IMPACT OF GENDER-BASED VIOLENCE ON WOMEN'S RIGHT TO HEALTH: LEGAL AND HUMAN RIGHTS PERSPECTIVES

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ABSTRACT

Gender Based Violence (GBV) is one of the most prevalent forms of human rights violations against women, yet its severe consequence on women's health is under-recognized in legal and public health systems. This paper places GBV within the framing of human rights and the right to health by indicating that each form of physical, sexual, emotional, and economic violence against women violates their basic rights to dignity and equality before the law and bodily integrity.

The study investigates how GBV has grave physical, reproductive, and psychological consequences. Women who experienced domestic violence or sexual assault are more likely to present injuries, chronic pain, reproductive tract infections, unintended pregnancies, and long-term gynaecological problems. Apart from the physical trauma, GBV contributes to psychological conditions like sadness, anxiety, trauma, and post-traumatic stress disorder. Most survivors face further adversities like social stigma, threats of vengeance, dependence for finances, and limited access to medical and legal facilities. These barriers hinder or limit the ability to access health services, thereby breaching the basic guarantee of the right to health under Article 21.

The study primarily evaluates the efficacy of some major Indian legislative frameworks, including the Protection of Women from Domestic Violence Act, the Indian Penal Code, and the Sexual Harassment of Women at Workplace Act, in securing the right of women to a life without violence. Judicial interpretations that expand the scope of Article 21 to include health, dignity, and mental well-being are also discussed. The report also draws on international human rights standards like CEDAW and the Universal Declaration of Human Rights, which cast specific duties upon states for non-violence, protection of survivors, and accessible treatment. Loopholes in implementation persist despite legislative safeguards. Many survivors experience insensitive medical treatments, discrepancies in medico-legal paperwork, inadequate mental health support, and a lack of coordination between health professionals and law enforcement. These systemic flaws

mirror broader structural bias and amount to a violation of the positive obligations of the State under both domestic and international law.

This study advocates for a holistic, survivor-centered, and gender-sensitive healthcare approach. Medico-legal strengthening, enhancement of hospital responses, trauma-informed therapy, and strengthening of collaboration among police, legal authorities, and health facilities are essential. Recognition of gender-based violence as a public health and human rights issue is fundamental for women to fully claim their rights to health and to live with dignity and equality.

Keywords: Gender-Based Violence, Women's Right to Health, Human Rights, Domestic Violence, Reproductive Health, Article 21, Mental Health, CEDAW, State Responsibility, Gender Equality.

INTRODUCTION

Gender-based violence is still one of the most common human rights abuses against women worldwide[1], cutting across class, caste, religion, and geography. In India, the manifestation of GBV takes many forms: domestic violence, marital rape, sexual assault, trafficking, cyber-abuse, dowry harassment[2], honor-based crimes, and psychological or economic pressure. These are not isolated incidents of violence but are instead deeply embedded in structures of patriarchal power that normalize women's subordination[3]. While GBV is typically analyzed in terms of criminality and social pathology, its far-reaching consequences for women's health-specifically, the right to physical, mental, and reproductive well-being-have received insufficient attention[4]. The right to health, as protected by international human rights law and interpreted broadly under Article 21 of the Indian Constitution, extends far beyond the absence of disease[5]; it includes the right to live with dignity, autonomy, and freedom from fear. GBV directly undermines all of these elements.

The health consequences of GBV are many and varied. Physical violence results in injury, disability, chronic suffering, and-even in extreme cases-death[6]. Sexual violence puts women at

[1] United Nations Office of the High Commissioner for Human Rights, *Gender-Based Violence Against Women*, OHCHR Fact Sheet (2022).
[2] National Crime Records Bureau, *Crime in India 2022: Crimes Against Women*, Ministry of Home Affairs, Government of India.
[3] Sylvia Walby, *Theorizing Patriarchy*, 23 Sociology 213 (1989).
[4] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000).
[5] Consumer Education and Research Centre v. Union of India, (1995) 3 SCC 42.
[6] World Health Organization, *Violence Against Women: Health Consequences* (2013).

risk of unwanted pregnancies, unsafe abortions, sexually transmitted diseases, and severe reproductive health problems. Of equal importance is the psychological toll-depression, anxiety, trauma, suicidal ideation, and post-traumatic stress-which often goes unnoticed due to either stigma or lack of accessible mental-health services[7]. These harms create a vicious cycle in which violence not only harms health but also inhibits seeking care out of fear of reprisal, judgment, or social ostracism. The cumulative impact is a systematic denial of their right to the highest attainable physical and mental health.

The Convention on CEDAW, the Declaration on the Elimination of Violence Against Women, and General Comment No. 14 of the Committee on Economic, Social, and Cultural Rights all recognize gender-based violence as a barrier to women's health rights[8]. Indian law has also evolved considerably, as various types of violence and their respective harms have been addressed within statutes like the Protection of Women from Domestic Violence Act[9]; the Criminal Law (Amendment) Act; the Medical Termination of Pregnancy Act; and the Sexual Harassment of Women in the Workplace Act. Judicial pronouncements have established that violence against women violates their fundamental rights to equality, privacy, and bodily integrity. This is despite the fact that such normative gain in implementation is fragmented with enforcement gaps, inadequate health care responses, and socio-cultural prejudices continuing to constrain the effectiveness of legal protections.

Crucially, the intersectional character of GBV exacerbates disparities[10]. Women from marginalized castes, tribal communities, rural areas, economically challenged households, and with impairments face greater vulnerability and reduced access to legal and healthcare services. In many instances, it is institutional responses—police, courts, and hospitals—that replicate the gendered hierarchies that women hope to escape and create a climate in which reporting abuse or seeking medical care becomes an added source of stress.

This article examines how gender-based violence impedes women's access to health and considers the efficiency of existing legal and human-rights frameworks in addressing such damages. Situating GBV within a rights-based analytical framework, the study argues that violence constitutes a systemic barrier to achieving gender equality and health justice, rather

[7] Judith Herman, *Trauma and Recovery* (Basic Books, 1997).
[8] Convention on the Elimination of All Forms of Discrimination Against Women, 1979.
[9] Protection of Women from Domestic Violence Act, 2005.
[10] Kimberlé Crenshaw, *Mapping the Margins: Intersectionality*, 43 Stanford Law Review 1241 (1991).

than a consequence of individual misdeed. The aim is to underline the imperative need for comprehensive legal, healthcare, and policy solutions that put women's dignity, self-determination, and freedom from abuse as priorities.

Objectives

- Assessing the impact of gender-based violence on women's physical, psychological, and reproductive health and violations of their right to health.
- To analyze the effectiveness of Indian legal and policy frameworks and international human rights norms in protecting women's right to health in cases involving gender-based violence.
- Identify gaps and barriers that exist in accessing healthcare and justice by survivors of gender-based violence and propose strategies for creating rights-based, survivor-centered responses.

Hypothesis

Despite India having powerful legal and legislative frameworks, it faces implementation gaps and structural barriers that hinder women from receiving good treatment after facing gender-based violence.

Research Problem

Despite the fact that the relevant legal frameworks and international norms on human rights are in place, women in India continue to face serious barriers in accessing their right to health in the aftermath of gender-based violence. While the health consequences of GBV are serious and multi-dimensional, survivors commonly experience stigma, a lack of proper medical care, a lack of understanding, insensitive institutions, and inter-institutional coordination between health and legal agencies. Therefore, the aim of this research is to look into why women's health rights are not fully protected in practice, as well as to outline the gaps at the levels of law, policy, and implementation in terms of ensuring the health needs of survivors of gender-based violence are responded to.

Review of Literature:

1. Heise, L. (1998) – Violence Against Women: An Integrated, Ecological Framework

The influential book by Heise views gender-based violence as being an outcome of individual, relationship, communal, and social issues. The ecological model developed by her shows how the structural disparities in the norms of culture have an impact on the health outcomes of GBV. This concept is often utilized to explore how patriarchal institutions undermine women's right to health through normalizing violence and hindering access to care.

2. World Health Organization (2013) – Global and Regional Estimates of Violence Against Women

The WHO study provides detailed information on physical, sexual, and intimate partner violence, plus the health consequences immediately and long after it occurs. It proves that gender-based violence is responsible for chronic pain, incapacity, despair, sexually transmitted diseases, and maternal health problems. The findings show how GBV directly violates the rights to health of women, thus requiring state-led public health responses.

3. CEDAW Committee General Recommendation No. 19 & 35

These United Nations human rights agreements recognize gender-based violence as a form of discrimination that violates women's human rights, particularly the right to health. They call for states to prevent, investigate, punish, and provide compensation for gender-based violence. They are also applied regularly to highlight shortcomings in India's fulfillment of international health-related commitments to women.

4. National Family Health Survey Reports (NFHS-5) (2019–21)

NFHS data shows that Indian women are more prone to domestic violence, report cases less, and seek treatment less frequently. It covers health risks associated with GBV, like anaemia, reproductive problems, and mental health issues. These data show how socio-cultural obstacles limit women's access to healthcare, even when violence takes place right in the home.

5. Jeyaseelan et al. (2007) - Intimate Partner Violence and Women’s Health in India

This large-scale Indian study explores the link between intimate relationship violence and poor

health outcomes. It details substantial associations between domestic violence, reproductive health issues, depression, and low nutritional status. The report emphasizes that health-care systems need to incorporate screening for GBV and survivor-friendly treatments.

6. Government of India, Ministry of Health & Family Welfare – Guidelines for Medico Legal Care for Survivors of Sexual Violence (2014)

These guidelines stress access to healthcare that is sensitive to gender and informed by trauma. Nevertheless, studies show that the implementation varies from one hospital to another, the shortage of qualified personnel, and poor collaboration with law enforcement agencies. Literature that has analysed these principles identifies critical systemic shortfalls that are detrimental to women's right to health after abuse.

Research Methodology

This study adopts a doctrinal and qualitative research method, primarily relying on the analysis of legislation, norms, policy documents, international human rights agreements, and relevant case law. A rights-based analytical approach is employed to evaluate how legal norms respond to the health needs of survivors of gender-based violence. Secondary data is presented by analyzing academic writings, reports of UN agencies, statistics given by the NCRB, official circulars and orders, and opinions, which help in understanding the ground realities, health impacts, and implementation concerns. The methodology adopted is analytical, descriptive, and interpretive, purporting to point out lacunae in the existing legal framework and recommending measures toward a more efficient survivor-centric approach.

Gender-Based Violence as a Human Rights Violation

GBV, increasingly, is recognized not only as a social or criminal justice issue but also as a grave violation of human rights. Violence against women, according to the international norms on human rights, is discriminatory in nature[11] because it emanates from the historically unequal power relations between men and women. In General Recommendations Nos. 19 and 35, CEDAW defines GBV as one form of gender-based discrimination that prevents or nullifies the ability of women to enjoy rights and freedoms equally as well as men do. The UN Declaration on the Elimination of Violence Against Women (1993) insists that states shall not

[11] Rebecca Cook, *State Accountability for Violence Against Women*, 7 Human Rights Quarterly 1 (1994).

only be prohibited from committing violence but also exercise due diligence to prevent, investigate, punish, and provide remedies for acts of violence committed by private individuals. From this perspective, GBV has not been confined to the private sphere of family life but, when the state fails to act through laws, institutions, or cultural norms that allow such acts of violence to continue unabated, it becomes a matter of governmental culpability.

In the Indian constitutional setting, the GBV strikes at the very heart of the rights protected by Articles 14, 15, and 21: equality, non discrimination, dignity, personal liberty, and bodily autonomy[12]. The judiciary's growth in interpretation demonstrates that violence against women runs counter to constitutional morality and the vision of a just social order in judgments such as Laxmi v. Union of India on acid attack regulation and Vishaka v. State of Rajasthan on workplace sexual harassment. The Protection of Women from Domestic Violence Act, 2005, represents a conceptual shift in the understanding of the range of violence-physical, emotional, sexual, and economic-that women may be subjected to within their families. Yet, the persistence of patriarchal norms, the normalisation of marital abuse, and the marginalization of women's voices display the fact that the legal system often fails to translate human rights principles into actual protection.

Looking at GBV through the prism of human rights violation allows for a deeper inquiry that goes beyond identifying individual perpetrators. It points out structural factors-cultural preconceptions, economic reliance, societal silence, and institutional apathy-that enable violence to happen and go unchecked. It also points out the importance of governmental accountability in safeguarding women's rights to life, liberty, dignity, health, and security. In the face of failure of the state to provide accessible judicial processes or gender-sensitive police and comprehensive support programs, such a situation contributes to perpetuating violence, as women feel uneasy approaching services for support. The human rights framework then calls for an integrated approach toward GBV; it is at once a consequence and cause of gender inequality. The framework perceives violence as a systemic issue in need of legal, social, and governmental remedies hinged on substantive equality and self-determination of women.

Health Consequences of Gender-Based Violence

The impact of gender-based violence on women's health is extensive and can be disastrous.

[12] UN General Assembly, *Declaration on the Elimination of Violence Against Women*, A/RES/48/104 (1993).

Physical, reproductive, and psychological health can be affected by violence, and the health consequences may persist well after the initial physical injury. Physical forms of maltreatment, including intimate relationship violence, assault, or injury related to dowry, could result in injuries ranging from minor bruises to fractures, burns, disfigurement, or long-term disability. GBV could result in lethal consequences like homicide and suicide and is, therefore, considered a major public health concern[13]. In accordance with the surveillance statistics, women who are subjected to intimate partner abuse are much more likely to acquire chronic pain, gastrointestinal ailments, hypertension, and other conditions related to stress. However, most injuries never get documented because so many women do not seek medical services for fear of stigma, repercussions, or institutional insensitivity.

GBV has serious consequences for reproductive and sexual health. Sexual assault exposes women to unwanted pregnancies, unsafe abortions, sexually transmitted diseases, pelvic inflammatory disease, and infertility[14]. Marital rape, still not criminalised in India, creates an environment in which women are deprived of agency over sexual and reproductive choices, increasing their vulnerability to reproductive trauma. Violence during pregnancy increases the risk of miscarriage, premature labor, and low-weight babies[15]. Some studies have documented that women who have faced long-term domestic violence are less likely to receive maternity care, contraception, or emergency medical services because of restricted mobility or coercive control by an intimate partner. This creates a vicious cycle wherein not only does the violence affect reproductive health, but it also limits the availability of healthcare services to address the same.

Another significant but often less discussed feature of GBV pertains to its effects on mental health. Survivors universally suffer sadness, anxiety, PTSD, sleep disturbances, suicidal feelings, and long-term psychological distress. So-called 'emotional or psychological' abuse (including humiliation, isolation, threats, and controlling behavior) can be as damaging in undermining self-respect and self-autonomy as physical assault[16]. Reporting abuse exacerbates emotional trauma because survivors may face denial, victim blaming, or ostracism. This comes at the high price of mental and emotional costs severely circumscribing women's abilities to

[13] World Health Organization, *Global Health Estimates on Violence* (2014).
[14] World Health Organization, *Global and Regional Estimates of Violence Against Women* (2013).
[15] Independent Thought v. Union of India, (2017) 10 SCC 800.
[16] National Institute of Mental Health and Neurosciences (NIMHANS), *Mental Health Issues of Women in India* (2016).

participate fully in social, economic, and family life, thus perpetuating cycles of dependence and disempowerment.

Importantly, health consequences of gender-based violence are mediated by intersecting inequities. Women from marginalised communities - Dalit, Adivasi, migratory, rural, economically impoverished, or disabled-access healthcare and justice with greater difficulty. Their injuries are more likely to be ignored, their mental health problems overlooked, and their needs concerning reproductive health undermined. Healthcare systems are often incapable of responding with empathy and lack trained professionals, privacy, counseling services, and guidelines for medico-legal documentation. Because of this, GBV is not only a cause of health violation but also a factor that accentuates imbalances in the health system, denying women's right to optimum health.

Barriers in Accessing Healthcare After Violence

Many women in India still experience significant barriers to healthcare access in the aftermath of gender-based violence. The challenges survivors confront are not merely logistic; rather, they reflect a broader sociocultural and institutional atmosphere of patriarchal norms. For many women, especially those with abusive personal relationships, obstacles to medical treatment include constant monitoring, fear of revenge, and a lack of freedom in mobility or money. Where incidents of violence have been normalized within the family, or where a woman economically depends on the perpetrator, it is dangerous to seek medical or psychological help. Consequently, many women delay medical attention for injuries, infections, or trauma, which sometimes leads to chronic health complications.

Most institutional barriers exacerbate this. Healthcare institutions rarely have skilled personnel who understand the dynamics of violence and its psychological sequelae. Many survivors receive judgmental treatment from medical personnel, or the latter ask intrusive questions, pushing them to reconcile with their perpetrators. Medical-legal procedures, including forensic examinations, are routinely carried out without proper consent or privacy, discouraging women from participating in the process. Even physical access through remote areas presents challenges: facilities are few, female doctors are inadequate, and transportation infrastructure is abysmal. And even when they reach hospitals, important treatments like emergency contraception, STI treatment, psychiatric therapy, or safe abortion care are often not available for lack of resources or due to stigma.

Social norms play an equally important role. Violence is still viewed as a private matter, and women who report violence face social exclusion, victim blaming, or loss of honor. Survivors of sexual violence face particular stigma, which prevents them from receiving appropriate medical care. It is at this juncture that intersectional discrimination compounds these challenges: Dalit and Adivasi women often face caste-based hostility in hospitals; women with disabilities may encounter inaccessible infrastructure; and migrant and impoverished women face language barriers and documentation requirements. These compound barriers erode the right to health and perpetuate structural disparities, making healthcare access after violence a human rights issue rather than a medical burden.

Legal and Policy Framework in India

The country has formulated an inclusive legislative system that addresses gender-based violence to protect the rights of women, but its effectiveness is weakened by lacunas in its implementation. It finds its foundation in Article 14-Right to Equality, Article 15-Right to Non-Discrimination, and Article 21-the Right to Life and Dignity-of the Constitution. The Supreme Court through interpretation has extended Article 21 to include the right to health and bodily integrity, hence linking violence to violation of constitutional rights.[17]

The Protection of Women from Domestic Violence Act, 2005, is a landmark act that acknowledges physical, emotional, sexual, and economic violence within the home. Its provisions are a civil, rights-based approach to protection orders, residency rights, psychotherapy, and access to medical services. However, this suffers from chronic underfunding, overloaded Protection Officers, and lack of cross-agency collaboration in its effectiveness.

Criminal laws have also been amended. The Criminal Law Amendment Act, 2013, expanded the definition of sexual offenses; enhanced penalties; and provided for time-bound investigations[18]. Laws on child marriage, honour crimes, dowry killings, workplace harassment, and acid attacks seek to provide complete protection. The Medical Termination of Pregnancy (Amendment) Act, 2021, facilitates access to safe abortions for rape survivors.

Policy interventions like the National Health Mission, One-Stop Centres, the Nirbhaya Fund,

[17] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37.
[18] Criminal Law (Amendment) Act, 2013.

and detailed medico-legal guidelines seek to integrate health and justice perspectives. The key deficiency, though, lies in implementation-actual absence of training for police and hospital staff, non-operating crisis centers, low levels of community awareness, and entrenched impunity. On paper, the legal frameworks are strong, though in practice, unequal. Therefore, more institutional accountability and survivor-oriented treatment delivery become synonymous with the essentials in this area.

International Human Rights Standards and State Responsibility

International human rights laws have shaped our understanding of gender-based violence as a denial of women's right to health. The most relevant is the Convention on the Elimination of All Forms of Discrimination Against Women. CEDAW identifies GBV as discrimination in General Recommendations 19 and 35, and it clearly obliges governments to exercise due diligence in preventing, investigating, and prosecuting acts of violence, and also in providing remedies to survivors[19]. From this perspective, it becomes quite clear that even violence by private actors-intimate partners-is a matter of state responsibility in cases where institutions have failed to respond effectively.

General Comment No. 14 of the ICESCR asserts that freedom from violence is part of the right to health, and this needs to be ensured through states providing accessible, acceptable, and good-quality health services, including reproductive and mental-health care for survivors.[20] The UN Declaration on the Elimination of Violence Against Women (1993) also highlights the need for countries to amend discriminatory laws, break harmful traditional practices, and ensure support mechanisms like medical treatment, psychological counseling, shelter, and rehabilitation.

As a signatory to these international agreements, India has an obligation to adopt a rights-based approach to gender-based violence. This encompasses training health personnel, and offering forensic and psychological support, maintaining confidentiality of victims, enhancing access to justice, and eliminating discriminatory practices in public institutions. International law also stresses that state inaction, including failure to register complaints, offering less than adequate medical assistance, insensitive treatment of survivors, or delaying the processes, is a denial of human rights. These thereby reinforce the understanding that the state plays an active role in

[19] Velásquez Rodríguez v. Honduras, Inter-American Court of Human Rights (1988).
[20] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000).

securing women's right to health against abuse. They place a normative framework for assessing national legislation and institutional performance, reminding governments that addressing GBV is a core human rights duty rather than a welfare measure.

Gaps and Challenges in Implementation

Although a strong legal and administrative structure for addressing gender-based violence exists in India, its implementation is incomplete and uneven. One major challenge arises from the mismatch between the legislative provisions and institutional preparedness. Healthcare systems, meant to play an important role in documenting injuries, undertaking timely treatment, and providing psychological counseling, are not fully equipped to address violent situations with empathy. Most hospitals lack trained staff, adequate medico-legal guidelines, private examination rooms, and counseling facilities. Women may thus face insensitive or dismissive attitudes among medical staff, leading to deterrence of their seeking help during critical times.

Another serious gap is found in policing and investigation. Police personnel are at times unwilling to register incidents of domestic abuse or marital rape, viewing them as "family matters." Survivors are habitually counseled to compromise rather than seek legal action. The prosecution is further weakened by a lack of forensic infrastructure and delays in medical tests. Protection Officers under the Domestic Violence Act have limited personnel, a lack of training, and enormous caseloads, which reduce their capacity to provide timely aid. Further, One-Stop Centres and shelter houses often experience poor financing, personnel shortages, and low levels of cooperation with hospitals and police, reducing their utility.

Societal attitudes remain a major barrier. Patriarchal mindsets that legitimise violence against women lead to widespread underreporting. Women who report abuse are shamed, socially ostracised, and economically insecure. Intersectional inequalities worsen these experiences; Dalit, tribal, migrant, disabled, and poor women face greater discrimination, fewer support services, and deeper institutional apathy. Thus, even where the laws exist, the socio-cultural environment is often inimical to survivors, making it impossible to fully exercise their right to health and safety.

Case Law Analysis

Indian courts have recognized gender-based violence as a violation of fundamental rights,

including the right to health.

In ***Vishaka v. State of Rajasthan (1997)***[21], the Supreme Court recognized that sexual harassment is a violation of constitutional rights to equality, dignity, and life. Looking to CEDAW, the Court articulated guidelines that later provided the foundation for the 2013 Sexual Harassment Act, emphasizing

In ***Laxmi v. Union of India (2014)***, the Supreme Court addressed acid attacks, commanding strict regulation with regard to the sale of acid, compensation to survivors, as well as medical care facilities. The judgment took note of the grave and long-lasting bodily and psychological trauma that survivors suffer and underlined the state's responsibility to protect their right to health and rehabilitation.

In ***Suchita Srivastava v. Chandigarh Administration (2009),*** the Court sustained a woman's right to reproductive autonomy within her right to privacy and dignity under Article 21. This idea has been applied in situations when reproductive coercion or sexual assault hinder bodily integrity of women.

More recently, in ***X v. NCT of Delhi (2022[22])***, the Supreme Court held that unmarried women enjoyed the same right to safe abortion as married women under the MTP Act, especially in cases of sexual assault. This evidences an increasing judicial awareness that reproductive consequences of violence must be responded to from a rights-based approach. In spite of these progressive judgments, implementation remains spotty. Survivors often face delays in courts, insensitive handling, and limited access to justice. However, jurisprudence indicates a concerted trend toward viewing violence as a denial of constitutional and human rights, highlighting the need for institutional reform.

The Need for a Survivor-Centred, Gender-Sensitive Approach

Recognising GBV as a public health issue requires a change in attitude. All health facilities should be ready to provide services that are sympathetic, trauma-informed, and maintain dignity and privacy. Gender sensitivity, communication skills, and legal obligations should be the emphases of training programs for physicians, nurses, and support workers.

[21] Vishaka v. State of Rajasthan, (1997) 6 SCC 241.
[22] X v. Principal Secretary, Health and Family Welfare Dept., NCT of Delhi, (2022) 9 SCC 1.

Integrated crisis response units comprising physicians, counsellors, police officers, and legal aid specialists can thus provide holistic support. Simplification of medico-legal documentation, streamlining forensic practices, and discarding obsolete testing are key to restoring faith in institutions.

Mental health services need to be enhanced through the establishment of specialist counseling clinics, easy access to therapeutic options, and community outreach programs. To overcome the circle of abuse, women need financial support, education, and social networks of support. Engaging men and boys in public awareness could serve to counteract unhealthy gender norms and promote respectful relationships.

Discussion and Findings

These results indicate that there is a persistent gap between legislative promises and women's lived realities. India has a wide range of legal provisions, but the success of these laws depends upon institutional capacity, socio-cultural acceptability, and state responsibility. Gender-based violence continues to jeopardize women's health because institutional barriers prevent survivors from accessing medical treatment, psychological support, and justice. Health facilities often lack gender-sensitive practices, leading to failures to record injuries, provide trauma-informed therapy, or ensure privacy. These weaknesses compromise both health outcomes and judicial processes and point to the fact that the health system is still not fully integrated into the entirety of response to violence.

In this case, the analyzed case law shows how the judiciary has played a fundamental role in expanding the rights framework by acknowledging bodily autonomy, reproductive choice, and the need for survivor-centered remedies. However, merely legal development cannot overthrow deep-seated patriarchal practices. Women have not stopped underreporting on account of social shame, economic consequence, and skepticism by authorities. Issues of intersectional discrimination further marginalize certain groups of women, where access to healthcare and justice becomes even more constrained. Conversely, while international human rights norms impose clear duties on India, they are only partly fulfilled in practice.

The results suggest that deep transformation will require a multidimensional approach: strengthening healthcare infrastructure, mandating necessary gender-sensitive training for medical and police personnel, expanding institutional coordination, and providing accessible

support services. At the same time, comprehensive reform at the community level through education, awareness, and empowerment will be needed in order to challenge those ingrained social norms that legitimize violence. Lastly, realizing women's health rights in the context of gender-based violence requires going beyond a purely legal framework toward an integrated approach of human rights centering on dignity, autonomy, and equality.

Conclusion

GBV fundamentally violates women's rights to health through physical injury, psychological trauma, and long-term implications for reproductive and mental health. Although widely recognized as a violation of human rights under both Indian and international law, the gap that persists between the legal framework and reality continues to impede women's access to timely, respectful, survivor-centered care. Social stigma, patriarchal norms, a lack of understanding, and institutional insensitivity further add to the agony, often leaving survivors with a dearth of medical care or support resources. The debate emphasizes that the right to health cannot be fulfilled until violence is addressed as a structural impediment linked to gender inequality. At the same time, the review of legislative frameworks and case law reveals that while significant progress has been achieved by India through legislation and judicial interpretation, the actual implementation remains uneven and fragmented. Health practitioners are often untrained, coordination between the police, health, and legal system is far from effective, and support structures are inadequate for the long-term rehabilitation of survivors. To address these gaps, better mechanisms of accountability, trauma-informed health treatments, and an integrated approach matching domestic policy with international human rights obligations are required. Finally, a comprehensive and rights-based response—centered on prevention, protection, and empowerment—is required to ensure women's health, dignity, and independence from violence.