



Withdrawal behaviors of working women in relation to reproductive health problems

Hamida NAZ

ORCID: 0009-0001-3719-4449

Ideal College, Dhanmondi Dhaka, Bangladesh

Noor MOHAMMAD

Jagannath University, Dhaka, Bangladesh

Asoke KUMAR SAHA

Jagannath University, Dhaka, Bangladesh

MAHADI-UL-MORSHED

Jagannath University, Dhaka, Bangladesh

Centre for Research in Multidiscipline, Barishal, Bangladesh

Shramana SINGHA ROY

Banaras Hindu University, Varanasi, India

Chinmoy KUMAR MONDAL

Anderson Center for Autism, Staatsburg, New York, USA

Shirajul ISLAM

Nurul Amin Degree College, Shibchar, Madaripur, Bangladesh

Parimol KUMAR

Bheramara Govt. Mohila College, Bangladesh

Abstract. *Purpose.* The main objective of the present study was to investigate the relationship between reproductive health problems and the withdrawal behavior of working women. *Study design.* In this study target population was the female workers of the garments factory situated in Dhaka city of Bangladesh. 100 female workers who had medical cards were selected following the purposive sampling method as respondents in the present study. *Measuring instruments.* The present study required: 1) Reproductive Health Related Check List H. Naz, and with the help of physicians who were experts in reproductive health; 2) Job Withdrawal Behavior, which measures the lateness and absenteeism of the respondents. *Findings.* The findings indicate that, reproductive health has the significant positive correlation with lateness ($r = .241, p < .05$) and there is also significant negative correlation between reproductive health problems and age ($r = -.209, p < .05$). Other findings indicate that the strongest predictor of withdrawal behavior was reproductive health problems which alone explained the 5.8% variance in reproductive health problems and 4.4% variance with age. It seems that, this result fit the model. Finally, it is concluded that, in developing countries is not just a health problem; it should be recognized also as a human rights issue.

Keywords: withdrawal behavior, working women, reproductive health problems.

Introduction

With time, the number and demand of working women in Bangladesh are increasing. Women no more want to depend on others financially, as financial independence brings self-honor, self-confidence, and self-identity (Mili, 2010). In Bangladesh, women are traditionally expected to be homemakers and take care of the household chores and their children. However, nowadays, many women manage their household and professional work simultaneously. A few years ago, work options were limited to teaching, but the scenario has changed now. Women are working as bankers, telecom professionals, and lecturers and also running their own ventures successfully. “Women’s work” can refer to tasks associated with child-rearing, such as diaper-changing, bathing, and teaching personal hygiene. It can also include professions like cooking, midwifery, governess, nanny, wet nursing and daycare worker that involve caring for infants. This term acknowledges the biological capacity to bring new life and their traditional role in raising children within the home. Although much of “women’s work” is indoors, some involve going outdoors, such as fetching water, grocery shopping, food foraging, and gardening (Wikipedia, 2014).

Working conditions in Bangladesh’s garment sector

The garment sector is the largest employer of women in Bangladesh and provides employment opportunities to women from rural areas who previously did not have any opportunity to be part of the formal workforce (Ahmed, 2004). This has helped them to be financially independent and have a voice in the family (BGMEA, 2010).

However, women workers face many problems and are paid far less than men due to their lack of education (Kabeer, Mahmud, 2004). Most come from low-income families, and their compliance has enabled the industry to compete with the world market. Unionization is discouraged by factory owners (Ahmed, 2004), and conditions in Export Processing Zones (EPZ) are better than most garment factories operating outside the EPZs. Nevertheless, buyers’ pressure to follow labor codes has helped maintain acceptable working conditions in some factories (BGMEA, 2010). Garment workers have protested against their low wages. Protests by workers, which began in 2006, have continued periodically since then, prompting the government to increase minimum wages (BGMEA, 2010). This has forced the government to increase workers’ minimum wages (Kabeer, Mahmud, 2004). However, even though having a baby is a human right, female garment workers are reluctant to exercise their rights because they fear of losing their jobs. According to P. Paul-Majumder, the rate of miscarriage among garment workers is alarmingly high, and most experienced abortions more than once (Paul-Majumder, 1998). In response, BGMEA has been implementing health education awareness and training programs since 1998, and UNFPA has already provided family welfare and reproductive health education services to more than 0.1 million workers (Mahtab, 2003). Despite these efforts, the current state of the garments industry and workers’ rights, particularly on reproductive health issues, requires urgent attention. Few previous surveys have also highlighted similar concerns (Mahtab, 2003; Paul-Mojumder, 1998).

Women’s health

A comprehensive understanding of women’s health requires a broad considering their role and position in society, particularly within the family institution. Women’s health differs from that of men in many unique ways. Women’s health is an example of population health, where health is defined by the World Health Organization (WHO) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”(WHO, 2016). Often treated as simply women’s

reproductive health, many groups argue for a broader definition pertaining to the overall health of women, better expressed as “The health of women”. These differences are further exacerbated in developing countries where women, whose health includes both their risks and experiences, are further disadvantaged.

Reproductive health

According to the World Health Organization’s definition, health is not merely the absence of disease or infirmity but a complete physical, mental and social well-being. Reproductive health, or sexual hygiene, addresses the reproductive processes, functions and systems at all stages of life (WHO, 2008a).

The WHO assessed in 2008 that “Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women, and 14% for men (WHO, 2008).” According to the United Nations Population Fund (UNFPA), “unmet needs for sexual and reproductive health deprive women of the right to make “crucial choices about their own bodies and futures”, affecting family welfare. Women bear and nurture children, so reproductive health is inseparable from gender equality (UNPF, 2016).

Reproductive health-related problems

Common reproductive health-related problems that people face on a daily basis include vulvovaginitis, abortion, sexually transmitted diseases, endometriosis, uterine fibroids, gynecologic cancer, polycystic ovary syndrome (PCOS), sexual violence, maternal death and disability, pregnancy-related problems (CDC, 2018). To address these issues, there is a need to strengthen the health and education systems and ensure the availability of essential health supplies such as contraceptives and medicines.

Withdrawal behaviors

Organizations seek to foster productive employees; however, employees often disengage from their work. Work disengagement can take both physical and psychological forms and can significantly impact workplace productivity and performance. Physical behaviours such as work absenteeism, tardiness, and turnover are readily identifiable, while psychologically expressed behaviors may manifest as “laziness” and “burnt-out”. as individuals tend to become passive, lack creativity, and put minimal effort into the job. Each form of withdrawal behaviour presents a unique challenge to understand and interact with, as well as to provide equilibrium for both the employee and the employer. It is critical to understand the origin of withdrawal behaviours so that one can trace them back to the root cause at an organizational, team, or individual level. One way of approaching the concept of performance is to examine withdrawal behaviours. Withdrawal behaviours are defined as behaviours involving physical withdrawal, such as absenteeism and turnover. Organizations are particularly motivated to understand these behaviours, as they result in high costs (Rosse, Noel, 1996).

Types of withdrawal behaviors

There are two types of withdrawal behaviour, Physical and Psychological.

Physical withdrawal behaviors

Physical withdrawal behaviors include next manifestations.

1. *Lateness*. Excessive tardiness can be a physical sign that an employee has disengaged from the company.
2. *Absenteeism*. Absenteeism is exhibited when an employee fails to report to work, typically for an extended period of time or days that have not been excused (Cohen, Golan, 2007).
3. *Turnover*. Turnover occurs when an employee leaves an organisation and frequently results from both lateness and absenteeism (Rosse, 1988).

Psychological withdrawal behaviors

Secondly, Psychological withdrawal behaviors include

1. *Presenteeism*. It occurs when an employee shows up for work but works in a limited capacity. This occurs due to physical impairment, such as being sick with a cold or mental or psychological strain. Employees might sit at their desks and stare off into space or spend time leisurely surfing the internet instead of accomplishing tasks. Decreased productivity due to presenteeism is more difficult to identify and measure than absenteeism (Trotter et al., 2009).
2. *Burnout*. Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job, characterised by emotional exhaustion, cynicism and inefficacy. It can occur when an employee can no longer cope with overwhelming stressors and has exhausted all their personal, mental and physical resources for the job (Maslach, Shaufeli, Leiter, 2001).

Withdrawal behaviours have become an important topic of study in Human resource management and organizational psychological research. In the process model developed by R. M. Steers and S. R. Rhodes, job satisfaction and organizational commitment are considered to play a role in employee attendance (Steers, Rhodes, 1978). In spite of such studies, the empirical evidence concerning the relationship between withdrawal behaviours and employee attitudes continues to be mixed and modest at best (Dipboye, Smith, Howell, 1994; Hackett, 1989; Meyer, 1997; Rosse, Noel, 1996; Spector, 1997).

Rationale of the study

The garment industry is the backbone of Bangladesh's economy, with over 5100 garment factories employing over three million people, of which 85% are women (Sikder, Sarkar, Sadeka, 2014). In the 2010–2011 financial year, the garment sector contributed 78.15 % to the total income and remained the largest source of the country's export earnings (Ahmed, Raihan, 2014). Physical fitness is essential for women to perform their work efficiently. However, women often experience reproductive health-related problems that lead to the decreased dedication, involvement, and satisfaction; it increases lateness, absenteeism, and turnover toward the job (Trier, 1954; Zinth, Kerr, 1951). Consequently, the ultimate goals of garments can be interrupted. A few findings were found on reproductive health issues and withdrawal behaviour. But there are no research findings regarding working women's reproductive health problems and withdrawal behaviours in Bangladesh and other countries. Therefore, the present study focuses on this considering its theoretical and practical importance. This can be helpful for other researchers, managing directors, and CEOs because they will be able to know how much reproductive health problems affect women's withdrawal behaviours. Thus, the relevant research questions is what type of relationship exists between reproductive health and withdrawal behavior of female garment workers in Dhaka?

Objectives

The main objective of the present study was to investigate the relationship between reproductive health problems and the withdrawal behaviors of working women. The specific objectives were to:

- investigate whether there is any relationship between reproductive health problems and lateness;
- investigate whether there is any relationship between reproductive health problems and absenteeism;
- investigate whether reproductive health problems vary according to age.

Method

The present part includes methodological details of the study. It includes- sample and sampling technique, selection of appropriate instruments, research design and data collection procedure, which are described below: The target population of this study was the female workers of the garments factory situated in Dhaka city of Bangladesh.

Sample

A total of 100 female workers who have medical cards were selected following the purposive sampling method. The age range of the respondents was 18 to 40. Data were collected from different garment factories such as SS Garment, TSR Apparels and Samad Sweater, Dhaka. All respondents do their assigned work eight hours per day without overtime. Their demographic details were recorded by PIF form.

Design

A cross-sectional survey design was used for the present study. All data were collected at a single point in time.

Measuring instruments

To collect data for this study, the following instruments were used: Personal Information Form (PIF); Reproductive Health Related Check List (Naz, 2017); Job Withdrawal Behavior.

Personal Information Form

The demographic data of the respondents were recorded in Personal Information Form.

Reproductive Health Related Check List

Reproductive health-related problems checklist was prepared by H. Naz with the help of expert reproductive health physicians (Naz, 2017). The lowest and highest score is 1 and 20, respectively. A higher score indicates more reproductive health problems.

Job Withdrawal Behavior

It is an objective measure and measures the lateness and absenteeism of the respondents. Here the researcher collected data from their logbooks. The data collector recorded their absent days out of three months, and side by side recorded their lateness days.

Procedure

For collecting proper information from participants, permission was taken from the concerned authority for data collection. After establishing rapport with participants, the researcher expressed the study's objectives and assured the confidentiality of the responses. Then, the respondents were requested to fill up personal information blank; after that, the booklet of the Bengali versions of the scale was given to them. After respondents went through the instructions given on the front page of the booklet, were advised to start the task. At last, the inventory booklet was collected from the respondents and respondents were thanked for their cooperation in the study. A total of three months was required for data collection.

Results

Table 1 represents the means and standard deviations of the present study variables. To begin with the correlation matrix of Table 2 is presented the simple correlation of independent variable with each dependent variable. The results indicates that there is a significant positive correlation between reproductive health problems and lateness ($r = .241, p < .05$) and a significant negative

correlation between reproductive health problems and age ($r = -.209, p < .05$). There is no significant correlation between reproductive health problems and absenteeism.

Table 1. Mean and standard deviation of reproductive health, absenteeism, lateness, and age

Variables	Mean	Standard deviation
Reproductive health	2.54	.98
Absenteeism	1.93	1.51
Lateness	1.64	1.26
Age	20.67	2.87

Table 2. Correlation matrix among reproductive health problem and absenteeism, lateness, and age

Variables	1	2	3	4
1. Reproductive health problem	—			
2. Absenteeism	.142	—		
3. Lateness	.241*	.498**	—	
4. Age	-.209*	.058	-.153	—

Note: * — $p < .05$ ** — $p < .01$.

Results of table 3 indicates that the strongest predictor was reproductive health which alone explained 5.8% variation in Lateness.

Table 3. Selected statistics from regression of lateness on reproductive health problem

Variables	R	R ²	R ² change	Sig. F
Predictor variable: Reproductive health problem	.241	.058	.058	.016
Dependent variable: lateness				

The results presented in Table 4, suggest that unstandardized B is .310., as reproductive health problem increases by a fraction of a unit, lateness increase by .310 units; this is true only if the effects of other variables are held constant. The value of standardized beta ($\beta = .241$) indicates as reproductive health problem increases by one standard deviation; lateness increases by .241 standard deviations.

Table 4. Simple regression of lateness on reproductive health problems

Model	Unstandardized coefficients		Standardized coefficient	t	Sig.
	B	Std. Err.	β		
(Constant)	.852	.343	.241	2.481	.015
Reproductive health problem	.310	.126		2.461	.016
Dependent variable: lateness					

From Table 5 it can be said that reproductive health is a good predictor. It is also said that ANOVA tells us reproductive health is statistically significant.

Table 5. The overall F -test for regression of lateness on reproductive health problems

Sum of variations	SS	df	MS	F	Sig. F
Regression	9.139	1	9.139	6.055	.016
Residual	147.901	98	1.059		
Total	157.040	99			

Results of table 6 indicate that the strongest predictor was reproductive health problems which alone explained 4.4% of the variance in age.

Table 6. Selected statistics from regression of age on reproductive health problems

Variables	R	R ²	R ² change	Sig. F
Predictor variable: reproductive health problem	.209	.044	.044	.037
Dependent variable: age				

The results presented in Table 7 suggests unstandardized $B = -.613$, as reproductive health problem decreases by a fraction of a unit, age increase by .310 units and this is true only if the effects of other variables are held constant. The value of standardized beta ($\beta = -.209$) indicates that reproductive health problem decreases with age increases by one standard deviation, lateness increases by .241 standard deviations.

Table 7. Simple regression of age on reproductive health problems

Model	Unstandardized coefficients		Standardized coefficient	t	Sig.
	B	Std. Error	β		
(Constant)	22.228	.787	-.209	28.235	.000
Reproductive health problem	-.613	.289			.037
Dependent variable: age					

From table 8 it can be said that reproductive health is a good predictor. It is also said that ANOVA suggests reproductive health is statistically significant.

Table 8. The overall F-test for regression of age on reproductive health problems

Sum of variations	SS	df	MS	F	Sig. F
Regression	35.691	1	35.691	4.439	.037
Residual	778.419	98	7.943		
Total	814.110	99			

Discussion

The main objective of the present study was to investigate the relationship between reproductive health problems and the withdrawal behavior of working women in the garment factory of Dhaka. There were some specific objectives to investigate — whether there is any relationship among reproductive health problems, lateness, absenteeism, and age. For this purpose, 100 female workers from different garment sectors were drawn by the purposive sampling method. Furthermore, a cross-sectional survey research design was followed to conduct the present study.

The first objective was to investigate whether there is any relationship between reproductive health problems and lateness. Result of the Table 2 indicate that lateness has a significant positive correlation with reproductive health-related problems. Standardized beta (Table 7) also indicates that reproductive health is positively related to lateness, that means as reproductive health problem increases, lateness increases. This result is like the results of some researchers (Trier, 1954; Zinth, Kerr, 1951). Like any other disease, reproduction-related diseases also simultaneously affect the mind and body. But developing countries like India and Bangladesh are lacking in proper reproductive health-related knowledge; therefore, this affects a large proportion of women (Rashid, Akram. Standing, 2011).

The situation is much harder for working females, as they have to take care of their family and job; sometimes, this boundary of self extends therefore workplace also becomes an extended family. Most of the time, reproductive health got neglected among working women, which results in chronic psychological and physiological problems, such as lateness. Fear of losing a job can also restrain them from taking proper reproductive care. Previous research report that pregnancy, pressure to

leave the job because of their pregnancy and withholding of maternity benefits cause stress, anxiety and hypertensive disorders among pregnant garment workers in Bangladesh (Akhter, Rutherford, Chu, 2017). Findings suggest that lateness can be due to reproductive health problems; therefore, new workplace policies can be built to provide security.

The second objective was to investigate whether there is any relationship between reproductive health problems and absenteeism. The results of the Table 2 indicate no significant correlation between reproductive health and absenteeism. As garment workers' job is not permanent, also the way they are being treated in the workplace creates stress and anxiety (Akhter, Rutherford, Chu, 2017). This anxiety of losing a job could be one reason for no correlation between absenteeism and reproductive health problems, though reproductive health issues are higher among them.

The third objective was to investigate whether reproductive health problems vary according to age. Results of Table 2 further indicate that age has a significant negative correlation with reproductive health-related problems. Standardized beta (Table 7) indicates that reproductive health is negatively related to lateness, as age increases, reproductive health problem decreases. This finding is like that of other authors (Frone, Russell, 1995). An increase in loss of sexual desire among females is positively correlated with age, while distress because of this loss of sexual desire is negatively correlated with age (Graziottin, 2007). This could be one reason for the significant negative correlation between age and reproductive health problems, also with aged women become more experienced in dealing with these problems, and their protective measures also become stronger.

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Отстранённое поведение работающих женщин в связи с проблемами репродуктивного здоровья

НАЗ Хамида

ORCID: 0009-0001-3719-4449

Идеальный колледж, Джанмонди, Дакка, Бангладеш

МОХАММАД Нур

Университет Джаяганнатхи, Дакка, Бангладеш

САХА Асоке Кумар

Университет Джаяганнатхи, Дакка, Бангладеш

МАХАДИ-УЛЬ-МОРШЕД

Университет Джаяганнатхи, Дакка, Бангладеш

Центр междисциплинарных исследований, Барисал, Бангладеш

РОЙ Шрамана Сингха

Индустский университет Банарас, Варанаси, Индия

МОНДАЛ Чинмой Кумар

Центр Андерсона по аутизму, Стаатсбург, Нью Йорк, США

ИСЛАМ Шираджул

Колледж Нурула Амина, Шибхар, Мадарипур, Бангладеш

КУМАР Паримол

Колледж Мохила, Бангладеш

Аннотация. *Цель.* Основная цель настоящего исследования заключалась в изучении взаимосвязи между проблемами репродуктивного здоровья и отстранённым поведением работающих женщин. *Дизайн исследования.* В этом исследовании целевой группой были работницы швейной фабрики, расположенной в городе Дакка, Бангладеш. В качестве респондентов в настоящем исследовании методом целевой выборки были отобраны 100 работниц, имевших медицинские карты. *Измерение.* В данном исследовании были использованы: 1) «Контрольный список по репродуктивному здоровью» Х. Наз и помощь врачей, являющихся экспертами в области репродуктивного здоровья; 2) «Поведение при отказе от работы», которое измеряет опоздания и прогулы респондентов. *Результаты.* Результаты показывают, что репродуктивное здоровье имеет значимую положительную корреляцию с опозданием ($r = 0.241, p < 0.05$), а также существует значимая отрицательная корреляция между проблемами репродуктивного здоровья и возрастом ($r = -0.209, p < 0.05$). Другие результаты показывают, что самым сильным предиктором отстранённого поведения были проблемы репродуктивного здоровья. 5,8% дисперсии отстранённого поведения объясняются проблемами репродуктивного здоровья, 4,4% дисперсии — возрастом. В целом этот результат соответствует модели. Наконец, делается вывод, что в развивающихся странах это не просто проблема здравоохранения; это следует признать также и проблемой прав человека.

Ключевые слова: отстранённое поведение, работающие женщины, проблемы репродуктивного здоровья.