GENDER RESPONSIVE BUDGETING AS A TOOL FOR ACHIEVING SDG 3: ASSESSING THE DOABILITY OF HEALTH GOALS IN INDIA

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ABSTRACT

Despite commitments to "leaving no one behind," India's progress toward SDG 3, which calls for healthy lives and well-being for all, remains constrained by an often overlooked issue: gender-blind budgeting. This paper examines whether India can achieve or accomplish SDG 3 (Ensure healthy lives and promote well-being for all at all ages) in the current fiscal framework unless Gender Responsive Budgeting (GRB) serves as a central accountability tool.

The report looks at how public investment in prominent public health policies, including the National Health Mission, POSHAN Abhiyan, and Ayushman Bharat, is sensitive to gender. It uses the framework of substantive equality found in constitutional and international law. The paper shows that women's unpaid household work, reproductive health needs, and intersectional disadvantage are often invisible in budgeting. These omissions cause systemic distortions in resource allocation, leading to indirect discrimination. The legal and moral foundation of SDG commitments is weakened by the absence of gender-specific impact evaluations. The goal becomes merely utopian rather than a right to be enforced, which people can legally demand as fundamental values like human dignity and non discrimination are undermined.

This study highlights GRB's ability to turn constitutional commitments like equality under Article 15 and the right to health under Article 21 into practical outcomes by presenting it as both a right based and feasibility enhancing instrument. Fiscal justice is the cornerstone of sustainable development, and the transition from symbolic inclusivity to accountability is ultimately crucial. By showing that "sustainable development" runs the risk of becoming development without women in the absence of Gender Responsive budgeting, the study adds to the conversation on the viability of the SDGs.

Keywords: Gender Responsive Budgeting, Sustainable Development Goals (SDG), Public Health Policies, Fiscal Justice, Intersectionality

Introduction:

To delve deep into gender-responsive budgeting, we primarily ought to understand what it actually is. Gender-responsive budgeting, as the name suggests, is not a specific budget for women but a budget that works for everyone—a budget that is gender-sensitive, inclusive, and responsive to the needs of all age groups. It seeks to guarantee gender-balanced allocations across policies and programs and the fair distribution of public resources. (Stephenson, 2018)

This approach is essential for both gender justice and sustainable development, as public expenditure affects individuals differently depending on their gender roles, responsibilities, and levels of access to economic, social, and political opportunities.

This distinction becomes essential because men and women lead different lives, have different social positions and perspectives, and experience different levels of power and autonomy in society, irrespective of constitutional guarantees of equality. These distinctions naturally shape their needs, experiences, and priorities. Simply put, the impact of policies and budgets is not uniform: the same policy can create different outcomes for different genders. Since most economic and legislative decisions are historically and even currently made by men because women remain underrepresented in many arenas of governance and policy formulation budgets can unintentionally increase existing inequalities instead of reducing them. Policies may also fail to account for women across different age groups or socioeconomic backgrounds, particularly when gender analysis is absent. The impact of this approach has been significant: women now hold a large proportion of parliamentary seats, and improvements are reflected in health access, schooling, and programme implementation. For example, In PM Kisan Yogana it provides income support to farmers, but requires land ownership to qualify, NFHS-5 shows only 14% of women in India own land irrespective of women constituting over 45% of agriculture labour. Even, though its gender neutral in design, it has resulted in unequal outcomes for women due to systematic limited asset ownership, lesser digital access and reduced mobility. (Choudhuri, 2023) (UNFPA,2023)

In this case, gender responsive budgeting (GRB) becomes crucial. GRB is a systematic and strategic technique for confronting these disparities by incorporating gender analysis at every stage of the budget cycle: planning, allocation, implementation, and evaluation. It addresses how budget decisions affect men and women differently and seeks to rectify imbalances through gender-equitable fiscal policies (Stephenson, 2018). The UN's 2030 Agenda makes it

clear that gender equality isn't just one goal—it cuts across all 17. Governments are expected to build this into the way they plan and spend public money. This becomes even more important for SDG 3, which focuses on ensuring healthy lives and well-being for everyone, because health outcomes are closely tied to how gender shapes access, care, and opportunity. Gender norms and unequal access have a significant influence on health budget policies. (United Nations, 2015).

Health budgets are shaped by real, everyday gender differences—who controls resources, who shoulders unpaid care work, and who faces greater health risks. But without gender-disaggregated data, these gaps often stay out of sight, leaving policies unable to reach the people who need the most support. Evidence from the National Family Health Survey shows how persistent these gaps are, from higher rates of anaemia and poor nutrition among women to unequal access to reproductive healthcare and limited decision-making power within households. These patterns make it clear that gender is not just a background factor—it is a core determinant of health in India.

Gender-responsive budgeting helps bring forward the inequalities that often stay unnoticed in health planning. It gives governments a clearer sense of how their spending truly supports SDG 3 by showing which investments address gender-based health gaps—whether in maternal and reproductive care, women's mental health, or services for survivors of gender-based violence. It also makes sure these essential needs aren't lost when bigger public health decisions are made.

In India, this work takes shape through the annual Gender Budget Statement (GBS). Each year, it groups schemes into three categories—those that devote all their funds to women, those that allocate 30–99%, and those that spend less than 30%. This helps reveal how much each programme actually prioritises women's needs. This system is meant to weave gender-responsive budgeting into the national budget process in a structured, transparent way. This framework shows a formal acknowledgement that deliberate financial planning is necessary to address gender-differentiated outcomes. (Government of India, Ministry of Finance, Department of Economic Affairs, 2024).

Integrating the insights from these sources reveals that GRB is not just a budgeting method but, it is a transformative governance strategy. It recognises that without institutionalizing gender responsive public finance, neither gender equality nor sustainable health outcomes can be truly

achieved. Thus, gender-responsive budgeting is sacrosanct for advancing SDG 3, ensuring that the notion of "healthy lives and well-being for all at all ages" is not genderblind but genuinely inclusive.

Conceptual and Legal Framework:

Gender-responsive budgeting (GRB) is often misunderstood as a technical or financial exercise, but in truth, it is about changing how a society values women. In India, GRB is engraved in both our constitutional promises and our international commitments, making it not just a policy choice but a responsibility. The central idea behind GRB is that budgets should not assume everyone starts from the same place. Instead, they must acknowledge that women have faced persistent disparities that require remedial action. (Elson, 2002)

This strategy has a solid and unambiguous base according to the Indian Constitution. Article 14 guarantees equality before the law, and Article 15(1) prohibits gender based discrimination. At the same time, Article 15(3) empowers the state to make special provisions for women for their welfare (Dhanda, 2006). These provisions apprise us that equality is not just about uniform treatment, but it is about ensuring that everyone receives the support they need to enjoy their rights in practice and uphold fairness, in contemplation of structural differences. Article 21, safeguarding life and personal dignity, encompasses vital elements such as health, nutrition, education, and livelihood, hence obligating the state to allocate resources towards these domains.

The Directive Principles sustains this outlook. Article 38 calls on the state to reduce inequality; Article 39(e) ensures that women are not placed in unsafe or exploitative work; Article 42 requires just working conditions and maternity relief; and Article 47 emphasises the state's responsibility to improve health and nutrition. All these provisions make it clear that a budget which ignores women's needs goes against the spirit of the Constitution. GRB is simply a way of turning these constitutional ideals into real, measurable policies (Kabeer, 2003).

India's obligations in the international arena lend additional support to this. CEDAW requires the country to end discrimination and ensure that women have equal access to economic and social opportunities (United Nations, 1979). The ICESCR asks governments to progressively realise socio-economic rights without discrimination. The Beijing Platform for Action (United Nations, 1995) goes even further by encouraging all countries to include gender perspectives

directly in their budgets. Together, these commitments show that GRB is not only a good practice—it is an expectation from the global community that India has agreed to uphold.

At a deeper level, GRB is built on two ideas: substantive equality and fiscal justice. Substantive equality acknowledges that women may require further focused assistance due to their prior experiences of inequality. Fiscal justice denotes the allocation of public resources in a manner that mitigates, rather than entrenches, inequality; thus, the incorporation of Gender-Responsive Budgeting (GRB) enables governments to ensure that tax measures, expenditures, and welfare programmes are deliberately oriented toward closing gender disparities (Duflo, 2012).

Ultimately, GRB reorients the budget from a purely fiscal instrument into a mechanism capable of advancing substantive social transformation. By anchoring financial

decision-making in constitutional values, international obligations, and the broader principles of equity, gender-responsive budgeting (GRB) catalyses a paradigmatic shift toward inclusive, gender-sensitive development in India. It underscores that equality must transcend its textual formulation and be concretely manifested through the judicious allocation and utilisation of public resources.

Methodology:

The plans are classified by the degree to which they are expected to benefit women (Ministry of Finance, Government of India, various years). This study uses a qualitative, document-based research approach, guided by the idea that budgets and policies reveal as much through their language and priorities as they do through numbers. Since the goal here is to understand how gender concerns are acknowledged within India's public health financing and not to measure statistical impact, a qualitative design allows for a more attentive reading of how programmes are framed, how resources are described, and what assumptions are woven into official documents (Elson, 1998).

The analysis relies entirely on secondary data, most of which is drawn from official government publications. The starting point is the set of Union Budget Gender Budget

Statements (GBS), which the Ministry of Finance releases each year (Ministry of Finance, Government of India, various years).The statements sort plans based on their anticipated benefit to women (Budlender, Sharp, & Allen, 1998). While the GBS are relatively simple in

structure and do not offer deep explanations, they remain an important indicator of how the government publicly positions its gender priorities. To better understand the financial context behind these entries, the GBS are examined alongside the Expenditure Budget Volumes, which lay out ministry-wise allocations in greater detail (Ministry of Finance, Government of India, n.d.). Reading through these documents together shows how the government's gender-focused goals slot into the bigger picture of public spending.

The research zeroes in on three flagship programmes: National Health Mission (NHM),

POSHAN Abhiyaan, and Ayushman Bharat (including PM-JAY and Health & Wellness Centres) because they form the core of India's public health expenditure and have a direct bearing on women's health, nutrition, and financial protection (Ministry of Health and Family Welfare & NITI Aayog, various years). We went through a pile of documents, annual reports, the official guidelines, dashboards that show progress, and review notes from the Health Ministry, NITI Aayog, and a few other agencies (NITI Aayog & MoHFW, various years).We looked at how gender is talked about, how much funding is set aside for gender components, and how outcomes are recorded.

The analysis adopts a thematic content approach, examining patterns, silences, inconsistencies, and the placement of gender within the budgeting narrative (Chakraborty, 2018).Yet gender-disaggregated data remain limited, particularly in NHM and Ayushman Bharat, hindering the ability to map outcomes to budget allocations (MoHFW, n.d.).One issue is that state-level reporting gaps, allocation is present but, at operational level, it doesn't get executed efficiently. The Gender Budget Statements show what the government plans to spend, not what gets spent, so they are not super reliable for measuring real impact (The Wire, 2018). Also, since we only looked at publicly available documents, we could not see the behind-the-scenes talks, political pressures, or informal ways of working that also shape budget decisions.

Analysis and discussion:

India's health budget has long been presented as an instrument of social protection, yet its gender sensitivity especially when evaluated against the backdrop of unpaid care work and layered inequalities reveals a picture that is far more complicated than what headline allocations suggest. At the surface level, health expenditure has been rising in absolute terms every year, but the increases rarely match the scale of demand arising from women's

disproportionate care responsibilities, higher morbidity, and the structural barriers they face in accessing public services. Budget statements routinely highlight their flagship commitments to maternal health, insurance, and nutrition, but once the numbers are broken down, the gender lens exposes gaps in both design and delivery. Central allocations to initiatives such as the National Health Mission have plateaued as a share of GDP, and even within that shrinking pie, the parts most important to women like reproductive health infrastructure, frontline workers, menstrual hygiene, and gender-based violence services, don't always receive the support they require. Analysts have consistently demonstrated that gender budgeting cells exist mostly on paper, and line ministries rarely justify how their spending actually satisfies gender-related needs Centre for Budget and Governance Accountability (Shruti Ambast, 2021). This disconnects between rhetoric and resource commitment sits at the heart of the problem.

A closer look at major public health schemes reinforces this duality of intent versus outcome. PM-JAY, India's flagship public health insurance system, is legally gender neutral, providing equal coverage regardless of age or sex. However, neutrality in design does not imply equity in access. Research shows that the way households handle enrolment often sidelines women — ration cards and ID documents are usually in men's names, and even the decision to seek treatment can depend on male approval. Even when women enroll, they have significantly lower utilization rates. Gendered mobility patterns, limited financial control, and the high cost of traveling to hospitals can all prevent people from receiving cashless benefits. A study showcased that women with limited education background or from Scheduled

Caste/Scheduled Tribe groups experience a dramatically reduced possibility of receiving from publicly funded health insurance, particularly for tertiary level care. (Lingam, 2021) What this means is that schemes framed as levelling the playing field may inadvertently augment the disadvantages faced by those already pushed to the margins.

The National Health Mission, which should ideally serve as the backbone of gender responsive primary healthcare, has improved indicators like institutional deliveries and basic maternal care, but cracks appear in places where women's needs exceed narrow maternal health metrics. The focus on reproductive roles has left limited room for addressing chronic conditions that disproportionately affect women with anaemia, non-communicable diseases, mental health needs generated by caregiving strain, and conditions linked to unpaid domestic labour. Frontline workers such as ASHAs, who carry the burden of executing community level health

interventions, remain underpaid and overworked. Their work is indispensable for sustaining the public system, yet it is classified as "voluntary," a euphemism that hides systemic dependence on women's labour without adequate compensation. The irony is hard to miss: a health system that depends on women to prop it up does not invest proportionately in services tailored to women's own well-being.

These gaps make more sense when placed within the broader ecosystem of unpaid care work, a dimension that continues to shape women's lives more than any other economic variable. Indian women spend significantly more hours per day than men on tasks like cooking, cleaning, caregiving for children and elders, and maintaining the household activities that barely show up in GDP calculations or fiscal planning. The absence of formal recognition translates into invisibility in budget design. A woman bearing the large weight of unpaid care has less time, flexibility, and energy to seek preventive or curative healthcare; her health concerns are often deprioritized because she cannot afford to miss a day of caregiving. Because of this dynamic, she is unable to work due to poor health, and her ability to seek care is further restricted by the increased care burden. Research from organisations studying women's economic participation shows that time poverty is not merely a social issue but a fiscal one: when governments ignore unpaid care, they underinvest in the childcare centres, elder-care services, community health staff, and flexible delivery platforms that would allow women to participate more fully in economic and public life Initiative for What Works to

Advance Women and Girls in the Economy (IWWAGE & The Quantum Hub, 2021)Ignoring unpaid care ultimately leads to budgets being designed with a view that women's labour is infinitely flexible a false assumption that makes the entire financial framework unstable.

Intersectionality adds another layer of complexity that conventional budgeting frameworks rarely deal with. Gender does not work in isolation; it is filtered through caste, class, tribe, disability, age, and geographic identity. For example, tribal women often live far from health facilities, lack transport, and face linguistic barriers in clinical interactions, making even nominally universal schemes difficult to access. Dalit women may experience discrimination inside health facilities or hesitation from staff, discouraging them from returning for followup. Muslim women in some areas face societal stigma that restricts movement and limits their participation in state institutions. Many urban migrant women miss out on welfare support because they don't have the documents needed or because benefits stop when they move.

Research on maternal and child health shows large gaps in breastfeeding, immunisation and nutrition across caste and income groups, confirming that disadvantage accumulates rather than occurring in isolation. This intersectional disadvantage means policy cannot rely on aggregate indicators alone, responses must account for the multiple, overlapping barriers that shape women's access to healthcare. (Valappil, 2024)

Accountability measures designed to track gender responsiveness often fall insufficient. Gender Budget Statements produced annually by the government list allocations in two categories—schemes exclusively for women and schemes where women constitute a significant proportion of beneficiaries. But these statements do not explain whether the allocations are adequate, how they address structural inequalities, or whether outcomes match commitments. Tracking how the money is used is still hard because most schemes only share overall numbers and not gender-wise data. We've made progress in gender budgeting, but we now need stronger data and accountability otherwise it risks becoming just a box-ticking exercise instead of real change for women.

Taken together, these trends reveal a health financing ecosystem that is not deliberately hostile to women but inadvertently structured around assumptions that sideline their needs. The system works reasonably well for people who resemble its default user someone with mobility, decision-making power, fewer family responsibilities, documents in order, and easy access to facilities. Women, especially those burdened by unpaid care and layered forms of disadvantage, rarely fit this profile. As a result, formal inclusion in schemes does not ensure meaningful access. Achieving fiscal justice requires more than increasing allocations; it requires reconsidering how the state understands work, care, and vulnerability. A genuinely gender sensitive health budget would fund community-based care support, expand ASHA compensation, strengthen infrastructure, build accountability into health insurance design, and invest in gender disaggregated data systems. It would recognise unpaid care as economic work that shapes every other aspect of a woman's health patterns and it would do so not as an act of charity but as a matter of equity, efficiency, and constitutional responsibility.

Case Studies

Any discussion of Gender Responsive Budgeting (GRB) risks remaining abstract until it is examined through real-world examples. Numbers, frameworks, and government circulars tell only a part of the story. To understand what meaningful GRB can look like — and equally,

what prevents it from working, it is necessary to look at places where the idea has been tested. This section reflects on two such experiences: one from within India Kerala and one from beyond — Rwanda. Each offers a different pathway shaped by context, institutional culture, and political will.

Kerala: Gender budgeting arising from active involvement

In Kerala, gender budgeting did not appear overnight. It grew step by step, supported by the decentralised planning culture that had already taken root and gradually changed how public priorities were identified and funded. By the mid-2000s, gender-budgeting cells were functioning across departments, and local governments were expected to integrate gender considerations into their planning cycles (Nair & Moolakkatta,2018). What set Kerala apart was not merely the existence of a budget statement but the fact that women's collectives — particularly Kudumbashree were invited into deliberative spaces and treated as stakeholders rather than beneficiaries (Vijayan & George, 2011).

Women in these local collectives routinely flagged concerns such as transportation to health facilities, unsafe labour conditions for informal workers, and the persistent burden of unpaid care. Over time, these concerns shaped health programmes, local budgetary priorities, and routine administrative attention. It would not be accurate to say that Kerala has solved gender inequity, but its experience shows that GRB has substance when it is rooted in dialogue and lived experience rather than confined to reporting templates.

Rwanda: When Gender Equality Becomes a Statutory Obligation

Rwanda presents a striking contrast and a reminder that institutional will can transform the pace of reform. After its post-genocide rebuilding process, Rwanda adopted gender equality as a core element of state building. Rwanda institutionalised gender budgeting through law, ensuring that ministries could no longer regard it as optional or symbolic. Budget submissions now must explicitly identify gender-related goals and projected outcomes, and this commitment is reinforced through ongoing review and performance-based auditing (Mutamba & Mbayiha, 2008).

This approach has contributed largely: increased women representation in parliamentary seats, and improvements have shown in health access, schooling, and programme implementation.

The country's legal mandate does not fully erase cultural hierarchies or structural disadvantage, but it has ensured that public finance leaves fewer spaces for gender to be ignored (PEFA Secretariat, 2022).

Reflections Across Contexts

These two examples do not point to a single best model and perhaps that is the key insight. Kerala demonstrates what is possible when budgeting is tied to participation and decentralised decision-making. Looking at Rwanda, one can see that reform gains real momentum when it is backed by both the text of the law and the conviction of those responsible for enforcement it.

For India as a whole, the most realistic path forward may be one that combines these elements: a legal foundation strong enough to prevent tokenism, administrative systems capable of monitoring outcomes, and participatory structures where women's voices can influence budgeting priorities.

Meaningful GRB is neither quick nor mechanical. It requires institutional patience, political commitment, and an acknowledgment that budgeting is not only a technical exercise it is a decision about whose lives matter.

Findings:

This study shows that India's efforts to achieve SDG 3 are held back by a budgeting system that continues to overlook the realities of gender. Even though health spending has grown over the years, it still does not reflect the different ways women experience illness, access services, or shoulder responsibilities at home. Much of the health budget remains genderneutral in appearance but gender-blind in practice. As a result, major programmes such as the National Health Mission, POSHAN Abhiyaan, and Ayushman Bharat often fall short of reaching women with the depth and consistency they require. Barriers linked to mobility, unpaid care work, dependence on others for financial decisions, and lack of documentation mean that women are not able to benefit from these schemes at the same levels as men, even when they are technically eligible.

The research also points to clear accountability gaps. Gender Budget Statements tend to focus on listing allocations rather than questioning whether the money actually addresses gender disparities. Gender Budgeting Cells are formally in place, but their role remains largely

symbolic, with little impact on how programmes are shaped or executed. Weak monitoring systems and uneven availability of gender and intersection specific data make it difficult to understand whether spending is improving outcomes for women or simply maintaining the status quo.

Put simply, public spending shows what a country considers important. Even though India's Constitution guarantees equality and dignity, those commitments are not always visible in the way financial decisions are made. When women's unpaid labour, reduced mobility, or social disadvantage go unacknowledged, budgets regardless of how progressive they appear on paper and can end up reinforcing existing gaps rather than closing them. The examples explored in this paper show that genuine progress comes when political intent, community voices, and accountability operate together. For India to truly advance SDG 3, budgeting must move beyond neutrality and recognise lived realities. Only then does fiscal governance shift from mere administrative compliance to a meaningful mechanism for advancing substantive equality.

Recommendations

If India truly wants to move closer to the promise of "healthy lives and well-being for all," it must begin by acknowledging that women do not walk into the health system on equal footing. They arrive carrying the weight of caregiving, limited mobility, social expectations, and, very often, silence. Gender-responsive budgeting is not a technical add-on—it is the only way to ensure that policies reach the people they are meant for. The recommendations below grow out of this understanding, not from theory but from the lived experiences that budgeting too often overlooks.

First, Gender Budget Cells need to become real, functioning spaces rather than formal units tucked away in ministry documents. They should be staffed with people trained in gender analysis, given the authority to question programme designs, and asked to justify how each rupee addresses gender barriers. Most importantly, ministries should be held accountable for the outcomes these cells produce, not for the paperwork they generate. A budgeting system that does not challenge its own blind spots cannot claim to be equitable.

Second, India must introduce Gender Impact Assessments before any major health scheme is approved. These assessments should ask a few honest questions: Will women be able to enrol

without depending on someone else's documents? Will they have the time, mobility, or autonomy to use the service? What happens to women facing multiple disadvantages—due to caste, age, location, disability, or marital status? A programme examined through this lens has a far better chance of becoming truly universal, not just universally announced.

Third, the focus must shift from how much money is allocated to what that money actually achieves. Outcome-based budgeting, backed by gender-disaggregated data, can bridge the gap between intentions and lived realities. Ministries should report not only how funds were spent but what changed: Did anaemia levels fall? Did more women use health insurance? Were ASHA workers paid fairly and on time? When results matter as much as allocations, gender equality stops being symbolic.

Fourth, women must be brought into budgeting conversations—not as recipients but as contributors. Kerala's experience is proof that when women's collectives, ASHA workers, and grassroots groups speak, budgets begin to reflect real needs: transport to hospitals, safe workplaces, childcare support, or simply the value of time. Similar spaces for participation—especially at the district and panchayat level—can make planning more grounded and less abstract.

Finally, India must recognise the enormous strain of unpaid care work. No health policy can succeed while assuming that women's time is endlessly elastic. Investments in affordable childcare, elder-care services, community kitchens, and better pay for frontline workers are not luxuries, they are essential pieces of a functional health system. When the state shares the burden of care, women's health stops being postponed indefinitely. Together, these reforms push budgeting out of the realm of paperwork and into the arena of real life where the promise of SDG 3 must ultimately be fulfilled.

Conclusion

What this study has shown, above everything else, is that gender is not a side note in India's health story, it is the thread that holds the entire picture together, even if budgeting documents rarely admit it. Behind every statistic sits a life: a woman who takes care of everyone in her family before thinking of herself, a girl who learns early that illnesses must wait because household duties cannot, an elderly widow who hesitates to seek treatment because she does not want to "be a burden." These realities never appear in spreadsheets, yet they quietly shape

who gets care and who goes without it.

India has made undeniable progress. Programmes like the National Health Mission, POSHAN Abhiyaan, and Ayushman Bharat have brought services and financial protection to millions. But a policy does not become equal simply because it is labelled universal. A scheme cannot touch a woman who cannot leave home. Insurance cannot protect someone who needs permission to seek help. A health system cannot succeed when the very women who hold it up — ASHA workers, Anganwadi workers, caregivers at home are undervalued and underpaid.

Gender-responsive budgeting is not about "special treatment" for women. It is about recognising that fairness requires more than identical rules; it requires attention to real lives. The case studies show this clearly. Kerala succeeded where women's voices shaped decisions. Rwanda proved that when governments choose to prioritise gender justice, it does not slow development, it accelerates it.

If India is to fulfil SDG 3 in a meaningful way, budgets must start from the reality that women do not live in the same world as men when it comes to time, freedom, mobility, or economic power. Change will begin the moment their struggles are seen not as personal sacrifices but as structural burdens that the state must help shoulder.

The promise of "healthy lives and well-being for all" will be fulfilled not when India spends more, but when it spends differently, when every woman, regardless of caste, income, age, or location, can seek care without hesitation, guilt, apology, or fear. Only then will health become a right, and not a privilege determined by gender.

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