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Women's Everyday Health Struggles: A Review of Gynaecological Morbidity in Indian Contexts

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ABSTRACT :

Gynaecological health remains an overlooked yet critical dimension of women's well-being in India. While public health discourse has increasingly focused on maternal and reproductive health, the everyday struggles related to gynaecological issues ranging from menstrual irregularities and infections to chronic pelvic pain—are often sidelined. This narrative review explores how social, cultural, and economic factors shape the gynaecological health of reproductive-age women in India. It highlights how cultural silence, social stigma, economic constraints, and unequal access to health services disproportionately affect women, especially in rural and marginalised communities. The review points to significant gaps in both policy and practice, urging a move beyond biomedical approaches to more integrated, gender-sensitive, and socially informed frameworks. In doing so, it emphasises the urgent need for intersectional public health strategies that can better respond to the lived experiences of women across India.

Key Words- Gynaecological Health; Reproductive Health; Social Stigma and Access to Health Services

Introduction

Women's reproductive health is a key component of public health discourse in India, but it is often narrowly understood in terms of fertility, childbirth, and population control. While these are undeniably important concerns, such a limited focus sidelines the broader spectrum of gynaecological health issues that affect women across their reproductive lifespan (Bhatia & Cleland, 1995). Conditions such as irregular menstruation, persistent white discharge, urinary tract infections, fibroids, endometriosis, and chronic pelvic pain are extremely common. Yet, they are frequently dismissed as routine discomforts, often going undiagnosed and untreated (Jejeebhoy & Koenig, 2003). These health issues may not always be life-threatening, but they have a significant and often unacknowledged impact on women's physical, emotional, and social well-being. In everyday life, many women experience gynaecological discomfort as a private matter, shaped by social silence, cultural taboos, and limited knowledge. In many Indian households, especially in rural areas or among lower-income groups, discussions about reproductive organs, menstruation, and bodily pain are discouraged or considered inappropriate (Tancman, HaCohen, Lazarus, Solt & Sagi-Dain, 2022). This silence is reinforced by deeply embedded gender norms that expect women to tolerate pain and carry on with domestic, caregiving, and economic responsibilities without complaint. As a result, women's gynaecological health concerns are often ignored not only by families and communities but also by the healthcare system itself.

The problem is not only social or cultural but also structural. Access to affordable, gender-sensitive healthcare remains highly unequal in India. Rural health infrastructure often lacks trained gynaecologists, diagnostic facilities, or even basic privacy for women seeking care. Government health schemes tend to emphasise maternal health, family planning, and institutional deliveries, while routine gynaecological care is relegated to the margins. Tohit & Haque (2024) argued that for women from socially marginalised backgrounds—whether due to caste, religion, or class—the barriers to accessing respectful and timely care are even more severe. Many avoid seeking medical help due to fear of stigma, embarrassment, cost, or lack of decision-making power within the family.

From a research and policy perspective, there is also a critical gap. Most available data focus on maternal health indicators, while systematic evidence on non-pregnancy-related gynaecological morbidities remains limited. As Sebitloane & Moodley (2017) pointed out that Biomedical research often treats these conditions in isolation, without paying attention to the layered social and cultural contexts in which they occur. As a result, women's voices, symptoms, and experiences remain invisible in mainstream health discourse. There is a pressing need to bring women's narratives to the forefront and to recognise that gynaecological morbidity is not only a medical issue but also a social one.

This narrative review attempts to respond to this gap by examining how social, cultural, and economic factors shape gynaecological health outcomes among reproductive-age women in India. It draws on insights from existing literature published over the past 10 to 15 years, and its thematic framework is guided by a structured interview schedule used in qualitative field studies. The review highlights recurring patterns such as the cultural silencing of pain, the stigma attached to certain bodily symptoms, and the economic constraints that influence whether and how women seek care. It also pays attention to the urban-rural divide in access and attitudes, and the multiple ways in which caste, class, religion, and gender norms interact to shape experiences of illness and health-seeking. By synthesising these diverse threads, the paper aims to broaden the conversation around women's health in India. It calls for an expanded lens—one that is not confined to reproductive roles but is attentive to the full range of women's bodily experiences. In doing so, it contributes to a growing body of work that advocates for intersectional, community-rooted, and gender-sensitive approaches to public health policy and practice.

Methodology

This paper adopts a narrative review approach to explore how social, cultural, and economic factors shape gynaecological health among reproductive-age women in India. Rather than relying solely on quantitative data or a meta-analytic synthesis, a narrative review allows for a more flexible and in-depth engagement with interdisciplinary sources—including public health, sociology, gender studies, and community medicine. This approach is particularly suitable for capturing the complexities of women's lived experiences, which are often shaped by unquantifiable factors such as shame, silence, and social expectations. The themes used to structure this review emerged from a semi-structured interview schedule designed for a qualitative research study on gynaecological health. This interview schedule included open-ended questions related to menstruation, bodily pain, discharge, access to healthcare, family attitudes, stigma, and the influence of socio-economic background. Though the current paper does not present field data, the schedule served as a conceptual guide to organise the literature into meaningful and recurring thematic areas.

A structured search was conducted across four major academic databases: Google Scholar, PubMed, JSTOR, and Scopus. Key search terms included combinations of: *"gynaecological morbidity," "reproductive-age women," "India," "menstrual health," "vaginal infections," "health-seeking behaviour," "social determinants of health," "stigma,"* and *"rural women."* The review also included relevant reports and working papers from organisations such as the National Family Health Survey (NFHS), Population Council, and World Health Organization (WHO) where appropriate.

By adopting this methodology, the paper aims not only to summarise existing evidence but also to uncover how knowledge about women's gynaecological health is constructed, ignored, or misunderstood within both academic and policy circles. The goal is to provide a layered understanding that remains grounded in everyday realities, especially those of women from rural, poor, and marginalised backgrounds whose voices are often absent from mainstream discourse.

Analysis

Having outlined the methodological approach guiding this review, we now turn to the recurring themes that emerge from the literature. These themes reflect not only the range of gynaecological health concerns experienced by women but also the complex social and structural realities that shape how these concerns are understood, voiced, or suppressed. The first and perhaps most pervasive thread running through the literature is the *silence and stigma* surrounding gynaecological symptoms—a silence so normalised that many women come to see pain and discomfort as part of their destiny rather than a health issue worthy of care.

Silence, Stigma, and the Normalisation of Pain

Jenkins (2012) maintained that across urban and rural India, women's gynaecological health concerns are often shrouded in silence. Menstruation, vaginal discharge, itching, or pelvic pain—common issues that many women experience—are rarely discussed, even among close family members. From a young age, girls are socialised to treat anything related to their reproductive organs as shameful or impure. This cultural discomfort prevents open conversations, delays diagnosis, and leads many women to silently endure discomfort without seeking help. Multiple studies have documented how the normalisation of pain is deeply embedded in everyday life. For instance, women often refer to burning sensations, backache, or excessive discharge as "normal" parts of being a woman, rather than symptoms of a potential health issue (Casale, et. al., 2021). Many do not consider these experiences worthy of medical attention unless the pain becomes unbearable or interferes with their ability to work or care for others. This tendency to downplay symptoms is particularly acute among women from low-income households, where economic dependence and caregiving responsibilities leave little room for self-care.

The stigma attached to bodily fluids further deepens this silence. White discharge, for example, is often interpreted through moral or superstitious frameworks. In some communities, excessive discharge is associated with sexual impurity, weakness of character, or punishment for not adhering to gender norms. Women who report such symptoms may fear being judged, blamed, or accused of being unfaithful (Ussher & Ussher, 2011). This fear keeps many from sharing their experiences, even with female family members, let alone a doctor. Urban women, while often more educated and exposed to public health messaging, are not entirely free from these taboos. Studies show that even in metropolitan areas, working women delay seeking care for gynaecological discomfort due to embarrassment or the belief that pain is something to be tolerated. The pressure to balance household duties with paid work also contributes to postponing medical visits (Gogna & Ramos, 2000).

These patterns point to a larger issue i.e. the invisibilisation of gynaecological pain in both public discourse and medical systems. Health services, including primary healthcare centres, rarely offer routine gynaecological check-ups unless related to pregnancy. Community health workers like ASHAs and ANMs are trained to promote antenatal and postnatal care, but less emphasis is placed on identifying and addressing routine gynaecological morbidity. As a result, many women do not even know that the discomfort they are living with could be treated (Zaleski, Zaleski & Bischoff, 2018). This highlights not only a lack of awareness but also the weight of cultural silence and stigma. Without creating safe, non-judgmental spaces—whether at home, in schools, or in health centres—women will continue to internalise pain as an inevitable part of their lives. The challenge, therefore, is not just one of information or access, but of deep-rooted gender norms that teach women that their suffering is unremarkable.

Socio-economic Status and Delayed Care-seeking

Economic conditions play a defining role in whether and how women seek care for gynaecological health issues (Amin & Bentley, 2002). Across India, particularly in rural and low-income urban households, financial insecurity limits access to timely, dignified, and quality healthcare. Many women postpone or completely avoid visiting health facilities due to the direct costs of treatment as well as the indirect costs of travel, missed wages, and the social expectation that their health concerns are secondary to family responsibilities (Rani & Bonu, 2003). For women engaged in informal labour, such as agricultural work, domestic work, or small-scale vending, daily income is crucial for survival. Taking a day off to visit a doctor—often located far from their homes—can mean losing wages or falling behind on domestic duties. This economic burden, combined with the perception that gynaecological symptoms are "not serious enough," results in significant delays in care-seeking. Studies have found that many women wait weeks, even months, before seeking help for infections, pain, or abnormal discharge—if they seek help at all (Barua & Apte, 2007; Singh et al., 2013).

Economic dependence on male family members adds another layer of complexity. In many households, women do not have independent access to money, and they must seek permission or approval to spend on health care. Gynaecological issues, particularly those not related to pregnancy, are often not seen as a priority (Amin & Bentley, 2002). Husbands or in-laws may discourage doctor visits unless the problem becomes visibly disruptive. In some cases, women are accused of exaggerating symptoms or misusing money, which reinforces their silence and hesitation. Even when women manage to reach health facilities, their economic position influences the quality of care they receive. Government hospitals, though free or low-cost, are often overcrowded and under-resourced. In many rural primary health centres (PHCs), there is a shortage of female doctors or specialists, making gynaecological consultation difficult or uncomfortable. Private clinics, though more accessible in urban areas, are often unaffordable for poor women and may prioritise profit over patient dignity.

The burden of socio-economic marginalisation is particularly visible among single women, widows, domestic workers, and women from historically disadvantaged communities. For these women, health is not just about access—it's about survival within constraints. Gynaecological health becomes a distant concern when food, housing, and safety are daily challenges (Sanneving, et al., 2021). This theme illustrates that women's bodies are deeply entangled with economic structures. A lack of resources often translates into postponed care, untreated illness, and normalisation of suffering. Addressing gynaecological health, therefore, demands more than building hospitals—it requires recognising the economic realities of women's lives, designing services that are not only affordable but also sensitive to the time, mobility, and autonomy constraints that many women face.

Family Dynamics and Intra-household Neglect in gynaecological health

Women's health decisions are rarely made in isolation. Within Indian households—particularly in joint or patriarchal family structures—women's ability to prioritise their own health often depends on how their needs are viewed by others. In the case of gynaecological health, which is already surrounded by stigma and silence, family dynamics play a crucial role in either supporting or suppressing care-seeking behavior (Raushan, 2017). Many women must negotiate permission, money, and time to seek medical care, especially when they are not financially independent. For married women, husbands are often the primary decision-makers, and their perception of the issue determines whether it is treated as urgent. If the pain or discomfort is not visible or does not interrupt household responsibilities, it is frequently dismissed. Some women report being accused of "making excuses" or being told to "tolerate" discomfort as a natural part of womanhood. This expectation to endure silently is reinforced by cultural ideals of sacrifice and resilience associated with being a 'good' wife or daughter-in-law (Brunson, 2017).

Mothers-in-law also play a significant gatekeeping role in many families. In some cases, older women, having normalised their own experiences of pain or vaginal discomfort in the past, advise younger women to ignore such problems or avoid the "shame" of medical consultations. The idea that gynaecological issues are private or even shameful is passed down intergenerationally, making it harder for younger women to express concerns without facing ridicule or dismissal (Dhamija, Roychowdhury & Shreemoyee, 2025). Unmarried women and adolescent girls face a different kind of challenge. Parents—particularly fathers—may avoid or actively block discussions about menstruation, bodily discomfort, or reproductive health. In conservative households, there is fear that acknowledging such issues may bring shame or raise suspicions about sexual activity. As a result, many young girls grow up with limited knowledge about their own bodies, feeling isolated when they face infections, cramps, or irregularities. Mothers, when supportive, may still lack accurate information or hesitate to involve doctors due to the perceived social risk (Raushan, 2017). Even when families are not actively hostile, neglect can take the form of passive indifference. Women's labour—cooking, cleaning, caregiving—is often expected to continue regardless of health status. Many women report that they keep working through physical discomfort because there is no one to take over their responsibilities. In such environments, even if a woman recognises her need for medical care, household pressure and emotional guilt often prevent her from taking action.

Health System Gaps and Gender-insensitive Infrastructure

While access to healthcare is a widely discussed issue in India, less attention is given to how the structure and functioning of the health system itself can discourage women from seeking gynaecological care. For many women, particularly in rural and low-income settings, the very design of the public health system is often not aligned with their needs, comfort, or dignity (Ravindran, et al., 2025). A major challenge is the lack of routine, preventive gynaecological care in the public health system. Most health facilities—especially primary health centres (PHCs) and sub-centres—are oriented towards maternal and child health, family planning, and institutional deliveries. While these services are undoubtedly important, they leave little space for addressing non-maternal gynaecological issues such as infections, abnormal discharge, or chronic pelvic pain. Women who approach PHCs with these concerns often report being told to come back only if they are pregnant or in "serious" condition (Rani & Bonu, 2003).

Another persistent barrier is the shortage of female health professionals, especially in rural areas. Many women feel uncomfortable or even fearful discussing intimate health concerns with male doctors, particularly in small communities where privacy is hard to maintain. In the absence of a female gynaecologist or even a female nurse, some women choose to remain silent rather than face embarrassment. Even where female staff are available, long wait times, lack of time for consultation, or dismissive attitudes make it difficult for women to feel heard or understood (Sen & Ostlin, 2011). Infrastructure also plays a critical role. Many public health facilities lack basic amenities such as private consultation rooms, clean examination spaces, or separate toilets for women. These conditions create discomfort and reinforce the idea that gynaecological care is something to be avoided unless absolutely necessary. The situation is no better in many urban slum clinics, where overcrowding and hurried consultations further reduce the quality of interaction between women and health providers.

Beyond infrastructure, attitudes within the health system also act as barriers. Several studies have noted that health workers—both doctors and nurses—often display moralistic or judgemental attitudes toward women reporting vaginal discharge or sexually transmitted infections. Questions are sometimes framed in ways that suggest suspicion or blame, particularly for unmarried women, widows, or women from marginalised backgrounds. Such interactions can be humiliating and deter women from returning for follow-up visits or disclosing symptoms truthfully (Ostlin, George, & Sen, 2001). While government schemes like the National Health Mission (NHM) and Reproductive and Child Health (RCH) Programme have made progress in maternal health, the scope for addressing non-maternal gynaecological morbidity remains limited. Frontline workers like ASHAs and ANMs are not always trained or encouraged to identify or follow up on such health concerns. Their role continues to be narrowly focused on contraception, antenatal care, and immunisation, missing the opportunity to address a wider spectrum of women's reproductive health needs.

Urban–Rural Divide in Knowledge, Access and Experience

The experience of gynaecological health—and the ability to respond to it—is shaped in profoundly different ways in urban and rural India. While women across geographies face stigma, shame, and neglect around gynaecological issues, the resources available to them, their exposure to health information, and their access to care vary significantly between urban and rural contexts (Lee, Lin & Snyder, 2020). In rural areas, physical access to health facilities remains one of the most visible barriers. Many villages still lack a functioning primary health centre (PHC) or sub-centre with qualified female doctors. Even where facilities exist, they may be located far from the village, require costly or unavailable transport, or operate for limited hours. Women in rural households—especially those with limited mobility or who are engaged in agricultural labour—find it difficult to travel to health centres unless absolutely necessary. Gynaecological discomfort is often seen as a lesser priority compared to urgent or maternal health needs (Rani & Bonu, 2003). Moreover, rural women are less likely to have access to accurate health information. School-based health education is often inadequate or absent in rural government schools, and few public campaigns address gynaecological health beyond menstruation or pregnancy. As a result, many women interpret symptoms through cultural or folk explanations rather than biomedical ones. For instance, white discharge may be seen as a result of eating "hot" foods or being "overworked," and pain is often considered a natural part of womanhood rather than a treatable symptom.

In contrast, urban women, particularly those in middle- or upper-income groups, often have better access to medical care and a wider range of health information through media, internet, or formal education. Urban areas have more hospitals and clinics, greater availability of female gynaecologists, and relatively less stigma about seeking care (Shastri & Ram, 2015). However, this access is not evenly distributed. Women living in urban slums or informal settlements often face overcrowded government hospitals, unregulated private clinics, and indifferent treatment from healthcare providers. Long waiting hours, rushed consultations, and lack of privacy in urban public hospitals create significant hurdles even when facilities are geographically close.

Interestingly, as Jaswal (1995) argued that the perception of symptoms also varies between urban and rural women. Urban women, particularly the educated, are more likely to identify and seek care for gynaecological issues early, recognising them as health concerns. In contrast, rural women often delay seeking help unless symptoms are visibly debilitating. But even among urban women, social norms around shame and silence persist, especially within conservative households or communities where discussions about reproductive health are still considered taboo. The urban–rural divide also reflects deeper inequalities in infrastructure, education, and gender norms. It is not merely about physical access to doctors but about the broader ecosystem of care and information. Women's confidence in seeking help, their ability to explain symptoms, and their comfort in undergoing intimate examinations are all shaped by their social surroundings. Addressing this divide requires not only improving rural health infrastructure but also tailoring public health communication and interventions to the specific realities of rural women, without assuming a one-size-fits-all approach.

Menstrual Health and Hygiene: Persistent Gaps in Policy and Practice

Joshi, et al. (2025) stated that the menstruation is one of the most common and natural biological processes experienced by reproductive-age women, yet it remains enveloped in secrecy, discomfort, and misinformation across much of India. Despite growing awareness in recent years—fueled by media campaigns, NGO interventions, and policy initiatives—deep-rooted stigma and structural neglect continue to shape how women and girls understand and manage their menstrual health. In many households, menstruation is still treated as a matter of shame. Adolescent girls are often taught to hide their periods, refrain from participating in religious or domestic activities, and avoid discussing menstruation openly—even with their mothers. This early experience of silence conditions girls to internalise the idea that their reproductive body is something to be concealed and controlled. As a result, many suffer in isolation when facing irregular cycles, heavy bleeding, or infections related to poor hygiene.

A major challenge lies in limited access to hygienic menstrual products. While urban girls in private schools often use branded sanitary pads, a large proportion of rural and low-income women continue to use old cloth, ash, sawdust, or unhygienic alternatives. Reusing cloth without drying it in sunlight—due to embarrassment or lack of private drying space—contributes to infections and long-term reproductive issues. Government schemes such as the *Menstrual Hygiene Scheme (MHS)* have attempted to address this by distributing low-cost sanitary pads through ASHAs and schools, but coverage remains patchy and irregular. In many cases, ASHAs themselves are uncomfortable discussing menstruation due to the taboo surrounding the topic in their own communities (Sharma, Sarkar & Priya, 2025). School-based interventions, where they exist, often suffer from a lack of depth. Many girls recall receiving only a brief lecture or a pamphlet, without the space to ask questions or clarify doubts. In schools lacking proper toilets or disposal systems for pads, girls may skip school during their periods altogether. The problem is especially acute in tribal and remote areas, where school dropouts among adolescent girls are sometimes directly linked to the absence of menstrual hygiene facilities.

Ghosh (2024) pointed out this and argued that for adult women, particularly those engaged in manual labour or daily wage work, the struggle is different but equally severe. Many report having no access to toilets or clean water while at work, forcing them to manage menstruation in unsafe and unhygienic conditions. The lack of employer sensitivity, coupled with the absence of workplace policies around menstrual leave or flexible work, adds to the burden. Despite increasing visibility of menstrual health in the media and development discourse, policy implementation remains weak, and many initiatives focus only on product distribution without addressing larger questions of education, stigma, or sanitation infrastructure. Moreover, menstrual health is rarely integrated into broader reproductive healthcare services (Patkar, 2020). Women who report pain, irregularities, or other menstrual-related issues are often dismissed or told it is "normal," leading to a neglect of potentially serious conditions like endometriosis, fibroids, or polycystic ovarian syndrome (PCOS).

Caste, Religion, and Intersections of Vulnerability

In India, women's access to gynaecological health is not only shaped by gender but also by deep and enduring structures of caste, religion, and community-based marginalisation. These intersecting identities profoundly affect how women experience illness, seek care, and are treated within the health system (Manasee, 2006). While public health discourse often speaks of "women" as a unified group, it risks ignoring how systemic inequality shapes whose suffering is acknowledged—and whose is ignored. Women from Dalit, Adivasi, and Other Backward Class (OBC) communities often face multiple and layered barriers in accessing gynaecological care. Many live in remote areas with limited or no public health infrastructure, and even where services exist, caste-based discrimination can manifest in both subtle and overt ways. Dalit women have reported being treated dismissively by health staff, being made to wait longer, or being given inadequate attention during consultations (Thorat & Newman, 2007). The humiliation and lack of dignity in such interactions deter many from returning to health centres, especially for sensitive gynaecological issues.

In rural areas, social hierarchies are mirrored in healthcare spaces. Women from marginalised castes may avoid certain clinics where upper-caste health workers dominate, fearing ridicule or mistreatment. In some cases, even within government programs, frontline workers like ASHAs or ANMs may carry caste biases that influence how and to whom they provide information or follow-up care (Datta & Thakkar, 2024). As a result, women from historically oppressed communities often turn to informal or traditional healers—even when they are aware that the treatment may not be adequate—simply because the interaction feels safer or more respectful.

Kiran & Singh (2025) argued that the religion also shapes access and attitudes around gynaecological health. In many Muslim communities, cultural norms around modesty, purdah, and gender roles restrict women's movement and willingness to undergo medical examinations, especially in the absence of female doctors. In conservative settings, reproductive issues are often silenced due to fears of shame or dishonour. Muslim women, particularly those from low-income urban neighbourhoods, may also avoid mainstream health centres due to fear of discrimination or surveillance, especially in the current socio-political climate. The intersection of poverty with caste or religion makes health vulnerability even more acute. For instance, a Dalit widow or a tribal single mother not only struggles with economic insecurity but also with social exclusion and limited mobility. These women often fall through the cracks of health policy, which rarely accounts for the compounding nature of multiple marginalisations. Programs tend to be designed for the "average woman," overlooking how caste, religion, region, and marital status combine to shape a woman's experience of her body and the healthcare system.

Discussion

The review of literature across these seven themes reveals a consistent and troubling reality: gynaecological health in India is not simply a matter of biology or medical access, but a deeply social experience shaped by gender, class, caste, culture, and geography. The persistence of silence, the tendency to normalise pain, and the lack of systemic support reflect how women's reproductive suffering is often made invisible—not just within families and communities, but also in public health institutions and policy frameworks. One of the strongest patterns emerging from this review is the intergenerational internalisation of silence and stigma. From adolescence through adulthood, many women learn to tolerate discomfort, avoid speaking about their bodies, and suppress the need for care. This is not only a reflection of individual hesitation but of societal structures that discourage women from prioritising their health (Rosenbaum, 2014). Whether it is a schoolgirl ashamed to ask for menstrual products or a domestic worker putting off treatment for pelvic pain, the outcome is the same—gynaecological suffering is silently endured, often until it becomes severe.

Social norms intersect powerfully with economic vulnerability, reinforcing patterns of delayed or avoided care. For women with limited financial independence or heavy domestic responsibilities, seeking healthcare becomes a logistical and emotional burden (Bourgois, Holmes, Sue, & Quesada, 2017; Jaswal, 1995). Many must negotiate time, permission, and money to attend even a basic medical consultation. These constraints are particularly acute for women in the informal sector, single mothers, widows, or those living in poverty-stricken households. Health, in these cases, becomes secondary to survival. At the same time, this review shows that institutional systems are ill-equipped to meet women's needs. Likis (2016) maintained that gynecological health continues to be viewed primarily through the lens of reproduction—pregnancy, contraception, and childbirth—while non-maternal issues such as menstrual irregularities, infections, or chronic discomfort receive little attention. Health centres are often poorly staffed, lacking in privacy, and ill-prepared to address women's symptoms with sensitivity or respect. The absence of female providers and the presence of judgemental attitudes further discourage women from accessing care.

The analysis also reveals significant urban–rural and caste–class divides. Rural women face greater geographical and infrastructural barriers, while urban poor women—despite being closer to facilities—encounter indifference, overcrowding, and humiliation (Kulkarni, O'Reilly & Bhat, 2017). Caste and religious identity further shape experiences of discrimination, neglect, or exclusion in healthcare spaces. These inequalities are not incidental—they are the outcome of systemic biases that render some lives more visible and valuable than others.

What becomes clear is that women's gynaecological health cannot be adequately understood through clinical categories alone. Impey & Child (2017) argued that it is deeply entangled with social expectations, household power relations, and structural inequalities. Pain is not just a medical symptom—

it is a lived reality shaped by who the woman is, where she lives, whom she depends on, and how her body is perceived by others. The act of seeking care is not a straightforward choice but a process negotiated through silence, resistance, hesitation, and hope.

This discussion invites us to shift from a narrow biomedical understanding of gynaecological morbidity to a holistic and intersectional lens—one that takes into account the multiple identities and vulnerabilities that shape women's health experiences. It challenges policymakers, practitioners, and researchers to listen more closely to women's narratives and to recognise the emotional, cultural, and structural barriers that shape access to care.

Conclusion

Gynaecological health among reproductive-age women in India remains one of the most neglected and misunderstood areas within public health. As this review has shown, the challenges women face go far beyond medical symptoms. They are embedded in everyday silences, shaped by social norms, family dynamics, economic hardship, and structural gaps in healthcare delivery. From adolescent girls facing shame around menstruation to older women tolerating chronic discomfort, a wide spectrum of gynaecological issues are normalised, hidden, or deprioritised. The invisibility of gynaecological morbidity is not accidental—it is a reflection of deeper societal attitudes toward women's bodies, autonomy, and pain. Health systems, shaped by the same gendered assumptions, often fail to recognise or respond to these realities. While policies exist for maternal and reproductive health, there is an urgent need to expand our frameworks to include the full range of women's gynaecological needs—especially those unrelated to pregnancy or childbirth. This review has highlighted how caste, religion, geography, and socio-economic status intersect to further marginalise already vulnerable women. It is not enough to speak of "women's health" in general terms. We must ask: which women? Whose pain is heard, and whose is ignored? Addressing these questions requires moving beyond clinical interventions to build a more inclusive, dignified, and socially grounded model of care.

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