

GENDER PERSPECTIVES ON HEALTHCARE ACCESS IN UNIVERSITIES

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ABSTRACT

The paper investigates the gendered patterns in accessing healthcare in university spaces. Institutions of higher education which are associated with inclusivity and multicultural values often reproduce barriers that disproportionately affect women students. The study draws on a structured narrative of secondary literature with thematic synthesis and analyzes empirical case studies from India and elsewhere through the lenses of structural violence and gender-based violence. It identifies three interrelated mechanisms through which gendered barriers to healthcare are produced and sustained i.e. infrastructural invisibility, procedural opacity and normative normalization. These mechanisms manifest in inadequate menstrual hygiene facilities, limited transparency in health services and the routinization of gendered norms that render women's health needs inconspicuous. The paper argues that barriers or inaccessibility to healthcare in university spaces may be understood as a form of institutionalized structural violence which is rooted in gendered relations of power. The notion of gender discrimination and violence reflects a structural character that is manifested through various norms and institutional practices in higher education institutions. Various policies in India explicitly recognize the prevalence of such issues and propose institutional measures which, if effectively implemented, hold significant potential for addressing and mitigating these challenges.

Keywords: Women and Health, Health & Gender, Sociology of Organizations, Institutions & Structures, Accessibility, University.

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INTRODUCTION

The access to adequate healthcare services is no longer considered a question of welfare demand but invoked as a matter of right (WHO, 2023). These services are channeled through various support systems, largely through

infrastructures which caters to the various strata of our social system. Such is the case for the students who are expected to receive adequate healthcare support having an enabling environment for their academic

growth in higher education institutions yet the persistence of the cases of absence of basic amenities or inaccessibility to existing services suggest the undermining of their dignity and autonomy. Women students are highly vulnerable to these infrastructural limitations as their academic performance and wellbeing are disproportionately affected than the male students. These inequality of gendered norms become part of the institutional structure which are often manifested in subtle routine practices, attitudes and institutional arrangements. Even institutions associated with values of equality and inclusivity may reproduce such disparities which often remain insufficiently examined. A closer engagement with empirical cases is therefore necessary to develop a better understanding of the processes that may contribute to the sustenance of such vulnerability and marginality within institutional context.

The broader objective of the study is to analyze the role of higher education institutions, specifically universities as an inclusive institution in shaping gendered patterns of discrimination and access for women. The study draws on sociological perspectives such as symbolic violence (Bourdieu, 2001; Schubert, 2008; Angeliqa and Sarwono, 2018), structural violence (Galtung, 1969; Farmer et al., 2006) and gender-based violence (Montesanti, 2015). The reviews of existing literature is guided by these two interrelated questions (i) what barriers do women students face in accessing healthcare services in universities and how do these barriers relate to their vulnerability to gender identity? And (ii) In what ways does limited accessibility reflect broader patterns of gender discrimination? The analysis is undertaken to develop a more comprehensive understanding of the structures of discrimination and the gendered nature of inaccessibility. The paper contributes to the existing literature by conceptualizing

healthcare inaccessibility in university spaces as a distinct form of institutionalized structural violence. The study employs narrative review of literature by operationalizing the tripartite analytical framework built through the synthesis of the findings. The first mechanism of the framework is the infrastructural invisibility which focuses on how women's healthcare needs remain insufficiently recognized in institutional design. The second mechanism of procedural opacity highlights the limited accessibility and transparency of the healthcare systems. Normative normalization is the last mechanism which captures how gender injustice is systematically entrenched within the everyday practices in the institutions. This tripartite framework facilitates the deeper analysis of how institutional arrangements shape gender inequalities in accessing healthcare in universities while moving beyond descriptive accounts of accessibility.

The next section of the paper provides a detailed discussion on the methodology and theoretical framework of the study. Then the second section examines the evolution of the concept of "access" and its meanings. It is followed by an analysis of empirical case studies to understand the relationship between gender and healthcare accessibility in both India and abroad. Then the fourth section will discuss the findings of the empirical case studies of institutional violence in the light of our theoretical framework. It is followed by a discussion of the key insights and limitations emerging from the literature. The final section reflects on the contemporary policies on improving healthcare services for women and their safety in higher education institutions in India.

METHODOLOGY

The study is primarily based on a structured narrative review of secondary literature with thematic synthesis on accessibility, gender

violence and healthcare in universities. The broader objective is to investigate how the lack of access to essential amenities and healthcare services in university spaces disproportionately undermine the well-being and safety of women students. The paper aims to develop a comprehensive understanding of how the denial of basic amenities perpetuate gender inequality, heighten the risk of violence which ultimately affect women's overall university experience. The experiences of transgenders or people from other sexualities (LGBTQ++) were deliberately excluded as the literature concerning their issues on the subject would lose their autonomy if situated within overarching experiences of women. Although they have been the subject of violence in a patriarchal system however their scholarships necessitates an autonomous treatment as the academic work on women has already been matured. Therefore the studies on transgenders and LGBTQ++ experiences of discrimination and gender violence in university spaces and beyond were placed in the exclusion criteria.

This paper approaches the topic through a sociological perspective using the conceptual understanding of symbolic violence (Schubert 2008), structural violence (Farmer et al. 2006) and gender based violence (Montesanti 2015) as a lens to access the empirical case studies. The symbolic violence is developed by Pierre Boudieu (2001). It is understood as a subtle form of violence where the victims do not recognize the violence being perpetrated on them and actively approve the acts as discussed in works of Angeliqa and Sarwono (2018) and Schubert (2008). On the other hand, structural violence was coined by Johan Galtung (1969) and it refers to the way social structures restrict the actors (Individuals, groups or societies) from realizing their full potential (Farmer et al. 2006) or work to their disadvantage. Farmer et al. (2006) argue that the entanglement and

interdependence of our social, political and economic realities enables the formation of structures which favor certain social groups while disfavoring others, in effect causing harm. The intersection of gender with structural violence is discussed in the work of Montesanti (2015) who conceptualizes gender-based violence as encompassing the gendered dimensions present across multiple forms of violence. All of these conceptual perspectives are used to develop a sociological understanding of the gendered nature of inaccessibility to healthcare in a university system.

The study is designed as a theoretically informed narrative literature review with the search and selection process outlined to enhance methodological transparency (Snyder, 2019). The choice of a narrative review over a strictly systematic design is guided by the nature of the inquiry which is oriented towards interpreting how structures of power operate through institutional practices rather than aggregating quantifiable findings. As Snyder (2019) notes, narrative reviews can be particularly useful for building conceptual understanding across diverse disciplinary perspectives which aligns with the broader sociological objectives of the present study. The literature survey was conducted using keyword-based searches on Google Scholar with keywords like "healthcare and university", "gender violence and university", "access in healthcare" on the search engine. The initial time frame was set to "Since 2024" to find the latest research papers on the subject and then it was switched to "anytime" for enhancing the relevance of the results. After the initial filtration, the second iteration of the literature survey was conducted by adding "India" at the end of the above mentioned keywords in the search title for the purpose of exploring literature based on Indian context. The selection of the papers were made based on the inclusion criteria of

the study design which was finalised to include the concept of "accessibility", "gender discrimination", "gender violence", "healthcare" along with the keyword "university" being used with each of them in the title itself, sparing few exceptions. The demography or the "population" of the study design were primarily university students, school students, patients or consumers of healthcare services. Exceptions were made for the research papers which were empirical in nature while also providing the conceptual clarifications on the above mentioned concepts.

The scope of the research is intentionally delimited to enable a more focused engagement with the selected literature. Expanding the range of empirical studies without sufficient conceptual integration may risk producing fragmented insights. Accordingly, the study emphasises the interpretive synthesis of existing research to contribute to a more coherent understanding of the gendered dimensions of healthcare access in higher education institutions.

The Concept of "Access" in Healthcare

The concept of 'access', despite its frequent uses in various regulatory or healthcare policies, had remained mostly undefined or ambiguous for a long time in academia and public policy domain (Penchansky and Thomas 1981). The concept of spatiality or distance to healthcare infrastructures had long been dominating the understanding of "access" in public policy (Khan and Bhardwaj 1994; Sibley and Weiner 2011). However, many studies attempted to break free from the theoretical convention either by shifting the attention from the presence of health facility to its actual utilisation (Donabedian 1972; Dominic et al. 2019) or synthesising and thematically segregating the perspectives provided by the existing body of literature (MacKinney 2014; Chapman et al. 2004).

A theoretical exploration by Khan and Bhardwaj (1994) highlights the spatial dimensions in the concept of "access" along with the conventional spatial definition. The authors developed a typology of access model by taking into account the policy planning perspective where the ability of the population to utilise healthcare services was given the central role in defining the conception of "access". The spatial typology refers to the geographical proximity of the healthcare services and the non-spatial typology denotes the differences in accessing or utilising healthcare services among various social groups or populations due to socio-economic, political or psychological barriers etc. Hence, the study provides a simplistic model for policy planners to effectively deal with the problem of "accessibility" by being cognizant of the multifaceted dimensions of the concept. However, the inherent bias in the majority of the studies and policy planning was the generalising tendency when approaching and ensuring accessibility for the masses. Hartley et al. (1994) in their quantitative study demonstrate how health insurance policy reforms of the state (Minnesota in United States), premised on the one-size-fits-all approach, lead to different health outcomes across the rural-urban spatiality. Their findings suggest that rural populations were at a great disadvantage in terms of low insurance coverage and high out-of-pocket expenditures made for getting insured. However, one interesting case reflected how the informal networks of altruism partially offset the impact faced by uninsured rural residents. The rural physicians altruistically provided care to most uninsured patients. Evidently, the top-down policy approaches mostly miss out on the contextualist factors which require greater attention to enhance the accessibility to healthcare services. The study concludes by providing bottom-up solutions for effective policy reforms.

The conceptual definition of "access" had undergone many revisions where the objective of reducing ambiguity led to the search for central tenets constituting the concept. One strand of study (Millman 1993) attempted to shift the definitional focus of access concept from the availability of health care services to the outcome obtained from their utilisation. Dominic et al. (2019) called it the "access performance" where the adequate delivery of expected health outcomes are measured. Under this framework, the unit of analysis is more inclined to the consumers rather than the provider of healthcare services. The concept of "equity" becomes central when the onus of the analysis is the population (Millman 1993; Chapman et al. 2004). Similarly, the systematic review of literature on access to primary health services conducted by Chapman et al. (2004) teases out an interesting discussion on access and access inequality. They deconstruct the concept of access into four dimensions of 'availability' or supply of health services, 'utilisation' in terms of demand, 'effectiveness' as the appropriateness of available services to cater to the needs and 'equity' indicating the social justice dimension of the concept. On the discussion of "access inequality", they underscore how certain policy interventions lead to ease of access for wealthy or financially sound patients only whereas the patients from lower strata are left outside the purview.

A survey-based quantitative study by Sibley and Weiner (2011) compares population's perception of access to healthcare across rural and urban continuum. Their finding unravels the inequities inherent across multiple parameters which restricts the population of certain spatiality i.e. rural or urban from adequately availing the benefits of healthcare despite infrastructural presence and wide coverage of health insurance. An interesting observation highlighted by the study pertains

to the perception of "unmet healthcare needs". The perception of rural population is determined by economic capability which extends their threshold of urgency of accessing healthcare services, in effect, downplaying the reality of their actual medical needs. Conclusively, they emphasised the need to integrate the contextualist parameters in policy planning rather than adopting the generalist perspective based on overall spatial assessment.

Taking a departure from earlier studies, MacKinney (2014) attempts to streamline the conception of "access" by dissecting it into four broad dimensions namely "people, place, provider and payment" extracted from the critical review of previous literature (MacKinney 2014, 1). The dimension of people emphasises the various individual or collective factors associated with health providers and consumers which facilitate or hinder the accessibility. Similarly, the place dimension highlights the spatial factors such as geographical distance, travelling time, urban or rural setting which affects accessibility. On the contrary, the provider perspective considers the number of healthcare professionals, infrastructure and policies which influence the quality of healthcare delivery, in effect, determining accessibility. The payment perspective focuses on the economic aspects such as insurance coverage or out-of-pocket expenditure to measure the degree of accessibility. Ultimately, the study proposed a synthesis of many dimensions of access which were scattered across different bodies of literature to highlight the interconnected and dynamic nature of the concept of access.

Another theoretical strand advanced by some studies (Carrillo et al. 2011; Millman 1993) emphasises the elimination of barriers to healthcare delivery as a measure to conceptualise "access". Similarly, the barrier model developed by Millman (1993) measured

barriers across three broad conceptual frames, namely structural, financial and personal. While the structural barrier refers to the availability, organisation and transportation of healthcare services, the financial barrier mostly emphasises the extent of insurance coverage and public support for accessing healthcare services. Finally, the personal barrier parameter covers the influence of cultural, linguistic, educational or income criteria on determining access to healthcare services. Similarly, the barrier model of Carrillo et al. (2011) examines the barriers on three parameters namely financial, structural and cognitive which almost converges with the understanding provided by Millman (1993). The financial barriers parameter mainly focuses on the challenges and constraints faced by the uninsured population whereas the structural barriers highlight the availability of services along several external factors such as long waiting time etc. The cognitive barriers are mostly associated with the personal beliefs and knowledge as well as the nature of communication influencing the "patient-provider interaction" (Carrillo et al. 2011, 566).

Employing the extensive critical review of existing literature, Ricketts and Goldsmith (2005) attempt to develop a comprehensive framework of understanding and measuring access to healthcare services. They emphasised on the need to acknowledge the dynamic process inherent in the structures and resources of health care services and infrastructure. The appropriate identification of elements which are static and dynamic is important for allocating resources judiciously and yield efficient outcomes. The transition from "potential access" to "realised access" is the result of dynamic interaction i.e. the knowledge exchange and development of experience in the medical environment, between the health infrastructure and the

population both providers and consumers of health services.

Gender and Accessibility in Healthcare Services

The intersection of gender identity and its role in influencing and shaping access to medical health utilisation and outcome are empirically substantiated by studies recurrently. A large-scale quantitative study conducted by Da Conceição et al. (2014), ranging across 8 major countries of Europe namely Greece, France, Germany, Ireland, Italy, Portugal, Spain, and the United Kingdom, unravels the gendered pattern in various challenges associated with accessing healthcare services. They open up a discussion on how populations with diverse backgrounds and characteristics result in many dimensions of accessibility or inaccessibility when their perception and utilisation are empirically approached and measured. Surprisingly, the quantitative assessment of variables such as the cost of medical healthcare services, distance travelled to reach the health centre and the waiting lists at the centre revealed a gendered pattern of accessibility where the challenges were mainly tilted towards female participants. The most critical factor in hindering accessibility was the "cost of healthcare services" where the tilt of unfavorability towards women reflects the gendered construction of economic vulnerability.

The educational institutions occupy a central position in ensuring availability and accessibility to students in medical health services. A quantitative study conducted by Kaur and Kaur (2019) assessed sanitation behaviours among school and college women in India. Their findings revealed a strong statistical association between information dissemination by the institution and sanitation practices and awareness of female students. For instance, "sanitary napkin vending

machines" installed within the institutional spaces were largely left unused as the appropriate information was not disseminated by the institutions. The challenge of menstrual health management in Indian educational institutions, however, extends well beyond isolated informational lapses. A systematic review and meta-analysis by van Eijk et al. (2016) of over 97,000 adolescent girls across India found that approximately one in four reported school absenteeism during menstruation, situating the Kaur and Kaur findings within a far wider pattern of structural inadequacy in institutional provisions for women's health. Conclusively, the Kaur and Kaur (2019) study underscores the centrality of educational institutions in cultivating good healthy practices among the students as well as providing institutional support and infrastructure for the same.

The above case studies highlight how the notion of accessibility becomes unfavourable for some when intersected with gender identities. The disadvantageous tilt towards women even in the so-called inclusive institutions like universities points towards an alarming situation of vulnerability and marginality of the weaker gender. These phenomena are so implicit and inconspicuous in our everyday experiences that they hardly become the subject of resistance.

Higher Education Institutions as a Site of Institutionalized Gender-Based Violence

Higher education institutions frequently function as arenas where gendered power relations are reproduced despite their stated commitment to inclusivity, equity and progressive values. This section examines universities as sites of institutionalized gender-based violence (GBV) and demonstrates how the structural mechanisms that sustain such violence also create and perpetuate barriers to healthcare access for women students. The contextualization of theoretical perspectives on GBV in the light

of empirical evidence from university settings reveals that inaccessibility to healthcare is not merely a service delivery gap but a manifestation of structural and symbolic violence embedded in institutional norms and everyday practices.

The theoretical traditions in the studies of gender-based violence have mostly relied on the analysis of structures inherent in gendered relations of power. A seminal work titled *Theorizing Patriarchy* (1991) by Sylvia Walby critically analyzes the three grand ideological traditions in feminist approaches. She critiques the liberal, Marxist and radical feminist frameworks for their limitations in providing a systematic analytical theory for analyzing gender violence and the underlying influence of the social structure. These limitations can be improved with inclusion of more recent approaches. This structural perspective closely aligns with Pierre Bourdieu's concept of symbolic violence (2001) where subordinated social groups become participatory to their own domination and normalize the system (Angeliqa & Sarwono, 2018; Schuber, 2008) and Johan Galtung's theory of structural violence (1969) which refers to the way social structures systematically restrict the actors (Individuals, groups or societies) from realizing their full potential and put them in "harm's way" (Farmer et al. 2006) or work to their disadvantage. The intersection of gender with structural violence is discussed in the work of Montesanti (2015). Gender-based violence is understood as a broad category to "recognize the gendered elements in nearly all forms of violence against women and girls, whether it is perpetrated through sexual violence or through other means" (Montesanti, 2015, p.1). These frameworks help capture the dynamic processes and practices through which gender relations of power manifests and function within institutional context.

A more concrete manifestation of such

institutionalized violence would become fathomable with closer examination of various empirical studies conducted in educational institutions across India and other countries. Kiguwa et al. (2015) conducted a qualitative study of South African higher education institutions and highlighted how the cases of sexual harassment are normalized in heteronormative institutional cultures where the blame is largely attributed to women for their presence, behaviour or dressing choices thereby legitimizing inappropriate conduct as routine. Similar dynamics are often observed in universities where gendered norms often shift responsibility onto female students. Symbolic violence theory is employed by Angeliqa and Sarwono (2018) to demonstrate the inescapability of patriarchal subordination of women even in the position of authority and power. It reflects that power relations of gender cannot easily be offset despite women occupying the leadership roles in inclusive institutions like universities. Furthermore, Mutinta's study (2022) in South African public universities lists out several risk factors that leads to heightened vulnerability of women to gender-based violence. These include enrolment in male-dominated disciplines, younger age, romantic partnership, limited financial resources and proximity to campus housing whose intersection or individual effects can cause greater difficulties in utilizing campus health services.

The widespread underreporting of cases of violence is also a critical aspect of institutionalized gender-based violence in university spaces. Multiple barriers have been consistently reported and documented in various studies which underscores risks such as shame, stigma, fear of retaliation by perpetrators and institutional pressure for preserving the reputation of the organization (Kiguwa et al., 2015; Ahmed, 2015; Rennison & Addington, 2014). Kiguwa et al. (2015) documented that many offensive and

aggressive behaviors are normalized and are hardly considered as violence by the victims whereas universities may actively discourage formal complaints to safeguard their public image. Over time, it is hardened into a culture of silence which may have direct and profound implications for women's access to healthcare services. It induces the same fear and stigma that prevent women students from reporting experiences of harassment or violence while also subtly acting as an everyday deterrence for claiming institutional support for timely healthcare services. Recent empirical evidence from Indian universities validates this hypothetical correlation. A cross-sectional study among medical undergraduates was conducted by Choudhary et al. (2025) in a North Indian tertiary care institution and reported that women students experienced significantly higher levels of gender-based discrimination in hostel facilities and healthcare services resulting in heightened mental distress and potential reluctance to access healthcare services in campus facilities. Similar observations were documented by Ramya et al. in their study in Coimbatore in 2024. They noted that more than 62% female college students experienced unmet menstrual practice needs with many citing embarrassment, lack of privacy and inadequate institutional support as key barriers which aligns with the larger normalization narrative observed in gender-based violence literature. Nayak et al. (2025)'s study on college women in rural Odisha reinforces this perspective as they highlight the persistent dissatisfaction with menstrual hygiene infrastructure and state supplied products alongside a tendency toward silence rather than complaint due to fear of judgement and institutional inertia. These findings collectively illustrate how procedural opacity and normative normalization operate across both violence redressal and healthcare domains. Women

students often internalize the notion that their specific health needs particularly those related to menstruation or reproductive health are private matters or secondary to academic priorities just as they learn to downplay experience of harassment.

DISCUSSION

Gender-based violence is a broad conceptual category that encompasses other forms of violence such as physical, emotional and sexual while simultaneously delineated from them (Mutinta, 2022). The concept largely reflects the structural character of various expressions of violence premised on inequalities embedded in gendered power relations. The concept largely reflects the structural character of various expressions of violence premised on inequalities embedded in gendered relations of power. The denial of healthcare services and their associated barriers may be understood as implicating concerns of human rights and dignity. Furthermore, the routinisation or normative normalization of these deficiencies disproportionately creates hurdles for women who often occupy a disadvantaged position within these power relations. Hence this paper attempts to extend the understanding of gender-based violence to include the denial or perpetuation of structural barriers to accessing basic healthcare services.

The assessment of the existing literature highlights several nuances while also indicating limitations in the frameworks employed. Classical approaches to gender-based violence reveal a methodological limitation in earlier studies where the focus of analysis has largely been on rape often overlooking more subtle forms of violence (Walby, 1991). Emerging studies draw attention to less visible forms such as stalking (Rennison and Addington, 2014) and symbolic violence where acts of violence may not be recognized as such (Angeliqa and Sarwono,

2018). These limitations indicate the need for greater conceptual clarity as legal definitions of violence often leave important ambiguities unresolved. Moreover the definition of institutional settings such as colleges requires clearer specification to appropriately situate experiences of violence and victimization. Much of the existing literature is also dominated by intimate partner violence although this is not necessarily the most prevalent form of gender-based violence experienced by women (Rennison and Addington, 2014). A notable limitation in empirical research is the limited inclusion of men despite some studies indicating the presence of male victimization (Kiguwa et al., 2015).

The findings of the review can be analytically organized through three interrelated dimensions of institutionalized structural violence i.e. infrastructural invisibility, procedural opacity and normative normalization. These dimensions provide a more precise understanding of how gendered barriers to healthcare access are produced and sustained within university settings. It has been noted that despite the availability of healthcare facilities, a range of structural barriers (infrastructural invisibility) continues to affect access within university systems. These include factors such as long waiting times, transportation challenges, multiple locations for tests and specialists, limited telephone access to providers, restricted operating hours and multi-step care processes (Carrillo et al., 2011) along with the lack of information dissemination (procedural opacity) by universities regarding available services (Kaur and Kaur, 2019; Ramya et al., 2024) and the unavailability of medical personnel. The implications of these barriers for women students have been discussed in the literature reviewed.

The gendered nature of discrimination within universities manifests in subtle and symbolic

forms in everyday interactions. Despite being associated with inclusivity and academic advancement, institutions of higher education may reproduce gendered disparities with women often disproportionately affected. The case studies examined in this paper indicate that such patterns are embedded within institutional norms. These embedded normative assumptions are reflected in practices, attitudes and institutional arrangements that may favour one gender over another. The resulting power relations are often asymmetrical and hierarchical. A closer examination of underlying institutional dynamics are critical for probing adequate measures for their redressal.

Policy Perspectives: Reflections on Current Indian Policies

Recent policy frameworks in India demonstrate a growing recognition of the need to address gendered barriers to healthcare access within higher educational institutions (HEIs). The University Grants Commission's (UGC) 'Guidelines on Basic Facilities and Amenities for a Safe, Secure Environment for Women and Women Cell' (2022) represents a key national mandate. These guidelines outline a comprehensive set of measures across infrastructural, administrative and awareness domains. They recommend the provision of gender-sensitive infrastructure including clean and well-maintained separate restrooms with sanitary vending and disposal facilities, 24-hour primary healthcare centres with ambulance services, professional counselling services and regular health awareness and check-up camps. They also emphasize gender sensitisation programmes, zero tolerance towards sexual harassment, mechanisms for anonymous complaints and periodic reporting to regulatory authorities. Complementary to this, the 'National Education Policy' (NEP) 2020 establishes a Gender Inclusion Fund to support equitable

access for women and transgender students while longstanding Menstrual Hygiene Scheme (MHS, 2011) and 'Rashtriya Kishor Swasthya Karyakram' (RKSK, 2014) under the 'National Health Mission' continue to target adolescent and young women through subsidized pads and awareness programmes. In 2025, the UGC further reinforced these efforts through campaigns such as '*Swasth Nari, Sashakt Parivar Abhiyaan*' and advisories promoting campus-level integration of Ayushman Bharat services. A landmark Supreme Court ruling in February 2026 *Dr. Jaya Thakur vs Government of India* declaring menstrual health a fundamental right under Article 21 has extended these obligations and strengthened the existing mandates for functional infrastructure across educational spaces and strengthened the policy impetus for HEIs.

Despite these progressive mandates, empirical evidence reveals persistent gaps between policy intent and institutional practice and underscores the structural violence embedded in university healthcare systems. Recent studies such as Ramya et al. (2024) and Nayak et al. (2025) document that over 60% of college women in Coimbatore and Odisha still experience unmet menstrual practice needs with vending machines frequently unused due to inadequate information dissemination and poor maintenance. These findings illustrate the three interrelated dimensions of institutionalized structural violence identified in this paper. *Infrastructural invisibility* persists as primary health centres and hygiene facilities remain under-equipped or poorly located particularly in rural and semi-urban campuses. *Procedural opacity* is evident in the limited transparency around grievance redressal through Women Cells and unclear pathways for accessing emergency care or menstrual products. *Normative normalization* further entrenches these barriers as gendered

norms lead to underreporting of health-related vulnerabilities and one-size-fits-all approaches that overlook intersectional factors of caste, class and region disparities (Mahapatro et al., 2021).

Interestingly, UGC 'Guidelines on Basic Facilities and Amenities for a Safe, Secure Environment for Women and Women Cell' (2022) comprehensively corresponds to our framework of institutional structural violence and moves towards the positive direction in addressing them. Their emphasis on dedicated infrastructure such as healthcare centres, sanitation facilities and counselling services reflects the recognition of gaps that correspond to *infrastructural invisibility*. Similarly, the requirement for information dissemination, grievance mechanism and institutional reporting indicates the presence of *procedural opacity* in accessing services and support systems. The focus on gender sensitisation and the explicit acknowledgment of a "culture of silence" and masculinized norms highlight the role of normative normalization in sustaining unequal power relations.

CONCLUSION

The persisting issue of gender-based violence is a multivarious phenomenon which extends beyond the superficial interpretation of empirical cases and demands critical engagement with intersections and contestations of broader socio-political processes. A structural understanding of gender violence helps explain how perceptions, attitudes and practices adopted by various actors reflect gendered patterns of power asymmetry which are embedded in the social norms. With the growing body of literature, the concept of violence now extends beyond its physical characteristics and includes subtle and everyday practices and hence seeps into the seemingly inconspicuous experiences such as infrastructural

deficiencies within university spaces. The denial of basic amenities such as healthcare services may therefore constitute concerns of rights and dignity to women students whose medical needs are expected to be fulfilled timely.

This paper argues that gendered patterns of inaccessibility in availing healthcare services within university spaces constitute a distinct form of institutionalized structural violence. Various barriers to accessing essential healthcare especially for women students with menstrual, reproductive and mental health needs are not isolated service deficiencies but emerge systematically through three interrelated mechanisms of infrastructural invisibility, procedural opacity and normative normalization. The power dynamics of gender relations seeps into the structure and culture of higher education institutions which reproduces asymmetrical power relations that disproportionately disadvantage women students. The synthesis of the empirical findings extends the argument beyond descriptive accounts of accessibility to highlight how seemingly neutral institutional arrangements systematically constrain the autonomy, wellbeing and academic participation of women students. The paper contributes a novel theoretical perspective by conceptualizing healthcare denial in higher education as a specific instantiation of structural violence which lies at the intersection of gender-based violence, health policy and institutional scholarship. The empirical evidential aspect of the paper integrates recent India oriented studies that provide fresh quantitative and qualitative insights into the lived realities of women students. The study also attempts to contribute to the policy domain by bringing into focus the potential implementation gap that might escape scrutiny. The growing progressive frameworks such as the UGC Guidelines on Basic Facilities and Amenities

for a Safe, Secure Environment for Women (2023), the National Education Policy (NEP) 2020's Gender Inclusion Fund and the Supreme Court's 2026 recognition of menstrual health as a fundamental right under Article 21 represent important normative advances but does not guarantee the mechanisms for their effective translation into practice which demands effective enforcement, intersectional design and accountability structures that explicitly address infrastructural, procedural and normative barriers.

The acknowledged limitations of the present study opens scope for future research. The methodological design is based on the narrative literature review with the scope of analysis deliberately delimited to focus primarily on women students to maintain analytical coherence. However the framework could be expanded to include the experiences of LGBTQ++ community for further research. Individuals or students belonging to transgender, non-binary and queer individuals face compounded forms of discrimination even in university healthcare settings. The cases may range from misguided facilities and hostile provider attitudes to the complete absence of gender affirming care which intersect with the same mechanisms identified here but manifest in distinct and often more acute ways. A more robust and generalizable empirical evidence base could be established by employing mixed methods designs including longitudinal tracing of health outcomes, participatory action research with student collectives and comparative analyses across public and private institutions.

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