ISSN 2250-3153

# Adolescence and Reproductive Behaviour: A study of Meitei-Pangals of Manipur

**Rajiya Shahani***

* Department of Sociology, Assam University, Silchar-788011

***Abstract-*** Reproductive health and behaviour of adolescents is an increasingly important component for the healthy nation. Adolescence, the second decade of life is a period when young people acquire new capacities for progress with physical growth, physiological and psychological change, the development of secondary sexual characteristics and reproductive maturation. Young people worldwide, however, face social, economic and health challenges that were unimaginable. Adolescence is, therefore, considered as a phase rather than a fixed age group; with physical, psychological, social and cultural dimensions. Programmes that can provide information, ensure access to services, and develop life skills are crucial to the future of this population. This paper will explore the existing practices or information on sexual and reproductive behaviour among adolescent girls' of Meitei-Pangals in Imphal East, Manipur; in relation with the knowledge and attitudes, socio-economic and cultural factors operating within, as well as their perception and awareness level pertaining to the health care services.

***Index Terms***- Adolescence, Reproductive Behaviour, Meitei-Pangal

## I. Introduction

Adolescence is a phase of transition through which young people acquire new capacities for progress with rapid physical growth, physiological and psychological changes, the development of secondary sexual characteristics and reproductive maturation. World Health Organisation uses to define "adolescence" as 10-19 years old, "youth" as 15-24 years old, and "young people" as 10-24 years old. Here, adolescence is defined as a transition phase through which a child becomes an adult. However, adolescence- the second phase of life which begins with the onset of puberty- is a crucial transition into adulthood. So, adolescence is considered as a phase with fixed age group, physical-psychological-social-cultural dimensions.

Adolescents constitute the healthiest group in the population, having the lowest mortality and morbidity compared with other population age groups. In a country like India, where discussion about sexuality and reproductive behaviour is almost absent, adolescents are not prepared mentally or psychologically to cope with those changes occur in adolescence (Gupta, 2003). In case of women, their adolescence is the period of pre-womanhood. In a women's lifetime her health status during any phase of life impinges upon the next phase. If their general health, reproductive health, the cultural and societal attitudes are taken care of, there will be less effort needed at the stage of womanhood. This approach insights the health of the girl child right from the birth, adolescent group through the reproductive years and into menopause and geriatric health. Therefore, one should not separate adolescents' health from the overall development of a girl to the womanhood.

Reproductive and sexual health include fertility, pregnancy, power within sexual relationships, access to and use of reproductive health services, sexually transmitted infection (STI) incidence, maternal health and HIV/AIDS (ICPD, 1994). Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations. Reproductive health thus affects the lives of women and men from conception to birth, through adolescence to old age, and includes the attainment and maintenances of good health and, at the same time, prevention and treatment of ill health.

The paper is meant to study the existing practices and information on sexual and reproductive behaviour among adolescent girls of Meitei-Pangal in Imphal East District of Manipur. It will explore the knowledge and attitudes, the socio-economic and cultural factors operating for their sexual and reproductive health along with the perception and awareness level pertaining to sexual and reproductive health care services.

The study is purely empirical. In order to carry in-depth study, simple random sampling through interview-schedule along with informal discussion is used. 100 adolescent girls and 100 adolescent mothers, within the age group of 15-24 years of age, have been taken for the study. The study has been conducted during May-June'2013. This is mainly exploratory and also takes the help of the descriptive designs.

***Socio-economic profile of Meitei-Pangal adolescent girls***

Meitei-Pangals: the Muslim inhabitants of Manipur had a total population of 202355 persons constituting 8.22% of the total state population (2440423 persons)[Socio-Economic Survey of Meitei-Pangals, 2004]. According to Socio-Economic Survey of Meitei-Pangals (2004), Imphal East had accommodated for 74709 persons with 36.91 % female population (37058 females). The survey showed sex-ratio of Meitei-Pangal of Imphal East as 984, literacy rate as 54.77, singulate mean age at marriage as 22.5 years. Further, as the overall economic conditions of Meitei-Pangal is not good, the same of the women group is also, obviously, not good. This, directly or indirectly, impacts their socio-economic conditions also.

A women's decision to seek health care could be affected by the influence of her partner or other family members; social norms; her education; her status in society; the distance she lives from the clinic, how sick she is; her previous experiences with

the health system and how she expects be treated by health care providers, her level of decision making power in the household, her access to credit, land and income (Lule et al, 2005). According to Garro (1998), there are four key criteria relevant for treatment choice: (1) gravidity of the illness, (2) whether an appropriate home remedy is known for the illness, (3) faith or confidence in the effectiveness of home remedies for a given illness, and (4) expense of treatment and the availability of resources. He provides two general principles which enable us to understand their choice: (1) for non-severe illnesses, actions are cost-oriented. People start with less costly treatments (home treatment) and only opt for more costly alternatives if the first treatments fail or if they do not know the treatment for the problem; (2) for illnesses considered serious, illness costs are secondary, and treatment selection primarily depends on "probability of cure", and normally persons opt for a physician. In short, numerous factors contribute to poor access to health care, delay in identifying and reaching medical facilities, and delay in receiving adequate and appropriate treatment (Thadeus and Maine, 1994).

***Table no. 1:***
***Information of socio-economic profile of the respondents' family***

| Variable | Percentage |
|---|---|
| ***1. Education*** | |
| Literate | 35% |
| Illiterate | 65% |
| **total** | **100%** |
| ***2. Income Sources*** | |
| Agriculture | 70% |
| Business | 25% |
| Govt. Services | 5% |
| **total** | **100%** |
| ***3. Housing*** | |
| Pakka | 10% |
| Kuccha | 90% |
| **total** | **100%** |
| ***4. Sources of Drinking Water*** | |
| River or rivulet | 85% |
| Pond | 15% |
| Tape-water | Nil |
| **total** | **100%** |

From Table 1, it is obvious that the basic socio-economic conditions of the population under study are not good. Most of them are illiterate (65%), they depend on agricultural income which is comparatively very low. They live in kuccha houses (90%) and most of them belonging to unhygienic and not sanitized surroundings. For instance, they depend on river/rivulet water for household uses and as potable.

***Awareness and perception towards sexual and reproductive health among Meitei-Pangal adolescent girls***

A study of Indian Council of Medical Research (ICMR) in 1992, showed that knowledge and awareness about puberty, menstruation, physical changes in the body, reproduction, contraception, pregnancy, childbearing, reproductive tract infections, sexually transmitted infections (STIs), and HIV were low among the girls, especially in younger adolescents (ages 10–14). Younger adolescents had little knowledge about the sex organs and most girls had not been informed about menarche prior to its onset. However, older adolescents (ages 15–19) had better knowledge and more aware than younger adolescent girls of the physical and physiological changes that take place in the body.

***Table no 2:***
***Awareness and perception level among respondents***

| Variables | Respondents | | |
|---|---|---|---|
| | Yes | No | Total |
| Knowledge about Nutritional Care | 20% | 80% | 100% |
| Knowledge about Reproductive Health | 10% | 90% | 100% |
| Knowledge about Changes in: | | | |
| 1.Physical | 60% | 40% | 100% |
| 2.Emotional | 20% | 80% | 100% |
| 3.Psychological | --- | no knowledge | 0% |
| Attitudes towards Sex | 2% | 98% (never talk) | 100% |
| Premarital Sex | 2% | 98% | 100% |
| Knowledge about STI and RTI | 5% | 95% | 100% |
| Need to have Sex Education | 5% | 95% | 100% |
| Aware about the Available Health Care Services | 10% | 90% | 100% |

Majority of girl respondents have not even heard of RTI/STD but have heard about HIV/AIDS through media like radio, TV, and NGOs etc. it can be seen from Table 2 that almost all the adolescent mothers (95%) do not have knowledge about RTIs and STIs, and importance of reproductive health. They do not much care about the correct diet. All these are related either with the lack of knowledge about the physical and physiological (80%) and psychological (no knowledge at all) occur in their adolescence, or lack of aware about the available health care services, or both.

The most common health complaints mentioned by the girls were general health problems like fever, skin problem etc. than the reproductive health problems like itching, white discharge, irregular menstruation and dysmenorrhea. It was also seen that for the treatment of their general illness rely on homemade medicine or self-medication. Most of the girls do not reveal their reproductive health problem even to their mothers thus it remains within self. Looking at the health care needs of the girls, it has been identified that the safe and supportive environment are not there within the family, schools, hospitals and society at large. There is no safety in the society because of the social violence and conflicting situations in Manipur. Very often they are unable to understand the emotional turmoil also.

Adolescence is shrouded in myths and misconceptions about sexual health and sexuality. In Indian culture, talking about sex is taboo. Consequently, little information is provided to adolescents about sexual health. Instead, young people learn more about sexual and reproductive health from uninformed sources, which results in the perpetuation of myths and misconceptions about puberty, menstruation, secondary sex characteristics, physiological and body changes, masturbation, night emissions, sexual intercourse, and STIs. Ramasubban and Jejeebhoy (2000) revealed that the most likely sources of information are peers, who may not be fully informed, or the media, which tends to focus on sexual and gender stereotypes or extremes. Young people indeed recognise the inadequacies of the media as appropriate sources of information.

Tineshowri (2010) finds female adolescents continue to be victims of social humiliation with social evils and practices. They are deprived in their understanding; perception and awareness level as the focus are much more given to HIV/AIDS, family planning programme. According to Pokra (1994), health services were essentially responsibility of individual and community. There is a gap between people and the system regarding understanding, acceptance and world view.

***Table no. 3:***
***Received information and preferred sources to obtain knowledge of pubertal changes***

| Sources | Received Information | Preferred Sources |
|---|---|---|
| Friends | 40% | 75% |
| TVs/Radios | 30% | 10% |
| Mothers | 10% | 5% |
| Sister | 10% | 5% |
| Relatives | 5% | 3% |
| Others | 5% | 2% |
| **total** | **100%** | **100%** |

In India, half of all young women are sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15 (Gupta, S.D., 2003). Despite the rising age at marriage and laws prohibiting marriage before 18 years for women and before 21 years for men, the majority of women marry as adolescents. Jejeebhoy et.al, (2003) revealed that after marriage adolescents face huge constraints on the autonomy of the marital home. It further adds that sexual negotiation among young married women in India highlights young women's lack of decision making authority in matters relating to sex. Adolescents are significantly less likely to be counselled about contraceptive use and are subsequently less likely than older women to adopt a contraceptive (Ganatra and Hirve, 2003).

Table 4 shows that 80% women in the age group of 15-18 years and 85% were pregnant or mothers of one or more child. The married female adolescent is also prone to unplanned and mistimed pregnancy resulting from low contraceptive use. A mere percentage of around 10% use it, so most of the married women have their child within the year. One important reason is women under 20 years of age hardly visit basic antenatal check-ups; 80% do not go for it. An interesting thing is that they have heard about HIV/AIDS awareness (70%), but they do not aware much about the use of condoms and others which could prevent them from HIV/AIDS.

***Table no. 4:***
***Information regarding reproductive behaviour***

| Variables | Percentage |
|---|---|
| ***Marriage***: | |
| 1. Married by 15-18 | 80% |
| 2. Married by19- 21 | 20% |
| **total** | **100%** |
| ***Pregnancy and child birth***: | |
| Girls aged (15-19) who were already mothers or pregnant | 85% |
| ***Contraceptive use***: | |
| 1. Married young women aged 15-24 practising contraception by self or husband | 10% |
| 2. Married women 15-24 practising modern contraception by self or husband | 5% |
| ***Maternal health seeking***: | |
| 1. Women below 20 who received any antenatal check-up | 20% |
| 2. Women below 20 who delivered at a health facility | 70% |
| ***Awareness of HIV/AIDS***: | |
| 1. Who have heard | 70% |
| 2. Who know the consistent condom use can reduce the chance of getting HIV/AID | 20% |

Among the young married women of Meitei-Pangal high rates of teenage pregnancy, high-risk of STIs/RTIs, and poor nutritional status are the main reproductive and sexual health problems. Teenage pregnancy alone is counted in huge for such poor health outcomes among adolescents. Further, adolescent pregnant mothers who are often poorly nourished have a high obstetric risk for premature delivery, low birth-weight delivery of

child, prolonged and obstructed labour, and severe intra-partum and post-partum haemorrhage (Verma and Das, 1997). In broad sense, early pregnancy is importantly associated with neo-natal mortality, and infant and child mortality. The NFHS-2 results show that mothers who are younger than 20 years old at the time of first birth were associated with a 1.7 times higher neonatal mortality rate and a 1.6 times greater infant mortality rate than were mothers giving birth between ages 20–29 (IIPS.2000).

***Needs and concerns of Meitei-Pangal adolescent girls and their sexual and reproductive health***

The study has explored the issues to provide not only the reproductive and sexual health but also the whole other factors that are associated with adolescents health that have not been seen by policy makers and programmes in the study area. The study has also made an effort to understand the complexity of adolescent girls' health problems and their association with social, cultural, and economic factors.

All the adolescents under the study have experienced restriction. Many of the girls respond that there is not much safe and supportive environment for them starting from family, schools, and hospitals and at large in the society. They are often neglected and restricted by the parents and society in their mobility, mixing up with friends; parents often neglect girls' participation in decision making. In short, they find that they are being neglected their potentials and abilities.

During the transition to adulthood, lack of knowledge and awareness about reproductive organs, physiological changes, or sexuality can promote psychosocial stress. This is particularly so for girls, who also face gender discrimination. Adolescent girls experience psychosocial stress. Girls felt that they were a burden on their families and had poorer self-image while their counterparts felt superior. The majority of them have no knowledge of menstruation. In most cases, their friends are the main source of information. Most girls perceive menstruation as disgusting and as a curse. Adolescent girls are also at higher risk of psychosocial stress because of gender discrimination.

The widening gap in communication between adolescents and their parents has been, in general. They have poor skills to communicate, negotiate and assert. Adolescent females are more susceptible to infections due to biological structure; lower status within gender relationship; lack of financial power. Girls also face mental and emotional problems related to too early sexual initiation. For unmarried mothers, there is social stigma, leading to horrifying consequences. Nutritional intake among adolescents especially girls is still a matter of concern. Several families do not yet recognize food intake needs of a girl. Girls are not served adequate nutritious food in comparison to male members, siblings in the family etc.

## II. Conclusion

Adolescence represents a resource for the future whose potential can either be wasted or nurtured in a positive manner. Reproductive ill health is one of the major causes of morbidity and mortality in young people. In a conservative society like Meitei-Pangal, where reproductive and sexual health related issues are consider taboo for discussion, young people are hindered from actively seeking counsel for their needs. Low rates of educational attainment, limited sex education activities and inhibited attitudes towards sex greatly contribute to the continuing ignorance on sex and reproduction. Seeking abortions to avoid social condemnation and being ostracised is therefore common among both married as well as unmarried adolescent girls. Even though programs and policies directed towards improvement of adolescent reproductive health exist, there is a paucity of Adolescent Friendly Health Services (AFHS), the expansion of which is still in the nascent stage. Moreover, very few programs have been able to differentiate between the special reproductive health needs of married and unmarried adolescents The empirical findings, as discussed above, earnestly emphasise the need look into and to discuss the various intermingling aspects related to reproductive behaviour. The problems related to reproductive are generally studied from medical perspective but as there are studies from cultural and socio economic perspective. So it is necessary to implement the programme and policy which have a proper link between members of the society.

Moreover most of the studies are relying on the school going girls and the programmes like sex education etc the question arise what about the girls who never enrolled in the schools, who will give counselling and awareness to them about their sexual and reproductive, is radio, TV sufficient for them or there should be some alternative means so that we can educate and make aware of their health. Building positive relationships with adolescents; opening channels of communication (two-way) with adolescents on their needs and concerns especially with regard to difficult subjects like Reproductive and Sexual Health.

## References

[1] Indian Council of Medical Research (ICMR) (1992), ICMR Task Force Study on "Field Supplementation Trial in Pregnant Women with 60 MG, 120 MG and 180 MG of Iron with 500 G of Folic Acid." New Delhi: Indian Council of Medical Research.

[2] Jeejebhoy, S.J. (2000), Adolescent Sexual and Reproductive Behaviour: A Review of Evidence from India.

[3] Pokara, K.N. (1994), Social Beliefs, Cultural Practices in Health and Disease, Rawat Publications, Jaipur

[4] Tineshowri, M. (2010), Reproductive Health and Adolescent Girls, Akansha Publication, New Delhi,India.

[5] Gupta, S.D. (2003). Adolescent ReproductivHealth in India: Status, Policies, Programs, and Issues, Indian Institute of Health Management Research Jaipur, India.

[6] Government of Manipur, (2006), Report on Socio-Economic Survey of Meitei-Pangal (Manipuri Muslims) 2004, Directorate of Economics and Statistics, and Directorate of Minorities and Other Backward Classes, Imphal.

[7] Lule, E., Ramana, G.N.V., Oomman, N., Epp, J., Huntington, D. and Rosen, J.E., (2005), Achieving the Millennium Development Goal of Improving Maternal Health: Determinants, Interventions and Challenges; Health, Nutrition and Population (HNP) Discussion Paper, The World Bank, Washington.

[8] Garro, L., (1998), On the rationality of decision-making studies: Part 1: Decision models of treatment choice, Medical Anthropology Quarterly, 12(3):319-340.

[9] Thadeus, S. and Maine, D., (1994). Too Far To Walk: Maternal Mortality in Context, Social Science in Medicine 38, 8: 109-110.

[10] Jejeebhoy, S.J., Santhiya, K.G. (2003). Sexual and Reproductive Health Needs of Married Adolescent Girls, Economic and Political Weekly (Oct. 2003)

[11] Ganatra, B., Hirve, S.S. (2003). Induced Abotions: Decision-making Providers Choice and Morbidity Experience among Rural Adolescents in

India, In Sarah et al. (Eds.) Adolescent Sexual and Reproductive Health: Evidence and Programme Implications for South Asia, WHO: Geneva.
[12] Verma V. and K.B. Das. 1997. "Teenage Primigravidae: A Comparative Study." Indian Journal of Public Health XXXI.
[13] IIPS. 2000. National Family Health Survey (NFHS-2). Mumbai: International Institute of Population Sciences.

## AUTHORS

**First Author** – Rajiya Shahani, Department of Sociology, Assam University, Silchar-788011, e-mail:dr.r.shahani@gmail.com