

INTERNATIONAL JOURNAL FOR LEGAL RESEARCH AND ANALYSIS



Open Access, Refereed Journal Multi-Disciplinary
Peer Reviewed

www.ijlra.com

DISCLAIMER

No part of this publication may be reproduced, stored, transmitted, or distributed in any form or by any means, whether electronic, mechanical, photocopying, recording, or otherwise, without prior written permission of the Managing Editor of the *International Journal for Legal Research & Analysis (IJLRA)*.

The views, opinions, interpretations, and conclusions expressed in the articles published in this journal are solely those of the respective authors. They do not necessarily reflect the views of the Editorial Board, Editors, Reviewers, Advisors, or the Publisher of IJLRA.

Although every reasonable effort has been made to ensure the accuracy, authenticity, and proper citation of the content published in this journal, neither the Editorial Board nor IJLRA shall be held liable or responsible, in any manner whatsoever, for any loss, damage, or consequence arising from the use, reliance upon, or interpretation of the information contained in this publication.

The content published herein is intended solely for academic and informational purposes and shall not be construed as legal advice or professional opinion.

**Copyright © International Journal for Legal Research & Analysis.
All rights reserved.**

ABOUT US

The *International Journal for Legal Research & Analysis (IJLRA)* (ISSN: 2582-6433) is a peer-reviewed, academic, online journal published on a monthly basis. The journal aims to provide a comprehensive and interactive platform for the publication of original and high-quality legal research.

IJLRA publishes Short Articles, Long Articles, Research Papers, Case Comments, Book Reviews, Essays, and interdisciplinary studies in the field of law and allied disciplines. The journal seeks to promote critical analysis and informed discourse on contemporary legal, social, and policy issues.

The primary objective of IJLRA is to enhance academic engagement and scholarly dialogue among law students, researchers, academicians, legal professionals, and members of the Bar and Bench. The journal endeavours to establish itself as a credible and widely cited academic publication through the publication of original, well-researched, and analytically sound contributions.

IJLRA welcomes submissions from all branches of law, provided the work is original, unpublished, and submitted in accordance with the prescribed submission guidelines. All manuscripts are subject to a rigorous peer-review process to ensure academic quality, originality, and relevance.

Through its publications, the *International Journal for Legal Research & Analysis* aspires to contribute meaningfully to legal scholarship and the development of law as an instrument of justice and social progress.

PUBLICATION ETHICS, COPYRIGHT & AUTHOR RESPONSIBILITY STATEMENT

The *International Journal for Legal Research and Analysis (IJLRA)* is committed to upholding the highest standards of publication ethics and academic integrity. All manuscripts submitted to the journal must be original, unpublished, and free from plagiarism, data fabrication, falsification, or any form of unethical research or publication practice. Authors are solely responsible for the accuracy, originality, legality, and ethical compliance of their work and must ensure that all sources are properly cited and that necessary permissions for any third-party copyrighted material have been duly obtained prior to submission. Copyright in all published articles vests with IJLRA, unless otherwise expressly stated, and authors grant the journal the irrevocable right to publish, reproduce, distribute, and archive their work in print and electronic formats. The views and opinions expressed in the articles are those of the authors alone and do not reflect the views of the Editors, Editorial Board, Reviewers, or Publisher. IJLRA shall not be liable for any loss, damage, claim, or legal consequence arising from the use, reliance upon, or interpretation of the content published. By submitting a manuscript, the author(s) agree to fully indemnify and hold harmless the journal, its Editor-in-Chief, Editors, Editorial Board, Reviewers, Advisors, Publisher, and Management against any claims, liabilities, or legal proceedings arising out of plagiarism, copyright infringement, defamation, breach of confidentiality, or violation of third-party rights. The journal reserves the absolute right to reject, withdraw, retract, or remove any manuscript or published article in case of ethical or legal violations, without incurring any liability.

INDIA'S CEDAW OBLIGATIONS ON GENDER-BASED VIOLENCE AND HEALTH: A CRITICAL ANALYSIS OF COMPLIANCE GAPS IN DOMESTIC LEGISLATION

AUTHORED BY - SAURABH KUMAR

Research Scholar,
National University of Study and Research in Law, Ranchi

Abstract

India signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1993. The CEDAW Committee says that this means India has a lot of work to do to stop violence against women and make sure they have access to health care. There are still significant discrepancies between India's international obligations and how they are carried out in India three decades later. This article critically analyses India's adherence to CEDAW obligations concerning the nexus of gender-based violence and women's health rights.

This research identifies enduring compliance deficiencies through a systematic doctrinal analysis of CEDAW General Recommendations, the Committee's Concluding Observations on India, and domestic legislative frameworks, including the Protection of Women from Domestic Violence Act, 2005, criminal law provisions, and health legislation. The paper contends that India's disjointed legislative framework does not acknowledge gender-based violence as a public health emergency that necessitates extensive medical, psychological, and reproductive health measures. Some of the most important gaps are the continuous exception for marital rape in criminal law, the lack of health protections for women who are pregnant or giving birth and are victims of violence, the lack of mental health care for survivors, and structural impediments to reproductive autonomy.

The study closes with proposals for legislative reform to align Indian legislation with CEDAW principles and to fulfill constitutional commitments to gender equality and women's right to health.

Keywords: CEDAW, Gender-Based Violence, Right to Health, Marital Rape, Reproductive Rights, International Human Rights Law, Constitutional Law.

I. Introduction

The United Nations General Assembly passed the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979. It is the most complete set of international laws protecting women's rights.¹ India signed CEDAW in 1980 and ratified it on July 9, 1993, with statements on Article 5(a) and Article 16(1) that have to do with personal laws.² India agreed to CEDAW, which means that it is now legally required to end all types of discrimination against women, including violence, and to make sure that women have the same access to healthcare services as men.³

The connection between gender-based violence (GBV) and women's health has been increasingly defined through CEDAW General Recommendations, notably General Recommendation No. 19 (1992)⁴, which identifies GBV as discrimination; General Recommendation No. 24 (1999), which addresses women and health; and General Recommendation No. 35 (2017), which updates and strengthens the GBV framework. These interpretive devices assert that States Parties must confront GBV not solely as a criminal justice concern but as an extensive health crisis necessitating medical, psychological, reproductive, and preventative health initiatives.⁵

Even though India signed CEDAW more than 30 years ago, it still doesn't do enough to meet its duties regarding GBV and health. The CEDAW Committee's Concluding Observations on India's combined fourth and fifth periodic reports (2014) voiced grave apprehensions regarding pervasive gender-based violence, restricted access to reproductive health services, maternal mortality, and insufficient legal safeguards. The Committee made specific suggestions, such as making marital rape a crime, making sure that women can get safe abortions, giving survivors of violence full support, and stopping harmful practices.⁶

¹ Convention on the Elimination of All Forms of Discrimination Against Women, opened for signature Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW]

² Declarations and Reservations to CEDAW: India, United Nations Treaty Collection.

³ CEDAW, *supra* note 1, arts. 2, 12

⁴ Committee on the Elimination of Discrimination Against Women, General Recommendation No. 19: Violence Against Women, U.N. Doc. A/47/38 (1992) [hereinafter CEDAW General Recommendation No. 19]

⁵ Committee on the Elimination of Discrimination Against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW General Recommendation No. 24].

⁶ Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Combined Fourth and Fifth Periodic Reports of India, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014) [hereinafter CEDAW Concluding Observations 2014]

India was supposed to submit its periodic report in 2018, but as of 2026, the combined sixth and seventh periodic reports are still not submitted, which could mean that India is not eager to deal with ongoing compliance issues. The article analyzes the significant compliance deficiencies in four essential domains: (1) domestic violence and intimate partner violence; (2) sexual violence and the marital rape exception; (3) reproductive health rights and maternal mortality; and (4) the mental health repercussions of gender-based violence. The article systematically analyses India's domestic legislation, revealing its significant deficiencies relative to CEDAW norms, hence compromising women's constitutional rights to health, equality, and a life of dignity as enshrined in Articles 14, 15, and 21.⁷

CEDAW Framework on Gender-Based Violence and Health

A. Evolution of CEDAW Jurisprudence on Gender-Based Violence

The original CEDAW language does not specifically address violence against women; nonetheless, the CEDAW Committee has gradually established that gender-based violence (GBV) is a form of discrimination within the Convention's framework. General Recommendation No. 19 (1992) was a turning point since it said that "gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."⁸

The Recommendation says that GBV makes it harder for women to enjoy many human rights, such as "the right to the highest standard attainable of physical and mental health." It says that gender-based violence is "violence that is directed against a woman because she is a woman or that affects women disproportionately." This includes physical, mental, and sexual harm and threats of harm, coercion, and loss of freedom.⁹

Twenty-five years later, General Recommendation No. 35 (2017) improves and strengthens this framework. It makes it clear that gender-based violence (GBV) affects women at all stages of their lives and happens in many places, such as the family, the community, and state custody. It is important because it says that States Parties must deal with both de jure and de facto discrimination. This means that they must do more than just make the law equal; they must

⁷ Status of Reports, Committee on the Elimination of Discrimination Against Women, available at <https://www.ohchr.org/en/treaty-bodies/cedaw> (last visited Jan. 2026)

⁸ CEDAW General Recommendation No. 19, 4, ¶ 1

⁹ *Id.* ¶ 7

also take steps to stop violence and its effects.¹⁰

B. CEDAW's Right to Health Framework

Article 12 of CEDAW says that States Parties must “take all appropriate measures to eliminate discrimination against women in the field of health care” and “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period.” General Recommendation No. 24 explains that this includes full sexual and reproductive health services, such as family planning, prenatal and postnatal care, emergency obstetric services, and legal access to safe abortion.¹¹

The Committee has made it clear that the right to health includes being free from gender-based violence that harms health. General Recommendation No. 24 says that “States parties should make sure that steps are taken to stop coercion in relation to fertility and reproduction, and to make sure that women are not forced to seek unsafe medical procedures like illegal abortion because they can't get the right services.” This establishes reproductive coercion including forced pregnancy, contraceptive sabotage, and denial of abortion access as violations of Article 12.¹²

C. Core State Obligations Under CEDAW

CEDAW requires States Parties to do three things: respect, protect, and fulfill women's rights. Obligation to Respect means that countries can't have laws, policies, or practices that are unfair to some groups. In the context of GBV and health, this forbids legislation that protect offenders (such exclusions for marital rape), make abortion illegal, or limit women's reproductive freedom.¹³

Obligation to Protect says that countries must stop other people from violating women's rights. This includes making and implementing laws that make violence a crime, setting up ways to protect people, and making sure that healthcare workers don't discriminate against or violate patients' rights.¹⁴

¹⁰ CEDAW General Recommendation No. 35, ¶¶ 16-17

¹¹ CEDAW, *supra* note 1, art. 12.

¹² CEDAW General Recommendation No. 24, *supra* note 5, ¶¶ 20-23.

¹³ CEDAW General Recommendation No. 35, *supra* note 6, ¶ 22.

¹⁴ *Id.* ¶ 25

Obligation to fulfill necessitates proactive actions to actualize rights, encompassing the establishment of accessible healthcare infrastructure, the training of healthcare providers, the allocation of sufficient resources, and the collection of disaggregated data to assess progress.¹⁵ CEDAW commitments are non-negotiable and must be met right away. The Committee has made it clear that “certain obligations must be undertaken immediately,” and States can’t use a lack of resources as an excuse for not following through.¹⁶

D. Specific CEDAW Recommendations Relevant to India

The CEDAW Committee’s 2014 Concluding Observations on India identified multiple areas of concern regarding GBV and health:

- 1. Domestic Violence:** Concern about widespread domestic violence, limited awareness of the PWDVA among women and law enforcement, inadequate implementation, and insufficient protection orders and shelter homes.¹⁷
- 2. Sexual Violence:** Alarm regarding high rates of sexual violence, the marital rape exception in Section 375 of the Indian Penal Code, now under 63 of Bhartiya Nyaya Sanhita, inadequate prosecution of rape cases, and insensitive treatment of survivors in the criminal justice system.¹⁸
- 3. Harmful Practices:** Concern about dowry-related violence, honour killings, witch-hunting, and the practice of devadasi (temple prostitution).¹⁹
- 4. Reproductive Health:** Serious concern about high maternal mortality rates, limited access to reproductive health services, particularly in rural areas, sex-selective abortion, and restrictive abortion laws.²⁰
- 5. Mental Health:** Absence of mental health support services for violence survivors and inadequate attention to psychological consequences of violence.²¹

The Committee made clear suggestions, such as making marital rape a crime, making sure that the PWDVA is fully enforced, making sure that women have access to safe, legal abortion, lowering the number of deaths of mothers, providing full support services to survivors of violence, including medical, psychological, and legal help, and collecting separate data on

¹⁵ *Id.*

¹⁶ CEDAW General Recommendation No. 24, ¶ 17

¹⁷ CEDAW Concluding Observations 2014, ¶ 23.

¹⁸ *Id.* ¶ 14.

¹⁹ *Id.* ¶ 25

²⁰ *Id.* ¶¶ 37-38.

²¹ *Id.* ¶ 38(f).

violence against women.²²

Domestic Violence and Intimate Partner Violence: Legislative Gaps

A. The Protection of Women from Domestic Violence Act, 2005

The PWDVA is India's main civil statute that deals with domestic abuse. The Act, which was passed in response to recommendations from the CEDAW Committee and continued lobbying by women's rights groups, recognizes domestic abuse as a civil wrong and allows for protection orders, residence orders, monetary redress, and custody orders.²³

Progressive Elements: The PWDVA's comprehensive definition of domestic violence, which includes physical, sexual, verbal, emotional, and economic abuse, is similar to CEDAW's broad definition of GBV. The acknowledgement of the right to inhabit the communal residence and the provision of financial assistance, encompassing medical expenses, recognise the tangible repercussions of violence.²⁴

Critical Gaps: Even with these strengths, the PWDVA has big gaps in compliance:

1. Health Services Provisions are Minimal and Underutilised

Section 5 says that medical establishments must help people who have been victims of domestic abuse. But this part has been read very narrowly, so it only applies to emergency physical injuries and not to full health care.²⁵ The Act does not require:

- Routine screening for domestic violence in healthcare settings
- Mental health counselling or psychiatric services
- Long-term rehabilitation services
- Reproductive health services, including emergency contraception or abortion access
- Training for healthcare providers in identifying and responding to domestic violence

A 2019 research on the implementation of the PWDVA found that less than 15% of government hospitals had procedures in place to find victims of domestic violence, and there were almost no mental health facilities. CEDAW General Recommendation No. 35 says that health care must be "sensitive to the needs of women subjected to gender-

²² *Id.* ¶¶ 14-15, 38-39

²³ Lawyers Collective, *Staying Alive: Fifth Monitoring and Evaluation Report 2012 on the Protection of Women from Domestic Violence Act, 2005*, at 12-15 (2013).

²⁴ The Protection of Women from Domestic Violence Act, 2005, No. 43, Acts of Parliament, 2005, §§ 18-22 (India) [hereinafter PWDVA]

²⁵ *Id.* § 5

based violence.” This does not come close to it.²⁶

2. Inadequate Protection Officer System

The Act sets up Protection Officers to help survivors get legal help. However, thorough investigations show that there is not enough staff in many districts that have only one Protection Officer for populations of more than a million, due to poor training and a lack of funding. Protection Officers seldom promote healthcare access or collaborate with medical facilities, indicating a failure to implement the Act’s health obligations.²⁷

3. Limited Scope: Exclusion of Non-Domestic Relationships

The PWDVA is only for women who are in domestic partnerships. It doesn’t cover violence in dating relationships, stalking by those who aren’t in a relationship, or sexual harassment at work. This restrictive scope is not in line with CEDAW General Recommendation No. 35, which says that GBV happens in many different places and that the State has a duty to deal with violence in all its forms.²⁸

4. Absence of Health Data Collection

The PWDVA does not require the gathering of health-related information on domestic violence survivors, encompassing the frequency of injuries, mental health issues, reproductive coercion, or maternity health challenges. Evidence-based health interventions cannot be planned or assessed without such data. This goes against CEDAW’s rule that countries must gather separate data to keep an eye on GBV and devise measures that work.²⁹

B. Criminal Law Provisions and Health Considerations

Section 498A of the Indian Penal Code, now section 85 Bhartiya Nyaya Sanhita, makes it a crime for husbands or in-laws to be cruel. This law has led to arrests, but it concentrates on punishment instead of helping victims and doesn’t include any health-related elements. Long trials don’t make it easier for people to get medical care, mental health services, or protection from more violence.³⁰

The lack of connection between criminal law and health institutions implies that survivors’

²⁶ International Center for Research on Women, *Masculinity, Intimate Partner Violence and Son Preference in India* 78-82 (2019).

²⁷ Lawyers Collective, *Staying Alive: Sixth Monitoring and Evaluation Report 2013 on the Protection of Women from Domestic Violence Act, 2005*, at 45-48 (2014).

²⁸ PWDVA, *supra* note 30, § 2(f)

²⁹ *Id.* ¶ 32(d).

³⁰ Indian Penal Code, 1860, No. 45 of 1860, § 498A (India)

health needs are still not being met, even when domestic violence is reported and prosecuted. CEDAW says that the criminal justice system must be supported by a wide range of services, including healthcare. India does not meet this criterion.³¹

Sexual Violence and the Marital Rape Exception: A Fundamental Compliance Failure

A. The Marital Rape Exception in Indian Law

According to Exception 2 to Section 375 of the Indian Penal Code, now section 63 Bhartiya Nyaya Sanhita “Sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape.” This law protects husbands from being charged with rape if they have sex with their wives without their consent while they are 15 or older. This is one of the worst violators of CEDAW requirements in India.³²

Historical Context: The exception comes from British law from the time of the colonies, which was founded on the idea of coverture and the idea that marriage constituted permanent sexual consent. Britain got rid of the marital rape exception in 1991, but India still has this old law, even though women’s rights groups, legal experts, and international authorities have been criticizing it for a long time.³³

Judicial Challenges: Indian courts have questioned the constitutionality of the marital rape exclusion. The Supreme Court largely dealt with the issue in *Independent Thought v. Union of India* (2017) by making it a crime for men to have sex with their wives who are 15 to 18 years old. They said that Exception 2 breaches the dignity and bodily integrity of girl children. The Court, however, clearly did not consider how the exception applies to adult women, leaving the main question unresolved.³⁴

The Delhi High Court is currently considering applications that question the validity of the exception for adult women. The Union of India is against making something a crime because they say it could hurt marriage and be used for bad things. This attitude goes against India’s CEDAW requirements in a concrete way.³⁵

B. CEDAW Committee’s Position on Marital Rape

The CEDAW Committee has always and without a doubt argued for making marital rape a

³¹ CEDAW General Recommendation No. 35, ¶ 31

³² Indian Penal Code, 1860, § 375, Exception 2.

³³ Ratanlal & Dhirajlal, *The Indian Penal Code 2032-35* (34th ed. 2014)

³⁴ *Independent Thought v. Union of India*, (2017) 10 S.C.C. 800, (India)

³⁵ *RIT Foundation v. Union of India*, W.P.(C) 284/2015 (Delhi H.C.)

crime. General Recommendation No. 19 says that all women should be protected by “laws against family violence and abuse, rape, sexual assault, and other gender-based violence.”“ General Recommendation No. 35 is clear: “The victim’s consent cannot be assumed and must be given voluntarily... Legal defenses or mitigating factors that rely on discriminatory stereotypes, including those related to... marriage... or any other status should be eliminated.”³⁶ The Committee’s 2014 Concluding Observations on India expressed alarm about the marital rape exception and explicitly recommended that India “remove the exception in the law on rape that exempts marital rape from criminal sanction and to ensure that rape is defined as any sexual act performed on a victim without her freely given consent.”³⁷ India’s failure to implement this recommendation for over a decade constitutes persistent non-compliance with binding treaty obligations.

C. Health Consequences of Marital Rape and India’s Failures

Marital rape inflicts severe and distinctive health consequences. Research demonstrates that sexual violence by intimate partners causes:

Physical Health Impacts: Genital injuries, sexually transmitted infections including HIV, unwanted pregnancies, gynecological complications, and chronic pain conditions. The WHO recognizes that intimate partner sexual violence is associated with significantly higher rates of adverse reproductive health outcomes compared to sexual violence by non-partners.³⁸

Mental Health Impacts: Women experiencing marital rape exhibit higher rates of PTSD, depression, anxiety, suicidal ideation, and complex trauma compared to those experiencing other forms of intimate partner violence. The betrayal by an intimate partner and the ongoing nature of the relationship create particularly severe psychological harm.³⁹

Reproductive Coercion: Marital rape is frequently accompanied by contraceptive sabotage, forced pregnancy, and coerced abortion. Indian studies document that reproductive coercion affects 25-30% of married women experiencing intimate partner violence.⁴⁰

By failing to criminalize marital rape, India violates multiple CEDAW provisions:

Article 2(f): Failure to repeal discriminatory laws that deny married women equal protection

³⁶ CEDAW General Recommendation No. 35, ¶ 29

³⁷ CEDAW Concluding Observations 2014, ¶ 14

³⁸ Claudia Garcia-Moreno et al., *Prevalence of Intimate Partner Violence: Findings from the WHO Multi-Country Study on Women’s Health and Domestic Violence*, 368 *Lancet* 1260, 1266 (2006).

³⁹ Jennifer Bennice et al., *Marital Rape: History, Research, and Practice*, 4 *Trauma, Violence, & Abuse* 228, 235-38 (2003).

⁴⁰ Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy*, 81 *Contraception* 316, 318 (2010).

against sexual violence.⁴¹

Article 12: Denial of health protections by immunizing a significant cause of physical and mental health harm.⁴²

Article 16(1): Denial of equal rights in marriage, as wives lack bodily autonomy and sexual consent rights accorded to unmarried women.⁴³

D. Comparative Perspectives

More and more countries throughout the world have made marital rape a crime. This shows that the world is moving toward definitions of sexual assault that are based on permission and that women have the right to control their own bodies in marriage. Several places in South Asia have made big strides in this area. In 2006, Nepal made marital rape a crime, making it clear that having sex without consent while married is a crime. Bangladesh has made some progress toward fully criminalizing marital rape by changing the law, although it is still not fully illegal.⁴⁴

South Africa adopts one of the most progressive models, defining rape as any act of non-consensual sexual penetration regardless of the relationship between the perpetrator and the survivor, including marriage. The United Kingdom, whose colonial legal doctrine India inherited, abolished the marital rape exemption in *R v. R* (1991), holding that marriage does not imply irrevocable consent to sexual intercourse.⁴⁵

In contrast, India's continued retention of the marital rape exception is increasingly anachronistic and indefensible in light of evolving international human rights standards and comparative regional practice, particularly given its binding obligations under CEDAW to eliminate all forms of gender-based violence without exception.

Reproductive Health Rights: Gaps in Maternal Health and Abortion Access

A. CEDAW Framework on Reproductive Rights

Article 12(2) specifically requires States to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where

⁴¹ CEDAW, *supra* note 1, art. 2(f)

⁴² *Id.* art. 12

⁴³ *Id.* art. 16(1)

⁴⁴ Equality Now, *The World's Shame: The Global Rape Epidemic* 28-35 (2017).

⁴⁵ Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, § 3 (S. Afr)

necessary.” General Recommendation No. 24 elaborates that reproductive rights encompass⁴⁶:

- Access to family planning information and services
- Skilled attendance at delivery
- Emergency obstetric care
- Post-abortion care
- Access to safe, legal abortion
- Freedom from forced sterilization⁶⁷

The Committee has emphasized that reproductive health rights are indivisible from freedom from violence, as reproductive coercion, forced pregnancy, and denial of abortion access constitute forms of gender-based violence.⁴⁷

B. Maternal Mortality and Access to Maternal Health Services

India continues to bear a disproportionate share of the global burden of maternal mortality, accounting for approximately 12 per cent of maternal deaths worldwide despite representing around 17–18 per cent of the global population. Although the maternal mortality ratio (MMR) has declined over time, it remained at 103 deaths per 100,000 live births during the period 2017–19, significantly above the Sustainable Development Goal target of 70. Persistent rural–urban and caste-based disparities are evident, with studies indicating that Scheduled Caste and Scheduled Tribe women experience maternal mortality rates approximately 25–30 per cent higher than the national average.⁴⁸

Linkage to Gender-Based Violence: An increasing amount of research shows that there is a strong link between intimate partner violence and bad health outcomes for mothers. Women who are victims of domestic violence face:

- around 40% more likely to have problems during pregnancy, such as hypertension, bleeding, and infection⁴⁹;
 - Almost twice as likely to have babies with low birth weight⁵⁰;
 - a far greater chance of delayed or absent prenatal care because to partner interference⁵¹;
- and

⁴⁶ CEDAW, *supra* note 1, art. 12(2)

⁴⁷ CEDAW General Recommendation No. 35, ¶ 18

⁴⁸ Ministry of Health & Family Welfare, *Special Bulletin on Maternal Mortality in India 2016-18*, at 2 (2020).

⁴⁹ Jejeebhoy Shireen et al., *Associations Between Domestic Violence and Pregnancy Outcomes: Evidence from India's National Family Health Survey*, 26 *Int'l J. Gynecology & Obstetrics* 83, 85-88 (2015)

⁵⁰ *Id.*

⁵¹ Saritha Nair et al., *Domestic Violence Against Women in India: A Systematic Review of a Decade of Quantitative Studies*, 6 *Global Health Action* 1, 8-10 (2013)

- a higher chance of maternal illness and death.

Even though there is evidence of a link between maternal health and domestic violence, India's maternal health programs do not regularly check for or deal with domestic abuse. Flagship programs like the Janani Suraksha Yojana (JSY) focus mostly on institutional delivery and financial incentives. They don't pay much attention to societal factors that affect maternal health, such as violence against women.⁵²

CEDAW Compliance Gaps: The CEDAW Committee's 2014 Concluding Observations highlighted concern about India's high maternal death rate and suggested improving maternal health care, making sure that experienced birth attendants are present, and removing barriers to access. Even though the rates of institutional delivery have gone up, the fact that violent screening and intervention measures haven't been put in place shows that CEDAW's health and due diligence responsibilities haven't been fully met.⁵³

C. Abortion Access and the Medical Termination of Pregnancy Act

The Medical Termination of Pregnancy Act, 1971, which was changed in 2021, allows all women to have an abortion up to 20 weeks into their pregnancy and certain groups of women, such as rape survivors, minors, women with disabilities, and other vulnerable groups listed in the Rules, to have an abortion up to 24 weeks into their pregnancy. Abortions that happen after these gestational limits need the approval of a Medical Board.⁵⁴

Progressive Aspects: The 2021 amendments expanded access by:

- extending the gestational limit to 24 weeks for vulnerable categories of women;
- removing marital status as a requirement for accessing abortion; and
- recognising contraceptive failure as a valid ground for termination.⁵⁵

Persistent Gaps:

1. **Gestational Limits Remain Restrictive:** The requirement for medical board clearance beyond 24 weeks essentially precludes abortion to women who discover major fetal abnormalities late in pregnancy or who encounter considerable delays in accessing care. CEDAW General Recommendation No. 24 stresses that "when possible, legislation

⁵² Ministry of Health & Family Welfare, *Janani Suraksha Yojana: Guidelines for Implementation* (2006).

⁵³ CEDAW Concluding Observations 2014, ¶¶ 37-38

⁵⁴ The Medical Termination of Pregnancy (Amendment) Act, 2021, No. 19, Acts of Parliament, 2021, § 3 (India).

⁵⁵ *Id.* § 3(2).

criminalizing abortion could be changed to get rid of the parts that punish women who have abortions.”⁵⁶

2. **Rape Survivors Must Prove Assault:** The MTP Act allows abortion for pregnancies originating from rape; nevertheless, survivors are required to furnish paperwork or evidence of sexual assault to healthcare providers. This need is an issue because more than 99% of sexual assaults in India are not reported. Women who are raped by their husbands have no legal remedy because the crime is not recognized by the law.⁵⁷
3. **Implementation Barriers:** Despite legal provisions, access to safe abortion remains severely constrained:
 - Only 20% of primary health centers provide abortion services.⁵⁸
 - Rural women face geographic, financial, and informational barriers
 - Provider conscientious objection is not regulated, resulting in service denial
 - Stigma and spousal consent requirements (though not legally mandated) create practical barriers.⁵⁹

Unsafe abortions are responsible for 8% of maternal fatalities in India. This shows that the state has failed to meet its Article 12 duty to make sure that people can get safe reproductive health care.⁶⁰

4. **Absence of Provisions for Coerced Pregnancy:** The MTP Act does not specifically address forced pregnancy due to reproductive coercion in personal relationships. Women who face contraceptive sabotage or coerced pregnancy by their spouses lack specific protections for obtaining abortion services, indicating a legislative failure to acknowledge reproductive coercion as gender-based violence (GBV).

D. Forced and Coerced Sterilisation

India has a bad history of forcing people to plan their families, including forced sterilisations during the Emergency period (1975–77) and current complaints of coercive tactics against women who are already underprivileged. The CEDAW Committee was worried by “reports of forced and coerced sterilisations, especially among women from marginalised groups.” They told India to make sure that all family planning services are voluntary and based on informed

⁵⁶ CEDAW General Recommendation No. 24, ¶ 31(c)

⁵⁷ The Medical Termination of Pregnancy (Amendment) Act, 2021, § 3(2)(a)

⁵⁸ Ministry of Health & Family Welfare, *Comprehensive Abortion Care: Training and Service Delivery Guidelines* 15 (2018).

⁵⁹ Suchitra Dalvie & Sharad Iyengar, *Abortion in India: Ground Realities*, 25 *Reprod. Health Matters* 85, 88-91 (2017).

⁶⁰ Ministry of Health & Family Welfare, *Special Bulletin on Maternal Mortality*, *supra* note 69, at 22.

consent.⁶¹

Recent reports show that there are still sterilisation camps with poor facilities, women are being pressured to get sterilised to achieve government goals, and there are no procedures in place for getting informed permission. Article 12 says that reproductive health services must be respectful and voluntary. These actions break that rule and are considered reproductive violence under CEDAW General Recommendation No. 35.⁶²

Mental Health Dimensions: Systemic Neglect

A. CEDAW Requirements on Mental Health

CEDAW General Recommendation No. 24 clearly states that mental health is part of the right to health framework. It says that “mental health should be given particular attention” in women’s healthcare. General Recommendation No. 35 says that “health services should be sensitive to the needs of women subjected to gender-based violence” and should include “sexual and reproductive health services, emergency contraception, post-exposure prophylaxis for HIV and other sexually transmitted infections, pregnancy-related services and psychological support.”⁶³

The term “psychological support” includes trauma therapy, psychiatric treatment, and long-term mental health care for survivors of gender-based violence (GBV).

B. India’s Legislative Silence

As thoroughly examined in the accompanying article regarding the Mental Healthcare Act, 2017, India’s legal structure inadequately addresses the mental health ramifications of gender-based violence (GBV). Some important compliance gaps are:

- 1. PWDVA Contains No Mental Health Provisions:** People have not understood the Act’s provision for medical expenses to include mental health treatment. Protection Officers are not trained to spot mental health concerns or help people get psychiatric help.⁶⁴
- 2. Mental Healthcare Act, 2017 Ignores GBV:** The Mental Healthcare Act does not include any provisions for GBV, does not require trauma-informed training, and does

⁶¹ Mohan Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic* 105-25 (2004).

⁶² Human Rights Watch, *India: Coercive Sterilization at Government Camps* (Dec. 2015)

⁶³ CEDAW General Recommendation No. 24, ¶ 29

⁶⁴ Lawyers Collective, *Staying Alive*, at 52-55

not set up any collaboration with violence protection measures, even though GBV is a major cause of mental illness in women.⁶⁵

3. **Criminal Law Marginalized Psychological Harm:** Section 376(2) of the IPC gives longer penalties for more serious types of rape, however psychological injury is not one of these types. Compensation schemes under Section 357A CrPC typically provide minimal amounts inadequate for long-term mental health treatment.⁶⁶
4. **No Mental Health Screening in Healthcare Settings:** India doesn't have any rules that say women who go to the hospital with injuries or ailments that signal violence must be screened for mental health issues. This is different from what the WHO says, which is that everyone should be screened in antenatal care and other healthcare settings.⁶⁷

C. Evidence of Mental Health Burden

Indian research illustrates significant mental health repercussions of GBV:

- 70% of domestic violence survivors experience clinical depression⁶⁸
- 45% experience PTSD symptoms.⁶⁹
- Suicide rates among women experiencing domestic violence are 9 times higher than general population⁷⁰
- Intergenerational trauma affects children witnessing violence.⁷¹

The National Mental Health Survey (2015-16) discovered treatment gaps of 85% for women with mental disorders, while survivors of gender-based violence encountered further obstacles of stigma and insufficient specialized resources.⁷²

India's inability to offer accessible mental health services to survivors of gender-based violence contravenes Article 12's right to health and signifies inadequate execution of CEDAW Committee recommendations.

⁶⁵ Mental Healthcare Act, 2017, No. 10, Acts of Parliament, 2017 (India)

⁶⁶ Indian Penal Code, 1860, § 376(2).

⁶⁷ World Health Organization, *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines* 23-28 (2013).

⁶⁸ Mohan Isaac et al., *Intimate Partner Violence and Its Relationship to Mental Health in India*, in *Mental Health and Illness of Women* 165, 170 (Prabha S. Chandra et al. eds., 2015)

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² National Mental Health Survey of India, 2015-16: Summary 28 (Nat'l Inst. of Mental Health & Neurosciences 2016).

Systemic Implementation Failures

A. Fragmentation of Legal Framework

India's approach to GBV and health is characterized by fragmentation across multiple disconnected statutes:

- PWDVA (civil protection)
- IPC (criminal prosecution)
- MTP Act (abortion)
- Mental Healthcare Act (mental health rights)
- Pre-Conception and Pre-Natal Diagnostic Techniques Act (sex selection)
- Protection of Children from Sexual Offences Act (child sexual abuse)

This fragmentation goes against CEDAW's mandate for coordinated and comprehensive approaches to GBV. Women who need help have to deal with many separate systems that only deal with one type of assault and not others.⁷³

B. Inadequate Budgetary Allocations

CEDAW General Recommendation No. 35 says that states must "give enough resources... to carry out laws, policies, and programs to stop and deal with violence against women."⁷⁴

India's budget allocations for GBV programs are grossly inadequate:

- The Nirbhaya Fund, established in 2013 with ₹3,000 crore for women's safety, has historically had low utilization rates, with only 23% utilized by 2018.⁷⁵
- One Stop Centres get very little money, usually between ₹10 and ₹15 lakh a year, which isn't enough to provide full services.⁷⁶
- The health budget does not have any explicit line items for health services connected to GBV.

Without sufficient resources, legal privileges are mere formalities, resulting in non-compliance with CEDAW duties.

C. Lack of Data Collection and Monitoring

Article 17 of CEDAW sets up the Committee and makes it mandatory for States Parties to send in regular reports so that monitoring can take place. For effective reporting, you need to collect

⁷³ CEDAW General Recommendation No. 35, ¶ 31

⁷⁴ *Id.* ¶ 32(a).

⁷⁵ Comptroller and Auditor General of India, *Performance Audit on Implementation of Nirbhaya Fund*, Report No. 15 of 2019, at 28-32 (2019).

⁷⁶ Ministry of Health & Family Welfare, *Demand for Grants 2023-24* (2023)

a lot of data, however India's systems have big problems⁷⁷:

- 1. No Integrated GBV-Health Data System:** Health management information systems do not capture GBV-related data. Medical records do not systematically document violence or link health outcomes to GBV exposure.¹¹¹
- 2. Underreporting in Official Statistics:** The National Crime Records Bureau data grossly underestimates GBV prevalence, covering only reported criminal instances. When you compare this to data from the National Family Health Survey, you can see that less than 1% of domestic abuse instances and 10% of sexual violence cases are reported to the police.⁷⁸
- 3. Delayed Reporting to CEDAW Committee:** India's sixth and seventh periodic reports were due in 2018, but they are still not done in 2026. This shows that monitoring compliance with CEDAW is not a high priority.⁷⁹

D. Cultural and Structural Barriers

Article 5 of CEDAW says that States must "change the social and cultural patterns of conduct of men and women" to get rid of biases and behaviors based on stereotypical roles. India's ongoing cultural norms that normalize violence and limit women's autonomy signify failures in compliance⁸⁰:

Normalization of Domestic Violence: The NFHS-5 result that 44% of women and 43% of men think that beating your wife is okay in some cases shows that Article 5 needs more work to educate the people and change society.⁸¹

Son Preference and Sex Selection: Even though the PC-PNDT Act is in place, sex-selective abortion is still common. India's sex ratio at birth is 907 females for every 1000 boys, which means that 460,000 girls go "missing" each year. This shows that the cultural value of daughters, which is a kind of gender-based discrimination, has not been dealt with.⁸²

Harmful Practices: Violence related to dowries, honor killings, and witch hunts still happen even if they are against the law. The CEDAW Committee particularly asked India to work harder to get rid of harmful practices, yet there are still no comprehensive prevention mechanisms in place.⁸³

⁷⁷ CEDAW, *supra* note 1, art. 17

⁷⁸ Ministry of Health & Family Welfare, *National Family Health Survey-5 (2019-21): India Report* 513-25 (2022).

⁷⁹ *Id.*

⁸⁰ Ministry of Health & Family Welfare, *National Family Health Survey-5*, *supra* note 113, at 522.

⁸¹ Ministry of Health & Family Welfare, *Sex Ratio at Birth: Annual Analysis 2020-21*, at 3-5 (2022).

⁸² *Id.*

⁸³ CEDAW Concluding Observations 2014 ¶ 25

Constitutional Implications of CEDAW Non-Compliance

A. Article 51(c) and International Obligations

Article 51(c) of the Constitution mandates the State to “promote respect for international law and treaty obligations.” The Supreme Court has said that this constitutional order means that India must follow its own laws in a way that is consistent with its duties under international treaties.⁸⁴

The Court in *Vishaka v. State of Rajasthan* explicitly used CEDAW to read sexual harassment prohibitions into domestic law when there was no specific law on the books. The Court said that “any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content.”⁸⁵

In the same way, the Court stated in *Apparel Export Promotion Council v. A.K. Chopra* that “the courts are under an obligation to give due regard to international conventions and norms for construing domestic laws.”⁸⁶

This doctrine indicates that CEDAW responsibilities are not only aspirational but entail obligatory commitments that must drive constitutional interpretation and legislative action. India’s ongoing inability to comply with CEDAW recommendations regarding gender-based violence (GBV) and health constitutes not just violations of international treaties but also breaches of constitutional requirements as outlined in Articles 14, 15, 21, and 51(c).

B. Intersection with Fundamental Rights

CEDAW non-compliance directly violates fundamental rights:

Article 14 (Equality): The marital rape exception and other unfair rules take away married women’s equal protection under the law, which is guaranteed to unmarried women and all males.⁸⁷

Article 15 (Prohibition of Discrimination): Not doing anything about GBV keeps discrimination against women going, which is against Article 15(1). Article 15(3)’s enabling element that allows particular measures for women makes it a duty to pass laws that stop

⁸⁴ India Const. art. 51, cl. (c)

⁸⁵ *Vishaka v. State of Rajasthan*, (1997) 6 S.C.C. 241,

⁸⁶ *Apparel Exp. Promotion Council v. A.K. Chopra*, (1999) 1 S.C.C. 759, ¶ 25 (India)

⁸⁷ India Const. art. 14

violence.⁸⁸

Article 21 (Right to Life): The Supreme Court's broad reading of Article 21 includes the right to health, dignity, and freedom from violence. Article 21 guarantees life with dignity, and GBV and denial of health treatments go against that.⁸⁹

The Court ruled in *Suchita Srivastava v. Chandigarh Administration* that reproductive decisions are an important part of personal freedom and dignity under Article 21. Laws and practices that infringe upon reproductive autonomy or neglect reproductive coercion consequently contravene fundamental rights.⁹⁰

Conclusion and Suggestions

Thirty years after signing CEDAW, India still doesn't do enough to protect women's rights to health and stop violence against women. This thorough research uncovers significant deficiencies in domestic abuse safeguards, sexual violence legislation, reproductive health services, and mental health measures, which cumulatively infringe upon women's constitutional rights to equality, life, and dignity as enshrined in Articles 14, 15, and 21. The retention of the marital rape exception constitutes India's most flagrant violation of CEDAW, depriving millions of married women of fundamental bodily autonomy and equal protection, while causing significant health repercussions, including unwanted pregnancies, sexually transmitted infections, psychological trauma, and maternal mortality. The Protection of Women from Domestic Violence Act is a step in the right direction, but it doesn't do enough to help with health issues. It doesn't provide enough mental health services, ignores reproductive health concerns, and doesn't coordinate healthcare well. Restrictive abortion legislation, insufficient maternal health services for violence-related complications, and ongoing complaints of forcible sterilization illustrate the weak implementation of reproductive rights commitments. Implementation difficulties are made worse by a lack of integrated data systems, fragmented legislation, and insufficient budgetary allocations.

These compliance gaps infringe upon women's rights and contravene India's constitutional duty under Article 51(c) to uphold international law. The Supreme Court's ruling in *Vishaka* makes it clear that CEDAW principles must be used to understand fundamental rights and guide lawmakers. India's ongoing failure to comply is due to a lack of political will, not a lack of

⁸⁸ *Id.* art. 15(1).

⁸⁹ *Id.* art. 15(1).

⁹⁰ *Suchita Srivastava v. Chandigarh Admin.*, (2009) 9 S.C.C. 1

resources.

We need to make important changes right away. First, comprehensive changes to the law must get rid of the marital rape exception in Section 375 IPC, change the PWDVA to require the integration of health services, including mental health counseling and reproductive healthcare, change the Medical Termination of Pregnancy Act to get rid of strict gestational limits while also dealing with reproductive coercion, and add provisions for gender-based violence to the Mental Healthcare Act to require trauma-informed care.

Second, integrated service delivery models must provide gender-based violence screening in basic healthcare centers, improve One Stop Centres by hiring skilled mental health specialists and giving them enough money, and make a National Action Plan with clear goals and ways to hold people accountable.

Third, to make sure that resources are used properly, there need to be separate budget lines for health services for victims of gender-based violence, a big increase in mental health funding, integrated data systems that connect health records to legal cases, and the immediate submission of overdue CEDAW periodic reports with honest assessments of compliance gaps. Finally, long-term social change through wide-ranging public education campaigns that challenge attitudes that normalize violence, the inclusion of gender equality curricula in schools, and a judicial continuing mandamus that holds people accountable for following constitutional and international obligations are all still very important for achieving real equality and women's health rights.