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Perception and Social Stigma of PCOD: A Study Among Female Pharmacy Students

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1. INTRODUCTION

Polycystic Ovary Syndrome (PCOS), also known as Polycystic Ovarian Disease (PCOD) is one of the most common endocrine diseases faced by women in the reproductive age group worldwide, with an expected prevalence rate between 5–15%. PCOS is the most common endocrine disorder consulted by health providers, yet it is a long-stigmatized condition which stigma is increased because of stereotypes related to cultural and community beliefs associated with traditional feminine body ideals, beauty/fertility.

Common female body image concerns diagnosed with PCOS (irregular periods, infertility, weight gain, acne) and/or hirsutism are often at odds with socially defined femininity. As a result,

Those affected women with PCOS frequently adopt these societal expectations, perceiving themselves as “less feminine” or inadequate due to their helplessness to meet cultural norms related to appearance and reproductive roles.

Also, the social stigma with PCOS further perpetuates misconceptions around the disorder like that it only results from poor lifestyle choices, or it only affects those of reproductive ages. This misunderstanding can trigger blame, lack of empathy and no social support. Also, stigma is not only associated with society but within healthcare environments as well, where patients may suffer emotional distress due to being undiagnosed for a long time and low levels of awareness.

Theoretical perspectives, including Erving Goffman’s stigma theory, explain how individuals can be classified and sidelined when they are deviating from social norms. For PCOS, physically obvious signs of conveniently available weight problems.

The global occurrence of PCOS varies depending on diagnostic criteria, but it is estimated to affect approximately 1 in 10 women worldwide. Despite this high prevalence, awareness regarding PCOS remains limited, particularly in developing countries. Cultural beliefs, lack of education, and inadequate healthcare access furthermore complicates early detection and diagnosis. In many cases, symptoms such as irregular menstruation or acne are normalized or hyped, delaying timely medical intervention.

Importantly, PCOS is not just a biomedical condition but also veers into the social and cultural discourse. At a time when womanhood is celebrated based on physical attributes and reproductive potential, the presentation of PCOS can be stigmatizing with negative consequences for socialization. Problems like infertility, weight gain and hirsutism are likely to cause women judgemental discrimination and unsolicited advice, which can mar their social identity and interpersonal relations. Additionally, some PCOS symptoms are chronic and overt in nature, further perpetuating internalized stigma. Women feel shame, social withdrawal, or inadequacy if they cannot fit into the societal mold.

Stigma contributes to psychological distress, anxiety, depression and diminished quality of life. This is a cause for women to remain hesitant in seeking medical sentiments or at least not feel comfortable articulating their concerns due to judgement and prohibiting. Delays in diagnosis and treatment can exacerbate the underlying condition, leading to long-term complications.

This necessitates assessing the public knowledge, attitude, and perception regarding PCOS. Survey based studies provide an exceptional means to capture statistics on public knowledge and misconceptions about this condition, and the level at which stigma comes connected.

From limited sex education to cultural beliefs about menstruation and gender, many factors contribute to the stigma surrounding reproductive health issues in India. Many adolescent girls and young women lack access to accurate information, and due to a lack of facts or misinterpretation, they sometimes become confused about the disease and ignore its symptoms.

PCOS awareness in many Indian communities - even basic responsiveness - is also severely limited. Most of the people still unaware that it is also a disease due to hormonal imbalance. Only, rather than be made sense of and accepted as normal, things like irregular periods or weight gain or acne or unwanted hair growth are pathologised. In fact, some women have irregular menstruation but is perceived as a “normal” condition or in other cases it is viewed disgracefully and should not n be spoken of freely. This leads to confusion resulting into delay in diagnosing.

The single biggest myth around PCOS is that it only happens to people who are lazy or have bad lifestyle choices. Women are frequently blamed for their size.

It is wrong-headed and harmful for singling out the person rather than promoting appropriate care an attitude that may even contribute to avoidable illness.

One of the most prevalent misconceptions in Indian society is about fertility. The common knowledge that PCOS narrates directly to not being able to get pregnant but also results in the false hypothesis that women who suffer from PCOS cannot get pregnant. This encourages fear and anxiety, predominantly in unmarried women or those of a marriageable age. Where a womanhas no children, yet childbirth potential seems to be closely connected with social value for many families.

1.1 Common myths about PCOS

- PCOS does not force a woman to become infertileand it is one of the most widespread and harmful myths by far. The ovulation that is performed may be sporadic in PCOS but does not equal infertility. However, with the right treatment and lifestyle choices, many women suffering from PCOS will go on to have a successful pregnancy.
- Acne and facial hair are just cosmetic issues.Hirsutism and acne are trivialized as beauty issues. PCOS is not a rare condition. In reality ,they are important clinical science of hormonal imbalance and should not be ignored.PCOS is considered pretty rare by most people but millions of women do have it.
- PCOS can be “cured” by way of marriage or pregnancy.One of the most common cultural myths in India. PCOS is a very serious medical condition and marriage or getting pregnant does not cure it. It involves appropriate medical treatment and lifestyle management.

- It is shameful to speak of a symptomatic situation resulting from hormonal or menstrual ill-health

- Many women experience lack of courage to discuss with their symptoms because of cultural taboos. It feeds into stigma and puts a delay on treatment.

- PCOS can be completely reversed through home remedies.Some lifestyle changes and natural remedies may assist in managing symptoms, but they are not a cure. To manage properly, you must seek medical advice

- PCOS is just a “character problem” or inability to exercise restraint. Other people consider women with PCOS simply do not control themselves (in eating, lifestyle, etc.). This is an offensive and unscientific belief that fails to acknowledge the biological reality of the disorder.

- PCOS makes women less feminine .Women are seen as not “properly feminine” for being hairy, or having irregular periods. This is a product of social bias, not medical fact.

- Diabetes of modern (Western) lifestyle only feature PCOS.PCOS is NOT a “modern disease” that can happen only due to junk food and urban living.

2. COMPARATIVE CASE ANALYSIS: HEALTHY FEMALE V/S PATIENT WITH PCOD

To understand the clinical impact of , a comparative analysis was performed between a healthy female and a patient diagnosed with PCOD. The comparison highlights the physiological, hormonal, and clinical differences associated with the disorder**.**

PARAMETERS	HEALTHY FEMALE	PCOD PATIENT
MENSTURAL CYCLE 	Regular cycle (28–30 days)	Irregular or delayed menstruation
OVULATION 	Normal ovulation occurs monthly	Irregular ovulation or anovulation
OVARIAN STRUCTURE 	Normal ovaries with developing follicles	Multiple small peripheral follicles (polycystic ovaries)
HORMONAL IMBALANCE 	Balanced estrogen and progesterone	Increased androgen levels causing hormonal imbalance
SKIN CONDITION 	Clear skin with minimal acne	Frequent acne due to androgen excess
FACIAL HAIR GROWTH 	Normal hair growth pattern	Excess facial/body hair (hirsutism) may occur
HAIR FALL 	Normal physiological hair shedding	Excessive hair fall commonly observed
BODY WEIGHT 	Usually maintained within healthy range	Increased tendency for weight gain

2. METHODOLOGY:

2.1 Study Design

The present study was conducted as a survey-based observational study to assess awareness, prevalence, symptoms, and lifestyle factors associated with Polycystic Ovarian Disease (PCOD) among female participants.

2.2 Study Population

The survey was conducted among adolescent girls and women of reproductive age group (**18–25 years**). Participants were selected randomly from students and young females willing to participate in the study.

2.3 Data Collection Method

Data was collected using a structured questionnaire prepared to evaluate menstrual health, lifestyle habits, clinical symptoms, and awareness regarding PCOD. Responses were collected directly from participants and analyzed for identifying common risk factors associated with PCOD.The survey was conducted among **40 female participants** (Sample Size = 40) belonging to the reproductive age group. Participants were selected randomly and voluntarily participated in the study. The questionnaire focused on menstrual health patterns, dietary habits, physical activity, stress levels, clinical symptoms, and previous diagnosis related to PCOD.

STUDY DESIGN	Survey based observational study
SAMPLE SIZE	40 participants
STUDY POPULATION	Female aged 18-25 years
DATA COLLECTION TOOL	Structured questionnaire
DATA ANALYSIS	percentage

2.4 Survey Questionnaire Used in Study is given below:

The questionnaire included the following questions:

- Consent:
  1. Do you voluntarily agree to participate in this study?
  2. Do you understand that your responses will remain confidential and will be used solely for research purposes?
- Demographic Information

  3. What is your age?
  4. What is your height (in cm)?
  5. What is your weight (in kg)?
  6. What is your current year of study?
  7. What is your place of residence?

- Awareness and Knowledge of PCOD

  8. Have you heard of Polycystic Ovarian Disease (PCOD)? (Yes/No)
  9. What is your primary source of information about PCOD?
  10. Which of the following do you believe can cause PCOD? (Select all that apply)

- Perceptions Regarding PCOD

  11. Do you believe that PCOD is a serious health condition?
  12. Do you think lifestyle modifications can help in the management of PCOD?
  13. Do you believe that women with PCOD are generally less healthy than women without PCOD?
  14. Do you think PCOD can affect a woman's fertility?

- Social Attitudes and Stigma

  15. Do you think women with PCOD are often judged by society?
  16. Do you believe that people commonly associate PCOD with poor lifestyle choices?
  17. Would you feel uncomfortable sharing a PCOD diagnosis with others?
  18. Do you think PCOD is considered a shameful condition in society?

- Personal Experience

19. Have you ever been diagnosed with PCOD? (Yes/No)
20. Do you frequently consume junk or fast food?
21. Do you usually get an adequate amount of sleep?
22. Have you ever hidden menstrual irregularities from your family members?
23. Have you experienced judgment, discrimination, or stigma related to PCOD or menstrual health?
24. If yes, did this experience affect your mental health?

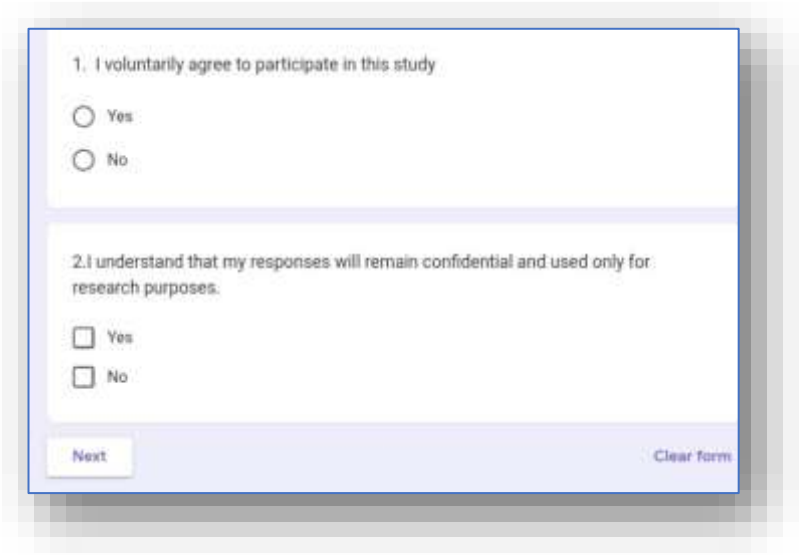
- Healthcare-Seeking Behavior

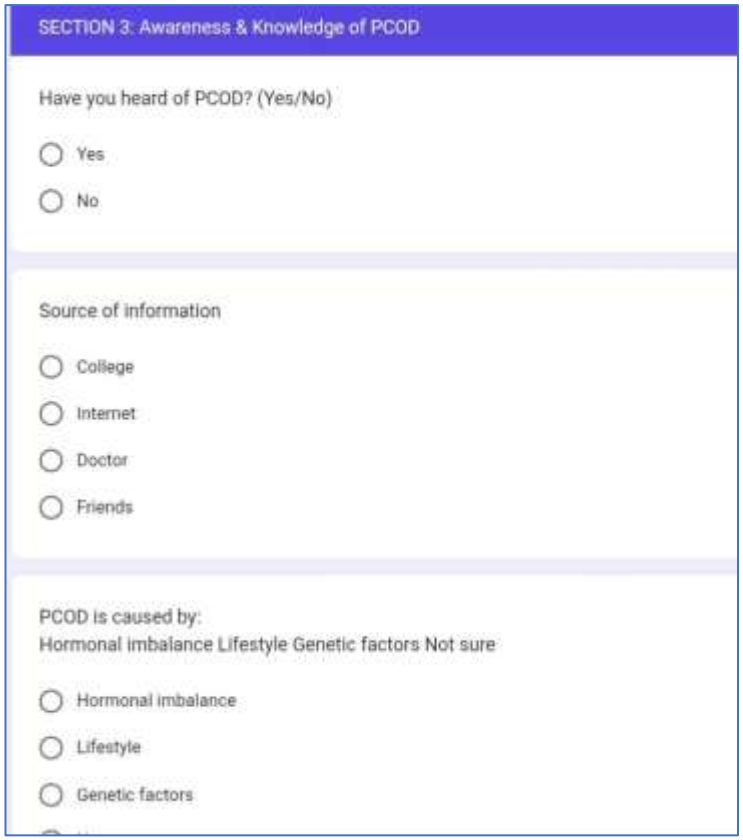
25. Would you seek medical advice if you suspected that you had PCOD?
26. Would concerns about stigma prevent you from consulting a healthcare professional regarding PCOD?

- Communication and Awareness

27. Are you comfortable discussing reproductive and menstrual health issues openly?
28. In your opinion, what changes are needed to reduce stigma and improve awareness regarding PCOD?

2.5 Survey questionnaire distributed among participants:





SECTION 3: Awareness & Knowledge of PCOD

Have you heard of PCOD? (Yes/No)

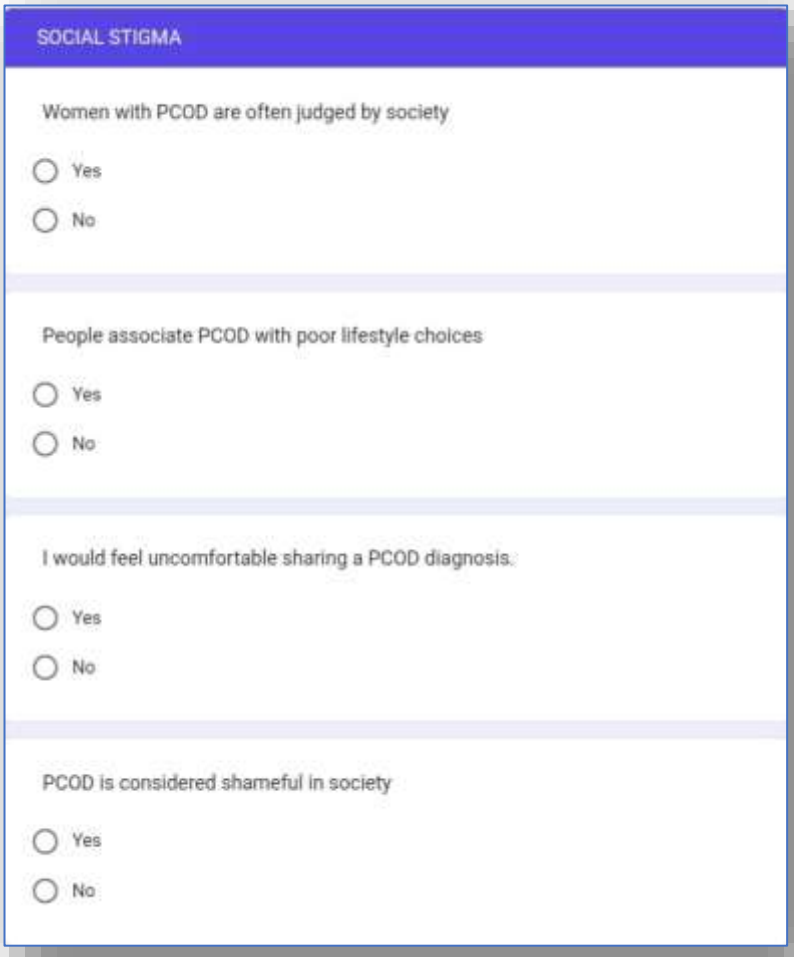
- Yes
- No

Source of information

- College
- Internet
- Doctor
- Friends

PCOD is caused by:
Hormonal imbalance Lifestyle Genetic factors Not sure

- Hormonal imbalance
- Lifestyle
- Genetic factors



SOCIAL STIGMA

Women with PCOD are often judged by society

- Yes
- No

People associate PCOD with poor lifestyle choices

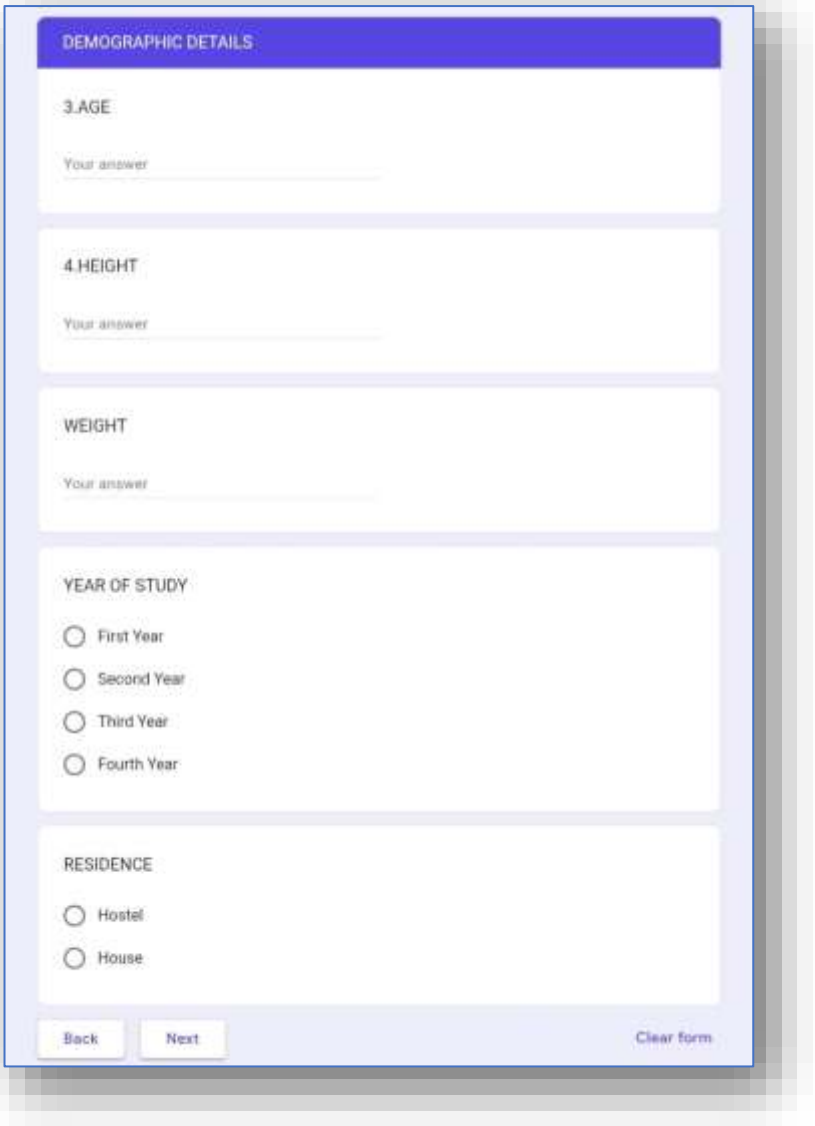
- Yes
- No

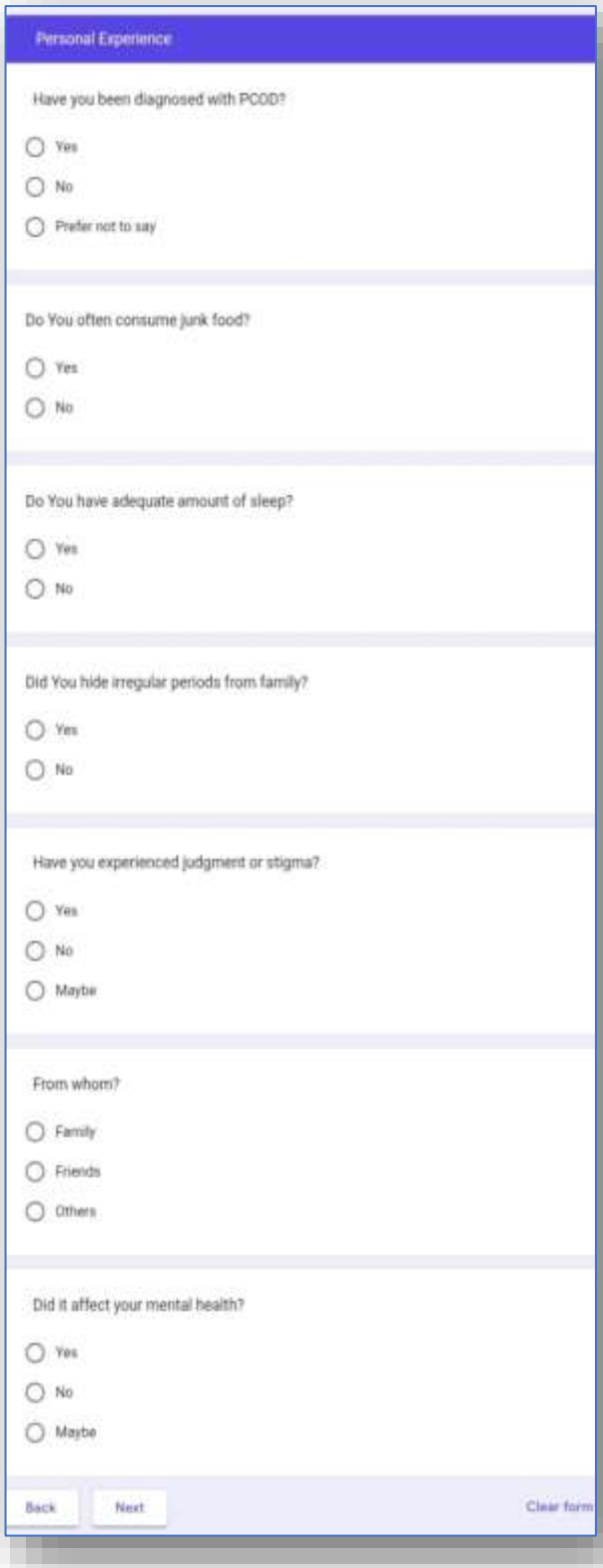
I would feel uncomfortable sharing a PCOD diagnosis.

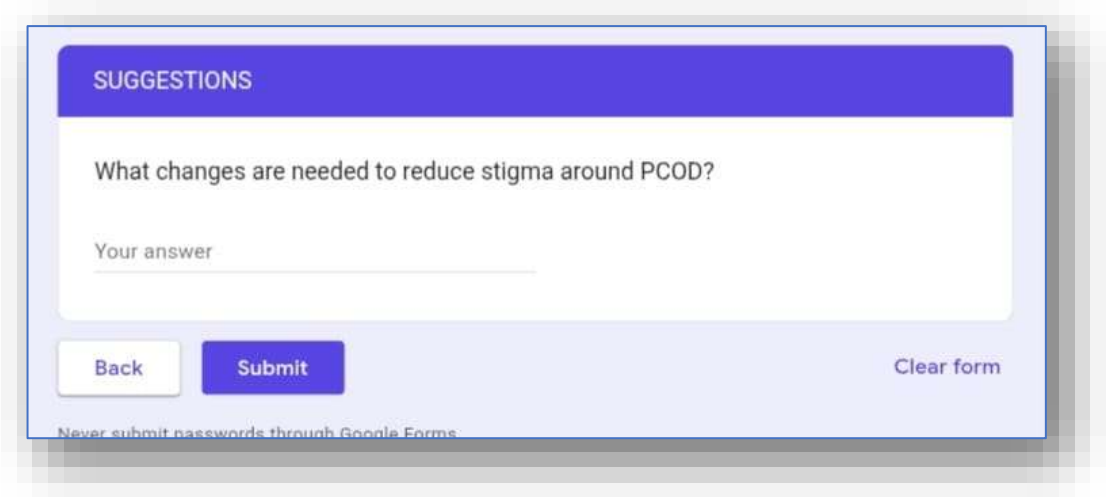
- Yes
- No

PCOD is considered shameful in society

- Yes
- No


DEMOGRAPHIC DETAILS
3.AGE
Your answer
4.HEIGHT
Your answer
WEIGHT
Your answer
YEAR OF STUDY
First Year
Second Year
Third Year
Fourth Year
RESIDENCE
Hostel
House
Back
Next
Clear form


Personal Experience
Have you been diagnosed with PCOD?
Yes
No
Prefer not to say
Do You often consume junk food?
Yes
No
Do You have adequate amount of sleep?
Yes
No
Did You hide irregular periods from family?
Yes
No
Have you experienced judgment or stigma?
Yes
No
Maybe
From whom?
Family
Friends
Others
Did it affect your mental health?
Yes
No
Maybe
Back
Next
Clear form



3. RESULTS:

3.1 Demographic Profile of Respondents

A total of 48 students participated in the survey. The demographic distribution is summarised in Table 1 below.

Demographic Variable	Category	Frequency (n)	Percentage (%)
Year of Study	First Year	32	66.7%
	Second Year	2	4.2%
	Third Year	2	4.2%
	Fourth Year	12	25.0%
Age Group	16–18 years	14	29.2%
	19–21 years	28	58.3%
	22–25 years	6	12.5%
Residence	Home (Day Scholar)	47	97.9%
	Hostel	1	2.1%

Table 1. Demographic profile of survey respondents (N=48)

3.2 Awareness and Sources of Information

All 48 respondents (100%) confirmed they had heard of PCOD prior to completing the survey, reflecting a high baseline level of awareness within this sample. Participants were asked to identify their primary source of information about PCOD. As illustrated in Figure 1, the Internet was the most frequently cited source (n=30, 62.5%), followed by college/educational institutions (n=13, 27.1%), doctor consultations (n=3, 6.3%), and friends (n=2, 4.2%). No respondent cited traditional media such as television or print as their primary source.

This finding underscores the dominant role of digital platforms in shaping health awareness among young adults. However, the predominance of internet-sourced information also raises concerns about accuracy, as online content on reproductive health is highly variable in quality.

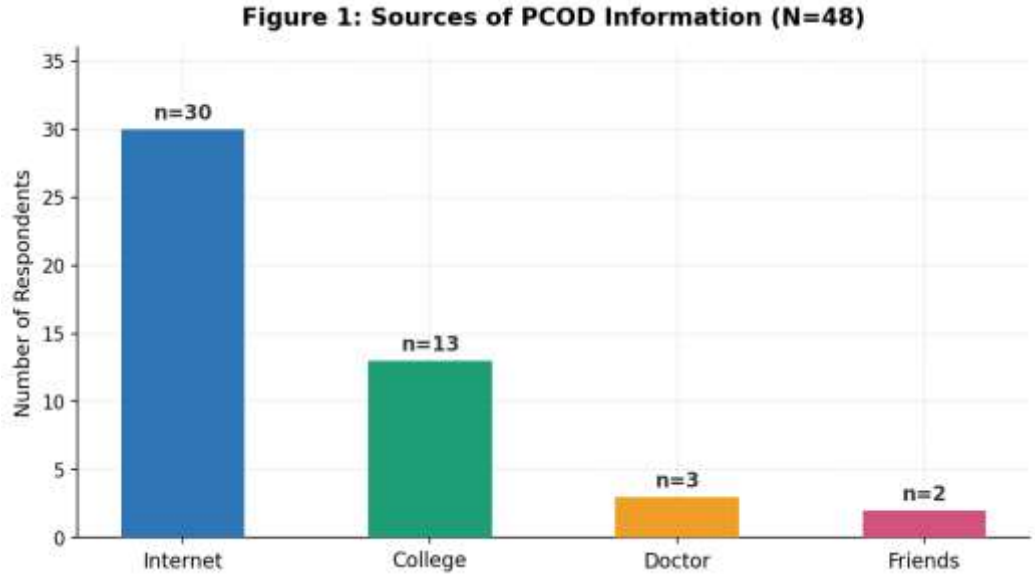
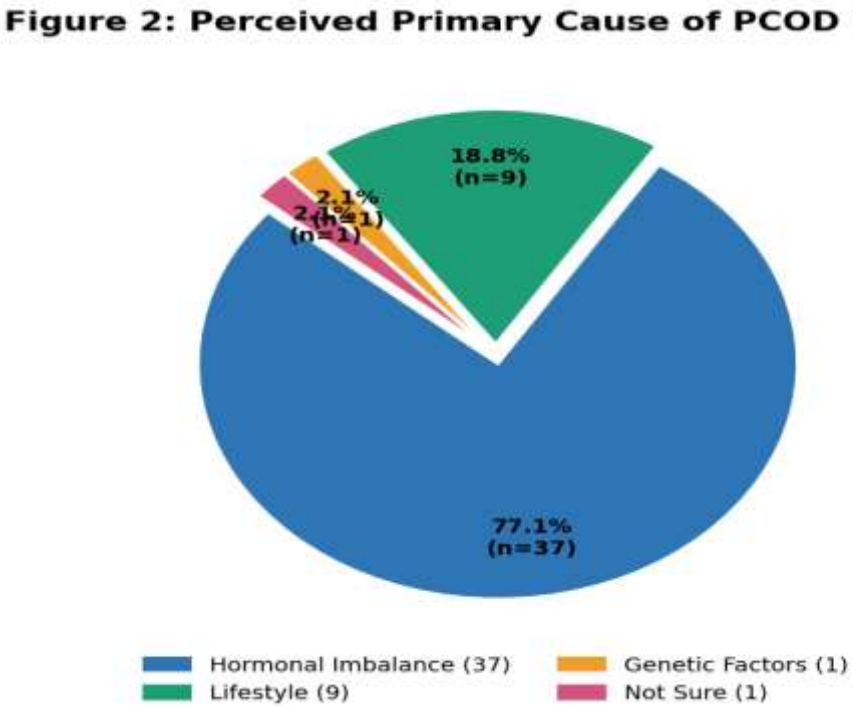


Figure 1: Awareness and Sources of Information

3.3 Perceived Causes of PCOD

Respondents were asked to identify what they believed to be the primary cause of PCOD. As shown in Figure 2, an overwhelming majority attributed PCOD to hormonal imbalance (n=37, 77.1%). Lifestyle factors were cited by 9 respondents (18.8%), while genetic factors and uncertainty ("not sure") were each reported by 1 respondent (2.1%) each.

The strong association with hormonal imbalance aligns with clinical understanding and suggests that awareness campaigns have been at least partially effective in communicating the biological basis of the condition. However, the notable proportion attributing PCOD to lifestyle factors alone (18.8%) may reflect a partial understanding, given that lifestyle is considered a modifiable contributor rather than a root cause in most clinical frameworks.



3.4 Attitudinal Perceptions Regarding PCOD

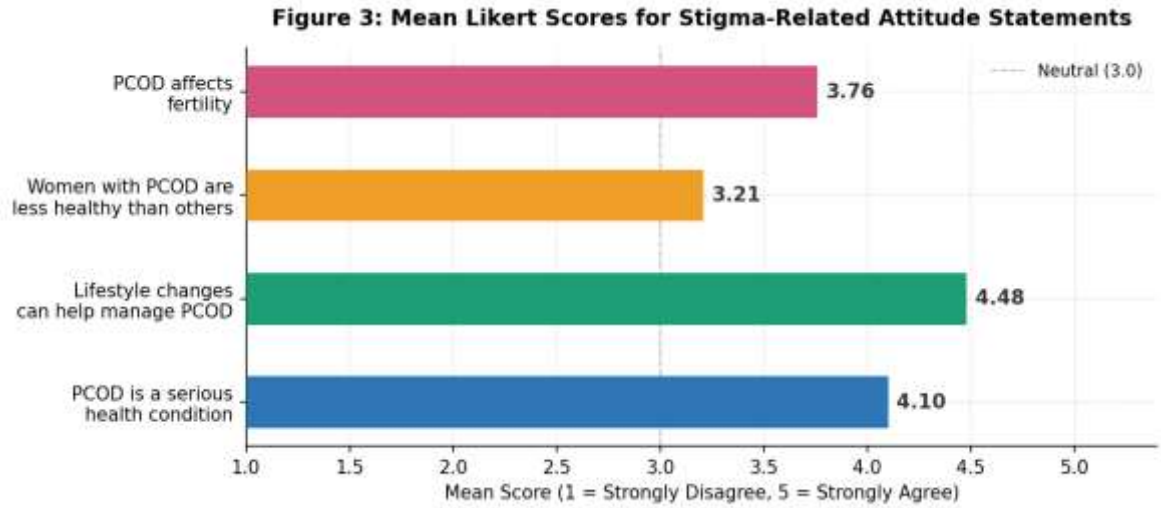
Participants responded to four attitudinal statements using a 5-point Likert scale. Mean scores for each item are summarised in Table 2 and illustrated in Figure 3.

Attitudinal Statement	Mean Score	Interpretation
PCOD is a serious health condition	4.10	Agree
Lifestyle changes can help manage PCOD	4.48	Strongly Agree
Women with PCOD are less healthy than others	3.21	Neutral–Agree
PCOD affects fertility	3.76	Agree

Table 2. Mean Likert scores for attitudinal statements (1 = Strongly Disagree, 5 = Strongly Agree)

Respondents most strongly agreed that lifestyle changes can help manage PCOD (M=4.48), indicating broad acceptance of behavioural interventions. There was also general agreement that PCOD is a serious health condition (M=4.10). The item regarding PCOD affecting fertility yielded a mean of 3.76, suggesting moderate agreement, though responses were mixed. Notably, the statement that "women with PCOD are less healthy than others" received a mean score of 3.21, indicating a tendency toward agreement that may reflect internalised negative health comparisons — a component of stigma.

Figure 3 — Stigma-Related Attitudes



3.5 Personal Experience: Diagnosis, Disclosure, and Stigma

The survey explored participants' personal experiences related to PCOD diagnosis, lifestyle habits, and exposure to stigma. Findings are summarised in Table 3 below.

Variable	Yes (n)	Yes (%)	No (n)	No (%)
Diagnosed with PCOD	29	60.4%	19	39.6%
Consumes junk food often	38	79.2%	10	20.8%
Has adequate sleep	20	41.7%	28	58.3%
Hid irregular periods from family	20	41.7%	28	58.3%
Experienced judgment or stigma	16	33.3%	32	66.7%
Stigma affected mental health	20	54.1%*	10	27.0%*

*Table 3. Personal experience with PCOD, lifestyle, and stigma (N=48). *Calculated among those who experienced stigma (n=37 responded to this item).*

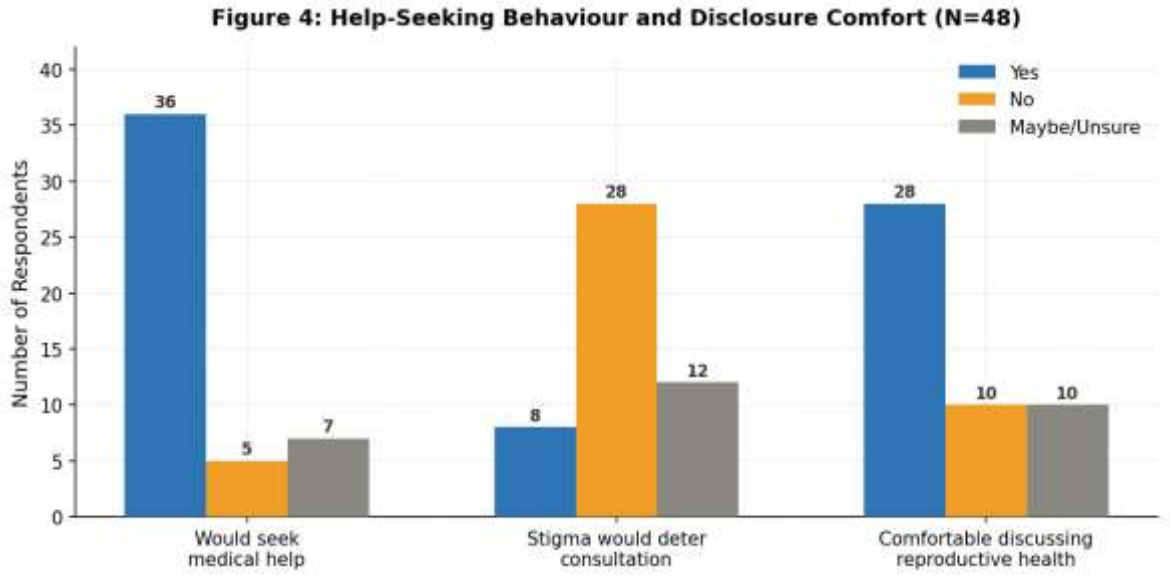
Among the 48 respondents, 29 (60.4%) reported having been diagnosed with PCOD. A substantial proportion (79.2%) reported frequently consuming junk food, and 58.3% indicated inadequate sleep — both recognised as lifestyle risk factors for PCOD symptom exacerbation. Disclosure behaviour was a key area of interest: 41.7% of respondents reported hiding irregular menstrual periods from their family members, which is indicative of the social stigma and discomfort surrounding menstrual health discussions in domestic settings.

When asked about experiences of judgment or stigma, 33.3% of respondents confirmed they had faced such experiences. Of those who had experienced stigma, family members were the most commonly cited source, followed by others (peers, acquaintances, or unspecified individuals). Among those exposed to stigma, over half reported a negative impact on their mental health.

3.6 Help-Seeking Behaviour

Three questions probed participants' willingness to seek medical help and their comfort with open discussions about reproductive health, as depicted in Figure 4.

A large majority of respondents (n=36, 75.0%) indicated they would seek medical help if they suspected PCOD. However, 12 respondents (25.0%) responded with "maybe" or "no", suggesting hesitancy. When asked whether stigma would prevent them from consulting a doctor, 28 respondents (58.3%) said it would not, while 8 (16.7%) said it would and 12 (25.0%) were uncertain. With respect to comfort in discussing reproductive health openly, 28 respondents (58.3%) expressed comfort, 10 (20.8%) were uncomfortable, and 10 (20.8%) were uncertain.



3.7 Suggested Strategies to Reduce Stigma

Open-ended responses regarding strategies to reduce stigma were analysed thematically. Five dominant themes emerged:

Theme	Representative Responses	Frequency
Education and Awareness	"Increase awareness and education"; "Conduct campaigns"; "Awareness among young individuals"	High
Normalising Open Conversation	"Normalising things would be a solution"; "Talk openly about this"; "Stop making it a big issue"	High
Stopping Body-Shaming	"Stop body shaming"; "Stop judging those who have it"; "Society needs more empathy"	Moderate
Mental Health Support	"Provide emotional support"; "Support mental health openly"	Moderate
Healthcare Access	"Proper diagnosis and treatment"; "Must be able to disclose problem with doctor"	Low–Moderate

Table 4. Thematic analysis of open-ended responses on stigma reduction strategies

4. DISCUSSION:

4.1 High Awareness, Persistent Stigma

One of the most striking findings of this study is the paradox between high levels of PCOD awareness and the continued presence of stigma and concealment behaviour. All 48 respondents confirmed awareness of PCOD, yet one-third had personally experienced stigma, and over 40% had hidden their menstrual irregularities from family. This divergence suggests that awareness, in and of itself, does not translate into stigma reduction. Information about the existence of a condition does not automatically alter the social attitudes or family dynamics that give rise to shame and concealment.

This is consistent with broader patterns observed in health stigma research, where improved awareness often coexists with deeply embedded cultural attitudes that continue to frame menstrual and reproductive conditions as matters of personal failure, moral weakness, or domestic concern rather than legitimate medical issues.

4.2 The Internet as the Primary Source of Health Information

One of the most notable findings of the study was that a substantial majority of respondents (62.5%) identified the internet as their primary source of information about Polycystic Ovarian Disease (PCOD). This finding reflects the growing role of digital platforms in shaping health knowledge among young adults and highlights a significant shift in how health information is accessed and consumed. In an era characterized by widespread internet availability, social media engagement, and instant access to information, young people increasingly rely on digital sources to understand health conditions, symptoms, treatment options, and preventive measures. From one perspective, this trend is encouraging, as it demonstrates a willingness among students to actively seek information and take an interest in their health. Access to online resources can empower individuals to learn about conditions that may not be adequately covered in formal education or openly discussed within families and communities.

The importance of online health information becomes even more apparent in the context of reproductive health. Topics such as menstruation, hormonal disorders, fertility, and gynecological conditions often remain surrounded by cultural taboos, social discomfort, and limited public discussion. Many young women may feel hesitant to approach family members, teachers, or healthcare providers with questions regarding reproductive health due to embarrassment, fear of judgement, or concerns about privacy. In such situations, the internet serves as an accessible and anonymous source of information, allowing individuals to seek answers without the perceived social risks associated with face-to-face discussions. For many students, online platforms may therefore represent the first point of contact for understanding symptoms and learning about conditions such as PCOD.

This concern is particularly relevant in the context of PCOD, a condition that is frequently discussed across social media platforms, blogs, online forums, and wellness communities. Digital content related to PCOD often focuses on highly simplified explanations, dramatic success stories, or unverified treatment claims. Information regarding fertility outcomes, hormonal treatments, dietary interventions, weight management, and the possibility of "curing" or "reversing" PCOD is often presented without adequate scientific context. Such content can create unrealistic expectations, reinforce misconceptions, and contribute to confusion among individuals attempting to understand the condition. In some cases, the spread of inaccurate information may be amplified through social media algorithms that prioritize engagement rather than scientific accuracy, increasing exposure to sensationalized or misleading content.

The influence of online misinformation may help explain some of the misconceptions observed within the study population. For example, a notable proportion of respondents attributed PCOD primarily or exclusively to lifestyle factors. While lifestyle behaviours undoubtedly influence symptom severity and disease management, PCOD is a complex endocrine disorder with genetic, hormonal, metabolic, and environmental determinants. The oversimplification of PCOD as merely the result of poor dietary habits, lack of exercise, or weight gain is a common narrative found across online health discussions. Repeated exposure to such messages may lead individuals to develop an incomplete understanding of the condition, inadvertently reinforcing self-blame and stigma. Consequently, although the internet serves as an important educational tool, it may also contribute to the formation and persistence of inaccurate beliefs when information is not critically evaluated.

Another significant finding is the comparatively low proportion of respondents (6.3%) who identified healthcare professionals as their primary source of information regarding PCOD. This figure warrants particular attention because healthcare providers represent one of the most reliable and evidence-based sources of medical information. The limited reliance on professional consultation suggests that many students may not be engaging with healthcare services at an early stage of symptom recognition or information seeking. Instead, they may be attempting to self-diagnose, self-educate, or self-manage symptoms based primarily on online resources. While self-directed learning can promote awareness, it cannot replace professional medical evaluation, particularly for conditions that require individualized assessment and treatment.

The low rate of consultation with healthcare professionals may reflect several underlying barriers. These may include limited awareness of symptoms, financial constraints, concerns regarding confidentiality, fear of diagnosis, lack of perceived symptom severity, or discomfort discussing reproductive health concerns. Social stigma surrounding menstrual and hormonal disorders may further discourage students from seeking professional advice, leading them to rely on online information as a more convenient and less intimidating alternative. While understandable, this reliance may delay appropriate diagnosis and treatment, increasing the risk of unmanaged symptoms and long-term health complications.

The consequences of delayed professional consultation extend beyond physical health. Without appropriate medical guidance, individuals may experience uncertainty, anxiety, and confusion regarding their symptoms. Exposure to contradictory online information can exacerbate these concerns, creating unnecessary stress and potentially leading to harmful health decisions. For example, individuals may adopt restrictive diets, unproven supplements, or ineffective treatment strategies based on online recommendations rather than evidence-based medical advice. Such behaviours may not only fail to address the underlying condition but may also contribute to additional physical and psychological burdens.

The findings therefore highlight the dual nature of the internet as a health information resource. On one hand, digital platforms have the potential to increase awareness, improve health literacy, and empower young adults to take an active role in understanding their health. On the other hand, the absence of quality control and the widespread availability of misinformation create significant challenges for informed decision-making. The effectiveness of online health education depends not only on access to information but also on the ability to critically evaluate its accuracy and credibility.

From a public health perspective, these findings emphasize the need to strengthen digital health literacy among young adults. Educational interventions should equip students with the skills necessary to assess online health information critically, identify credible sources, and recognize misinformation. Universities and educational institutions can play an important role by integrating evidence-based reproductive health education into student health programmes and directing students toward reliable medical resources. At the same time, healthcare professionals and public health organizations should expand their digital presence to ensure that accurate, accessible, and scientifically grounded information about PCOD is readily available online.

4.3 Lifestyle Misconceptions and the Risk of Self-Blame

One of the notable findings of the study was the strong agreement among respondents that lifestyle modifications can play an important role in managing PCOD, reflected in the high mean score (M = 4.48). This finding is encouraging, as it demonstrates a general awareness of the benefits of healthy dietary practices, regular physical activity, weight management, and stress reduction in controlling symptoms and improving overall health outcomes. Lifestyle interventions are indeed recognized as an important component of PCOD management and are frequently recommended alongside medical treatment. However, a closer examination of the responses reveals a potentially problematic misconception: approximately 18.8% of participants believed that lifestyle factors are the primary cause of PCOD. Although this represents a minority of respondents, the implications of this belief are significant because it reflects a misunderstanding of the complex and multifactorial nature of the condition.

PCOD is a heterogeneous endocrine disorder influenced by a combination of genetic, hormonal, metabolic, environmental, and lifestyle-related factors. While lifestyle behaviours may influence symptom severity and disease progression, they are not the sole cause of the condition. Simplifying PCOD as merely the result of unhealthy habits risks reducing a complex medical disorder to an issue of personal responsibility. Such oversimplification can shape public perceptions in ways that inadvertently reinforce stigma and misunderstanding. When health conditions are viewed primarily as consequences of individual choices, affected individuals may be judged more harshly than those whose illnesses are perceived as unavoidable or biologically determined. Consequently, women with PCOD may face criticism, blame, or assumptions that their condition is the result of poor self-care rather than a legitimate medical disorder requiring comprehensive management.

The attribution of PCOD primarily to lifestyle factors also creates fertile ground for self-blame and internalized stigma. Individuals who believe their condition has been caused by their own behaviours may experience feelings of guilt, shame, and personal failure. Rather than viewing PCOD as a health condition that requires support and treatment, they may interpret their diagnosis as evidence that they have somehow failed to maintain an acceptable lifestyle. This perception can be particularly damaging because it shifts attention away from the biological realities of the disorder and places disproportionate responsibility on the individual. In doing so, it may undermine psychological wellbeing and negatively affect self-esteem.

The risk of self-blame is especially concerning given that many symptoms of PCOD, such as weight gain, difficulty losing weight, acne, and menstrual irregularities, are highly visible and often subject to social scrutiny. Women experiencing these symptoms may already face external judgement from family members, peers, or society. If they simultaneously internalize the belief that they are personally responsible for their condition, the emotional burden may be substantially intensified. Internalized stigma can lead individuals to adopt negative beliefs about themselves, resulting in persistent feelings of inadequacy, embarrassment, and reduced self-worth. Over time, these psychological consequences may become as challenging to manage as the physical symptoms of the disorder itself.

The broader findings of the study further reinforce these concerns. Respondents demonstrated a moderate level of agreement with the statement that *"women with PCOD are less healthy than others,"* yielding an average score of 3.21 out of 5. Although this score does not indicate overwhelming endorsement of the statement, it nevertheless suggests the presence of negative health-related perceptions associated with PCOD. Such perceptions are important because they reveal how the condition may be socially constructed and understood within the population. Viewing women with PCOD as inherently less healthy can contribute to stereotyping and reinforce the idea that individuals with the condition are somehow deficient, unhealthy, or unable to maintain their wellbeing compared to others.

These health-based comparisons may have profound psychological and behavioural consequences. When women perceive that they are being evaluated negatively because of their diagnosis, they may become increasingly self-conscious about their symptoms and reluctant to disclose their condition. Fear of judgement or negative evaluation can encourage secrecy, social withdrawal, and avoidance of conversations related to reproductive health. In some cases, individuals may attempt to conceal symptoms or avoid seeking professional support altogether in order to escape potential criticism. Ironically, this reluctance to seek help may worsen health outcomes by delaying diagnosis, treatment, and symptom management.

Furthermore, the perception that women with PCOD are "less healthy" can contribute to broader social stigma by reinforcing distinctions between those who are considered healthy and those who are not. Such distinctions may appear subtle, but they can influence attitudes, behaviours, and interpersonal interactions. Individuals who are labelled as unhealthy may experience exclusion, reduced social support, or assumptions regarding their capabilities and future wellbeing. In contexts where reproductive health is closely linked to notions of femininity, attractiveness, and fertility, these perceptions may be particularly damaging. Women with PCOD may feel that they are being judged not only for their health status but also for their ability to meet societal expectations surrounding womanhood and reproductive functioning.

The findings therefore highlight the importance of distinguishing between disease management and disease causation in health education efforts. While it is essential to promote healthy lifestyle practices as part of effective PCOD management, educational messages must avoid implying that lifestyle choices are solely responsible for the development of the condition. Public health campaigns, healthcare providers, and educational institutions should emphasize the multifactorial nature of PCOD, explaining that genetic predisposition, hormonal imbalances, metabolic factors, and environmental influences all contribute to its development. Such an approach can help reduce misconceptions while simultaneously encouraging positive health behaviours.

Addressing lifestyle misconceptions is particularly important because inaccurate causal beliefs can inadvertently perpetuate stigma. When people understand that PCOD is a complex medical condition rather than a consequence of

personal failure, they may be less likely to blame affected individuals and more likely to offer empathy and support. Similarly, women living with PCOD may be less inclined to internalize negative beliefs about themselves and more likely to engage in proactive healthcare-seeking behaviours. Educational interventions should therefore aim not only to increase awareness of symptoms and treatment options but also to challenge narratives that assign moral responsibility for the condition.

Ultimately, the findings suggest that although awareness of lifestyle management strategies is relatively high, misconceptions regarding the causes of PCOD remain present within the study population. These misconceptions have the potential to fuel self-blame, reinforce stereotypes, and contribute to both external and internalized stigma. Addressing these beliefs is essential for creating a more accurate understanding of PCOD and fostering a supportive environment in which affected individuals can seek care without fear of judgement or shame. By shifting the conversation from blame to understanding, health education initiatives can contribute to improved psychological wellbeing, greater treatment engagement, and a reduction in the stigma associated with PCOD.

4.4 Family as the Primary Source of Stigma

One of the most significant findings of the study was that, among respondents who reported experiencing stigma related to PCOD, family members were identified as the most common source. This finding is particularly noteworthy because it challenges the common assumption that stigma primarily originates from external social environments such as peers, educational institutions, workplaces, or the wider community. Instead, the results suggest that stigma often emerges from within the very social unit that is expected to provide emotional security, understanding, and support. In the Indian sociocultural context, where family plays a central role in shaping beliefs, behaviours, and healthcare decisions, this finding carries substantial implications for both reproductive health promotion and stigma reduction efforts.

For many young women, family represents the first and most influential source of guidance regarding health, relationships, and personal development. Families often serve as gatekeepers to healthcare access, providers of emotional support, and primary decision-makers in matters concerning treatment and wellbeing. Consequently, when family members become sources of judgement, criticism, or misunderstanding, the effects may be considerably more damaging than stigma encountered in other social settings. Unlike interactions with peers or strangers, family relationships are continuous, emotionally significant, and deeply embedded in daily life. As a result, negative attitudes expressed within the family environment may be internalized over time, influencing self-perception, confidence, and health-related behaviours.

The nature of family-based stigma can be subtle yet deeply impactful. It may not always take the form of overt discrimination or direct criticism. Instead, it often manifests through repeated comments, unrealistic expectations, or dismissive attitudes that gradually shape how women perceive themselves and their condition. Respondents' experiences suggest that stigma may emerge through unsolicited remarks about body weight, appearance, dietary habits, or lifestyle choices—factors frequently associated with PCOD symptoms. Women affected by PCOD often experience weight fluctuations, acne, excessive hair growth, or other visible symptoms that may attract unwanted attention within the household. Family members, despite potentially having good intentions, may attribute these symptoms solely to personal habits or lack of self-discipline, thereby reinforcing feelings of guilt and self-blame.

In addition to concerns about physical appearance, societal expectations surrounding marriage and fertility may further intensify family-related stigma. In many Indian communities, reproductive health is closely linked to perceptions of femininity, womanhood, and marital suitability. Because PCOD is commonly associated with fertility concerns, young women may face explicit or implicit pressure regarding their future ability to conceive and fulfil traditional family roles. Questions about marriage prospects, childbearing potential, or reproductive capability can create significant emotional distress, particularly when raised repeatedly or without adequate understanding of the condition. Such interactions may lead women to perceive their diagnosis not merely as a medical issue but as a threat to their social identity and future aspirations.

Another important aspect of family-based stigma is the tendency to normalize or dismiss menstrual symptoms. Irregular periods, excessive menstrual pain, or hormonal disturbances may be viewed as ordinary experiences that women are expected to tolerate silently. This normalization can discourage young women from discussing symptoms openly or seeking medical attention. When symptoms are minimized or dismissed by family members, affected individuals may begin to question the legitimacy of their own concerns, leading to delays in diagnosis and treatment. Over time, this can contribute to the progression of symptoms and increase the risk of long-term complications associated with PCOD.

The psychological consequences of such experiences are evident in the study findings. More than half of the respondents who reported experiencing stigma indicated that it had negatively affected their mental health. This observation is consistent with a growing body of literature demonstrating strong associations between reproductive health stigma and adverse psychological outcomes. The emotional burden of living with PCOD is often compounded by social judgement, misunderstanding, and lack of support. Women who experience stigma may develop feelings of shame, embarrassment, isolation, frustration, or inadequacy. These emotional responses can contribute to heightened levels of stress, anxiety, depressive symptoms, reduced self-esteem, and diminished overall quality of life.

Importantly, the relationship between stigma and mental health is often cyclical. Experiences of stigma may lead to emotional distress, while psychological difficulties may further discourage individuals from seeking support or discussing their condition openly. As a result, women may become trapped in a cycle of silence and isolation in which both physical and mental health needs remain unmet. This cycle can be particularly harmful during adolescence and young adulthood, a period characterized by identity formation, academic pressures, social transitions, and increasing concerns about future relationships and career aspirations.

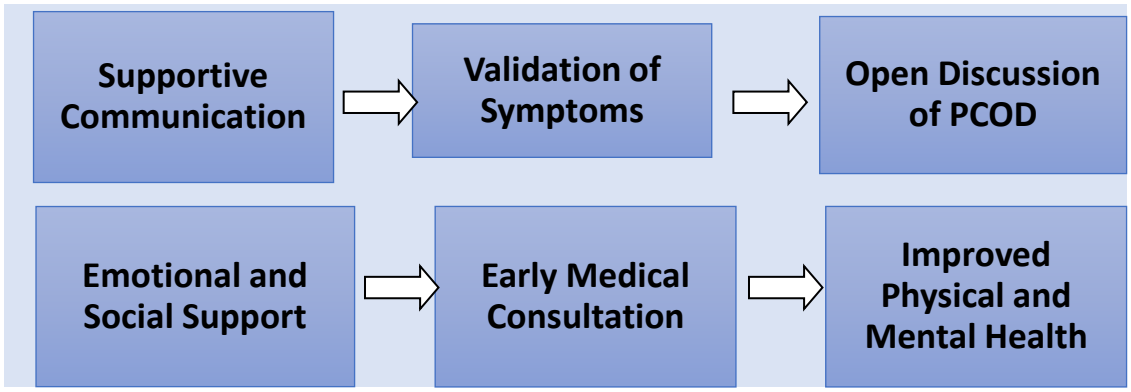
The findings also highlight the limitations of awareness initiatives that focus exclusively on students or affected individuals. While improving individual knowledge about PCOD is essential, awareness alone may not be sufficient to overcome the barriers created by family-based stigma. A young woman may possess accurate information about her condition and understand the importance of seeking medical care, yet still face resistance, misunderstanding, or judgement within her home environment. Therefore, interventions that target only the individual risk overlooking one of the most influential determinants of health behaviour—the family system itself.

Addressing family-related stigma requires culturally sensitive, multi-level interventions that acknowledge the central role of family in health decision-making. Educational programmes should extend beyond schools and colleges to actively engage parents, guardians, and other family members. Community awareness campaigns can help dispel myths regarding menstruation, hormonal disorders, and fertility while promoting supportive attitudes toward individuals living with PCOD. Healthcare professionals should also consider involving families in counselling and educational sessions where appropriate, enabling them to better understand the condition and provide informed support.

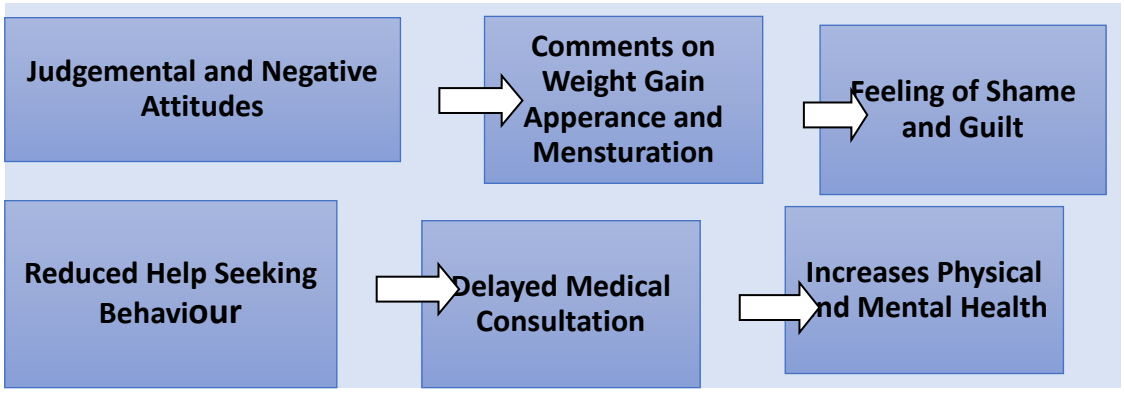
Furthermore, public health strategies should focus on reframing PCOD as a legitimate medical condition rather than a personal failing or social liability. Encouraging open family discussions about reproductive health, challenging harmful stereotypes, and normalizing conversations about menstrual disorders can contribute to creating more supportive home environments. Such efforts are particularly important in societies where family approval and involvement strongly influence healthcare-seeking behaviour.

Ultimately, the identification of family as the primary source of stigma reveals that the challenge of addressing PCOD extends far beyond the clinical setting. The findings demonstrate that stigma is not merely an individual experience but a social phenomenon embedded within interpersonal relationships and cultural expectations. If families remain uninformed or continue to perpetuate judgement and misconceptions, efforts to improve awareness and treatment uptake may achieve only limited success. Therefore, reducing the burden of PCOD requires not only empowering affected women with knowledge but also transforming the familial and social environments that shape their experiences. Creating supportive, understanding, and stigma-free family systems has the potential to improve both physical and psychological wellbeing, encourage earlier healthcare-seeking behaviour, and ultimately enhance the overall quality of life of women living with PCOD.

FAMILY AWARENESS AND UNDERSTANDING:



FAMILY MISCONCEPTIONS ABOUT PCOD:



This version is written at a stronger dissertation discussion level, linking findings to Indian family structures, stigma theory, mental health consequences, and public health implications.

4.5 Male Respondents and the Inclusion Gap

One of the most thought-provoking findings of the study emerged from the responses of the small number of male participants. Although limited in number, their reflections offered valuable insight into an often-overlooked dimension of PCOD awareness. Two male respondents explicitly acknowledged that they had little or no prior knowledge of PCOD before participating in the survey. One respondent remarked, *"As a boy, I was not aware of PCOD because of this I got some information."* While seemingly simple, this statement highlights a deeper structural issue within reproductive health education: the persistent exclusion of males from conversations surrounding menstrual, hormonal, and reproductive health conditions.

Historically, health education initiatives related to menstruation and reproductive disorders have been designed primarily for female audiences. While this approach is understandable given that women are directly affected by conditions such as PCOD, it has unintentionally reinforced the notion that reproductive health is solely a "women's issue." As a result, many boys and men progress through adolescence and adulthood with little understanding of common reproductive

health conditions, their symptoms, or their impact on the lives of women around them. This educational gap contributes to a cycle of misunderstanding, misinformation, and silence that can indirectly perpetuate stigma.

The findings suggest that lack of male awareness is not necessarily the result of disinterest but rather the consequence of limited exposure to relevant information. The willingness of male respondents to acknowledge their lack of knowledge and recognize the educational value of the survey indicates that awareness can be improved when opportunities for learning are provided. This is a significant observation because it challenges the assumption that reproductive health education should remain gender-segregated. Instead, it highlights the potential benefits of adopting a more inclusive educational framework that recognizes reproductive health as a shared social concern rather than an issue confined to one gender.

The exclusion of men from reproductive health discourse has implications that extend far beyond individual knowledge deficits. Male family members, friends, classmates, partners, and future spouses often play important roles in shaping attitudes toward health, influencing healthcare-seeking behaviour, and providing emotional support. When these individuals lack awareness of conditions such as PCOD, they may unintentionally dismiss symptoms, reinforce misconceptions, or contribute to feelings of shame and isolation experienced by affected women. Conversely, informed and supportive men can serve as important allies in reducing stigma, encouraging timely medical consultation, and fostering open conversations about reproductive health.

This finding is particularly relevant in cultural contexts where family structures and social relationships significantly influence health-related decision-making. Young women who experience symptoms of PCOD may rely on parents, siblings, or partners for emotional encouragement, healthcare access, and financial support. If these support networks lack understanding of the condition, women may encounter barriers to diagnosis and treatment. Therefore, improving male awareness is not merely an educational objective; it is a strategy for strengthening the broader social support systems that influence women's health outcomes.

Furthermore, the exclusion of men from discussions surrounding menstruation and reproductive disorders inadvertently reinforces gender stereotypes. It perpetuates the belief that reproductive health is a private female concern rather than a legitimate public health issue deserving of collective understanding and engagement. Such perceptions contribute to the continued stigmatization of menstrual and hormonal disorders, making it more difficult for women to discuss symptoms openly or seek help without fear of judgement. Inclusive education has the potential to challenge these stereotypes by normalizing conversations about reproductive health among all genders and fostering greater empathy and understanding.

From a public health perspective, the findings suggest that awareness campaigns aimed solely at women may be insufficient to address the social dimensions of PCOD-related stigma. Effective stigma reduction requires interventions that engage entire communities, including men and boys, in conversations about reproductive health. Educational programmes in schools, colleges, and universities should therefore incorporate comprehensive reproductive health content that is accessible to all students regardless of gender. Such initiatives can help create informed communities where reproductive health concerns are understood, respected, and supported rather than misunderstood or marginalized.

Ultimately, the responses of the male participants reveal an important inclusion gap that is frequently overlooked in reproductive health initiatives. Although women bear the direct burden of PCOD, the social environment in which they live is shaped by individuals of all genders. Addressing stigma, promoting early diagnosis, and improving health outcomes therefore require a shift from women-centred awareness alone to community-wide understanding. By involving men as informed participants and allies in reproductive health education, it may be possible to create a more supportive, empathetic, and health-literate society capable of addressing PCOD not only as a medical condition but also as a broader social and public health concern.

LIMITED MALE INVOLVEMENT IN REPRODUCTIVE HEALTH EDUCATION:

Low Awareness of PCOD

↓

Misconceptions and Knowledge Gaps

↓

Reduced Understanding of Women's Health

↓

Lack of Emotional and Social Support

↓

Persistence of Stigma and Silence

↓

Delayed Help-Seeking and Reduced Disclosure

↓

Negative Health and Psychological Outcomes

INCLUSIVE REPRODUCTIVE HEALTH EDUCATION:

Increased Male Awareness

↓

Better Understanding of PCOD

↓

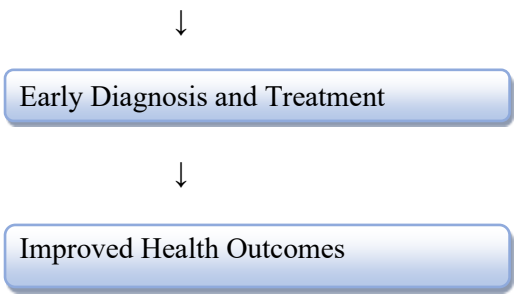
Greater Empathy and Support

↓

Reduction in Stigma and Taboos

↓

Open Communication and Disclosure



4.6 Stigma as a Barrier to Healthcare Consultation

Although a majority of respondents (75%) reported that they would seek medical attention if they suspected they had Polycystic Ovarian Disease (PCOD), the remaining 25% either expressed hesitation or uncertainty regarding consultation with a healthcare professional. While this proportion may not initially appear substantial, its implications become more significant when considered in the context of a condition that relies heavily on early detection and timely intervention. PCOD is not merely a reproductive disorder confined to menstrual irregularities; rather, it is a complex endocrine condition with far-reaching consequences for physical, metabolic, reproductive, and psychological health. Delays in seeking medical advice can lead to prolonged symptom burden and increase the risk of complications such as infertility, insulin resistance, type 2 diabetes mellitus, obesity, metabolic syndrome, cardiovascular disease, endometrial abnormalities, and mental health disorders including anxiety, depression, body image dissatisfaction, and diminished quality of life. Therefore, the finding that one in every four respondents may not promptly seek medical help represents a potentially vulnerable subgroup that could remain undiagnosed and untreated during a critical period of disease progression.

The data further reveal concerning patterns of silence and concealment surrounding menstrual and reproductive health issues. Nearly half of the respondents (41.7%) reported hiding their irregular menstrual cycles from family members. Menstrual irregularity is often one of the earliest and most recognizable symptoms of PCOD, and concealing such symptoms may contribute to delays in diagnosis, treatment, and access to support systems. This behaviour suggests that menstrual health continues to be viewed as a private or sensitive issue rather than a legitimate health concern requiring attention and discussion. In many cultural contexts, menstruation remains surrounded by taboos, misconceptions, and social discomfort, creating an environment in which young women may feel reluctant to disclose symptoms even to those closest to them. Such silence can have serious consequences, as family members often play an important role in recognizing health concerns, facilitating access to healthcare services, and providing emotional and financial support during treatment.

Equally noteworthy is the finding that 16.7% of respondents explicitly stated that stigma would prevent them from consulting a doctor. Although this represents a minority of the study population, it highlights the persistent influence of social perceptions and cultural attitudes on healthcare-seeking behaviour. Stigma surrounding reproductive disorders can manifest in various forms, including fear of being judged, concerns about being perceived as unhealthy or infertile, anxiety regarding future marriage prospects, or apprehension about discussing intimate health concerns with healthcare providers. Such fears can discourage individuals from seeking medical advice even when they recognize that something may be wrong. Importantly, stigma does not need to affect the majority of a population to be considered a public health concern. Even when experienced by a relatively small proportion of individuals, its impact can be profound, contributing to delayed diagnoses, poorer health outcomes, and avoidable emotional distress. The presence of stigma within a university student population—often considered more educated, informed, and exposed to health information than the general population—suggests that deeply rooted social attitudes continue to exert considerable influence despite advances in awareness and education.

A particularly revealing aspect of the findings is the apparent contrast between respondents' reported openness toward discussing reproductive health and their tendency to conceal symptoms within family settings. While 58.3% of participants indicated that they felt comfortable discussing reproductive health openly, a substantial proportion

simultaneously reported withholding information about menstrual irregularities from family members. This apparent contradiction underscores the complexity of health communication and suggests that comfort is highly dependent on social context. Students may feel comfortable discussing PCOD and related reproductive health topics in academic environments, among peers, or through social media platforms where health information is increasingly accessible and normalized. Educational institutions and online communities often provide relatively non-judgmental spaces in which reproductive health can be discussed openly. However, these same individuals may encounter very different expectations within their households, where cultural norms, traditional beliefs, generational differences, and concerns regarding social reputation may discourage open communication.

This discrepancy highlights an important distinction between awareness and disclosure. Possessing knowledge about a condition does not necessarily translate into the ability or willingness to discuss personal symptoms. A student may understand the causes, symptoms, and complications of PCOD and may even advocate for awareness among peers, yet still feel uncomfortable revealing her own experiences to family members. This gap between knowledge and action illustrates that educational interventions alone may not be sufficient to promote positive health behaviours. Emotional, cultural, and social factors often influence decision-making as strongly as factual knowledge. Consequently, strategies aimed solely at increasing awareness may fail to address the deeper barriers that prevent young women from seeking support and treatment.

The findings also point toward the continuing influence of societal expectations regarding femininity, fertility, and reproductive health. In many communities, menstrual regularity and reproductive capability are closely linked to perceptions of womanhood and future marital prospects. Conditions such as PCOD may therefore be viewed not only as medical issues but also as threats to social identity and future aspirations. Young women may fear that disclosing symptoms could lead to unwanted scrutiny, negative assumptions about their health, or concerns about their ability to conceive in the future. Such fears can foster secrecy, self-stigma, and avoidance behaviours that ultimately delay diagnosis and treatment. The burden of these concerns is often compounded during adolescence and young adulthood, a developmental stage in which individuals are particularly sensitive to social acceptance and peer perceptions.

From a public health perspective, these findings emphasize that the challenge of PCOD management extends beyond clinical diagnosis and treatment. Effective prevention and management require addressing the social environment in which health behaviours occur. Educational initiatives should therefore move beyond merely providing information about symptoms and complications. Programmes must actively challenge myths, misconceptions, and stigmatizing attitudes surrounding menstruation and reproductive disorders. Universities, healthcare institutions, and community organizations have an important role to play in fostering supportive environments where reproductive health discussions are normalized and encouraged.

Furthermore, interventions should not focus exclusively on students themselves but should also engage families and communities. Family-centred awareness programmes can help improve understanding of PCOD, encourage supportive communication, and reduce the shame or embarrassment that may be associated with menstrual irregularities. Parents and guardians who are equipped with accurate information are more likely to recognize symptoms, provide emotional support, and facilitate timely medical consultation. Community-based campaigns that openly address menstrual and reproductive health issues can also contribute to dismantling long-standing taboos and creating a culture in which seeking help is viewed as a responsible and empowered health behaviour rather than a source of stigma.

Ultimately, these findings reveal that while awareness and willingness to seek care are relatively high among the study population, significant barriers remain. The persistence of symptom concealment, hesitation to seek medical advice, and stigma-related concerns demonstrates that knowledge alone is insufficient to ensure positive health outcomes. The challenge lies not only in educating young women about PCOD but also in transforming the social and cultural environments that shape their attitudes and behaviours. Addressing these barriers is essential for promoting early diagnosis, improving treatment adherence, reducing long-term complications, and enhancing overall quality of life. In this regard, the findings serve as a reminder that reproductive health is not solely a medical issue but also a social and

cultural one, requiring comprehensive interventions that empower individuals while simultaneously addressing the broader structures that influence health-related decision-making.

CONCLUSION:

This study set out to examine the awareness of PCOD, the nature and sources of associated stigma, and the consequent effects on health-seeking behaviour among college students in India. What has emerged from the data is a picture that is, in equal measure, encouraging and sobering. On the one hand, the universal awareness of PCOD among respondents — all 48 of whom confirmed familiarity with the condition — attests to the progress made by digital health communication and informal peer education in disseminating basic reproductive health knowledge. On the other hand, the coexistence of this awareness with active concealment behaviours, experienced stigma, and hesitancy around medical consultation reveals that awareness, without attitudinal change and structural support, remains an incomplete intervention.

The core paradox documented in this study — that students know about PCOD and yet hide, avoid, and are judged for it — is not incidental. It reflects a broader cultural architecture in which menstrual and hormonal health continues to be treated as a private matter, a source of shame, and a marker of moral or physical deficiency. The high proportion of respondents (79.2%) who frequently consume junk food, combined with the attribution of PCOD to lifestyle factors by 18.8% of participants, points to a risk of self-blame narratives taking hold. When society frames a complex, multifactorial hormonal disorder as primarily the result of poor personal choices, it assigns culpability rather than compassion, deepening the very stigma it claims to address through wellness messaging. This study, through its Likert-scale analysis, found that respondents moderately agreed that women with PCOD are "less healthy than others" (M=3.21), a troubling finding that suggests stigma is not merely externally imposed but may be internalised by affected individuals themselves.

Family emerged as the most frequently cited source of stigma among respondents who had experienced judgment — a finding that carries particular weight in the Indian socio-cultural context. For young women in college, the family home is not only a physical space but the primary arena for identity formation, emotional security, and social belonging. When that same space becomes a site of judgment — whether through comments about body weight, references to fertility and marriage prospects, or the pressure to remain silent about menstrual irregularities — the consequences for mental health are significant. Over half of those who experienced stigma in this sample reported that it negatively affected their mental health. This is not a marginal or anecdotal concern; it is a public health finding that demands urgent attention. Reproductive health stigma has documented associations with anxiety, depression, delayed help-seeking, and reduced quality of life. The pathway from stigma to mental health deterioration is not speculative — it is demonstrated, and this study provides further empirical grounding for it within the Indian college student population.

Equally important is what this study reveals about the gendered nature of PCOD education. The candid self-disclosures from male respondents — two of whom explicitly noted that they had been unaware of PCOD before completing this survey — reveal the extent to which reproductive health education is siloed. By directing all menstrual and hormonal health communication exclusively at female audiences, educational and healthcare systems inadvertently reinforce the notion that these are "women's problems" that need not concern, or be understood by, the broader community. Yet it is precisely within mixed social environments — families, colleges, workplaces, and relationships — that stigma is most actively reproduced or resisted. Inclusive education that reaches male students, families, and community members is therefore not supplementary to stigma reduction; it is central to it.

The thematic analysis of open-ended responses offers a clear and consistent message from students themselves: what is needed is not merely more information, but a fundamental shift in how reproductive health is talked about, taught, and socially sanctioned. Across all year groups and age cohorts, respondents called for normalised open conversation, cessation of body-shaming, mental health support, and education that reaches families as well as individuals. These are not passive recommendations — they represent a collective articulation of what a stigma-free environment for PCOD management might look like. Policymakers, educators, healthcare providers, and media practitioners alike would do well to heed this student-generated evidence.

The internet, as the dominant information source for 62.5% of respondents, presents both an opportunity and a challenge. It has clearly succeeded in reaching young people with PCOD-related content. However, the quality and accuracy of

digital health information are highly variable, particularly on social media platforms where anecdotal narratives, diet culture, and body-image discourse intersect with hormonal health content. There is an urgent need for institutional investment in verified, accessible, and destigmatising digital health resources tailored for young adults in India. This includes platforms that address not only clinical aspects of PCOD management but also the social and psychological dimensions of living with the condition in a stigmatising environment.

In conclusion, this study demonstrates that the burden of PCOD stigma among Indian college students is not merely a matter of insufficient information. It is a multidimensional problem embedded in cultural norms, familial dynamics, gendered educational frameworks, and the psychological architectures of shame and self-blame. Addressing it will require coordinated, culturally sensitive, and structurally grounded interventions — from formal curriculum reform and family-level sensitisation programmes to inclusive public health campaigns and strengthened reproductive health services within institutional settings. The students who participated in this study have made their needs clear: they want to be believed, supported, and free from judgment. Delivering on that aspiration is both a moral obligation and a public health imperative. Early, stigma-free diagnosis and management of PCOD is not merely beneficial — for many young women, it is the difference between a condition managed and a life constrained.

5.1 Limitations

- The sample size of 48 respondents is relatively small, limiting the generalisability of findings to broader populations.
- Convenience sampling introduces selection bias; respondents who self-select into a survey about PCOD may already have higher awareness or personal investment in the topic.
- The study was conducted at a single institution, restricting cross-institutional comparison.
- All data are self-reported, which introduces the possibility of social desirability bias — particularly in responses relating to stigma and disclosure.
- As a cross-sectional study, no causal relationships can be established between variables.