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WOMEN'S REPRODUCTIVE HEALTH IN A TOURISM SETTING: A DESCRIPTIVE STUDY IN LOVINA, BALI

(Kesehatan Reproduksi Perempuan di Kawasan Pariwisata: Studi Deskriptif di Lovina, Bali)

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Abstract

Women's reproductive health is shaped by social, economic, cultural, and environmental factors, particularly in high-mobility settings such as tourism areas. In Lovina, Bali, tourism activities may influence reproductive health through lifestyle changes, psychosocial stress, and sexual behavior. This study aimed to describe the reproductive health profile of women living in this tourism area. A quantitative descriptive study with a cross-sectional design was conducted among 160 women aged 20–45 years, selected through purposive sampling. Data were collected using structured questionnaires and analyzed descriptively. Most respondents were aged 30–39 years, predominantly married, and had lived in the area for over five years. The majority experienced menarche at 13–14 years and reported normal menstrual cycles (21–35 days). Most had a history of pregnancy, commonly one to two pregnancies, although some had no live births. Contraceptive use was relatively high, especially injectable methods, but more than one-third had never used contraception. Miscarriage and unplanned pregnancy were reported by a notable proportion, while pregnancy complications were less common. Sexual behavior was generally low risk, though a small proportion reported sexually transmitted infections. Reproductive health was favorable, but gaps in contraception and STI prevention remain.

Keywords: *Reproductive Health, Women, Tourism Area*

Abstrak

Kesehatan reproduksi perempuan dipengaruhi oleh faktor sosial, ekonomi, budaya, dan lingkungan, terutama pada wilayah dengan mobilitas tinggi seperti daerah pariwisata. Di Lovina, Bali, aktivitas pariwisata dapat memengaruhi kesehatan reproduksi melalui perubahan gaya hidup, stres psikososial, dan perilaku seksual. Penelitian ini bertujuan untuk menggambarkan profil kesehatan reproduksi perempuan yang tinggal di kawasan pariwisata tersebut. Penelitian deskriptif kuantitatif dengan desain potong lintang dilakukan pada 160 perempuan usia 20–45 tahun yang dipilih melalui purposive sampling. Data dikumpulkan menggunakan kuesioner terstruktur dan dianalisis secara deskriptif. Hasil: Sebagian besar responden berusia 30–39 tahun, berstatus menikah, dan telah tinggal di wilayah tersebut lebih dari lima tahun. Mayoritas mengalami menarche pada usia 13–14 tahun dan memiliki siklus menstruasi normal (21–35 hari). Sebagian besar memiliki riwayat kehamilan, umumnya satu hingga dua kali, meskipun

beberapa tidak memiliki anak hidup. Penggunaan kontrasepsi tergolong tinggi, terutama metode suntik, namun lebih dari sepertiga belum pernah menggunakan kontrasepsi. Keguguran dan kehamilan tidak direncanakan dilaporkan oleh sebagian responden, sementara komplikasi kehamilan relatif jarang. Perilaku seksual umumnya berisiko rendah, meskipun sebagian kecil melaporkan riwayat infeksi menular seksual. Kesehatan reproduksi secara umum tergolong baik, namun masih terdapat kesenjangan dalam penggunaan kontrasepsi dan pencegahan infeksi menular seksual.

Kata Kunci: Kesehatan Reproduksi, Wanita, Daerah Wisata

1. LATAR BELAKANG

Women's reproductive health is an important part of public health that includes physical, mental, and social conditions related to reproductive functions and processes. The scope of reproductive health is vast, including maternal and newborn health, control of sexually transmitted infections (STIs), prevention of unwanted pregnancy, use of contraception, and treatment of reproductive disorders (Kemenkes RI 2022). Various social, cultural, economic, and environmental factors also affect the reproductive health condition of women, especially in communities that live in high mobility dynamics such as tourist areas (Lestari, Erviantono, and Noak 2025).

The Lovina tourist area in Kalibukbuk Village, Buleleng District, Bali, is one of the fastest-growing marine tourism destinations and has heterogeneous social interactions. Tourism activities have the potential to cause lifestyle changes, increased stress, and exposure to risky sexual behaviors that have an impact on reproductive health (Ok, Ahn, and Lee 2019). High population mobility, domestic and foreign tourist arrivals, and growth of the tourism industry sector can also increase the potential for the spread of STIs and other reproductive health problems (Ok, Ahn, and Lee 2019; Yung, Cotter, and McGorry 2021).

Several studies have shown a link between tourism development and an increased risk of reproductive health problems. Intense social interaction and lack of education can increase the risk of unwanted pregnancy, improper use of contraception, and changes in sexual behavior (Rukmasari 2024). In addition, environmental pressures, workloads, and psychological stress can affect a woman's menstrual cycle and fertility (Ok, Ahn, and Lee 2019). Other studies also reported that tourist areas had a higher tendency to risky sexual behaviors, including sexual contact with migrants (Wijaya and Setiawan 2025).

However, most existing studies focus on specific aspects of reproductive health, such as sexual behavior or STI risk, and are often conducted in general populations rather than in tourism-specific settings. Moreover, there is a lack of comprehensive, descriptive data that simultaneously capture multiple dimensions of women's reproductive health such as menstrual characteristics, fertility history, contraceptive use, pregnancy outcomes, and sexual behavior within a single population.

In the context of the Lovina tourism area, no previous study has systematically described the overall reproductive health profile of women despite its unique characteristics, including high population mobility, economic dependence on tourism, and intensive interaction with visitors. This creates a critical evidence gap for understanding how these contextual factors shape women's reproductive health conditions.

The absence of such integrated data limits the ability of health providers and policymakers to design targeted, community-based reproductive health interventions that are responsive to the specific needs of women in tourism settings.

Based on this context, this study aimed to describe the reproductive health profile of women in the Lovina tourism area. The findings are expected to provide a comprehensive overview of women's reproductive conditions and serve as a foundation for developing more effective and sustainable health interventions.

2. RESEARCH METHOD

This study employed a quantitative descriptive design with a cross-sectional approach, aimed at describing the reproductive health profile of women in the Lovina tourism area at a single point in time. This design was selected to provide a comprehensive overview of reproductive health characteristics without examining causal relationships(Sofya et al. 2024).

The research was conducted in the Lovina tourism area, Kalibukbuk Village, Buleleng District, Bali, one of the major and rapidly developing tourism destinations in Buleleng Regency. Data collection took place from May to August 2025. The study population focused on women aged 20–45 years, which falls within the standard definition of women of reproductive age (15–49 years) as defined by the WHO (Organization 2024). Due to the high

mobility of the population, the total population size could not be precisely determined; therefore, the 160 respondents represent a sample rather than the entire population. A purposive sampling technique was applied to recruit participants who met the study criteria, considering the specific characteristics of the population and the absence of a complete sampling frame. A total of 160 respondents were included, with the sample size determined based on the rule of thumb and the principle of sample adequacy, ensuring sufficient representation for descriptive analysis in line with the study objectives. The inclusion criteria were: (1) women aged 20–45 years; (2) residing or working in the tourism area; and (3) willingness to participate as respondents. Participants were recruited through direct community engagement, with support from community health cadres and local primary healthcare services. Eligible respondents were approached in both residential and work settings, and informed consent was obtained prior to data collection. Recruitment was conducted across different locations and times, and consistent inclusion criteria were applied. Although the sampling method limits generalizability, efforts were made to ensure variation in participant characteristics

Data were collected using a structured questionnaire adapted from the reproductive health module of the Indonesian Basic Health Research (Riskesdas), Ministry of Health of the Republic of Indonesia. The questionnaire was validated by experts, pilot-tested, and demonstrated acceptable reliability (Cronbach's alpha=0,78), with minor revisions made before data collection.The questionnaire comprised six sections: (1) respondent characteristics, (2) reproductive period, (3) fertility, (4) contraceptive use, (5) history of miscarriage and unintended pregnancy, and (6) sexual behavior.

Prior to data collection, a literature review was conducted, and ethical clearance was obtained (Approval No.: 983/EC-KEPK-SB/VII/2025) along with relevant research permits. Enumerators received standardized training on questionnaire administration. All respondents were provided with information regarding the study objectives, participant rights, and data confidentiality. Written informed consent was obtained before questionnaire completion and structured interviews. Respondent anonymity and data confidentiality were strictly maintained.

Data analysis was performed descriptively using SPSS for Windows, employing frequency distributions, percentages, means, medians, and standard deviations. The findings are presented in the form of tables and narrative descriptions to facilitate interpretation.

3. RESULTS AND DISCUSSION

3.1 Results

Based on Table 1, The respondent profile demonstrates that women were predominantly within the 30–39-year age group, largely married, and had resided in the tourism area for more than five years. This pattern reflects a relatively established reproductive-age population embedded within a socially dynamic and high-mobility environment. Such stability, despite the surrounding mobility associated with tourism, may influence both health-seeking behavior and reproductive decision-making.

Table 1: Respondent Characteristics (n=160)

Variable	Category	n	%
Age	20-24 years old	7	4,4
	25-29 years old	29	18,1
	30-34 years old	56	35
	35-39 years old	52	32,5
	40-45 years old	16	10
Marital Status	Marry	153	95,6
	Unmarried	7	4,4
Long stay in tourist areas	< 1 year	6	3,8
	1-5 years	20	12,4
	> 5 years	134	83,8
Work	Freelance day laborers	17	10,6
	Teacher	1	0,6
	Housewife	92	57,5
	Private employees	29	18,1
	Student	10	6,3
	Village Apparatus	1	0,6
	PNS	4	2,5
	Self employed	6	3,8
Education	Elementary School	7	4,4
	Junior High School	13	8,1
	Senior High School	97	60,6
	College	43	26,9

From a reproductive health perspective (Table 2), most respondents reported menarche within the normal age range (13–14 years) and maintained regular menstrual cycles. These findings suggest that, in general, the

physiological reproductive function of women in this population is within normal limits.

Table 2: Female Reproduction Period (n=160)

Variable	Category	n	%
Age menarche	10 years	1	0,6
	11 years	3	1,9
	12 years	23	14,4
	13 years	54	33,8
	14 years	50	31,3
	15 years	25	15,6
	16 years	4	2,4
Regularity of the menstrual cycle	Regular (21-35 days	116	72,5
	Irregular but within normal range (21-35 days, inconsistent)	28	17,5
	Irregular(<21 or >35 days)	16	10
Length of menstrual cycle	Uncertain	28	17,5
	< 21 days	8	5,0
	21-35 days	116	72,5
	> 35 days	8	5,0
Menstrual-related symptoms (self-reported)	Yes	25	15,6
	Not	135	84,4

In terms of fertility (Table 3), the majority of respondents had experienced pregnancy, typically one to two pregnancies, indicating generally normative fertility patterns. However, the presence of respondents without live births suggests heterogeneity in reproductive outcomes, which may be influenced by biological, behavioral, and contextual factors.

Table 3: Fertility Rate (n=160)

Variable	Category	n	%
Have been pregnant/not	Yes	150	93,8
	Not	10	6,2
Number of pregnancies (Gravida)	0	10	6,2
	1	43	26,9
	2	54	33,8
	3	37	23,1
	≥4	16	10,0
Number of living children (Parity)	0	28	17,5
	1	44	27,5
	2	37	23,1
	3	37	23,1
	≥4	14	8,8
Planning a pregnancy	Yes	29	18,1
	No	126	78,8
	Uncertain	5	3,1

**The discrepancy between the number of pregnancies and the number of living children may be attributed to pregnancy loss, including miscarriage or stillbirth, as further presented in Table 5.*

Although contraceptive utilization was relatively high dominated by injectable methods (Table 4) this pattern also reflects a reliance on short-term, provider-dependent methods rather than long-acting reversible contraception. Importantly, a substantial proportion of women had never used any contraceptive method, signaling persistent unmet needs in family planning. This finding may indicate gaps in access, autonomy, or informed choice, particularly within the context of a tourism-influenced community where social norms and mobility may affect reproductive behavior.

Table 4: Use of Contraceptives (n=160)

Variable	Category	n	%
History of Contraceptive Use	Ever used	99	61,9
	Never used	61	38,1
Types of Contraceptive Methods Ever	Natural methods	1	1,0

Used*			
	Condom	10	10,1
	Oral contraceptive pill	22	22,2
	Injectable contraceptive	27	27,3
	Implant	15	15,2
	Intrauterine device (IUD)	21	21,2
	Female sterilization (MOW)	4	4,0
Current Contraceptive Use	Yes	64	40
	Not	96	60

**Percentages for contraceptive methods were calculated based on respondents who had ever used contraceptives (n = 99).*

Pregnancy-related outcomes (Table 5) reveal that miscarriage and unplanned pregnancy were not uncommon among respondents, despite the relatively low occurrence of reported pregnancy complications. These findings underscore a divergence between general reproductive health status and specific adverse outcomes. Unplanned pregnancies, in particular, may reflect inconsistencies in contraceptive use or limitations in reproductive health literacy, while miscarriage may point to underlying health, environmental, or psychosocial stressors.

Table 5: Pregnancy-Related History Among Ever-Pregnant Women (n = 150)

Variable	Category	n	%
Have had a miscarriage	Yes	38	25,3
	Not	112	74,7
Have had an unplanned pregnancy	Yes	24	16,0
	Not	126	86,0
Have had complications during pregnancy	Yes	9	6,0
	Not	141	94,4

**Data on miscarriage, unplanned pregnancy, and pregnancy complications were analyzed only among respondents with a history of pregnancy (n=150)*

In terms of sexual behavior (Table 6), while the majority of respondents reported low-risk sexual behavior, the identification of sexually transmitted infections (STIs) among a subset of participants highlights an important area of vulnerability. Even at a low prevalence, the presence of STIs in a tourism setting is epidemiologically relevant, as increased population mixing and transient interactions may facilitate transmission dynamics.

Table 5: Sexual Behavior (n=160)

Variable	Category	n	%
Age of first sexual intercourse	Never had sexual intercourse	1	0,6
	≤ 18 years	12	7,5
	19-21 years	45	28,1
	22-24 years	68	42,5
	≥ 25 years	34	21,3
Number of sexual partners (last 12 months)	One partner	144	90,6
	More than one partner	15	9,4
	Not applicable (no sexual history)	1	0,6
Sexual contact with tourists	Yes	2	1,3
	No	157	98,1
	Not applicable (no sexual history)	1	0,6
History of Sexually Transmitted Infections (STIs)	Yes	12	7,5
	No	147	91,9
	Not applicable (no sexual history	1	0,6

3.2 Discussion

This study provides a comprehensive overview of women's reproductive health profiles in the Lovina tourism area, highlighting the interplay between biological, social, and environmental determinants. Beyond descriptive findings, these results can be interpreted through the lens of the social determinants of health, where health outcomes are shaped by

structural conditions such as employment, environment, and social interaction patterns.

In tourism settings, this aligns with the concept of the tourism health nexus, which posits that tourism development influences community health through mobility, occupational exposure, and socio-cultural interaction (Tourism Health Nexus). Empirical evidence shows that tourism can produce both positive and negative health externalities depending on local adaptation capacity (Godovykh et al. 2022).

Most respondents were aged 30–39 years, representing women in active reproductive age, and were predominantly married, reflecting local sociocultural norms in which reproductive events largely occur within marriage. Women in this age group also tend to have greater autonomy in reproductive decision-making, which may influence contraceptive use and pregnancy planning. The majority had lived in the tourism area for more than five years, indicating prolonged exposure to the social and environmental dynamics associated with tourism activities, which may influence reproductive health through lifestyle changes and psychosocial stress (Godovykh et al. 2022). Prolonged residence in such environments may also lead to normalization of certain behaviors and coping mechanisms that indirectly shape reproductive health practices.

Menstrual characteristics showed that most respondents experienced menarche at 13–14 years, which is within the normal range. Normal menstrual cycles are generally defined as lasting between 21 and 35 days, and adult women typically exhibit cycle lengths within this range (Itriyeva 2022). This finding suggests that, from a biological perspective, the majority of respondents do not exhibit major endocrine or reproductive dysfunctions. Although a proportion of respondents reported menstrual irregularities, most still had cycle lengths within the normal physiological range (21–35 days), suggesting that these irregularities were largely functional rather than pathological. Such functional irregularities are often associated with modifiable factors, including stress, nutritional status, and physical activity. Factors such as stress, workload, and environmental changes common in tourism areas have been associated with menstrual irregularities, indicating that even mild deviations may reflect underlying psychosocial influences (Anto-Ocrah et al. 2023). Menstrual-related symptoms were reported by a relatively small proportion of respondents, indicating generally favorable menstrual health conditions.

In terms of fertility, most respondents had a history of pregnancy, with the majority experiencing one to two pregnancies. However, a notable proportion reported no live births, which may be attributed to pregnancy loss or respondents who were pregnant at the time of data collection. This discrepancy highlights the potential burden of pregnancy loss or other reproductive challenges that may not be immediately visible through parity data alone. Only a small proportion of respondents were currently planning a pregnancy, suggesting that fertility intentions may be influenced by socioeconomic considerations and life stage factors. The observed pattern, in which a notable proportion of women reported no live births despite pregnancy history, may be partly influenced by pregnancy loss and psychological factors. Previous research indicates that experiences of pregnancy loss can alter fertility desires and intentions, particularly within the life course and among women at different reproductive stages, potentially reinforcing or diminishing future childbearing plans. Moreover, perceived stress and related psychosocial variables have been shown to negatively affect fertility intention, mediated by anxiety and well being, highlighting the complex interplay of biological and social determinants in reproductive decision making (Beringer and Milewski 2024).

Contraceptive use was relatively high, with injectable contraceptives being the most commonly used method, followed by oral pills and IUDs. This preference may also indicate reliance on short term, provider dependent methods rather than long acting reversible contraceptives (LARCs), which are generally more effective but less utilized. This preference reflects broader national trends in Indonesia, where short-acting hormonal methods are widely utilized due to their accessibility, convenience, and availability in primary healthcare settings (Hidayati et al., 2022). However, the finding that more than one third of respondents had never used contraception indicates a significant unmet need for family planning services. This unmet need may increase the risk of unintended pregnancies and closely spaced births, which are associated with adverse maternal and child health outcomes. This gap may be attributed to limited knowledge, cultural beliefs, fear of side effects, or barriers in accessing services (Hidayati et al. 2022).

Regarding pregnancy outcomes, the prevalence of miscarriage and unplanned pregnancy highlights ongoing reproductive

health challenges, despite the low occurrence of pregnancy complications. These findings underscore the importance of strengthening reproductive health education, family planning services, and antenatal care, particularly in tourism-driven communities where social dynamics and environmental pressures may affect women's reproductive health.

The occurrence of miscarriage (25,3%) and unplanned pregnancy (16.0%) highlights important reproductive health challenges within the study population. These findings indicate that favorable general reproductive health conditions do not necessarily eliminate the risk of adverse reproductive outcomes. Miscarriage is a multifactorial condition influenced by biological, environmental, and psychosocial factors. Factors such as maternal age, nutritional deficiencies, and chronic stress may interact to increase vulnerability to pregnancy loss. In the context of tourism areas, stress related factors, occupational demands, and lifestyle changes may contribute to adverse pregnancy outcomes. Similarly, unplanned pregnancy is often associated with inconsistent or ineffective contraceptive use, reflecting gaps in reproductive health education and counseling. This underscores the importance of strengthening not only access to contraception but also the quality of counseling and informed decision-making (Beyene 2019). High-quality counseling is a key indicator in family planning services, leading to increased informed choice and effective contraceptive method selection (Napitupulu, Aritonang, and Simanjuntak 2023).

Regarding sexual behavior, most respondents reported initiating sexual activity at 22–24 years of age, which aligns with the high proportion of married respondents and reflects sociocultural norms in the community. The majority reported having only one sexual partner in the last 12 months, indicating predominantly monogamous relationships. However, a small proportion of respondents reported multiple sexual partners and sexual contact with tourists, suggesting the presence of higher-risk subgroups within the community. Even small high-risk subpopulations can play a significant role in the transmission dynamics of sexually transmitted infections. Tourism areas are often characterized by increased interaction between local residents and visitors, which may create opportunities for risky sexual behaviors, even if such practices are not widespread.

The prevalence of self-reported STIs (7.5%), although relatively low, remains a public health concern. This finding indicates that even in predominantly monogamous populations, the risk of STIs persists, potentially due to limited awareness, delayed diagnosis, or partner-related transmission. The occurrence of STIs may also be associated with adverse reproductive outcomes, including pregnancy complications and miscarriage, emphasizing the importance of integrated reproductive and sexual health services. Previous research has demonstrated that STIs during pregnancy are linked to unfavorable perinatal outcomes such as small for gestational age infants, stillbirth, and prematurity, highlighting the need for improved screening and treatment prior to and during pregnancy. These findings underscore the importance of integrated reproductive and sexual health services that address STI prevention, early detection, and management within antenatal and community health programs (Chico et al. 2012)(Smolarczyk et al. 2021) (Dunne et al. 2025).

Overall, the combined findings underscore the interconnectedness of sexual behavior, contraceptive use, and pregnancy outcomes. While most respondents demonstrated low-risk sexual behavior patterns, the presence of miscarriage, unplanned pregnancy, and STIs highlights the need for comprehensive, context-specific reproductive health interventions. These gaps reflect the complex interaction between individual behavior, health system factors, and the unique socio-environmental context of tourism areas. Strengthening family planning services, STI screening, and reproductive health education tailored to tourism-area communities is essential to improve women's reproductive health outcomes in the Lovina tourism area.

4. CONCLUSION

This study highlights the reproductive health profile of women living in the Lovina tourism area, where prolonged exposure to tourism related social and environmental dynamics may influence reproductive outcomes. Most respondents were of active reproductive age, predominantly married, and long term residents of the area. Menstrual characteristics were largely within normal physiological ranges, indicating generally favorable menstrual health.

Most women had experienced pregnancy, although a notable proportion reported no live births, likely related to pregnancy loss or ongoing pregnancies. Fertility intentions were relatively low, suggesting the influence of life stage and socioeconomic factors. Contraceptive use was relatively high, particularly injectable

methods, yet gaps in family planning coverage remain, as many women had never used contraception.

Despite predominantly low risk sexual behavior patterns, the presence of miscarriage, unplanned pregnancy, and self reported STIs indicates ongoing reproductive health challenges. These findings underscore the need for strengthened, integrated reproductive and sexual health services including family planning, STI screening, and reproductive health education tailored to tourism-area communities such as Lovina.

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