproductive politics" to describe their involvement in issues related to contraception, abortion, sterilization, adoption, and sexuality as well as other related subjects [6]. The term has been useful because it captures the way politics lies at the center of these issues. For example, who has the power to make the decision about keeping or ending a pregnancy: the pregnant woman, a physician, or a member of Congress? Who has the power to define a legitimate mother, that is, a woman who has the right to raise her own child: a city welfare official, an adoption agency and its client, a judge, or the mother herself?

Many believe that a woman's decision to get pregnant, or not, and to have a baby, or not, remains a private matter, an orientation reflected in the commonly used term "choice." We may assess some choices as good ones, others as bad, but in the end, a majority of Americans currently believe that such choices belong to those most directly affected.

Others believe that reproductive capacities are public concerns and therefore subject to legislation. A number of recent laws and policies have had profound impacts on private reproductive decisions. For example, Congress's decision to deny federal funding for abortions and reproductive counseling services-the 1976 Hyde Amendment-has been perceived as mandating "forced motherhood" for those who don't have enough money to pay for private services. Together with regulations governing contemporary welfare provisions for low-income families, these policies reflect a belief that childbearing, and even sex itself, is not, or not simply, a private matter.

Birth control advocates (including socialist feminists, notably Emma Goldman; a few outspoken physicians; and leaders Mary Ware Dennett and Margaret Sanger) recognized in the early twentieth century that women were desperate to control their fertility. They saw that women were educating themselves about their reproductive choices, through both reliable and unreliable means. As we've seen, women with resources could sometimes depend on the secret help of private physicians. Hundreds of thousands of women became willing to break the law to avoid having another baby.

An increasingly professionalized medical community began to seek control over all matters pertaining to pregnancy and childbearing; many physicians were not receptive to women-led or feminist efforts in this domain, from midwifery to lay efforts to disseminate birth control information. By the 1940s, Sanger's organization, now called Planned Parenthood Federation of America, to accentuate the importance of "planning" to achieve a strong nation and responsible individuals, began to cite economic self-sufficiency as a criterion for parenthood. Such emphasis on economic status served to heighten the sense that only well-off white women were entitled to regulate their bodies and reproductive decisions.

The birth control pill championed by Sanger and others was introduced to the US market in 1960. The pill is often linked to the "sexual revolution," a cultural development whose meanings sociologists, journalists, and historians are still debating. Most have described the sexual revolution as marking an era when sexuality was no longer considered primarily a vehicle for procreation. Rather, they argue, for both males and females, sexuality became a means of achieving individual satisfaction and self-expression. Scholars have debated many aspects of the sexual revolution, including when and where it started, whether the behavior ascribed to it amounted to a revolution, and whether it is possible to capture a general meaning of new sexual expressions without paying attention to its various impacts on different demographic groups. It is important to add that the sexual revolution—whatever it means—was happening during the civil rights movement. Some proponents and opponents of racial equality put reproductive politics at the center of their agendas.

Sexual, class, and racial conflicts shaped negotiations over reproductive control [7]. Women's ability to control their sexuality and the terms and conditions of motherhood stood at the center of debates about birth control, sterilization, and abortion. Class

and race background determined whether women had access to reproductive health care, whether they came into contact with state sterilization and birth control programs, how they were treated by the representatives of these programs, and how they experienced sexuality and reproduction. Assumptions about the links between sexuality, class, and race shaped public perceptions of women's sexual behavior, policy debates surrounding issues of sexuality and reproduction, the formulation of reproductive policies, and the delivery of services to patients.

Women's Health

Contraception, the desire for parenthood, medically assisted insemination, abortion are just some of the important issues in the area of gynecology that women are reluctant to talk about because they are extremely personal issues that sometimes overwhelm their intimacy [8]. Health, but also reproductive health, are important issues not only for women but for society as a whole. Because of this, they have become the subject of studying a series of scientific disciplines that are, each in their own way, related to medicine and gynecology. These are law, sociology, philosophy, ethics and others. A woman as a gynecological patient on these issues should be discussed first and foremost with her gynecologist because she will receive a professional health advice on further treatment for the preservation of her reproductive health. Modern medicine has made a huge contribution to addressing these issues because today's most modern scientific cognitions is in using. When considering the social and humanistic aspects of this issues, it is also important to emphasize the existence of a religious component that has a significant influence on society. The attitudes of the church are not negligible, but should be said to be unequal, which means that different confessions also have different views on these issues.

Traditionally, the focus of women's health has been relegated to those systems "between the breasts and the knees [9]." Pregnancy and childbirth were long the focus when it came to health care of women, because the value of women was based on their role in procreation and continuation of the citizenry. Historically, this focus on reproductive health created opportunities to promote maternal and child health reforms in the public health arena. In such cases, women typically took advantage of the focus on reproductive health to advance an agenda that addressed both maternal and child health. At the same time, the practice of addressing only reproductive health carried risks, as it enabled normal physiological reproductive processes to be medicalized within a biomedical context.

In response to the practice of medicalizing aspects of women's health and traditional models of women's health care, consumer activism by women has been directed at reframing women's health and calling for reforms at even the most basic levels. The strategy of "analyzing your own role or relationship to the issue" may help reveal the role women play in relation to the process of rejecting medicalization of many of the normal healthy physiologic processes they experience.

The lack of understanding of so many dimensions of women's health as women themselves understand them stems, in large part, from the fact that women are still essentialized as reproducers [10]. In other words, their most essential characteristic is seen as their ability to reproduce, to give birth, to mother their children, to reproduce the generations. Although one could argue that the overwhelming focus on women and their reproduction is empowering—given the centrality of reproduction in women's lives and its function as a fundamental source of women's power in many societies around the globe—essentializing characterizations of women that continue to tie them to the realm of reproduction are both unfortunate and potentially constraining. As generations of feminist scholars, including many of the feminist anthropologists listed in the appendix, have pointed out, being thought of only as a wife—mother certainly has its limitations in that other aspects of women's lives, such as work, activism, leadership, and worship, are ignored and women's capabilities in these various realms unrecognized.

In the broad field of women's health, the unfortunate replication of this view of women as reproducers is clearly seen. The medical and public-health fields devoted to women's health—namely, obstetrics-gynecology and maternal and child health—literally target women as reproducers or potential reproducers. The field of obstetrics-gynecology is devoted exclusively to women's reproductive organs and complaints and to the processes of pregnancy and childbirth. Other kinds of women's health issues are to be handled elsewhere, although for many women around the world, reproductive health services are the only point of contact for health care delivery.

Sexual Health of Adolescents

Approximately 16 million girls aged 15 to 19 years and 2.5 million girls under 16 years give birth each year in developing regions [11]. These are the figures that worry, and when teenagers engage in sexual relationships, they do not think about the consequences. The consequences for health can be terrible. Therefore, it is necessary to invest much in the prevention of reproductive health. Prevention should not only be directed at preventing sexually transmitted diseases and preventing pregnancy in adolescence because it should be geared towards adopting attitudes about responsible sexual behavior. This primarily refers to the delay in the beginning of the sexual life of young people because too early accession into sexual relationships can seriously harm the health.

In addition to the provision of education, young people also need good quality, accessible services from health and social care professionals about sexual health, STIs (Sexually transmitted infections), contraception and relationships [12]. They have a right to confidential advice: anxiety about confidentiality can be a major deterrent to not seeking advice. One of the first reasons that young people contact health services independently is when they need emergency contraception or a pregnancy test. Young people may return repeatedly for emergency contraception or pregnancy tests and these visits can be used as opportunities for sexual health and/or relationships advice. This advice may not be acted on by the young person immediately but may form the basis of a positive advisory relationship for the future. Essential elements for sexual health services for young people include the core provision of reproductive health advice within accessible and young person-friendly settings where non-judgemental staff of both genders are available to offer advice and treatment to self-referred young people. Staff should be aware of issues of consent and competence, confidentiality and clinical care and there should be clearly defined routes of liaison with other child welfare services.

Consider an adolescent reproductive health campaign focused on reducing teenage pregnancy [13]. Teenagers are a diverse group of people representing many different socioeconomic, cultural, geographical, psychographic, and age cohorts. Within the age

range of fourteen to eighteen years, for example, some individuals are sexually active and some are not, suggesting that different products and different promotional strategies are necessary to meet different needs. Some might argue that sexual abstinence messages are appropriate for all teenagers, yet for those who are already sexually active, educating about contraceptive use may be essential, whereas for those who are not sexually active, encouraging continued abstinence may be appropriate. Therefore, an audience segmentation strategy for teenage pregnancy prevention, based on sexual activity status, might focus on condom use for teens who are sexually active and delay of sexual debut for teens who are not sexually active. Each product would have its own bundle of benefits, product and message placement, description of costs and benefits, and promotional strategy (perhaps using different types of role models) appropriate for the target audience.

The sexual health of adolescents is a public health priority [14]. The promotion of adolescents' sexual health will require a multifaceted approach that considers the intrapersonal, interpersonal, and contextual influences on sexuality and sexual behavior. Doing so will require more research to increase our understanding of adolescents' sexuality, including sexual decision-making. That is, we need to better understand the psychological, physical, and cognitive factors associated with the initiation or delay of sexual activity, across time. Adolescents must also be protected from sexual coercion and violence. Individual, community, and governmental action is required to change cultural norms associated with non-consensual sex, increasing the possibility of satisfying and safe sexual experiences. Finally, age-appropriate sexual and reproductive health information, contraceptives, and services should be made available at low- or no-costs to adolescents. Services that target the specific needs of adolescents should be made available in locations which adolescents frequent, such as schools and community centers.

Be Parent or No

Historically we have had few options in determining our reproductive health [15]. Many forces have acted to deprive us ofthis basic choice. Poverty, racism, religion, elements of our culture, political powerlessness, and our own constraints as individuals have made it very difficult to exercise any choice. These forces have been used to keep us in the home and outside of social and institutional decision-making regarding our reproductive lives. Nonetheless, we have taken some very significant steps that have changed our consciousness. Gains in employment, educational opportunities, and growing access to birth control technology have all helped.

Women's reproductive health encompasses a wide range of topics, including menstruation, conception, abortion, pregnancy, miscarriage, childbirth and menopause [16]. Although mainly focussed on women, these events involve issues that affect both men and women and include sexual dysfunction, infertility and becoming a parent. Reproduction also encompasses a range of illnesses, such as endometriosis, sexually transmitted diseases, pelvic pain, premenstrual syndrome and testicular cancer. These disorders and their treatments can have implications for fertility and reproduction. For example, endometriosis is associated with reduced fertility in women. Common procedures and treatments associated with reproduction include contraception, cervical smears and hormone replacement therapy. Reproductive issues raise unique ethical dilemmas, such as the point at which terminating a pregnancy is morally defensible; the rights of donor parents and children of donors; whether a subsequent pregnancy should be used by parents to provide a child with the right genetic make-up to be an organ or tissue donor for a sick older sibling.

Early identification with parents, siblings, and others encourage us to take for granted that our life-cycle awaits unfurling—a trajectory of childhood, adolescence, adulthood, and beyond that, parenthood will follow if we so choose, perhaps even grandparenthood, too [17]. But we live in a changed world. Alongside feminism, availability of efficient birth control has fostered greater self-determination in women. We now feel free to decide when to have a baby, with whom, how, and indeed, whether to do so at all.

Today, with female-based contraceptive methods, the "morning after" pill, and safe abortion, almost a fifth of Europeans choose not to reproduce, and this figure rises among educated women—some forty per cent of whom in Germany remain "childfree" by choice. Around the world, in societies as diverse as Armenia, Bulgaria, Greece, Hong Kong, Italy, Korea, Latvia, Russia, and Spain the current birth rate has fallen to around one child per woman.

Confident in our fertility and/or the power of technology, when an unplanned pregnancy does occur many westernised women resort to abortion, preferring to remain childless for now, to keep the family small. Some postpone having a baby until they feel emotionally, professionally, economically, and/or socially ready to do so (often as menopause approaches). As a consequence, the number of first-time mothers giving birth over the age of forty has almost doubled in ten years, reflecting this trend for women to delay motherhood until they have built up their careers. Nonetheless, many fail to become parents even with the help of donated eggs. Postmenopausal mothers comprise just two per cent of all live births. More than three million babies have been born using in vitro fertilisation and other assisted reproductive technologies (ART) since the world's first IVF baby was born in 1978. However, availability differs dramatically across countries, and success rate varies among age groups, and even across fertility clinics in the same city.

When considering the issue of health in the context of human rights, it must not be ignore the question of reproductive autonomy. Reproductive autonomy is a concept developed through human rights law and academic theory and it prioritises the right to choose if, when, and how to reproduce [18]. The concept, therefore, has application both in a negative sense (a right to choose not to reproduce by the use of contraceptives or by a termination of pregnancy) and in a positive sense (a right to found a family, if necessary by means of assisted conception methods such as IVF). Both of these aspects of reproductive autonomy generate heated political and legal debate.

Conclusion

The protection of reproductive health is a part of general human rights, and includes free and consciously decision making on the most favorable time for parenting, the birth of the desired number of children and the interval between birth. It also includes the availability of information and contraceptives and the right to the highest standards of protection of sexual and reproductive health. The protection of reproductive health includes sexuality and reproductive education, family planning counseling, reproductive health care, prevention, diagnosis and treatment of various diseases and disorders, abortions and prevention of sexual abuse and care of victims.

References

1. Dickens BM, Cook RJ, Kismodi E (2006) Reproductive Health-Case Studies with Ethical Commentary, UNESCO Chair in Bioethics, Haifa, Israel 1.
2. The Center for Reproductive Law and Policy (2000) Women of the World-Laws and Policies Affecting Their Reproductive Lives-East Central Europe, The Center for Reproductive Law and Policy, New York, USA 8.
3. Anderson B J, Macaluso M, Wilcox LS (2007) Reproductive Health in Goodman RA, et al. (eds), Law in Public Health Practice, Second Edition, Oxford University Press, Inc, New York, USA 452.
4. Needle RB, Walker LEA (2008) Abortion Counseling-A Clinician's Guide to Psychology, Legislation, Politics, and Competency, Springer Publishing Company, LLC, New York, USA 74.
5. van den Akker OBA (2012) Reproductive Health Psychology, John Wiley & Sons Ltd, Chichester, UK 3.
6. Solinger R (2013) Reproductive Politics-What Everyone Needs To Know, Oxford University Press, Oxford, UK 2: 21-23.
7. Schoen J (2005) Choice and Coercion - Birth Control, Sterilization, and Abortion in Public Health and Welfare, The University of North Carolina Press, Chapel Hill, USA 5.
8. Franjić S (2018) Woman as a gynecological patient. J Gynecol Res Obstet 4: 001-004. DOI: http://dx.doi.org/10.17352/jgro.000047
9. Low LK, Bailey JM (2017) Women's Health from a Feminist Perspective in Schuiling KD, Likis FE (eds), Women's Gynecologic Health, Third Edition, Jones & Bartlett Learning, Burlington, USA 12.
10. Inhorn MC (2007) Defining Women's Health: A Dozen Messages from More than 150 Etnographies in Inhorn MC (ed) Reproductive Disruptions-Gender, Technology and Biopolitics in the New Millennium", Berghahn Books, New York, USA 7-8.
11. Siniša Franjić (2018) Adolescent Pregnancy is a Serious Social Problem. J Gynecol Res Obstet 4: 006-008. DOI: http://dx.doi.org/10.17352/jgro.000049
12. Andrews S (2006) Sexuality and Sexual Health Throughout the Childhood and Teenage Years in Balen R, Crawshaw M (eds) Sexuality and Fertility Issues in Ill Health and Disability-From Early Adolescence to Adulthood", Jessica Kingsley Publishers, London, UK 28.
13. Storey JD, Saffitz GB, Rimón JG (2008) Social Marketing in Glanz K, Rimer BK, Viswanath K (eds) Health Behavior and Health Education-Theory, Research, and Practice, Fourth Edition, Jossey-Bass, Wiley Imprint, John Wiley & Sons, Inc., San Francisco, USA 443-444.
14. Scott-Sheldon LAJ, Johnson BT (2013) The Sexual Health of Adolescents-When, Where, and Why Adolescents Use Contraceptives in Bromberg DS, O'Donohue WT (eds) Handbook of Child and Adolescent Sexuality - Developmental and Forensic Psychology, Elsevier, Oxford, UK 242-243.
15. Sewell SS (1980) Sterilization Abuse and Hispanic Women in Holmes HB, Hoskins BB, Gross M (eds) Birth Control and Controlling Birth-Women-Centered Perspectives, The Humana Press Inc., Clifton, USA 121.
16. Ayers S, Ford E (2017) Psychosocial Context of Illness and Well-Being in Women's Health in Edozien LC, O'Brien PMS (eds) Biopsychosocial Factors in Obstetrics and Gynaecology, Cambridge University Press, Cambridge, UK 3.
17. Raphael-Leff J (2013) Opening shut doors-the emotional impact of infertility and therapeutic issues in Quagliata E (ed) Becoming Parents and Overcoming Obstacles-Understanding the Experience of Miscarriage, Premature Births, Infertility, Karnac Books Ltd, London, UK 80-81.
18. Wicks E (2007) Human Rights and Healthcare, Hart Publishing, Portland, USA 15.