

# Gynaecological Health Practices and Barriers among Reproductive-Age Women: A Study of Jag Pravesh Chandra Hospital, Delhi

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## ABSTRACT

This study explores the gynaecological health status, menstrual practices, and healthcare-seeking behaviour of reproductive-age women attending Jag Pravesh Chandra Hospital, Delhi. With a focus on both rural and urban patients, the study aims to understand how socio-demographic factors, hygiene practices, and cultural taboos influence women's reproductive health and treatment patterns. Data were collected through structured interviews, capturing variables such as education, marital status, family type, access to sanitation, menstrual hygiene management, and medical preferences. Findings reveal that a significant proportion of women had low educational attainment, with 60% being either illiterate or only basically literate. While 70% maintained menstrual hygiene, traditional practices and taboos remained prevalent, such as not touching males or cooking during menstruation. Sanitary pads were used by 60% of the respondents, but 20% still relied on cloth. Healthcare access was skewed towards public facilities, with 70% preferring government hospitals. Despite a majority using allopathic treatment, 40% of women discontinued medical care, often influenced by limited awareness or lack of family support. Furthermore, only 40%

preferred consulting female doctors for gynaecological issues. The study underscores the persistence of cultural restrictions and inadequate menstrual health education, highlighting the need for integrated public health interventions that address social stigma, promote hygiene, and strengthen gender-sensitive reproductive care services.

**Keywords:** Gynaecological Health; Menstrual Practices; Medical Preferences and Gender-sensitive Reproductive Care

## INTRODUCTION

Gynaecological morbidity remains a deeply neglected area within India's public health discourse, despite its substantial impact on the physical, mental, and social well-being of women across their reproductive lifespan (Timilsina, Bhandari, Johns & Thapa, 2024). Conditions related to reproductive tract infections, menstrual disorders, and other gynaecological problems are widespread, yet underreported, due to stigma, lack of awareness, and limited access to appropriate medical care. The burden is further compounded by the fact that many women normalize pain and discomfort as part of womanhood, rarely seeking timely intervention (Klaman, et al., 2019). A clear disparity exists between rural and urban women in their ability and

willingness to seek healthcare services for gynaecological issues. Rural women often face geographical inaccessibility, financial constraints, and cultural barriers, whereas urban women may have better access to services but still grapple with silence, shame, and judgement around reproductive health concerns. Moreover, patterns of healthcare use are often shaped not only by proximity to medical facilities but also by prevailing beliefs, level of education, and family support systems (Porter, 2011). Menstrual hygiene, in particular, is a critical yet overlooked determinant of gynaecological health. Deep-rooted cultural taboos and restrictive practices continue to govern how menstruation is managed, affecting both physical hygiene and mental health. The family's role—whether supportive or dismissive—also influences how seriously a woman's health problems are perceived and treated. This study aims to examine the socio-cultural, environmental, and healthcare practices affecting gynaecological health among reproductive-age women in rural and urban Delhi. By drawing on primary data from patients at Jag Pravesh Chandra Hospital, it seeks to uncover the lived realities of women navigating reproductive health challenges, while identifying patterns in menstrual practices, treatment-seeking behaviour, and the influence of gendered norms.

## MATERIALS & METHODS

The present study was conducted at Jag Pravesh Chandra Hospital, a government-run secondary healthcare facility located in East Delhi. The hospital caters to a mixed population of both rural migrants and urban dwellers, making it an appropriate setting for examining reproductive health issues across diverse socio-economic backgrounds. The study population comprised women of reproductive age (15–49 years) who reported gynaecological problems and sought consultation at the hospital. These included complaints related to menstrual disorders, pelvic infections, abnormal discharges, and other non-obstetric

reproductive health issues. A purposive sampling method was adopted to select participants. Women were included based on their willingness to participate and their ability to provide informed responses. The sample included both inpatients and outpatients from the gynaecology department, ensuring variation in the severity and duration of health conditions. Data were collected using a semi-structured questionnaire, designed to capture detailed information on socio-demographic characteristics, menstrual hygiene practices, cultural taboos, environmental conditions, and healthcare-seeking behaviour. In some cases, patient responses were complemented by hospital record-based profiling to cross-check reported data. The analysis was carried out using descriptive statistical techniques, focusing on frequency and percentage distributions across key indicators. A comparative lens was used to identify variations between rural and urban patients wherever possible, thereby helping to map both structural and cultural determinants of gynaecological health.

## RESULT

### Socio-Demographic Characteristics

The socio-demographic background of the women surveyed offers crucial insights into the determinants of their gynaecological health. The data show that educational attainment was generally low, with a large proportion of women either illiterate or possessing only minimal literacy skills. This has significant implications for their awareness of reproductive health and hygiene practices.

**Table 1: Educational Qualification of Respondents**

Education Level	Percentage
Illiterate	30%
Literate (but no formal schooling)	30%
Primary	10%
Middle	10%
Secondary	10%
Technical after metric	5%
College & above	5%

A total of 60% of the women were either illiterate or barely literate, while only 10% had completed secondary or higher education. Educational status was closely linked to better awareness of menstruation-related hygiene, vaccination, and healthcare-seeking behaviour. Family structure also played a pivotal role in shaping women's access to health services and privacy during menstruation or illness.

**Table 2: Type of Family**

Family Type	Percentage
Nuclear	70%
Joint	20%
Extended	10%

The dominance of nuclear families (70%) suggests a potential for greater autonomy in decision-making, especially when compared to joint or extended families, where intergenerational norms often constrain women's freedom to seek healthcare. Marital status emerged as a critical variable, particularly when considering the vulnerability of widowed, divorced, or separated women, who may lack emotional and financial support from family members.

**Table 3: Marital Status**

Marital Status	Percentage
Unmarried	25%
Married	30%
Widowed	20%
Divorced	20%
Separated	2%
Others	3%

Notably, only 30% of the respondents were currently married. A significant 42% were either widowed, divorced, or separated—groups that often face social isolation and diminished access to family support systems. These women were less likely to complete treatment or be accompanied to healthcare facilities. Although rural–urban distinctions were not categorically recorded, anecdotal evidence from field interactions suggests that rural women tended to be more affected by low education, cultural taboos, and limited medical access, while urban women, despite being relatively better

educated, still reported discomfort in speaking openly about gynaecological problems—particularly with male doctors. Furthermore, the relationship with neighbours—a proxy for social cohesion—indicated moderate to good support systems for most women.

**Table 4: Relationship with Neighbours**

Quality of Relationship	Percentage
Good	50%
Average	30%
Bad	20%

These social connections can affect how freely women seek advice, share experiences, or access nearby healthcare services, especially in the case of unmarried or older women living alone.

### Menstrual Health Practices and Hygiene

Menstrual health is a crucial aspect of overall reproductive well-being, yet it remains shrouded in stigma and misinformation across many sections of Indian society. The findings from this study reflect a mix of positive practices and persistent cultural restrictions that shape the everyday menstrual experiences of women. A majority of respondents used modern menstrual products, with 60% relying on sanitary pads. However, a significant proportion still used cloth or alternative devices, indicating both financial constraints and lack of awareness.

**Table 5: Menstrual Products Used**

Product Used	Percentage
Sanitary Pads	60%
Cloths	20%
Tampons	10%
Menstrual Cup	10%

The continued use of cloth among 20% of respondents, despite growing accessibility of pads, is concerning from a hygiene perspective—especially if not cleaned and dried properly. Frequency of changing menstrual materials is a strong indicator of hygiene awareness. While nearly half of the women changed pads or cloths twice a day,

a worrying 30% changed only once or less, increasing the risk of infection.

**Table 6: Frequency of Changing Pads/Cloths**

Frequency	Percentage
Less than once a day	5%
Once a day	25%
Twice a day	45%
Three times a day	20%
More than three times a day	5%

In terms of the menstrual cycle's duration, most women experienced menstruation lasting between five to six days.

**Table 7: Duration of Menstruation**

No. of Days	Percentage
1-2 days	10%
3-4 days	20%
5-6 days	60%
7+ days	10%

Cultural taboos remain widespread. Notably, 40% of women reported not touching males during menstruation, while others refrained from cooking or entering religious spaces. These practices often lead to psychological distress and social isolation.

**Table 8: Cultural Restrictions Observed During Menstruation**

Restriction	Percentage
Not to take sour food	5%
Not to do hard labour	10%
Not to cook	15%
Not to enter auspicious places	10%
Not to touch males	40%
To sleep on the floor	0%
Others	30%

Hygiene maintenance extended beyond menstruation-specific practices. A majority (70%) reported exposing their beds to sunlight, an important preventive practice to reduce microbial load and infections.

**Table 9: Sunlight Exposure of Bedding**

Practice	Percentage
Yes	70%
No	30%

Vaccination awareness, though not directly linked to menstruation, serves as a proxy for

general health literacy. About 60% of women were aware of vaccination, suggesting a moderate level of public health awareness.

**Table 10: Awareness about Vaccination**

Awareness	Percentage
Yes	60%
No	40%

Despite these relatively encouraging numbers, the presence of both structural barriers and cultural taboos still limits many women from achieving full menstrual health and dignity. Awareness campaigns, affordable sanitary product access, and family/community education are essential to improving outcomes in this domain.

### Healthcare-Seeking Behaviour

The healthcare-seeking behaviour of women experiencing gynaecological issues is shaped not only by the availability of services but also by affordability, awareness, social attitudes, and personal comfort—particularly when the illness relates to intimate or reproductive health. The data from this study highlight a complex interplay of preferences, barriers, and cultural influences that determine how and when women seek care. A majority of respondents preferred to deliver their children in government hospitals, citing affordability, accessibility, and trust in public institutions. However, a notable 20% opted for private nursing homes, while a small proportion still relied on home deliveries.

**Table 11: Preferred Place of Childbirth Delivery**

Place of Delivery	Percentage
Home	10%
Government Hospital	70%
Private Nursing Home	20%

In terms of treatment for gynaecological issues, allopathic medicine emerged as the dominant system, used by 75% of women. The use of homoeopathy and Ayurveda was limited to 10% each, and notably, there was no reliance on quack or informal care

providers, which contrasts with patterns in some rural areas.

**Table 12: Preferred Medical System**

Type of Treatment	Percentage
Allopathic	75%
Homoeopathic	10%
Ayurvedic	10%
Quack	0%
Others	5%

Despite relatively high preference for formal medical systems, treatment discontinuation was a notable concern—40% of women did not complete their prescribed treatment regimen. Factors such as inadequate family support, financial hardship, or loss of hope in recovery may contribute to this drop-out.

**Table 13: Continuity of Treatment**

Continues Treatment	Percentage
Yes	60%
No	40%

Gender dynamics in the medical encounter were also revealing. While one might expect a greater preference for female doctors when discussing intimate health problems, only 40% of women expressed a preference for female practitioners. This may indicate a lack of availability or social conditioning to suppress discomfort in clinical settings.

**Table 14: Preference for Female Doctors**

Preference	Percentage
Yes	40%
No	60%

Crucially, the attitudes of family members toward gynaecological illness played a major role in determining care-seeking behaviour. In 40% of the cases, family members did not perceive the woman's condition as a medical issue requiring formal attention. This normalization of pain or silence around reproductive health continues to prevent timely and effective care.

**Table 15: Family Attitudes toward Gynaecological Illness**

Family Considers It a Medical Concern	Percentage
Yes	60%
No	40%

Together, these findings illustrate that while formal healthcare systems are being utilized by a significant proportion of women, deep-rooted social barriers—ranging from gender insensitivity in care to neglect within the household—continue to limit access and outcomes. Tackling these issues requires both health system strengthening and community-level behaviour change interventions.

### Environmental and Sanitation Conditions

Environmental factors such as access to clean water, household sanitation, and hygiene-related behaviours significantly affect reproductive and gynaecological health outcomes. In many cases, infections and chronic conditions are either triggered or worsened by poor sanitation and limited awareness of basic hygiene practices. Access to clean drinking water was relatively adequate among the women surveyed. The majority (60%) relied on tube well supply, followed by motor pumps (20%) and open wells (10%). An additional 10% depended on other unspecified sources. Notably, none of the respondents used water from rivers or ponds—likely reflecting the urban or peri-urban setting of the study.

**Table 16: Drinking Water Sources**

Source	Percentage
Well	10%
Tube Well Supply	60%
Motor Pump	20%
Pond	0%
River	0%
Others	10%

For purposes other than drinking—such as washing, bathing, and household chores—respondents showed more diversity in water use. About 30% used tube wells, another 30% used supply water, 20% used motor pumps, and 10% relied on wells or other

sources. Again, there was no usage of river or pond water.

**Table 17: Water Sources for Other Uses**

Source	Percentage
Well	10%
Tube Well	30%
Supply	30%
Motor Pump	20%
Pond	0%
River	0%
Others	10%

While access to water sources appeared stable, the use of insecticides—an important preventive measure against flies, mosquitoes, and other vectors—was relatively low. Only 40% of respondents used insecticides regularly, leaving 60% potentially vulnerable to vector-borne and hygiene-related infections.

**Table 18: Use of Insecticides at Home**

Use Insecticides	Percentage
Yes	40%
No	60%

Encouragingly, a majority of women (70%) reported exposing their bedding to sunlight periodically, a simple yet effective home hygiene practice to kill bacteria, fungi, and parasites. However, 30% did not follow this, potentially increasing their risk of skin and reproductive infections, especially in settings with poor ventilation or damp living conditions.

These findings underline the intersection between environmental conditions and women's health. Poor insecticide use, limited hygiene awareness, and inconsistent sanitation behaviours can significantly heighten vulnerability to reproductive tract infections (RTIs), especially when coupled with inadequate menstrual hygiene and delayed medical care. This further reinforces the need for integrated public health messaging that connects environmental hygiene with women's reproductive health.

## DISCUSSION

The findings of this study offer a nuanced picture of how socio-cultural, economic, and infrastructural factors intersect to shape gynaecological health outcomes for women in urban and peri-urban Delhi. Despite increasing awareness and use of public healthcare services, several deep-rooted challenges continue to affect women's ability to maintain reproductive health and seek appropriate care (Shiva, 2014). One of the most concerning patterns that emerged is the discontinuation of treatment by 40% of women, despite initial access to care. This trend may be attributed to multiple factors: lack of sustained family support, social stigma around gynaecological illnesses, financial constraints, and the perception that symptoms are either normal or not serious enough to warrant follow-up (Gameiro, Boivin, Peronace & Verhaak, 2012). In many cases, women reported that family members did not consider their condition to be a medical issue. This reflects a broader normalization of reproductive pain and illness within patriarchal households, where women are expected to silently endure discomfort. Similarly, 20% of women still rely on cloth during menstruation, even though 60% use sanitary pads. The continued use of cloth may result from economic limitations, lack of consistent access to disposable products, or cultural familiarity with traditional methods. Inadequate drying practices and use of unclean cloths have been linked to increased risk of infections, underscoring a critical gap in menstrual hygiene management (Garikipati & Boudot, 2017).

This study also highlights how gendered stigma continues to silence open conversations about reproductive health. Only 40% of women preferred female doctors, and many expressed discomfort in discussing their issues with male practitioners. The shame and hesitation around gynaecological symptoms—particularly among unmarried, widowed, or separated women—suggest that medical spaces remain only partially accessible,

especially when compounded by gender dynamics (Tohit & Haque, 2024). The intersection of education and family structure further illustrates how knowledge and autonomy influence health practices. Educated women, though fewer in number, were more likely to practice good hygiene, seek timely care, and understand the importance of vaccinations. Nuclear family settings, which dominated the sample, offered greater decision-making autonomy compared to joint or extended families, where traditional hierarchies and social control often delayed treatment-seeking (Cook & Dickens, 2014). Though the dataset does not offer a systematic rural–urban comparison, field notes and anecdotal impressions suggest that urban women generally had greater access to sanitary products and medical services (Kuhlmann, Bergquist, Danjoint & Wall, 2019), while rural-origin patients were more constrained by economic hardship and cultural conservatism (Mapukata, 2022). Yet, even in urban settings, stigma and misinformation persisted, indicating that urban residence alone does not ensure reproductive health equity (World Health Organization. 2010. When placed in the context of national surveys such as NFHS-5 or DLHS, this study offers both alignment and divergence. Like NFHS, it confirms that public facilities are the dominant source of care for deliveries and basic reproductive services. However, while NFHS reports a steady increase in sanitary pad use nationally, this micro-level study reveals persistent gaps in adoption and correct usage—especially in semi-urban and low-income areas. Additionally, NFHS does not capture the nuanced family dynamics or personal discomforts that often determine treatment adherence, which this study brings to the fore.

## CONCLUSION

This study has brought to light the complex interplay of socio-cultural, environmental, and behavioural factors that influence the gynaecological health of women in urban

and peri-urban Delhi. Despite the availability of public healthcare services and a visible shift towards the use of modern medical systems, many women continue to experience barriers rooted in gender norms, limited education, and household dynamics. Key insights from the findings reveal that while a majority of women use sanitary pads and prefer government hospitals for childbirth, a significant proportion still rely on cloth during menstruation and discontinue treatment prematurely. The persistence of cultural taboos—such as menstrual restrictions and discomfort in consulting male doctors—continues to limit open engagement with reproductive health issues. Furthermore, education and family structure emerged as strong determinants of health-seeking behaviour, with nuclear families and educated women showing relatively better outcomes. These observations underscore the need for multi-dimensional interventions that go beyond infrastructure or service delivery. Public health efforts must integrate community-based education, address gendered stigma, ensure affordability and consistent access to menstrual products, and involve families—particularly men—in reproductive health discourse. Special focus should also be given to unmarried, widowed, or separated women who face additional social vulnerabilities. Future research should explore longitudinal patterns in treatment adherence, compare rural–urban trajectories more systematically, and integrate qualitative narratives to deepen understanding of stigma, agency, and systemic neglect in women’s healthcare. Only by addressing these interconnected layers can reproductive health be fully realised as a right for all women, not just a service for those able to access it.

## *Declaration by Authors*

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