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STATUS OF REPRODUCTIVE HEALTH OF MEITEI PANGAL: A STUDY OF KWAKTA IN BISHNUPUR DISTRICT, MANIPUR

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ABSTRACT

Reproductive health refers to the overall health and well-being of individuals in relation to their reproductive systems, including physical, emotional, and social aspects. Poor reproductive health can lead to adverse outcomes such as infertility, sexually transmitted infections (STIs), maternal and child mortality, and morbidity. The Meitei Pangals (Muslims) of Manipur faces various challenges in accessing reproductive health care services. These include lack of awareness, inadequate healthcare facilities, gender inequality, and socio-cultural barriers. Cultural and religious norms may also contribute to limited knowledge and understanding of family planning, contraception, and reproductive health. Additionally, poverty and low levels of education among the community made it difficult to access quality reproductive health care services. This often leads to poor maternal and child health outcomes and high rates of STIs. Overall, concerted efforts are needed to improve the reproductive health of the Meitei Pangal (Muslim) community of Manipur. This includes increasing access to quality healthcare services, raising awareness on reproductive health, and addressing barriers related to gender and socio-cultural norms. Hence the proposed study is trying to unearth the reproductive health of Meitei Pangals of Kwakta in Bishnupur district. The study is focused on 80 married women who have been further sub-divided into 3 age groups i.e., a) 16-25, b) 26-35, c) 36-45. The respondents have been selected by purposive sampling and the data have been collected with the help of a structured interview schedule covering particularly their socio-economic status, health, education, decision making, cultural factors and their perception and awareness level about the health care services.

Key Words- Reproductive Health, Decision Making, Sexually Transmitted Infections (STI)

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INTRODUCTION

It is well recognised that in a patriarchal setting such as India, hierarchical gender relations and unequal gender norms impact women's sexual and reproductive health and choice and act as significant obstacles to access of services and facilities. Equally, the achievement of good sexual and reproductive health may be inhibited by structural factors such as poverty and malnutrition, early marriage and inadequate educational and health care systems etc. Gender roles have significant implications for sexual and reproductive health and choice. Be the lack of awareness, lack of spousal intimacy and communication on sexual matters, and widespread gender-based violence compound women's inability to negotiate safe sex, seek appropriate health care or experience a healthy pregnancy. Finally, gender roles that perpetuate the 'culture of silence' inhibit women from communicating health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores. This 'culture of silence' is even more exaggerated for gynaecological and reproductive morbidity that are so closely linked with sexuality.

Since 1990's women have been identified as key agents of sustainable development, women's equality and empowerment as central to a more holistic approach towards establishing new patterns and processes of sustainable development. The World Bank has suggested that empowerment of women should be a key aspect of all social development programs (World Bank, 2001). Although a considerable debate on what constitutes empowerment exists, in this paper we find it useful to rely on Kabeer's (2001) definition: "The expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them." For women in India, this suggests empowerment in several realms: personal, families, economic and political. Hence, empowerment has its impact on the all-round development of women, particularly their health. Increased empowerment of women is likely to increase their awareness of the health problems faced by them, their symptoms and facilities available to cure them, and it also encourages the ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood.

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Hence the study aimed to unearth the status of reproductive health and to understand the impact of socio-economic and cultural factors on reproductive health of Meitei Pangals of Kwakta in Bishnupur district.

OBJECTIVE

1. To know about the status of women in terms of reproductive health and education.
2. To understand the impact of socio-economic and cultural factors on reproductive health of women in the study area.

METHODOLOGY

The study is focused on 80 married women respondents of Kwakta municipal area of ward no 4, 5, 6 and 8 of Bishnupur district of Manipur. The respondents have been selected by purposive sampling covering 80 married women, who are further sub-divided into 3 age groups i.e., a) 16-25, b) 26-35, c) 36-45. The data is collected with the help of a structured interview schedule covering particularly their status of socio-economic background, sexual and reproductive health, sexual & reproductive, education, decision making, cultural factors and their perception and awareness level about the sexual & reproductive health care. The secondary data collected from books, journals, newspapers, websites, and government records etc.

PROFILE OF THE RESPONDENT

Age

Age group of the respondents are classified into 3 categories i.e., 16-25, 26-35 and 36-45. The distribution into these categories have been shown in table no. 1.

TABLE

Table-1: Age of the respondents

Age group	Frequency	Percentage
16-25	25	31.25
26-35	21	26.25
36-45	34	42.5

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TOTAL	**80**	**100**

Source: Field work

From the table 1, it is seen that, most of the respondents 31.25 percent are between 16-25 years, followed by 26.25 percent of the respondents are from 26-35 age group and the remaining 42.5 percent are from 36-45 age group.

Size of the family

Size of families are categorized into three categories i.e., Small (1-4 members), Medium (5-8 members) and large (above 8 members). The distribution into these categories have been shown in table no. 2.

Table- 2: Family size of the respondents

Family size	Frequency	Percentage
1-4 (Small)	38	47.5
5-8 (Medium)	23	28.75
Above 8 (Large)	19	23.75
Total	**80**	**100**

Source: Field work.

In the study it is found that majority 47.5 percent of the respondent's families belongs to nuclear family, and a little more than half 28.75 percent of the respondent's families are from medium family size with 5-8 members, and only 23.75 percent of them are from large families with more than 8 members.

Occupation of the head of the household

Occupations of the head of the households are categorized into four i.e., agriculturist, skilled workers, private jobs and government service. The distribution into these categories have been shown in table no. 3.

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Table- 3: Occupation of the head of the households

Occupation of the respondents husband	Frequency	Percentage
Agriculturist	37	46.25
Skilled worker	17	21.25
Private job	16	20
Govt. service	10	12.5
TOTAL	**80**	**100**

Source: Field work

As far as the occupation of the head of the household is concerned, 46.25 percent of the respondent's husband are agriculturist; by 21.25 percent of the respondent's husband are skilled worker; 20 percent engaged in Private Job; however, 12.5 percent are doing government service.

Monthly household income

Moving to the most important variable that determines the economic status of the household is the monthly household income. Here, monthly household income is categorized into four i.e., very low (up to 5000), low (5000-10,000), average (10,000-15000) and high (above 15,000). The distribution into these categories have been shown in table no. 4.

Table- 4: Monthly income of the household

Level of cost	Income in rupees	Frequency	Percentage
Very low	Up to 5000	38	47.5
Low	5000-10,000	19	23.75
Average	10,000-15,000	10	12.5
High	Above 15,000	13	16.25
Total		**80**	**100**

Source: Field work

From the above table, it is observed that most of the respondent's (47.5 percent) monthly household income is very low (up to Rs. 5000), followed by 23.75 percent of the respondent's monthly household income is low (Rs. 5000-10,000), 12.5 percent of the respondent's monthly

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household income is average (10,000-15,000) and 16.25 percent of the respondent's monthly household income is high (Above 15,000).

Hence, the study reveals that majority of the respondents' household are economically poor which is reflected from their occupation and monthly household income.

Educational qualification of the respondents

Educational qualifications of the respondents are categorized into 6 i.e., illiterate, primary level, high school level, higher secondary level, graduate and post-graduates. The distribution into these categories have been shown in table no. 5.

Table- 5: Educational Qualification of the respondent

Educational Qualification of the respondents	Frequency	Percentage
Illiterate	6	7.5
Primary level	16	20
High School level	36	45
Higher Secondary level	10	12.5
Graduate	9	11.25
Post-graduate	3	3.75
Total	**80**	**100**

Source: Field work

The above table depicts that most of the respondents (45 percent) have high school degree and 11.25 percent & 20 percent respondents are educated up to graduation and primary level respectively. 12.5 percent of the respondents are educated up to higher secondary level, and only 3.75 percent of the respondents are educated up to post graduation and 7.5 percent of the respondents are illiterate.

Occupation of the respondents

Occupations of the respondents are categorized into four i.e., housewife, skilled worker, petty business and government service. The distribution into these categories have been shown in table no. 6.

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Table- 6: Occupation of the respondents

Occupation of the respondents	Frequency	Percentage
Housewife	40	50
Skilled worker	23	28.75
Petty business	15	18.75
Government service	2	2.5
Total	**80**	**100**

Source: Field work

The above table depicts that 50 percent respondents are housewife; 28.75 percent of the respondents are skilled workers (weaver), 18.75 percent of the respondents are in petty business and only 2.5 percent of the respondents are engaged in Government service.

Decision making

Major roles taken in decision makings in matters related to household expenses, education of children, size of the family and use of contraceptives are classified into three i.e., husband, wife, both husband and wife. The distribution into these categories have been shown in table no. 7.

Table- 7: Major role taken in decision makings

Decision making		Frequency	Percentage
Household expenses	**Husband**	37	46.25
	Wife	19	23.75
	Both	24	30
	Total	**80**	**100**
Education of children	**Husband**	15	18.75
	Wife	8	10
	Both	57	71.25
	Total	**80**	**100**
Size of the family	**Husband**	21	26.25
	Wife	12	15
	Both	47	58.75
	Total	**80**	**100**
Use of contraceptive	**Husband**	0	0
	Wife	0	0
	Both	27	33.75

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	N/A	53	66.25
	Total	**80**	**100**

Source: Field work

The role women played in decision making reflects the status of women. As far as the decision-making regarding household expenses, the study reveals that majority 30 percent of the respondent household expenses are decided by both husband and wife, 23.75 percent of the family expenses is decided by wives and 46.25 percent is decided by husband. Hence, we can say that females are playing equal role in matters related to household expenses.

The study reveals that decision making regarding children's education is taken mostly (71.25 percent) by both husband and wife, in 18.75 percent of the respondents' house the husband takes the major role in decision making and only in 10 percent of the respondent's house, decision regarding children's education is taken by wives. Hence, we can say that males are playing more dominant role in decisions regarding children's education rather than household expenses.

As far as the family size is concerned the study shows that nearly 58.75 percent of the respondent family size is decided by both husband and wife, followed by in 26.25 percent of the respondents household, the decision is taken by the head of the family and in only 15 percent of the respondents' household the decision is taken by wives.

Regarding the use of contraceptives, nearly 33.75 percent of the respondents are using contraceptives by the joint decision of both husband and wife.

Overall, it can be concluded that women play almost an equal role as male in decision making regarding household expenses, education of children, size of the family and contraceptives.

Major decision taken regarding having sex

Major decision taken regarding having sex is categorized into three i.e., decision taken by husband, decision taken by wife and decision taken by both husband and wife. The distribution into these categories have been shown in table no. 8.

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Table- 8: Decision taken regarding having sex

Decision taken	Frequency	Percentage
Husband	61	76.25
Wife	0	0
Both	19	23.75
Total	**80**	**100**

Source: Field work

On the basis of decision taken regarding having sex, 76.25 percent of the respondent's husband take decision regarding having sex and in the rest 23.75 percent of the families, the decision is taken jointly by both husband and wife.

Most interesting finding of the study is that women play almost an equal role as male in decisions regarding household expenses, education, education of children, size of the family and contraceptives but when it comes to sexual behaviour female decision is very low.

STATUS OF REPRODUCTIVE HEALTH

Age at menarche

Menarche is the onset of menstrual cycle. Age of menarche differs from individual to individual. Here, age of menarche of the respondents are classified into 3 i.e., 10-12 years, 13-14 years and 15-16 years. The distribution into these categories have been shown in table no. 9.

Table- 9: Age at menarche of the respondents

Age of menarche	Frequency	Percentage
10-12 years	17	21.25
13-14 years	49	61.25
15-16 years	14	17.5
TOTAL	**80**	**100**

Source: Field work

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In the study, majority of the respondents (61.25 percent) menstruation starts at the age of 13-14 years, 21.25 percent of the respondents' menstruation starts at the age of 10-12 years and 17.5 percent of the respondents' menstruation starts at the age of 15-16 years. From the above data it can be said menstruation starts at the age of 13-14 in majority of the respondents.

Problems related to menstruation

Problems related to menstruation are classified into 7 i.e., Weakness during periods, irregular periods, scanty bleeding, excessive bleeding, itching, stomach ache and pack pain. The distribution into these categories have been shown in table no. 10.

Table- 10: Problems related to menstruation

Problem	**Frequency**	**Percentage**
Weakness	6	7.5
Irregular	16	20
Scanty bleeding	**7**	8.75
Excessive bleeding	8	10
Itching	12	15
Stomach ache	13	16.25
Back pain	18	22.5
Total	**80**	**100**

Source: Field work

In the study we found that out of the total respondents 22.5 percent respondents reported to have problem of back pain, followed by 20 percent of the respondents who have problem of irregular menstruation, 8.75 percent of the respondents have problem of scanty bleeding, 16.25 percent of the respondents have problem of stomach ache, 15 percent of the respondents have problem of itching, 10 percent of the respondents have problem of excessive bleeding and 7.5 percent of the respondents have problem of weakness during menstruation.

Due to careless and lack of knowledge together with lack of medical facilities in the area, cent percent of the respondents don't consult doctor and don't take medicines for these problems.

RTI/STI among the respondent

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RTI/STI among the respondents are classified into the following- white discharge, white discharge with odour, itching over vulva, pain in lower abdomen not related to menses, low backache and painful passage of urine. The distribution into these categories have been shown in table no. 11.

Table- 11: RTI/STI among the respondent

Problem	**Frequency**	**Percentage**
White discharge	10	12.5
White discharge with odour	5	6.25
Itching over vulva	3	3.75
Pain in lower abdomen not related to menses	34	42.5
Low backache	20	25
Painful passage of urine	8	10
Total	**80**	**100**

Source: Field work

It is found that 12.5 percent respondents have white discharge, 6.25 percent respondents face the problem of white discharge with odour, moreover 3.75 percent respondents have itching over vulva, 42.5 percent respondents face pain in lower abdomen not related to menses, 25 percent respondents face the problem of low backache and lastly, 10 percent respondents have problem of painful passage of urine.

Moreover, in many cases lack of awareness and knowledge about RTIs and STDs lead to the rare cases of diagnosis of the problems.

Restrictions on food during the menstruation

The study reveals that majority of the respondents 94% believe in the restriction from consuming some particular food during menstruation (fruits like banana, amla, lemon, guava etc and milk, vegetables like brinjal, coriander, bamboo shoot, banana flower, *yongchak* (tree bean), and traditional curry like *oohti* (dish made of pea, rice and baking soda). As they believe that consuming these foods during the menstruation period will impede the blood circulation and it also makes the menstrual blood soaking cloth stain.

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Restrictions on performing religious practices

In the Meitei Pangal society during periods, performing religious practices is prohibited and marriage during menstruation is also not preferred.

Soaking material for menstrual blood

There is a common belief in the area that wearing panties will hamper the flow of menses and it will cause stomach ache, hence, majority of the respondents do not prefer wearing panty during the period. Their *phanek* is used as blood soaking material and in some cases they use rags, usually torn from used clothes. At home, a culture of shame forces women to find well-hidden places to dry the rags. These places are often damp, dark and unhealthy. Rags that are unclean can cause urinary, vaginal and perineal infection. Very often serious infections are left untreated and may sometimes lead to potentially fatal toxic syndrome. Due to poor lifestyle, economic condition and traditional beliefs, none of the respondent is using sanitary napkins. As a tradition, women did not keep their undergarments openly, and as a result of this majority of the respondents (96%) don't dry their undergarments and cloth for soaking menstrual blood openly i.e. directly under the sunlight.

Bashira *(local Dais) said "Today's generation face lots of menstruation problem because of wearing panty, blood can't flow freely as a result they are facing the problems of stomach ache, scanty period etc.".*

Sexual behaviour during the menstruation period

Cent percent of the respondents avoid sharing bed with their husband during the menstruation period. As they believe sharing bed during this period will hamper their health.

Age at marriage

Age at marriage in the study is classified into four i.e., 18-21, 22-25, 26-29 and 30-33. The distribution into these categories have been shown in table no. 12.

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Table- 12: Age at marriage of the respondents

Age at marriage	Frequency	Percentage
18-21	29	36.25
22-25	25	31.25
26-29	14	17.5
30-33	12	15
TOTAL	**80**	**100**

Source: Field work

The data reveals that nearly 36.25 percent respondents were married at the age of 18-21 years, 31.25 percent of the respondents were married at the age of 22-25, 17.5 percent of the respondents were married at the age of 26-29 and 15 percent of the respondents were married at the age of 30-33.

Abortion

Respondents who opted for abortion are classified in four categories based on their age at marriage. The distribution into these categories have been shown in table no. 13.

Table- 13: Percent of the respondents opted for abortion

Age at marriage	Frequency	Percentage
18-21	0	0
22-25	4	5
26-29	11	13.75
30-33	9	11.25

Source: Field work

The data reveals that no respondents opted for abortion at the age of 18–21 years, 5 percent of the respondents opted for abortion at the age of 22–25; 13.75 percent of the respondents opted for abortion at the age of 26–29; and 11.25 percent of the respondents opted for abortion at the age of 30-33.

Social restrictions during pregnancy

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In Meitei Pangal women, from the day of confirmation of pregnancy, the expected mothers are prescribed not to leave the house without tying their hair and without *dhopata* to prevent them from evil eye.

Perception and practices of delivery

Due to lack of medical facilities and poor economic conditions in the area, majority of the respondents (80%) prefer home delivery which is done through the supervision of the local dais, only in complicated cases institutional delivery is preferred. In traditional home delivery, the mother use to sleep in a mattress made of straw and a hearth is kept near the mother to keep her warm.

Bashira Bibi (local dais) *said "Sleeping in a mattress made of straw helps in the blood circulation and reduces the chances of body ache after the delivery. The warmth of the fire helps to keep the delivering mother warm and discourages the growth of viruses. The warmth of the fire also keeps the body of the mother free from aches".*

> *She said* ***(local dais)*** *"I cut the umbilical cord of the baby with some mantras after that I wash the newly born baby than I advise them to feed the baby honey or mother's milk. If it is bleeding after cutting the umbilical cord I apply saliva with soil of the floor (leibak) with some mantras".*

DISCUSSION

Reproductive health behaviour of the Meitei Pangal women is intimately related to their value system and cultural system. Cultural values and practices have a deep influence on health behaviour in general and reproductive health in particular. The study clearly reveals that even education and empowerment of women is not affecting their status of reproductive health. Thus, it does not seem to be possible to raise the health status and quality of life of the people unless such efforts are integrated with the wider effort to bring about an overall transformation of the society as a whole.

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Conscious efforts need to be made to address the needs and interest to use proper sanitation, personal hygiene, safe drinking water, and dispelling the misbelieves, taboos and magico-religious practices etc. These invariably call for all stakeholders to urgently address entrenched and incorrect sexual, menstrual and pregnancy perceptions, and enable proper hygiene practices amongst this segment of the population. There is a significant need for organizations working in the Reproductive Health and Water, Sanitation and Hygiene sectors to work concertedly towards developing appropriate policy and adequate actions on the reproductive health needs of women in the area.

Health services in the form of health education should be given more emphasis by developing effective communication strategies on health education and health care. Giving training to the local dais can be an alternative. It is also apparent that the health development programs need to be integrated conveniently with the larger program of overall development in such a way that the two become mutually self-supporting. This would be possible only, when a number of supportive services such as development of transport and communication, nutrition and education etc, are considered simultaneously. Moreover, any attempt to introduce modern medical system in the area should take into consideration the fact that the people have their traditional concept of ailment and health seeking news. Efforts are made to have a negotiable synthesis between the two systems in order to avoid confrontation and enhance acceptability of the modern Medicare system.

CONCLUSION

The study provides an overview of the reproductive health of the Meitei Pangal (Muslim) community in the study area with respect to their socio-economic conditions, cultural value and practices, challenges faced etc. The socioeconomic conditions like age, family type, occupation, educational qualification etc. are seen to have some impact on the reproductive health of the respondents. A comparative study was also done as to who are the major decision makers in matters related with household activities including their reproductive acts. Women are found to play almost an equal role as male in decision making regarding household expenses, education of children, size of the family and contraceptives. As per the reproductive health is concerned,

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studies were done on menarche, problems during menstruation and RTI/STI among the respondents. But owing to factors such careless, lack of knowledge, lack of medical facilities, counselling and clinical services in the area, majority of the respondents don't consult doctor in spite of having reproductive health problems. Cultural values and practices like rituals and acts at the time of puberty, particular food habits during menstruation, restrictions in movements, reuse clothes and soaking materials are all related to the level of reproductive health problems of the respondents. Overall, concerted efforts are needed to improve the reproductive health of the Meitei Pangal (Muslim) community of Manipur.

Thus, Meitei Pangal women need to emphasis to obtain information, skill building opportunities, Counselling and Clinical services in Kwakta.

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