Received Date: July 2020 Revised: Oct. 2020 Accepted: Dec.2020

https://doi.org/10.3126/pragya.v7i1.35207

Gender Disparities- Issues on Sexual and Reproductive Health; Knowledge and Practices on Decision Making

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Abstract

Sexual and Reproductive health rights are key human rights instruments. Since last few decades, sexual and reproductive health and rights has been recognized as a major topic in the international health and development agenda. Sexual and reproductive rights of women became recognized as universal human rights in 1994, violations of which happen in some reproductive health areas including gender concern. But in the developing countries like ours, patriarchal society rooted deeply that male control over women's mobility, sexuality and reproduction. Men's control over women's mobility like imposition of Parda, restriction on leaving domestic space, strict separation of public and private space and limits on interaction between the sexes. Male controls over women's sexuality like women are obliged to provide sexual services to their men when they desire, the legal and moral values restrict women's sexuality outside marriage, men may force their women in sex trade. Even in reproduction male control over them. Men also control over women's reproductive power in many societies by no freedom to decide how many children they want and when, cannot decide to use the contraceptive or terminate the pregnancy. In most of the South Asian countries women are forced to give birth to a son or her place is not secured so she is compelled to give several births if she cannot produce son.

Sexual and reproductive health and rights are important rights in themselves, but can also greatly enhance possibilities for empowering girls and women and for achieving gender equality. Reproductive health stresses people rights to sexuality, reproduction, and family planning, and the information to actualize these rights, which has been inseparably linked to development.We examine how sexual and reproductive health and rights interventions can have positive and lasting impacts not only on the health outcomes of girls and women, but can also enable women's access to opportunities across social, economic and political life. Many efforts had been done in these issues nationally and internationally.

Keywords: Gender disparities, sexual, reproductive health, knowledge, practices on decision making.

Introduction

Within the framework of the World Health Organization's (WHO) 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, or sexual health/hygiene, addresses the

reproductive processes, functions and system at all stages of life. UN agencies claim sexual and reproductive health includes physical, as well as psychological well-being vis-a-vis. (https://en.wikipedia.org/wiki/Reproductive_health)

Reproductive health implies that people are able to have a responsible, satisfying, healthy reproductive system and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed on how to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant. (ibid)

Individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health.(ibid)

Adolescent health, maternal health, contraception, sexually transmitted infection, abortion, female genital mutilation; child and forced marriage are the major components of reproductive health. Few examples of common reproductive health concerns for women are endometriosis, uterine fibroids, gynecologic cancer, HIV/AIDS, Interstitial cystitis, polycystic ovary syndrome (PCOS) and sexually transmitted diseases (STDs). The main objectives of increasing awareness for reproductive health are: It helps in educating every youth about sexual and reproductive health. It creates awareness among adolescents about safe sexual practices. It helps in preventing sexually transmitted infections, including HIV/AIDS.

Its functions include producing female gametes called eggs, secreting female sex hormones (such as estrogen), providing a site for fertilization, gestating a fetus if fertilization occurs, and giving birth to a baby, and breastfeeding a baby after birth. Sexually Transmitted Diseases (STDs), including pelvic inflammatory disease (PID), HIV/AIDS, human papillomavirus (HPV), syphilis, gonorrhea and herpes (HSV). These diseases are transmitted through sexual intercourse from one person to another.

To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby.

Since the United Nations Population Fund (UNFPA) was created 50 years ago, the number of births per woman has dropped by nearly half to 2.5 births. Also, there has been a significant decrease in fertility rates in the least developed countries, as well as deaths from pregnancy-related causes. But the UNFPA reports more than 200 million women worldwide are subjected to unwanted pregnancies because they have no access to modern contraceptives. In addition, more than 800 pregnant women die each day from preventable causes because of limited access to reproductive health services. Two-thirds of maternal deaths today occur in sub-Saharan Africa, according to the report.

Indeed women all over the world, especially in developing countries have been and continue to be exploited despite the fact that they are efficient users of resources in that when given access to say training, raw materials, market opportunities or credit; they are able to add their own initiative to come up with ventures that are normally successful. Higher income for rural women means improvement in basic foods and health of their households while health education for these women means increased levels of nutrition, health and sanitation of their households. However, because the women lack the above resources, they are constantly victims in their homes and even in the societies in which they live. For instance, women are almost solely responsible for their families 'health and for the provision of food, water and yet their work is not paid, nor is it recognized (Matewa, 2003).

The World Health Organization (WHO) is working on others additional indicators for the global monitoring of reproductive health, including indicators on the incidence and prevalence of sexually transmitted diseases (STDs), the quality of family planning services, access to and the quality of maternal health services, and the incidence of female genital mutilation.

International Efforts

Human rights and particularly women's human rights have been burning issues in this decade. The protection of women's human rights has been discussed in various conferences from the past up to till date. The Cairo meeting on population has taken a further step towards securing these rights, since population issues are directly related to this sector. The Cairo meeting faces the challenge of controlling population growth rate through three negotiations. First, the reduction in infant, child and maternal mortality, and universal access to family planning information and services; second, estimates of financial resources, i.e. the breakdown, levels and resources that will be required to provide reproductive health services, including family planning; and third the issue of the definition of terms like "reproductive health", "safe motherhood", "fertility regulation" and "family planning". Family planning not only decreases population, but must also be regarded as a branch of

human rights. Women, who are the main sufferers, must be given rights over their own bodies as well as rights to take decisions with regard to family planning. (Thapalia, 1994)

A series of World Conferences related to women have strengthened social, economic, and political magnitude of gender equality through empowerment of women, internationally as well as nationally. The two calculated objectives of Beijing Platform of Action concerning women and media that aims to promote women empowerment is to increase women involvement in decision-making through media and other technologies of mass communication; and promotion of non-stereotyped portrayal of women in media (Guleria, 2010).

The First World Conference in women was held in Mexico City in 1975 which highlighted the themes of "Equality, Development and Peace". The Second World Conference on women convened in Copenhagen in 1980, added three sub-themes: "Education, Employment and Health". In Nairobi, The Third World Conference was held to review and appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace (1976-1985). The goal was set here for the adoption of "Forward-looking Strategies for the Advancement of Women to the year 2000". In this Thirty-Seventh Session, the Commission urged the Fourth World Conference on Women to consider women's right and concerns in November 1991. This Conference was held in the capital city of China, Beijing in September 1995. The Beijing Conference, in a series of UN-sponsored global conferences on women laid the foundation in the field of human rights of women, who constitute nearly of the world population (Prabhudas, 2011).

In 1995, the UNDP's Human Development Report established that there is no country in the world where gender equality has been achieved. The same year the women's conference in Beijing endorsed an Action Programme for the promotion of equality between women and men. The Beijing Platform for Action identified twelve common, critical areas of concern, including poverty, education, health, violence, armed conflict, environment, power, decision-making, and the situation of female children (Kabeer, 2001).

Two powerful examples of how the links between sexual and reproductive health and rights and gender equality can be explicitly enshrined in international policy commitments are the Beijing Platform for Action and the human rights treaty on the Convention on the Elimination of All Forms of Discrimination against Women. (CEDAW) is an international human rights treaty that enshrines women's human rights and obliges State parties to meet their obligations to fulfil and respect these rights. The Convention devotes major attention to women's reproductive rights; notably, it is the only human rights treaty to mention family planning and guarantee women's reproductive choice.The review of the ICPD + 25

(International Conference on Population and Development) highlights the progress made over the past two decades with respect to gender equality. There has also been some progress in access to contraception, but at an estimated 4.6 children per woman, Africa has the highest fertility rate in the world. This is largely because of inequitable sexual and reproductive health care information and services.

Reproductive Health Status in Nepal

Women's development in Nepal has a long history of about a century, but the wave length of development was different than what is at present. A slow and gradual development of women since 1950-51, has been accelerated after the declaration of women's decade in 1975. A ten years period from 1975-1985 provided an opportunity to take a retrospective look at the role and status of women. A three- year research study started in 1979 on the status of women in Nepal. This study carried out to determine the actual participation and decision making process, their role in the social and cultural milieu and in economic activities. One of the visible achievements of the UN decade for women in Nepal was the establishment of institution of women in both the government and the NGO sector. But despite some legal reforms intending to improve women's condition, the absence of a truly democratic political environment made it difficult for the people to raise a voice (Sharma, 2004).

The maternal mortality rate of Nepalese women, associated with adolescent pregnancies and poor health services, is among the highest in the world. Recent studies reveal that one out of every thirty-two pregnant women die due to pregnancy and childbirth related complications. According to the Gender Development Index (GDI), socioeconomic conditions for Nepalese women are worse than for other South Asian women. Moreover, women remain far behind men in Nepal according to the Gender Empowerment Measure (GEM). Indeed, women's participation in politics is only one-fifth that of men and the same pattern prevails in professional occupations and administrative jobs. Although a substantial proportion of women, around 40 percent, are economically active, many are unpaid family workers involved in subsistence agriculture. (Mahat, 2003)

The census of 2011 indicates that fertility has been declining at a faster rate over the last decade. The crude birth rate for the year 2011 is estimated to be around 22 per thousand. Similarly, the total fertility rate (TFR) of a woman throughout her lifetime is expected to be around 2.52 children against 3.25 in 2001. Mortality is also a declining trend. The crude death rate (CDR), which shows the number of deaths per thousand populations, is estimated to be around 7.3 per thousand populations in 2011 against 10.3 in 2001. (CBS, 2014)

Life expectancy at birth (e0) for the census year 2011 is estimated at 66.6 years against 49.6 in 1981. The life expectancy of females has overtaken males in the last 30 years. Life expectancy at birth for females has increased from 48.1 years in 1981 to 67.9 years in 2011. With the improvement in living standards, an educational status and health facility, the life expectancy of the Nepalese population has been increasing. (ibid)

Objectives of the Study

The broad objective of the study is to examine the role and performance of mass media in promoting women's empowerment in the study area. However, the study has some specific objectives. They are:

- To examine the level of knowledge about sexual and reproductive health.
- To analyze the practices of participation on decision making about sexual and reproductive health.

Research Methodology

Research Design: Descriptive as well as analytical.
Study Area: Municipality and Village municipality of Kavrepalanchowk district.
Study Population: Married women.
Sample Size: 40 married women were selected using purposive sampling.
Nature and Sources of Data: Qualitative as well as quantitative in nature and primary data were used as a sources of data.
Data Collection Techniques: Schedule Interview, Observation and Key Informant Interview.

Respondents profile

The demographic characteristics include age, sex and marital status of the respondents. Result as shown in Table 1 revealed that out of 40, majority of the respondents are in the age group of 20-45, 26 (65%). only 9 respondents (22.5%) were in the age group of above 45, minority of the respondents are in the age group of below 19, 5 (12.5%). All the respondents were female and married.

Table 1: Socio-demographic profile of the respondents.

Socio-demographic profile	Frequency	Percentage
Age group		
Below 19	5	12.5
20 to 45	26	65
45 above	9	22.5
Total	40	100
Caste/ethnicity		

Brahmin	8	20
Chhetri	10	25
Damai/ Kami/Sarki	4	10
Gurung/Magar	12	30
Newar	6	15
Total	40	100
Religion		
Hindu	24	60
Buddhist	13	32.5
Christian	3	7.5
Total	40	100
Education		
Illiterate	6	15
Up to school level	26	65
Higher education	8	20
Total	40	100
Occupation		
Agriculture/ animal husbandry	21	52.5
Wage labour/ house hold work	9	22.5
Service/ business/ industries	10	25
Total	40	100
Economic Status of family		
Not enough	17	42.5
Enough	16	40
Surplus	7	17.5
Total	40	100

Source- Field Study, 2019

Along with these demographic characteristics caste/ethnicity, religion, education, occupation and family economic status of respondents were taken as a socio-economic status. Table shows that majority of the respondents were from the caste/ethnic group Gurung/Magar, 12 (25%). Only few respondents were from the Damai/Kami/Sarki ethnic/caste group, 4 (10%). Majority of the respondents were from the Hindu religion, 24 (60%), only few respondents are from the Christian religion, 3, (7.5%). Buddhist religions were, 13 (32.5). With the majority 26, (65%) belonging to up to school level education. Among them 8 (20%) respondents belonging to higher education and 6 (15%) of them were illiterate. More than half respondents, 21 (52.5%) were involving in agriculture/ animal husbandry, 10 (25%) respondents were involving in service/business/ industries, and rest, 9 (22.5%) were involving in wage labour/ house hold domestic work. Among the respondents

family economic status 17 (42.5%) were lower, 16 (40%) were in the middle and only 7 (17.5%) were in economically high class. Knowledge on Sexuality and Reproductive Health, to examine the level of knowledge on sexuality and reproductive healthknowledge about reproductive health, child marriage, mensuration, age of marriage, sexual and reproductive health related diseases, pregnancy, abortion and family planning were considered here under.

Table 2: Distribution of the respondents by knowledge about the reproductive health

Variables	Classification	Frequency	Percentage
Knowledge on reproductive health	Have knowledge	35	87.5
	Don't have knowledge	5	12.5
Child marriage	Have knowledge	38	95
	Don't have knowledge	2	5
Mensuration	Have knowledge	40	100
	Don't have knowledge	0	0
Age of marriage	Have knowledge	39	97.5
	Don't have knowledge	1	2.5
Reproductive health related diseases	Have knowledge	29	72.5
	Don't have knowledge	11	27.5
knowledge about STDs/HIV AIDS	Have knowledge	33	82.5
	Don't have knowledge	7	17.5
Pregnancy	Have knowledge	35	87.5
	Don't have knowledge	5	12.5
Abortion	Have knowledge	29	72.5
	Don't have knowledge	11	27.5
Family planning	Have knowledge	38	95
	Don't have knowledge	2	5

Source- Field Study, 2019

The above table discloses that the majority of the respondents, 35 (87.5 %) responded that they have knowledge about reproductive health. Only 5 (12.5%) respondents reported that they don't have knowledge about reproductive health. Those respondents who reported that they have knowledge about reproductive health were again asked have you maintain few

issues of reproductive health respondents mentioned being aware of health, cleaning reproductive organs, planned pregnancy and no heavy manual work during pregnancy, regular health check-up and if needed safe abortion.

To revels the knowledge on child marriage, respondents were asked whether they have knowledge on child marriage or not. Over whole respondent, 38 (95%) reported that they are aware about child marriage. Only a few respondents, 2 (5%) reported that they are not aware about child marriage.In order to disclose the knowledge about the mensuration, respondents were asked whether they have knowledge about mensuration or not 40 (100%) respondents reported that they have knowledge about mensuration. But few of them don't have knowledge about menopause.

To revels the appropriate age of marriage, respondents were asked whether they have knowledge about appropriate age of marriage or not over whole majority of the respondents 39 (97.5%) reported that they have knowledge about appropriate age of marriage only 1 respondent (2.5%) reported don't have knowledge.

To explore the knowledge regarding sexual and reproductive health related diseases, they were asked whether they have knowledge about the sexual and reproductive health related diseases or not, Majority of the respondents 29 (72.5%) reported that they have a knowledge, only few 11 (27.5%) reported that they don't have knowledge. Those people who have knowledge were asked about Endometriosis, Uterine Fibroids, Gynaecologic Cancer, Interstitial Cystitis, Polycystic Ovary Syndrome (PCOS) and Sexually Transmitted Diseases (STDs) only few respondents know about little knowledge about sexual and reproductive health's related diseases. On the other hand, when they were asked knowledge about Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome(HIV/AIDS), 33 (82.5%) reported that they have knowledge, but only few 7 (17.5%) respondents reported that they don't have knowledge.

In order to disclose the knowledge about the pregnancy, abortion and family planning, respondents were asked whether they have knowledge, majority 35 (87.5%) respondents reported that they have knowledge about pregnancy but only few 5 (12.5%) respondents reported they don't have. Majority 29 (72.5%) respondents reported that they have knowledge about abortion butminority 11 (27.5%) respondents reported they don't have. Over whole majority 38(95%) respondents reported that they have knowledge about family planning but only 2 (5%) respondents reported they don't have knowledge about family planning. Respondents who have knowledge about family planning were asked about family planning methods- long-acting reversible contraception such as the implant or intra uterine device (IUD), hormonal contraception such as the pills or Depo Provera Injection, barrier method such as condoms, emergency contraception, fertility awareness and permanent contraception such as vasectomy and tubal ligation it reveals that they have only knowledge which method of family planning they are adopting.

Practices of Participation on Decision Making

In order to analysed the women's practices of participation on decision making in sexual and reproductive health respondents were asked their freedom on mobility and whether they have participating in the decision on the issues of marriage, use of contraception, terminate pregnancy, abortion, interval between two baby, treatment of sexual and reproductive health diseases and family planning. Their responses are shown in the table given below.

Table 3: Distribution of the respondents by freedom on mobility and practices of participation on decision making

Variables	Classification	Frequency	Percentage
Freedom on mobility	Yes	14	35
	No	26	65
Decision on marriage	Yes	14	35
	NO	20	50
	Self	6	15
Use of contraception	Yes	9	22.5
	No	26	65
	Non users	5	12.5
Terminate pregnancy	Yes	13	32.5
	No	23	57.5
	Not pregnant till date	4	10
Abortion	Yes	7	17.5
	No	4	10
	Never did	29	72.5
Interval between two babies	Yes	14	35
	No	16	40
	Don’t have a baby/ only one baby	10	25
Treatment of sexual and reproductive health diseases	Yes	22	55
	NO	14	35
	No needed to treatment till date	4	10
Adopting method of family planning	Yes	9	22.5
	No	23	57.5
	Not adopting	8	20

Source- Field Study, 2019

Above table shows that majority of the respondents, 26 (65%) reported that they don’t have freedom on mobility. Only 14 (35%) respondents reported that they have freedom on mobility. Respondents who have freedom of mobility asked how long you can move out of home without asking your husband/ father in law/ mother in law or any other family

member. Majority of the respondents reported that up-to three hours. Only a very few reported that they can move out more than twelve hours. Those respondents who don't have a freedom of mobility were asked with whom you have to take permission; many respondents reported that they have to take the permission with husband/ father in law/mother in law or any member of the family.

To understand the participation on decision of marriage, respondents were asked whether they were involve in the decision of marriage, half of the respondents 20 (50%) reported that they were not involved in their marriage decision. Minority of the respondents 14 (35%) reported that they were involve in marriage decision. only few respondents 6 (15%) reported that they were decided themselves (*BhagiBibaha*).

On the basis of data received it can be said that majority of the respondents 26 (65%) reported that they are not involving in the decision of use of contraception. Minority 9 (22.5%) respondents reported that they were involving.Only few 5 (12.5%) reported that they are non-users. Further asked to the respondents whether they were involving in decision of terminate pregnancy, majority of the respondents 23 (57.5%) reported that they were not asked for terminate pregnancy. Minority of the respondents 13 (32.5%) were involve in decision. Only few 4 (10%) respondents reported that they were not pregnant till date.

Above table shows that majority of the respondents 29 (72.5%) reported that they werenever did abortion. Among others 7 (17.5%) reported that they were participate in the decision on abortion but few 4 (10%) respondents reported that they were not participate in the decision of abortion.

To revels the participation on decision of interval between two babies, respondents were asked whether they were involved in decision about the interval between two babies, 16 (40%) respondents reported that they were not participate in the decision. Minority of the respondents 14 (35%) were involved. Only few 10 (25%) respondents reported that they don’t have children or only one baby.

To understand the participation on decision of treatment regarding sexual and reproductive health respondents were asked whether they were involvementin decision on treatment of sexual and reproductive health, Majority of the respondents 22 (55%) reported that they were involving. Minority of the respondents 14 (35%) reported they were not involving. Only few 4 (10%) respondents reported that no need to treatment till date. They reported that most of the treatment is related to the pregnancy.

In order to disclose the participation on decision regarding the method of family planning adoption, respondents were asked whether they were involving in decision of adopting method of family planning, majority 23 (57.5%) respondent reported that they were not involving. Minority of the respondents 9 (22.5%) reported that they were involving. Only few 8 (20%) respondents reported that they were not adopting method of family planning. Respondent who reported that they were adopted permeant family planning, were asked who (male/female) did family planning, most of the respondents reported that she did.

Findings

Knowledge about sexual and reproductive health

- Majority of the respondents, 87.5 % responded that they have knowledge about reproductive health.
- Over whole respondent, 95% reported that they are aware about child marriage.
- 100% respondents reported that they have knowledge about mensuration.
- Over whole majority of the respondents 97.5% reported that they have knowledge about appropriate age of marriage.
- Majority of the respondents 72.5% reported that they have knowledge about the sexual and reproductive health related diseases.
- Majority of the respondents 82.5% reported that they have knowledge about Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS).
- Majority 87.5% respondents reported that they have knowledge about pregnancy.
- Majority 72.5% respondents reported that they have knowledge about abortion.
- Over whole majority 95% respondents reported that they have knowledge about family planning.

Practices of participation on decision making about sexual and reproductive health

- Majority of the respondents, 65% reported that they don't have freedom on mobility.
- Half of the respondents 50% reported that they were not involved in their marriage decision.
- Majority of the respondents 65% reported that they are not involving in the decision of use of contraception.
- Majority of the respondents 57.5% reported that they were not asked for terminate pregnancy.
- Respondents 10% reported that they were not participate in the decision of even abortion.
- Respondents 40% reported that they were not participating in the decision about the interval between two babies.
- Respondents 35% reported that they were not involving in decision on treatment of sexual and reproductive health.

- Majority 57.5% respondent reported that they were not involving in decision of adopting method of family planning. Female doesmost of the permanent family planning.

Conclusion

Sexual and reproductive health is widely considered as a gender issues. In the context of sexual and reproductive health services can be effective in preventing the recurrence of violence and enabling the empowerment of women and girls. Given the infrequent contact by many women with the public health sector, sexual and reproductive health and rights programmes are often a vital access point for women to address in their lives, improve health outcomes and open access to opportunities. The main objectives of increasing awareness for reproductive health are: It helps in educating every youth about sexual and reproductive health. It creates awareness among adolescents about safe sexual practices. It helps in preventing sexually transmitted infections, including HIV/AIDS.

Female are aware about sexual and reproductive health like child marriage, mensuration, age of marriage, sexual and reproductive health related diseases, pregnancy, abortion and family planning but in practices female participation on decision making about sexual and reproductive health like decision on the issues of marriage, use of contraception, terminate pregnancy, abortion, interval between two baby, treatment of sexual and reproductive health diseases and adoption of family planning method consider very poor.

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