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Reproductive Health of Indigenous Women: A Case Study on Manipuri Community at Sylhet District in Bangladesh

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RESEARCH ARTICLE

Abstract
The Manipuri Community, also known as the Meitei people, primarily hails from the northeastern Indian state of Manipuri. There is a lack of extensive research on the reproductive health of women in Bangladesh. Generally, Manipuri women go through a disproportionate number of hardships due to their poor socio-economic status, which multiplies their vulnerability. This study aims to explore women's reproductive health status, especially the Manipuri Community. The specific objectives are to assess the socio-economic and demographic conditions of women in the Manipuri community as additionally as the availability and quality of reproductive health facilities for women, investigate the challenges faced by women in accessing reproductive health services, and finally, propose solutions and recommendations to address the identified reproductive health challenges faced by women. The research follows a qualitative case study method and uses a purposive sampling method for selected five Manipuri women to collect information related to reproductive health. Data were collected through in-depth interviews and analyzed thematically. The result of this study is that Manipuri women are suffering from many health problems; they do not know about reproductive health, such as endometriosis, uterine fibroid, gynecologic cancer, HIV/AIDS, STD, and sexual violence. There is no improvement in their health care, sanitation, or communication system. They do not even get any support from their family and neighbors and cannot make any decisions in the family, and in most cases, they do not get respect and support from their society. The results of this research will provide an important guide for policymakers, development practitioners, and social scientists to clear ideas about the reproductive health of peoples, especially in the Munipuri community.

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1 INTRODUCTION

Bangladesh has around 1.5 million people (1.8% of the total population) divided into 52 distinct ethnic groups. Indigenous peoples in Bangladesh are amongst the most deprived population

groups (Rahman, Khan, Hossain, & Iwuagwu, 2021). Here, different groups and communities may be ethnic people, people, and others. In the country, Chakma, Draft Galley Marma, Garo, Tripura, Santal, Manipuri, etc., have indigenous and ethnic communities. The ethnic minority population in Bangladesh is 1,650,159, which is 1% of the total population, males are 824,751 (1.01%) and female are 825,408 (0.99%) (Bangladesh Bureau of Statistics, 2022). Manipuri people rank four, and the population is 30,000, 0.1% (*Global Dashboard: An Overview of the People Groups of the World*, n.d.). Their major religion is Hinduism; others are Muslim and Christian, and some are unknown. Manipuri, the ethnic community in Bangladesh, lives in Sylhet. Their original home is Manipur, India (Ahmmed & Singh, 2006). In the early days, Manipur had different names, such as Kyangleipak, Kyangkleipang, Kyanglei, Meitrabak, and Mekhali, and they were known as Meitei. Manipuri migrated to Bangladesh and settled here at different times due to wars, conflicts, and other socio-political reasons. Manipuri communities in Bangladesh often reside in remote and hard-to-reach areas, which can result in limited access to healthcare facilities, including maternal and reproductive health services. This lack of access can lead to inadequate prenatal care and maternal health services.

Likewise, Manipuri communities in Bangladesh have their own languages and cultural practices. Language barriers can make it difficult for Manipuri women to communicate with healthcare providers, which can hinder the provision of appropriate care and information, and they may have traditional beliefs and practices related to pregnancy, childbirth, and reproductive health. These beliefs can sometimes conflict with modern healthcare practices, leading to misunderstandings or reluctance to seek medical care. Maternal mortality rates can be higher, especially among Manipuri women, due to limited access to healthcare, poverty, and lack of education. Efforts have been made to reduce these rates, but challenges persist. Also, education can play a crucial role in improving reproductive health outcomes. However, indigenous communities in Bangladesh, especially Manipuri, often have lower literacy rates and limited access to quality education, which can affect their understanding of reproductive health and family planning. They have also faced economic disparities, impacting their ability to access healthcare services, afford nutritious food, and maintain overall well-being during pregnancy and childbirth. This study mainly focuses on women's reproductive health, especially in the Manipuri community in Bangladesh. It focuses on the knowledge about sexual and reproductive health, disease, care, development, etc. Health is wealth. So, the health knowledge is very essential. Especially knowledge about reproductive health (Ahmmed, Chowdhury, & Helal, 2021). It's related to holding future generations. Nowadays, reproductive health conditions have become worse. Women suffer from various problems and diseases like unintended and teen pregnancy, unsafe abortion and delivery, maternal death, STDs, cervical cancer, etc., due to the lack of knowledge and awareness, access to health care services, and geographical location.

This study is important for adult and adolescent women of indigenous, especially in Manipuri. The Manipuri community in Bangladesh has a rich and unique history. The Manipuri people reside primarily in Bangladesh's Sylhet and Moulvibazar districts, often called "Kukis" or "Meiteis." Here's a brief overview of their history in Bangladesh: The Manipuri community's history in Bangladesh can be traced back to the 18th century when they migrated from the Manipur region in Northeast India. They settled in the hilly and forested areas of Sylhet and Moulvibazar. Despite living outside Manipur, the Manipuri people have preserved their distinct culture, traditions, and language. They are known for their vibrant dance forms, including the Manipuri dance, integral to their cultural identity. Most Manipuri in Bangladesh follow Hinduism, although their religious traditions significantly influence beliefs and practices. Indigenous communities, especially Manipuri communities in Bangladesh, often reside in remote and rural areas, which may have limited access to healthcare facilities. This can result in delayed or inadequate prenatal care, lack of access to family planning services, and difficulties in accessing emergency obstetric care. Due to the limited healthcare access and lack of skilled birth attendants, Manipuri women are at a higher risk of maternal mortality. Complications during pregnancy and childbirth can be life-threatening without proper medical care. The practice of child marriage is prevalent in some communities in Bangladesh, and Manipuri Community is one of them. In their community, early marriage practice often leads to early pregnancies, which can be detrimental to the health of young mothers and

their infants. On the other hand, they have traditional beliefs and practices related to childbirth and reproductive health, which may not align with modern healthcare practices.

This can hinder access to and acceptance of reproductive healthcare services for women, especially Manipuri women, and the women of Manipuri may have limited awareness and knowledge about family planning methods and contraceptives, leading to unintended pregnancies and larger family sizes than desired. Reproductive health involves people who can have a responsible, satisfying, and safer sex life, and they can reproduce and have the freedom to decide when and how often to do so. It can be noted that younger women are in the risk group of reproductive problems related to pregnancy, delivery, post-delivery, menstruation, menopause, and family planning than older women (*Reproductive health*, n.d.). So, the Reproductive health of Manipuri women is a very crucial situation, and it will greatly impact their health status, especially of the Manipuri women and their future generation. The main objective of this study is to know the quality of reproductive health of women in the Manipuri community, including some other specific objectives, which are as follows: to assess the socio-economic and demographic conditions of women in the Manipuri community; to analyze the availability and quality of reproductive health facilities for women; to investigate the challenges faced by women in accessing reproductive health services; to propose solutions and recommendations to address women's identified reproductive health challenges.

2 METHODOLOGY

The main approach of this study is qualitative, and data are collected from the participants through in-depth interviews and case study methods. The population of this study was the women in Moulvibazar district. Among them, the researchers selected Kamalganj upazila for sampling. In this study, the subject of the case was the Manipuri women, and the objects were their Reproductive health conditions, livelihood patterns, socio-demographic information, and the challenges they face. The qualitative data has been collected from only one level (individual) as a unit of analysis. The study used purposive sampling to select the interviewees, with a sample size of five. Due to the limited sample size, purposive sampling has been used to reach a targeted sample quickly and develop an in-depth exploration. The thematic analysis approach was used for data analysis because of its flexibility and for interpreting data sets more easily by sorting them into broad themes. Keeping in view the study's specific objectives, the data was analyzed. Key themes were identified by transcribing recorded data and through repeated reading of the transcribed texts. The researchers used the non-priory or instant theme taken directly from the participants or found out from inside the transcribed text later. The coded themes were analyzed manually with the help of a pen-pencil system. Finally, to relate those themes to the objectives, the researchers conducted a comparative discussion with the previous literature linked to the research objectives.

3 RESULT AND DISCUSSION

3.1 Analysis of the Socio-demographic & economic Information

Demography provides a context of the participants and their relevance to the findings of the study, and thus, this strengthens the triangulation process (Patton, 1990). The researchers interviewed five participants in selected areas and found that the lowest weight was 24 and the highest weight was 40. Out of them, three participants had only basic literacy skills (able to write their name), and one participant had completed 10th standard. The participant is illiterate.

One of the participants said,

"*I got married at the age of 13, my two sons and daughters work at my husband's house. The income is enough to support the family. My youngest is in Class three. My daughter and I were very sick once. My son was 10th then. The researchers don't owe huge sums of money from NGOs while running medical expenses of sons and daughters and family expenses.*"

Many of the tribal do not know how to read, their role in the world is low and their household income is very tight and stretched. They cannot build good relations with neighbors and people in the society. Another participant said,

"*I am an educated Putin. I have 2 sons and 1 daughter. My husband runs the family by farming and I am a chicken keeper. Even so, our family is very strained. My son-in-law is not the breadwinner in the family. People around No help.*"

There are some people who have the opportunity to study, play a role in the family, and easily become self-reliant.

One participant said,

"*I know, and I studied up to SSC. Due to family problems, he took Dia. My husband is a farmer by profession and the researchers have businesses that I manage. I have three sons and daughters. They all doing study. Children's, family but everything goes well with us. In terms of business, the researchers are no different from German banks. I have a good relationship with my neighbors..*"

Most of the Adivasis are educated in primary and they do not have enough Maya or a source of income; they cannot engage themselves in satisfactory sources of work from which they cannot earn a satisfactory share. Most of them were to fulfill their financial needs. Almost every participant had to fend for their own food and medicine. They were able to earn an average of 80000tk with a maximum of 15,000tk and a minimum of 3000tk.

3.2 Analysis of the reproductive health facilities among the women

Medical literature defines reproductive health as an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases, post-natal infection, and maternal and child health-related concerns (Dudgeon & Inhorn, 2004). Reproductive health facilities are healthcare facilities and centers that specialize in providing a wide range of services related to reproductive health, including family planning, sexual health, prenatal care, maternity services, and more. These facilities play a crucial role in promoting and ensuring the well-being of individuals and families in matters related to their reproductive and sexual health (Hira et al., 1990). Analysis of the reproductive health facilities of the women means the facilities of reproductive health, including family planning, sexual health, prenatal care, maternity services, and more for women, especially for the Manipuri women.

The researchers have noted that the reproductive health facilities among the Manipuri communities are not sufficient for their needs. In the remote areas, they have been following traditional viewpoints and traditional instruments for solving their health problem.

One of the participants said that

"*The reproductive health facilities in my area are not good; I do not get proper family planning-related medicine and pall from the hospital. The service of maternal health, prenatal care, and service at pregnancy time has not yet been at our community level, and many women like me do not know how to clean sensitive organisms during the period of menstruation.*"

The Government organization and non-government organizations' services in the Manipuri community areas are not sufficient, and they give the service for developing reproductive health that has not reached the grassroots level. It is expected that medical officers working at the union level might also visit these clinics when an order is passed to this end (Hoque & Hoque, 1994).

One of the participants said that

"*The researchers do not get proper facilities that the researchers need, there has no maternal health care related program in the hospital level that are suited in our areas. The researchers need check-up in pregnancy time and need to know about different knowledge at pregnancy period for adjusting at the critical period.*"

Health campaigns and health-related knowledge are very crucial elements for the better reproductive health of women, especially Manipuri women, and the researcher asked the participants about reproductive health-related campaigns in their area.

4 ANALYSIS OF THE REPRODUCTIVE HEALTH CONDITIONS, CHALLENGES AND OBSTACLES OF THE MONIPURI WOMEN

Reproductive health-related beliefs may include influences from cultural and traditional practices adopted during the birthing process, early care of the newborns (Sharma & Varma, 2008), and even during the pregnancy period. Such beliefs are more common in remote rural areas, poorer geographic areas, and more prevalent among religiously observant segments (Siddiqi, Khan, Nisar, & Siddiqi, 2007). The survey found that they do not use sanitary napkins during periods, they use torn clothes, etc. Very few participants said they use napkins. One said,

"*During period time, her husband does not talk to her, does not come near her. He stays away from buying napkins and does not even help her with work. The sanitation problem in my house is very bad. I have to go to people's houses during this time. Because the condition of the family is bad. Can't provide better sanitation.*"

The majority of participants are suffering from sanitation problems, no good medical centers, and no family support; if this continues, Manipuri women will suffer extreme health problems.

One participant said,

"*I am old. My husband is dead. Boys and girls don't want to see me, so they keep me apart. I can't do anything with such a sick body so now I beg. They now consider me a burden to them. My diseases keep coming. My health is not good, I pass the days in extreme health. The neighbors don't take any notice.*"

Research has shown that none of them have any idea about reproductive health. Health-belief also depends on cultural and religious norms such as Purdah restrictions that can prevent Bangladeshi women from seeking health care from outside their home for themselves and their children (Rashid, Hadi, Afsana, & Begum, 2001).

One participant said,

"*She was married at a very young age. There are three boys and girls. He suffers from various physical problems. No help from family during periods. At that time, his family members did not see him anymore. Due to the lack of good health centers in the vicinity, many problems have to be faced.* "

The survey found that they don't get proper treatment when they get sick, said the participant,

"*There is a community clinic in our area, but they don't get good facilities there. There are no good medical centers around. There is no health worker, no one to understand their physical problems.*"

The study also showed that Manipuri women are not aware of their health; they have no reproductive health or sex-related. Only 30% of women receive antenatal care, against 47.6% of the general population (Davis & Blake, 1956). They face many problems during this period of time.

One participant said,

"*During the period time I have to do more family work, at that time I am far away from giving mental support, my husband-mother-in-law cannot see me.*"

Most of the participants faced problems in decision-making in their families. They get value in the family when they can contribute to their family or fulfill their financial role.

In case (1):

"*Often, since my financial contribution is very little, they don't value my opinion. I am very neglected in my family.*"

The researchers found that the views of those who can contribute financially to the family are considered by their family members, whereas the views of those who cannot contribute financially are rejected by their families. If they could run a small shop or cloth business from home then they would have an impact on their family.

Most of the participants do not get emotional support from society and family. Those with good family status received not good emotional support and those with good family status did not receive much emotional support. Thus, there was a direct link between family status and receiving emotional support from society and family. Few participants received family support, and the remaining participants received no family support; in most cases, family members were indifferent to the mental condition of those living in uneducated families.

It is stated in the case (02):

"*I got married at a very young age, I have 4 sons and daughters. My mother-in-law can't see me, my husband doesn't see me well either. I do all the household chores. Our family runs on the income of my father-in-law alone.*"

5 SUMMARY OF FINDINGS

This study wanted to know about the socio demographic and economic information, livelihood patterns, reproductive health conditions socio-demographic & challenges, and obstacles of the Munipuri community of Bangladesh and the researchers got the following findings and results under the research objectives:

- In this research, the majority of the participants suffer from malnutrition and various complications. They cannot eat enough nutritious food. Because of this, various diseases persist.
- In this study, no necessary medical center is near their residence. In such cases, they do not get good medical care. They have to go to the city for better treatment. There are community clinics in their area, but not enough facilities.
- Many of them suffer from various diseases, such as back pain, chest pain, and hip pain. Many of them used long-term birth control. Which is a threat to their body.
- If they are sick, they follow the traditional home remedies.
- Their periods occur at the right time of the month and last 3-5 days. At that time, they have various physical problems.
- In this study, most of the participants do not use sanitary napkins; they use old clothes. However, those who are educated use sanitary napkins.
- During the period, husband, mother-in-law do not help them, at that time they have to do various family activities.
- In this research, their family condition is not good, they take loans from Grameen Bank and various NGOs but still the family is not financially stable.
- Their communication system is not good, they do not have modern medical services. They cannot talk openly about their problems.
- Their sanitation system is not good, which is a threat to their health and their system is not good. There are not many good educational institutions around their area.

In this study, the researchers found that the Manipuri women face different social problems. They cannot fulfill their livelihood with their little income and face various health problems and lead a very inhumane life.

6 DISCUSSION

Manipuri women have faced unique challenges and exhibited remarkable resilience when it comes to their health conditions. In a region known for its diverse culture, traditions, and vibrant communities, the health of Manipuri women reflects a complex interplay of socio-cultural factors, healthcare accessibility, and economic conditions. This discussion delves into the health condition of Manipuri women, shedding light on the strengths and struggles they encounter. Access to

healthcare services remains a pivotal concern for Manipuri women. The state's hilly terrain and underdeveloped infrastructure pose significant challenges for reaching healthcare facilities, particularly in remote areas. This geographical barrier, coupled with limited transportation options, often results in delayed or inadequate medical attention. Maternal health in Manipur presents both encouraging progress and persisting issues. While maternal mortality rates have shown improvement over the years, there are still instances of complications arising from home births due to cultural beliefs and limited access to healthcare. Initiatives like the Janani Suraksha Yojana have sought to promote institutional deliveries and provide financial support to pregnant women, but more efforts are needed to bridge existing gaps. Nutrition plays a critical role in women's health, and Manipuri women face challenges related to dietary diversity and food security. The region's traditional diet is rich in vegetables and herbs, but economic constraints can limit access to essential nutrients. Anemia, a prevalent health issue among Manipuri women, demands attention.

Addressing anemia requires not only nutritional interventions but also awareness campaigns and improved healthcare infrastructure for early diagnosis and treatment. Family planning and reproductive health remain critical aspects of women's health in Manipur. Awareness about contraception methods and family planning is essential to empower women to make informed choices about their reproductive health. Culturally sensitive education and outreach programs can help in this regard, ensuring that women have access to a range of family planning options. Mental health is an often overlooked aspect of women's well-being in Manipur. The region's history of conflict and insurgency has left a lasting impact on the mental health of its residents, including women. Addressing mental health issues requires stigmatization, improved access to mental health services, and community-based support systems. Empowering Manipuri women through education is instrumental in improving their overall health. Access to quality education equips women with knowledge and skills to make informed decisions about their health and well-being. Furthermore, education can challenge traditional gender norms and foster a more equitable society.

Overall, the health condition of Manipuri women is a multifaceted issue that is deeply intertwined with socio-cultural factors, healthcare accessibility, and economic conditions. While progress has been made in areas such as maternal health and education, there is still work to be done to address challenges related to healthcare access, nutrition, anemia, reproductive health, mental health, and empowerment. Efforts should continue to focus on improving healthcare infrastructure, raising awareness about health issues, and promoting gender equality through education and empowerment initiatives. By addressing these complex challenges holistically, Manipuri women can look forward to a healthier and more promising future, where their well-being is prioritized and their contributions to society are fully recognized and celebrated.

7 RECOMMENDATIONS

Improving reproductive health conditions in the Manipuri community involves a multifaceted approach. Here are some recommendations:

1. Access to Healthcare: Ensure that healthcare facilities, including clinics and hospitals, are readily accessible in Manipuri regions. This includes improving healthcare infrastructure and transportation options to reach these facilities.
2. Health Education: Implement comprehensive health education programs within the community. Focus on educating individuals about reproductive health, family planning methods, and the importance of prenatal and postnatal care.
3. Family Planning Services: Provide easy access to family planning services, including contraceptives, counseling, and reproductive health consultations. Promote informed family planning decisions.
4. Maternal and Child Health: Enhance maternal and child healthcare services emphasizing safe pregnancy and childbirth practices. Encourage regular check-ups for pregnant women and newborns.

5. Community Engagement: Involve community leaders, elders, and influencers to raise awareness about reproductive health. Engage them in promoting positive health-seeking behaviors and breaking down cultural taboos related to family planning and reproductive health.
6. Cultural Sensitivity: Develop healthcare programs that respect and integrate the cultural practices and beliefs of the Manipuri community. This will help in addressing any cultural barriers to seeking reproductive health services.
7. Youth Engagement: Focus on reproductive health education among young people. Promote delayed marriages and ensure that adolescents have access to information and services related to sexual and reproductive health.
8. Government Initiatives: Advocate for policies and initiatives prioritizing reproductive health in Manipuri regions. Collaborate with government agencies to improve healthcare access and infrastructure.
9. NGO Support: Collaborate with non-governmental organizations (NGOs) and community-based organizations to implement healthcare projects and awareness campaigns focused on reproductive health.
10. Data Collection and Research: Collect and analyze data on reproductive health within the Manipuri community to better understand specific challenges and track progress. Research can guide targeted interventions.
11. Accessibility of Medication: Ensure essential medications and contraceptives are affordable and readily available to all community members.
12. Mobile Clinics: Consider mobile healthcare units that can reach remote or underserved areas within the Manipuri community, providing basic healthcare and reproductive health services.
13. **Peer Support Groups**: Establish peer support groups where community members can share experiences, seek advice, and provide emotional support related to reproductive health issues.

Improving reproductive health conditions in Manipuri requires collaboration among healthcare providers, government agencies, NGOs, and community leaders. It should be a holistic effort that addresses cultural, social, and economic factors while ensuring access to quality healthcare services.

8 CONCLUSIONS

The time has come to support these deprived tribal women nationally and regionally. Special attention should be paid to their reproductive health. Laws and policies should be enacted for their cooperation. As tribal they should be given legal protection so that they can earn a living like common people in the country. By ensuring their reproductive health care, future generations can be helped to keep pace with the present society and they can contribute significantly to the development of the country. By ensuring their education facilities, on the one hand, they can be informed about reproductive health, and on the other hand, they will represent different organizations in the country to bring about change and development.

9 ETHICAL CONSIDERATION

The researchers considered ethical issues in this study from the thinking stage. In a qualitative case study, ethical dilemmas are likely to emerge at two points: during the collection of data and in the dissemination of findings (Bongaarts, 1978). Each interview was conducted individually in private or in the participant's home without access by outsiders. The researchers developed an informed consent form for the participants to sign before they participated in the study. The researchers assured the participants that confidentiality would be maintained while collecting

data during the interview. The researchers recorded their interviews with prior permission. The researchers assured the results would bring no harm to them. While conducting the interview, the researchers provided the participants with complete information about the study, and the researchers asked questions that were related to the topic of the interview. As the participants gave their valuable time in the interview session, the researchers provided some compensation to them. The identities of the participants were removed during data transcription, including their names or any significant aspect of identity. In presenting the findings of the study, the participants were referred to by their pseudonyms names. The researchers left their biased thoughts out and avoided misinterpretation in data analysis. The anonymity and confidentiality of the participants were preserved.

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