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RESEARCH PAPER

Access to Healthcare among Domestic Violence Survivors during COVID-19: A Socioeconomic Analysis

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Abstract

Social determinants of health (SDOH), such as poverty, education, and gender inequality, significantly increase women's risk of experiencing domestic violence, which in turn leads to serious physical and mental health issues, including increased risk of STIs and low birth-weight babies. Health promotion efforts must address these root causes by challenging harmful gender norms, providing access to resources like child care and safe housing, and strengthening healthcare systems to identify and support survivors.

Social determinants of health (SDOH) that increase a woman's risk of domestic violence (during COVID-19) include: Poverty and Financial Instability, Education and Gender Norms, Housing and living conditions, and social support.

Health outcomes are not determined solely by biological and genetic factors but are profoundly shaped by social, economic, and environmental conditions collectively known as the social determinants of health (SDH). These determinants include income, education, employment, housing, gender, social support, and access to healthcare services, which interact to influence individual and community well-being (Marmot and Wilkinson, 2005). The WHO defines SDH as the conditions in which people are born, grow, live, work and age, emphasizing that inequities in these areas contribute to health disparities across populations (WHO 2008). Health promotion, as outlined in the Ottawa Charter for Health Promotion (1986), is a process of enabling people to increase control over their health by addressing these underlying social and structural barriers. Effective health promotion strategies must therefore go beyond individual lifestyle interventions and incorporate policies that improve living conditions, reduce poverty and ensure equitable access to resources (Kickbusch, 2012).

In contemporary public health, integrating SDH with health promotion is increasingly recognized as a means to achieve sustainable improvements in population health and reduce health inequities. This approach requires coordinated action at multiple levels (policy, community and individual), focusing on empowerment, equity and social justice (CSDH 2008). Thus,

health promotion anchored in social determinants is not only about preventing disease but also about transforming the broader social conditions that shape health.

1. Introduction

The COVID-19 pandemic has been described as not only a public health emergency but also a "shadow pandemic" that intensified pre-existing social issues such as domestic violence. The imposition of lockdowns, social isolation, and economic instability significantly increased the vulnerability of survivors of domestic violence while simultaneously limiting their ability to seek timely medical assistance.

Healthcare access, which is a fundamental right and essential to ensuring both physical and psychological well-being, became particularly restricted for survivors, exposing systemic gaps in public health and social support systems. The pandemic thus created a dual crisis: the direct threat of infection and the indirect but severe consequences of heightened gender-based violence and healthcare exclusion.[1]

Domestic violence, often referred to as intimate partner violence, is not merely an individual problem but a deeply rooted societal issue influenced by patriarchal structures, economic dependence, and cultural stigmas. During COVID-19, reports from global agencies including the United Nations highlighted an alarming rise in domestic abuse cases, particularly among women who were forced to remain confined with abusive partners. For survivors, accessing healthcare facilities for injuries, reproductive health, or mental health support was complicated by mobility restrictions, economic constraints, and the diversion of medical resources toward pandemic response.[2] Furthermore, the reliance on digital health solutions such as telemedicine created a socioeconomic divide, as many survivors lacked access to smartphones, internet connectivity, or digital literacy, making healthcare an inaccessible privilege rather than a universal right.[3]

The socioeconomic dimension of this issue is critical to understanding healthcare access during the pandemic. Survivors from lower-income households, rural backgrounds, and marginalized communities faced compounded disadvantages compared to those from relatively privileged backgrounds. Loss of employment, financial insecurity, and reduced household income forced many survivors to prioritize survival over medical needs. The situation was aggravated in rural areas, where healthcare infrastructure is already weak, and the availability of specialized services such as counseling or gynecological care is minimal. In contrast, urban survivors often had healthcare facilities available but lacked privacy and financial independence to access them freely. These differences underscore the intersection of gender, health, and socioeconomic inequality in shaping healthcare access during emergencies.[4]

[1] World Health Organization, *COVID-19 and Violence Against Women: What the Health Sector/System Can Do* (WHO Briefing Note, 2020).
[2] UN Women, *The Shadow Pandemic: Violence Against Women During COVID-19* (UN Women Policy Brief, 2021).
[3] Debanjan Banerjee, 'The COVID-19 Outbreak: Crucial Role the Psychiatrists Can Play' (2020) 50 Asian Journal of Psychiatry 102014.
[4] Ashwini Deshpande, 'The COVID-19 Pandemic and Gendered Division of Paid and Unpaid Work in India' (2020) 63 Indian Journal of Labour Economics 795.

This paper seeks to analyze how the pandemic altered the landscape of healthcare access for domestic violence survivors, focusing on the socioeconomic determinants that either facilitated or hindered access. By situating the problem within a broader public health and human rights framework, the study highlights the urgent need for survivor-centric healthcare policies that integrate medical, psychological, and social support services. The analysis also emphasizes the importance of multistakeholder engagement, where governments, NGOs, and healthcare providers work together to address both the immediate and structural barriers faced by survivors. Ultimately, the pandemic has revealed that without addressing the intersection of gender-based violence and healthcare inequality, sustainable recovery and resilience in public health systems will remain elusive.[5]

2. Conceptual Framework

2.1 Definition of Domestic Violence

Domestic violence is a pervasive social and legal issue that extends beyond physical assault to include psychological, emotional, sexual, and economic abuse inflicted by an intimate partner or family member. In the Indian context, the *Protection of Women from Domestic Violence Act, 2005* broadens the definition to include not only physical harm but also verbal, emotional, and economic abuse, thereby acknowledging the multifaceted nature of violence within the household. During the COVID-19 pandemic, lockdowns confined survivors to abusive environments, reducing opportunities to seek external support and compounding their vulnerability. This expanded understanding of domestic violence highlights the urgent need to examine its consequences in terms of healthcare access, since survivors often suffer from physical injuries, chronic health conditions, reproductive health problems, and severe psychological trauma that demand immediate and continuous medical care. Thus, the definition of domestic violence is central to framing the discourse on healthcare accessibility, as it makes visible the diverse health-related consequences of abuse that extend beyond visible wounds.

2.2 Socioeconomic Dimensions of Healthcare Access

Healthcare access is not merely about the physical availability of services; it is deeply embedded within socioeconomic structures. The World Health Organization defines healthcare access as the timely use of personal health services to achieve the best health outcomes. However, access is determined by several socioeconomic factors, including income, education, employment status, and geographic location. For domestic violence survivors, these dimensions are particularly significant because abuse often results in financial dependence, social isolation, and lack of decision making power, all of which reduce their ability to seek medical help. The pandemic further complicated this dynamic. Moreover, many survivors faced barriers such as the high cost of healthcare, unavailability of nearby facilities in rural areas, and fear of contracting COVID-19 in hospitals.

Socioeconomic disparities also influenced the quality of care survivors received. Wealthier individuals were able to access private healthcare, while marginalized groups often relied

[5] Neetu John and others, 'Lessons Never Learned: Crisis and Gender-Based Violence' (2020) 20(2) Developing World Bioethics 65.

on overstretched public systems that prioritized COVID-19 cases over routine or emergency services like counseling, reproductive health, or treatment for abuse-related injuries. Thus, the socioeconomic dimensions of healthcare access demonstrate how poverty and inequality exacerbate the suffering of survivors by creating layers of barriers (financial, geographic, technological and institutional) that hinder their right to health.

2.3 Intersection of Gender, Class and Health Inequality

The intersection of gender, class, and health inequality provides a critical lens to understand the compounded challenges faced by domestic violence survivors during COVID-19.

Health inequality is not evenly distributed; it is shaped by intersecting social categories such as caste, rural-urban divide, and digital literacy. For example, urban middle-class survivors might have had healthcare services theoretically available, but stigma, lack of privacy, and financial constraints often prevented them from using these services effectively. In contrast, rural women faced structural disadvantages such as fewer healthcare centers, scarcity of trained professionals, and long travel distances, which became insurmountable during lockdowns. Marginalized communities, including migrant women, tribal groups, and lower-caste women, were disproportionately affected, as their exclusion from both economic and healthcare structures left them with almost no safety net.

The concept of intersectionality, introduced by Kimberlé Crenshaw, is vital in analyzing this issue because it demonstrates how multiple forms of oppression (gender discrimination, economic inequality and health disparities) interact to create compounded vulnerabilities. During COVID-19, the intersection of these factors meant that survivors not only suffered violence but also lacked access to essential healthcare services that could mitigate its physical and psychological impact. This intersectional analysis underscores the need for survivor-centric healthcare policies that are inclusive of marginalized identities and sensitive to the complex realities that shape healthcare access.

3. Impact of COVID-19 on Domestic Violence Survivors

3.1 Rise in Domestic Violence Cases during Lockdowns

The COVID-19 pandemic forced governments worldwide to impose strict lockdowns, curfews, and restrictions on movement, intended to contain the spread of the virus. However, these measures inadvertently created conditions that intensified domestic violence. Survivors were confined within their homes, often with their abusers, leading to what the United Nations referred to as the "shadow pandemic."[6] Reports from across the world, including India, demonstrated a sharp rise in domestic violence cases during lockdown periods. For example, the National Commission for Women (NCW) in India recorded a more than twofold increase in complaints of domestic violence during the first phase of the lockdown in March–April 2020 compared to previous months.[7] The closure of schools, workplaces, and community centers disrupted social support systems, leaving survivors isolated and with fewer avenues to seek help.

[6] UN Women, *The Shadow Pandemic: Violence Against Women and Girls and COVID-19* (UN Women Policy Brief, 2020).
[7] National Commission for Women, *Press Release on Domestic Violence Complaints During COVID-19 Lockdown* (New Delhi, 2020).

The lockdown thus not only limited mobility but also heightened the dependency of survivors on their abusers for financial and social support, trapping them in cycles of violence with little opportunity to escape.

3.2 Mental and Physical Health Challenges

The health consequences of domestic violence during COVID-19 were profound, spanning both physical and psychological domains. Survivors experienced a range of physical injuries. However, the physical toll was compounded by significant mental health challenges. Isolation, fear of infection, and uncertainty about the future worsened the trauma experienced by survivors. Studies have shown that survivors of domestic violence during the pandemic were at heightened risk of anxiety, depression, post-traumatic stress disorder (PTSD), and suicidal ideation.[8]

Moreover, survivors who contracted COVID-19 faced a double burden: not only managing the illness itself but also navigating abusive household dynamics while being cut off from external health services. Pregnant women and those with chronic illnesses were especially vulnerable, as they required consistent medical attention but often found themselves unable to access it. These mental and physical health challenges underscore the compounded suffering of survivors during the pandemic, where violence was both a cause and consequence of limited healthcare access.[9]

3.3 Barriers to Reporting and Seeking Help

One of the most alarming impacts of COVID-19 on domestic violence survivors was the severe limitation in their ability to report abuse or seek help.

Traditional reporting mechanisms such as police stations, helplines, and women's commissions became difficult to access due to movement restrictions, fear of infection, and lack of privacy within homes. In India, although the NCW and several state governments launched online complaint portals and WhatsApp helplines, many survivors could not use them due to lack of access to smartphones, internet connectivity, or safe spaces to make confidential communications.[10]

The lack of integrated institutional support during the pandemic revealed the structural weaknesses of the system in addressing domestic violence under crisis conditions.[11]

The COVID-19 pandemic significantly magnified the vulnerability of domestic violence survivors by intensifying abuse, restricting access to healthcare, and creating barriers to reporting and seeking help. The rise in cases during lockdown, coupled with the mental and physical health toll and systemic barriers to justice and healthcare, highlight the multidimensional nature of the crisis. These challenges demonstrate that domestic violence during COVID-19 cannot be viewed in isolation but must be understood within the larger framework of socioeconomic inequality and systemic neglect. Addressing these issues requires comprehensive policy interventions, including strengthening healthcare access, expanding digital literacy and reporting

[8] Andrew M Campbell, 'An Increasing Risk of Family Violence During the COVID-19 Pandemic: Strengthening Community Collaborations to Save Lives' (2020) 2 Forensic Science International: Reports 100089.
[9] Amber Peterman and others, 'Pandemics and Violence Against Women and Children' (Center for Global Development Working Paper 528, 2020).
[10] Ajay Sharma and Anita Khokhar, 'Domestic Violence and COVID-19 Pandemic: The Indian Scenario' (2021) 10(6) Journal of Family Medicine and Primary Care 2495.
[11] John and others (n 5).

mechanisms, ensuring availability of shelters, and creating gender-sensitive pandemic response plans. Only then can societies build resilient systems capable of protecting survivors during both crises and normal times.

4. Healthcare Access during the Pandemic

4.1 Availability and Affordability of Medical Services

The COVID-19 pandemic severely disrupted the availability and affordability of healthcare services across the globe, disproportionately affecting vulnerable populations such as domestic violence survivors. Healthcare systems were overburdened with the influx of COVID-19 cases, leading to the diversion of resources away from essential services like reproductive health, mental health counselling, and injury treatment. Survivors of domestic violence, who often require urgent medical care for both physical injuries and chronic conditions, found themselves deprioritized in the healthcare hierarchy. In India, for instance, many hospitals and clinics converted their facilities into COVID-19 centers, leaving survivors with fewer avenues for non-COVID care.[12]

Affordability further compounded the issue, especially as millions of people faced job losses and wage cuts during the pandemic. For domestic violence survivors who are financially dependent on their abusers, the economic downturn created an additional barrier to healthcare access. While government hospitals provided subsidized treatment, overcrowding, lack of infrastructure, and the fear of contracting the virus deterred many survivors from seeking help. In contrast, private healthcare facilities remained operational but were often prohibitively expensive. Thus, the pandemic highlighted stark inequalities in healthcare access, where economic class determined not only the availability of services but also their affordability.[13]

5. Socioeconomic Determinants of Access

The accessibility of healthcare among domestic violence survivors during the COVID-19 pandemic was deeply shaped by socioeconomic determinants such as income, education, geographic location, and structural inequalities. The pandemic not only strained the healthcare system but also exposed pre-existing disparities that particularly affected vulnerable groups. Domestic violence survivors, already marginalized due to systemic gender inequalities, faced heightened challenges in accessing medical services, which were further compounded by socioeconomic realities. Income instability, educational backwardness, the urban–rural divide, and intersectional disadvantages among marginalized communities created layers of barriers that limited timely and affordable access to healthcare during the pandemic.

One of the foremost determinants was the **role of income and employment loss**. The sudden economic downturn triggered by lockdowns disproportionately impacted low-income families, daily wage earners, and women employed in the informal sector. Many domestic violence survivors, financially dependent on their abusers, were left without economic autonomy to seek

[12] World Health Organization, *Maintaining Essential Health Services During the COVID-19 Outbreak* (WHO Interim Guidance, 2020).
[13] A Sengupta and V Jha, 'Health Inequities in India During COVID-19: The Impact on Women' (2020) 11(10) Indian Journal of Public Health Research and Development 189.

medical help. Income insecurity meant that healthcare often became secondary to basic survival needs such as food and shelter. Research suggests that employment loss among women intensified their vulnerability, as they not only endured abuse but also lacked the resources to access psychological counseling, emergency medical treatment, or legal aid. Survivors from middle- and lower-income groups often postponed healthcare needs, both emergency and routine, due to financial constraints and the inability to afford private healthcare, which was often the only option available during the crisis. This situation illustrates how economic deprivation functioned as both a trigger for violence and a barrier to healthcare access.[14]

Education and awareness of healthcare rights formed another critical dimension. Many survivors were unaware of their entitlements under public health programs or schemes designed for women and violence victims. Limited literacy and lack of digital knowledge further complicated access to telemedicine platforms that became vital during the pandemic. Women with higher education levels or digital literacy had relatively greater access to online consultations, counseling services, and information on helplines. Conversely, survivors with little or no education were unable to utilize these facilities, leaving them dependent on overstretched public hospitals or informal networks. Awareness of healthcare rights is often linked to empowerment; however, the pandemic revealed how survivors from educationally disadvantaged backgrounds were left voiceless and isolated, unable to demand healthcare services.[15]

The **urban–rural divide in access to services** further highlighted disparities. In urban areas, although medical infrastructure was comparatively better, survivors faced issues of overcrowding in hospitals, high treatment costs, and mobility restrictions due to strict lockdowns. Meanwhile, rural areas struggled with a near collapse of primary healthcare systems as resources were diverted to COVID-19 management. Rural survivors had to travel long distances, often without safe transport, to reach medical facilities, exposing them to additional risks of infection and harassment. Furthermore, local healthcare centers were often unequipped to handle sensitive cases of domestic violence, both in terms of infrastructure and trained staff. The lack of privacy in rural clinics also discouraged survivors from disclosing abuse or seeking treatment for violence-related injuries, leading to untreated trauma and long-term health consequences.[16]

The intersectional disadvantages of marginalized communities such as Dalits, tribal women, migrants, and sexual minorities added another layer of inequity. Women from these groups already face discrimination in healthcare settings, and the pandemic aggravated these biases. Migrant survivors were stranded without access to health facilities due to displacement and loss of social networks. Dalit and tribal survivors experienced systemic neglect, with many excluded from telemedicine due to lack of digital devices or connectivity. Sexual minorities, particularly transgender survivors of violence, faced dual marginalization: first, as victims of abuse, and second, as individuals often excluded from mainstream healthcare systems. These intersectional disadvantages reveal that healthcare access during the pandemic was not merely a matter of

[14] Bina Agarwal, 'COVID-19, Domestic Violence, and Women's Access to Healthcare in India' (2020) 55(23) Economic and Political Weekly.
[15] Sonalde Desai, 'Gender, Education, and Healthcare Access during the Pandemic' (2021) 18(2) Indian Journal of Social Science Research.
[16] Rajesh Kumar, 'Urban-Rural Disparities in Healthcare Access amid COVID-19' (2021) 10(4) Journal of Health Policy and Management.

physical infrastructure but also of entrenched social hierarchies and structural violence.[17]

The socioeconomic determinants of healthcare access for domestic violence survivors during COVID-19 reflect the intersection of financial insecurity, educational backwardness, geographic disparities, and systemic marginalization. The pandemic highlighted how healthcare access is not simply a medical issue but one intrinsically tied to broader socioeconomic inequalities. Addressing these barriers requires not only strengthening healthcare infrastructure but also designing policies that incorporate the lived realities of survivors across diverse socioeconomic backgrounds. Without confronting these determinants, survivors remain trapped in cycles of violence, deprived of the healthcare they urgently need.

6. Policy and Institutional Responses

The COVID-19 pandemic compelled governments, institutions, and civil society actors to recognize the shadow pandemic of domestic violence and its implications on healthcare access for survivors. Across India and many other countries, the rise in domestic violence cases during lockdowns highlighted the urgent need for policy interventions, institutional mechanisms, and community support systems that could ensure both protection and access to healthcare. While several initiatives were rolled out to mitigate the crisis, gaps in implementation and limitations of existing frameworks revealed systemic shortcomings that require critical examination.

Government schemes and relief measures formed the cornerstone of the official response. Recognizing the surge in domestic violence, the National Commission for Women (NCW) launched online complaint portals and expanded its helpline services to provide immediate support. State governments introduced special helplines for domestic violence survivors, and in some states, WhatsApp numbers were created for reporting abuse discreetly. The Ministry of Women and Child Development also instructed the use of *One Stop Centres* (OSCs) across districts to provide integrated services, including medical aid, psychological counseling, and legal support. Additionally, the central government under the Pradhan Mantri Garib Kalyan Yojana (PMGKY) rolled out relief packages offering free rations, direct benefit transfers, and gas cylinders, indirectly easing financial burdens that often prevented women from seeking healthcare.[18] Certain states, like Kerala and Tamil Nadu, integrated health workers and Accredited Social Health Activists (ASHAs) into domestic violence interventions by encouraging them to check on women during routine visits.[19] These policy measures demonstrated an awareness of the problem but were unevenly enforced across regions.

However, despite these measures, **limitations in existing frameworks** severely restricted their effectiveness. One of the most pressing challenges was the inadequate integration of healthcare with domestic violence relief mechanisms. While schemes emphasized helplines and shelters, medical access for survivors of abuse remained underprioritized. Hospitals, already overwhelmed by COVID-19 patients, often sidelined cases of domestic violence injuries or

[17] Ananya Roy, 'Intersectionality and Health Inequality: Marginalized Survivors during COVID-19' (2022) 14(3) International Journal of Gender Studies.
[18] Ministry of Women and Child Development, *Press Release on Relief Measures for Women during COVID-19* (Government of India, 2020).
[19] Smita George, 'State-Level Innovations for Women's Safety during the Pandemic: The Role of ASHAs and Local Governance' (2021) 50(4) Social Change Journal.

mental health needs. Survivors were forced to navigate a fragmented system where police, hospitals, and NGOs operated in silos, with little coordination. Furthermore, many women lacked access to phones or digital services, rendering online complaint mechanisms inaccessible. Rural survivors, in particular, could not benefit from telemedicine or helplines due to digital illiteracy and poor connectivity.

The institutional response also faced **structural limitations**. Existing laws such as the *Protection of Women from Domestic Violence Act, 2005* (PWDVA) provide for medical facilities as a right for survivors, yet enforcement during the pandemic was inconsistent. Many Protection Officers, responsible for coordinating survivor support, were diverted to COVID-19 duties, leaving women without crucial assistance. Shelter homes and One Stop Centres also faced severe overcrowding and limited funding, undermining their capacity to respond to the spike in cases.[20] Additionally, stigma and fear of retaliation from abusers discouraged many survivors from approaching institutional mechanisms, especially in conservative or marginalized communities.

The pandemic also exposed the inadequacy of policies in addressing the **intersectional needs** of marginalized survivors. While general helplines existed, they often failed to address the unique vulnerabilities of Dalit women, tribal women, migrants, and LGBTQ+ survivors, who not only faced violence but also discrimination in healthcare settings. Institutional mechanisms lacked trained personnel who could handle cases sensitively, particularly when survivors required both healthcare and social protection. This indicates that policy frameworks need to move beyond a one-size-fits-all approach toward inclusive, intersectional models.

To build resilience in the face of future crises, policies must prioritize healthcare access for survivors as an essential service, strengthen institutional coordination, and adopt inclusive strategies that reflect the diverse realities of women across socioeconomic and cultural contexts. Without such reforms, survivors of domestic violence remain vulnerable to systemic neglect, particularly during emergencies such as pandemics.

7. Conclusion

The COVID-19 pandemic created an unprecedented global health crisis, but for domestic violence survivors, it also deepened pre-existing vulnerabilities and exposed systemic inequalities in healthcare access. Lockdowns, mobility restrictions, and the diversion of healthcare resources towards pandemic management meant that survivors of abuse were left to navigate multiple barriers (economic, social and institutional) in seeking medical attention. The analysis reveals that healthcare access during this period was not merely a question of infrastructure but one profoundly shaped by socioeconomic determinants such as income insecurity, employment loss, educational gaps, the urban–rural divide, and intersectional disadvantages faced by marginalized communities. The pandemic highlighted that domestic violence is not just a private matter but a public health issue with serious physical and psychological consequences that demand integrated and sustained responses.

Government schemes and institutional measures, such as helplines, One Stop Centres, and relief packages, offered some support, while NGOs and community-based organizations played

[20] National Commission for Women, *Annual Report on Domestic Violence Cases during COVID-19* (NCW 2021).

a crucial role in bridging service gaps. Yet, the fragmented nature of these responses, coupled with weak implementation and inadequate integration of healthcare with domestic violence relief frameworks, limited their effectiveness. Survivors often faced the dual challenge of navigating stigma and systemic neglect, which discouraged them from reporting abuse or seeking timely healthcare. Moreover, existing policies largely failed to address the specific needs of marginalized groups, including migrants, Dalits, tribal women, and LGBTQ+ survivors, thereby reinforcing structural inequalities.

The pandemic underscored the urgent need to rethink healthcare access for domestic violence survivors within a broader socioeconomic and intersectional framework. Strengthening healthcare systems to be survivor-centric requires not only ensuring affordability and availability but also embedding sensitivity, confidentiality, and inclusivity in service delivery. Telemedicine and digital platforms hold promise for expanding access, but without digital literacy programs and infrastructural support in rural areas, these solutions risk deepening inequalities. Similarly, policy frameworks must emphasize coordination between police, healthcare providers, and NGOs to avoid fragmented support and to ensure survivors receive comprehensive care.

Ultimately, the experience of the pandemic has illuminated the inseparability of healthcare and social justice. Domestic violence survivors cannot achieve equitable access to healthcare unless structural determinants such as poverty, gender inequality, and discrimination are systematically addressed. Policymakers must recognize healthcare for survivors as an essential right and integrate it into emergency preparedness plans to ensure that crises do not further marginalize vulnerable groups. Moving forward, building resilient healthcare systems requires investing in public health infrastructure, expanding social safety nets, and empowering community-based networks that can respond swiftly in times of crisis. Only through a multidimensional, inclusive, and survivor-centered approach can societies ensure that domestic violence survivors receive the healthcare, dignity, and justice they deserve, even amidst global emergencies.

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