Original Article
ISSN (Online): 2582-7472

ShodhKosh: Journal of Visual and Performing Arts
Special Issue on Contemporary Perspectives in Science, Technology, Humanities and Management 7(10s)

A STUDY ON THE ROLE OF EDUCATION ON WOMEN'S REPRODUCTIVE HEALTH IN DOLLANG VILLAGE, NONEY DISTRICT, MANIPUR

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Received 23 February 2026
Accepted 25 April 2026
Published 18 May 2026

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DOI
10.29121/shodhkosh.v7.i10s.2026.8172

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

ABSTRACT

Purpose: The primary purpose of the study is to examines the role of education in influencing women's reproductive health in Dollang Village, Noney District, Manipur.

Method: A descriptive survey was conducted among 100 married women using a structured questionnaire incorporating elements from established reproductive and women's autonomy scales. Descriptive and inferential statistics were applied to assess differences in reproductive health knowledge, attitudes, and practices by educational level.

Results: Educated women demonstrated significantly higher reproductive health knowledge ($M = 28.84$ vs. 26.92; $SD = 3.78$ vs. 6.91; $t = 1.72$, $p < 0.05$) and more positive attitudes ($M = 28.38$ vs. 23.52; $SD = 3.32$ vs. 6.47; $p < 0.001$) than uneducated women. Although educated women reported better practices ($t = 0.61$, $p = 0.26$), the difference was not statistically significant. Overall reproductive health scores were significantly higher among educated women ($M = 84.52$ vs. 76.72; $SD = 8.53$ vs. 17.99; $t = 2.77$, $p = 0.004$).

Conclusion: The findings of this study conclude that education significantly improves knowledge and attitudes, though its impact on practices remains limited.

Keywords: Education, Women's Reproductive Health, Dollang Village

1. INTRODUCTION

Women's reproductive health constitutes a foundational dimension of human well-being and a core human rights concern, extending well beyond clinical care to encompass education, empowerment, and socio-cultural contexts. As articulated by international bodies such as the WHO, ICPD, and UNFPA, reproductive health is a holistic, life-course construct integrating physical, mental, social, and rights-based dimensions. It affirms individuals' autonomy, informed choice, and access to quality services in matters of sexuality and reproduction, while underscoring the profound influence of women's social position and educational status on health outcomes. Consequently, women's reproductive

health shapes not only individual life trajectories but also family stability, community health, and intergenerational development. Decena (2026)

Education emerges as a critical determinant of reproductive health, particularly in rural and resource-constrained settings. Conceptualised as a lifelong, community-embedded process rather than formal schooling alone, education enhances health literacy, self-efficacy, and informed decision-making related to family planning, maternal care, safe childbirth, and prevention of reproductive tract and sexually transmitted infections. In rural India, including Manipur, women's reproductive health remains constrained by entrenched socio-cultural norms, early marriage, economic marginalisation, and limited access to healthcare services, despite policy initiatives such as the National Rural Health Mission. Within this context, education holds transformative potential to challenge structural inequalities, strengthen women's autonomy, and enable the exercise of reproductive rights.

The contemporary understanding of reproductive health is inseparable from the historical struggles that have shaped it. The women's health movement of the mid-twentieth century, particularly during the Second Wave of Feminism, challenged paternalistic medical authority and reframed reproductive care through a rights-based, patient-centred lens. Legal milestones such as Roe v. Wade (1973) institutionalised reproductive autonomy as a matter of health and civil rights, while its reversal in 2022 underscores the enduring political and ethical contestations surrounding women's bodily autonomy. These developments highlight the persistent intersection of reproductive health with law, gender equity, and socio-political power.

Dollang Village in Noney District, Manipur, provides a compelling socio-educational setting to examine these dynamics at the community level. Characterised by agrarian livelihoods, strong kinship structures, and limited infrastructure, the village reflects the material and cultural conditions shaping women's reproductive lives in hilly and underdeveloped regions. Restricted access to higher education and healthcare services, alongside reliance on traditional care providers, coexists with a youthful demographic and wide variation in women's educational attainment. Studying the relationship between education and reproductive health in this context offers valuable insights for designing context-sensitive interventions and policies aimed at advancing women's empowerment, improving health outcomes, and strengthening community well-being.

2. REVIEW OF LITERATURE

The literature review on Women's education and reproductive health provides an overview of the existing body of knowledge, identifies theoretical perspectives and highlights the gaps that the present study seeks to address. It reviews relevant state, national and international studies that link education to women's reproductive health which is provided below:

- Studies done abroad
- Studies done in India (excluding Manipur)
- Studies done in Manipur.

2.1. STUDIES DONE ABROAD

A substantial body of global scholarship affirms education as a central determinant of women's and girls' sexual and reproductive health, empowerment, and broader societal well-being. International evidence demonstrates that education delays early marriage and childbearing, reduces adolescent fertility, and enhances contraceptive knowledge and use, particularly in low- and middle-income countries (Psaki, McCarthy & Mensch, 2019). Despite notable progress in education and legal reforms over recent decades, significant inequities persist, with millions of girls remaining out of school and facing intersecting disadvantages in health access, digital inclusion, and protection from violence, thereby constraining progress toward the Sustainable Development Goals (UNICEF, 2025). Intervention-based and systematic studies further show that both general education and health-specific literacy substantially improve reproductive health knowledge, attitudes, and behaviours, underscoring education's role as a powerful mechanism for advancing reproductive well-being across diverse socio-cultural contexts (Tork, 2015; Kilfoyle et al., 2016; Junaedi et al., 2022).

2.2. STUDIES DONE IN INDIA (EXCLUDING MANIPUR)

Evidence from India (excluding Manipur) reinforces these global patterns while highlighting context-specific disparities. Empirical studies consistently associate higher educational attainment with improved health awareness, better nutrition, increased utilisation of maternal and reproductive health services, and greater autonomy in health-related decision-making (Gond & Kumari, 2022; Nazir, 2022; Sujatha, 2018). Conversely, low education among rural, tribal, Dalit, and adolescent married women is strongly linked to early marriage, high fertility, anaemia, malnutrition, inadequate maternal care, and limited contraceptive knowledge and use (Kumari & Verma, 2021; Wankhede & Priyanka, 2021; Patra, 2016). Large-scale analyses using NFHS data further establish that women's education—particularly at the secondary level—plays a decisive role in fertility transition processes, including delayed childbearing, extended birth intervals, and strengthened reproductive autonomy (Sujatha & Reddy, 2009).

Across both global and national literatures, socio-cultural norms, economic marginalisation, and unequal access to healthcare emerge as critical mediating factors shaping reproductive health outcomes. Studies among tribal populations, rural communities, and religious groups demonstrate that cultural taboos, gendered power relations, and poverty often constrain women's reproductive choices, even in the presence of health services (Fazli, n.d.; Lalmalsawmzauva, 2012; Prasad, 2020). Moreover, critiques of prevailing empowerment frameworks highlight an overemphasis on individual decision-making at the expense of structural and institutional determinants, calling for more culturally responsive and methodologically robust approaches (Vizheh et al., 2021)..

2.3. STUDIES DONE IN MANIPUR

Studies from Manipur and the broader Northeast reinforce these patterns while highlighting region-specific challenges. Research among the Rongmei, Maram, Meitei, Chiru, and other communities demonstrates that although educational initiatives have improved female literacy, persistent barriers—such as early marriage, patriarchal norms, household responsibilities, and limited educational and healthcare infrastructure—continue to constrain women's empowerment and reproductive health outcomes (Gonmei, 2021; Stephen, 2020; Khuraijam, 2015; Yelam, 2015; Yumnam & Devi, 2012; Lairenlakpam & Devi, 2011).

2.4. RESEARCH GAP

Collectively, this body of literature establishes education as a transformative lever for women's reproductive health and empowerment, while simultaneously revealing a critical research gap: the scarcity of village-level, integrative studies that examine how education and health jointly shape reproductive outcomes within specific socio-cultural contexts. The absence of localized evidence from settings such as Dollang village, Noney district, underscores the necessity of a context-sensitive investigation to inform culturally responsive interventions and policy frameworks aimed at advancing women's agency, equity, and well-being in rural tribal communities

3. RATIONALE OF THE STUDY

Reproductive health problems are one of the major causes of poor health and death among women across the world. Women living in rural and tribal areas are especially affected due to poverty, limited access to healthcare services, and lack of proper information. In India, rural women play an important role in supporting their families and the national economy, yet their contribution is often overlooked. Although women work long hours and contribute to household income, they are rarely recognised as productive workers, which affects their access to health services and development programmes.

Education plays a key role in improving women's reproductive health. It helps women gain knowledge about family planning, maternal care, safe childbirth, prevention of sexually transmitted infections, and healthy practices during pregnancy and after childbirth. Educated women are more likely to seek medical care, delay early marriage and childbearing, and take part in decisions related to their reproductive health. On the other hand, women with little or no education often avoid healthcare services. This may be due to lack of awareness, fear, or low confidence in understanding health information, leading to poor reproductive health outcomes.

Many studies have focused on women's social and economic conditions, employment, and health status. However, fewer studies have examined these issues in the context of tribal women living in remote and hilly areas. The problems faced by tribal women differ from one region to another because of variations in geography, culture, and social change. Therefore, region-specific studies are necessary to understand their real needs.

Dollang Village in Noney District, Manipur, is one such area where limited research has been conducted on women's reproductive health. This study is important as it aims to understand how different levels of education affect women's reproductive health in Dollang Village. The findings will help in identifying gaps in education and healthcare access and may support better planning of health and development programmes for women in the region.

4. STATEMENT OF THE PROBLEM

Many women in Dollang village, a remote tribal area in Noney district of Manipur, face serious reproductive health problems like painful periods, urinary tract infections, white discharge, and unplanned pregnancies. These issues lead to poor health for mothers and babies because women often don't know enough or get proper care, and village clinics lack doctors and supplies. Education is low here, few women can read or understand health advice, which makes it worse. This study checks if educated women know more about safe pregnancy, birth control, hygiene, and healthy habits compared to uneducated women. It looks at real knowledge and daily practices in the village. We need clear proof from this Manipur hill village to suggest better ways to teach and support women.

5. OBJECTIVE OF THE STUDY

This study focuses on understanding how education influences women's reproductive health in Dollang village. It explores the extent to which education affects women's knowledge about reproductive health, their attitudes toward related issues, and the practices they follow in their daily lives. The study also looks at the overall role of education in shaping women's reproductive health in the village.

6. HYPOTHESES OF THE STUDY

- **H_{01}:** Education plays a positive role on knowledge of women's reproductive health in Dollang village.
- **H_{02}:** Education plays a positive role on the attitude towards women's reproductive health in Dollang village.
- **H_{03}:** Education plays a positive role in practices relating to women's reproductive health in Dollang village.
- **H_{04}:** Education plays a positive role on women's reproductive health in Dollang village.

7. METHODOLOGY

7.1. RESEARCH DESIGN

The study employed a descriptive survey method, which is suitable for understanding the relationship between education and health – related practices between educated married women and uneducated married women.

7.2. POPULATION

The target population consisted of married women of Dollang village.

7.3. SAMPLING

A total sample of 100 married women from Dollang village, Noney district, Manipur was selected. The sample was divided into two categories : 50 educated married women and 50 uneducated married women.

7.4. INSTRUMENT

A self-developed questionnaire was used as a primary tool by incorporating elements and insights from established tools, namely the Reproductive Autonomy Scale developed by Upadhyay. Dworkin, Weitz and Foster and Women

Autonomy Scale for measuring Psychosocial Freedom from Conventional Gender Roles developed by Husain, Ammar. Trabelsi and Jahrami. The 25-item instrument measured across three dimensions : knowledge(items 1-8), attitude(items 9-16) and practices(items 17-25)relating to women's reproductive health. Responses were recorded on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). For statements reflecting an opposing or unfavourable point of view, the scoring was reversed.

7.5. DATA COLLECTION PROCEDURE

Prior to data collection, permission was obtained from the concerned authorities. The researcher personally visited Dollang village and collected data through face-to-face interactions. The purpose of the study was explained, informed consent was obtained, confidentiality was assured, and the data were used solely for academic purposes.

7.6. DATA ANALYSIS

The analysis incorporated both descriptive and inferential statistical techniques. Descriptive statistics including means, standard deviations, and t-tests were computed to summarize the data. All analyses were performed using IBM SPSS version 2.2, with the significance level set at $p < 0.05$ for hypothesis testing.

8. RESULTS

8.1. EDUCATION AND REPRODUCTIVE HEALTH KNOWLEDGE AMONG MARRIED WOMEN

Table 1

Table 1 Comparison of Reproductive Health Knowledge by Educational Status

Category	N	Total Score	Mean	SD	T-Score	One-Tailed p-Value
Educated	50	1442	28.84	3.78	1.72	0.044
Uneducated	50	1346	26.92	6.91		

The findings show a meaningful difference in reproductive health knowledge between educated and uneducated women in Dollang village. Educated women scored higher on average (M = 28.84) than those without education (M = 26.92), suggesting better understanding of reproductive health issues. Knowledge levels among educated women were also more consistent (SD = 3.78), while scores among uneducated women varied more widely (SD = 6.91). The independent-samples t-test confirmed that this difference is statistically significant, $t(98) = 1.72$, $p = 0.044$ (one-tailed). Overall, the results indicate that education plays an important role in improving women's reproductive health knowledge.

8.2. EDUCATION AND REPRODUCTIVE ATTITUDE AMONG MARRIED WOMEN

Table 2

Table 2 Comparison of Reproductive Attitude by Educational Status

Category	N	Total Score	Mean	SD	T-Score	One-Tailed p-Value
Educated	50	1419	28.38	3.32	4.72	<0.001
Uneducated	50	1176	23.52	6.47		

The findings indicate a clear difference in attitudes towards women's reproductive health between educated and uneducated women in Dollang village. Educated women reported a higher mean attitude score (M = 28.38) than uneducated women (M = 23.52), suggesting more positive and progressive views on issues such as family planning, healthcare decisions, and gender norms. The lower standard deviation among educated women (SD = 3.32) reflects greater uniformity in attitudes, whereas the higher variability among uneducated women (SD = 6.47) points to more diverse and less consistent views. The t-test results confirm that this difference is statistically significant, supporting the conclusion that education positively influences attitudes towards women's reproductive health.

8.3. EDUCATION AND REPRODUCTIVE PRACTICES AMONG MARRIED WOMEN

Table 3

Table 3 Comparison of Reproductive Health Attitude by Educational Status

Category	N	Score	Mean	SD	t-score	0ne-Tailed p-Value
Educated.	50	1365	27.3	4.91	0.61	0.26
Uneducated	50	1314	26.28	10.59		

The findings show a small difference in reproductive health practices between educated and uneducated married women in Dollang village. Educated women reported slightly higher mean practice scores (M = 27.30) than uneducated women (M = 26.28). However, this difference was not statistically significant, t = 0.61, p = 0.26 (one-tailed). As the p-value exceeds the 0.05 level, the hypothesis that education positively influences reproductive health practices is not supported, suggesting that factors other than education may affect women's reproductive health practices.

8.4. EDUCATION AND WOMEN'S REPRODUCTIVE HEALTH AMONG MARRIED WOMEN

Table 4

Table 4 Comparison of Reproductive Health Outcomes by Educational Status

Category	N	Total Score	Mean	SD	T-Score	One-Tailed p-Value
Educated	50	4226	84.52	8.53	2.77	0.004
Uneducated	50	3836	76.72	17.99		

Educated married women reported significantly higher overall reproductive health scores (M = 84.52, SD = 8.53) than uneducated married women (M = 76.72, SD = 17.99), indicating better knowledge, attitudes, and practices. The difference was statistically significant, t = 2.77, p = 0.004 (one-tailed), meeting the 0.05 criterion. These findings support the hypothesis that education positively influences women's reproductive health in Dollang village and suggest that educated women are more likely to adopt informed and healthy reproductive health behaviours.

9. DISCUSSION

The findings indicate that education significantly improves women's reproductive health knowledge and attitudes in Dollang Village, enhancing awareness, autonomy, and reducing cultural taboos. Educated women demonstrated better understanding of reproductive health issues and more positive attitudes toward maternal care and family planning. However, education did not result in significantly better reproductive health practices. Structural barriers such as limited healthcare access, affordability constraints, and socio-cultural influences restrict the translation of knowledge into consistent behavioural change. Thus, while education is a critical enabling factor, supportive socio-economic and institutional conditions are essential for improving reproductive health practices.

10. KEY FINDINGS

1) Education had a significant positive effect on reproductive health knowledge (M = 28.84 vs. 26.92).
2) Education significantly improved attitudes toward reproductive health (M = 28.38 vs. lower mean among uneducated women).
3) Differences in reproductive health practices were not statistically significant (M = 27.30 vs. 26.28; high SD = 10.59 among uneducated women).
4) Overall reproductive health scores were significantly higher among educated women (M = 84.52, SD = 8.53) compared to uneducated women (M = 76.72, SD = 17.99).
5) Structural and socio-economic barriers limit the translation of education into consistent health practices.

11. EDUCATIONAL IMPLICATIONS

1) **Curriculum Integration:** Include comprehensive and culturally sensitive reproductive health education in school curricula.
2) **Skill-Based Teaching:** Adopt experiential methods to translate knowledge into practical health behaviours.
3) **Collaboration and Community Support:** Strengthen education - health sector collaboration and community engagement to overcome structural and socio-cultural barriers.

12. LIMITATIONS AND FUTURE RESEARCH

The study was confined to married women in Dollang Village and compared only educated and uneducated groups, which limits the generalizability of the findings. Furthermore, the analysis focused solely on three dimensions—knowledge, attitudes, and practices of reproductive health. Future research may expand the scope by including unmarried women, diverse geographic settings, additional socio-economic variables, and broader health indicators to provide a more comprehensive understanding of the education–reproductive health relations.

CONFLICT OF INTERESTS

None.

ACKNOWLEDGMENTS

None.

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