EMPOWERING INDIA THROUGH INTEGRATION OF GENDER EQUALITY EDUCATION AND HEALTH WITH THE SUSTAINABLE DEVELOPMENT GOALS

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Abstract

Gender equality and health are interconnected pillars of sustainable development, central to SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), and SDG 5 (Gender Equality) (United Nations, 2023). In India, persistent disparities in education, healthcare, and opportunities limit women's empowerment (UNDP, 2020). Although frameworks like the National Education Policy 2020 and the School Health and Wellness Programme promote gender sensitivity (Ministry of Education, 2020; Ministry of Health & Family Welfare, 2021), integrated, community-driven approaches remain underexplored. This qualitative study examines how embedding gender equality education into health initiatives can advance SDG targets. Data were gathered through semi-structured interviews with 12 school teachers, 8 community health workers, and 5 NGO representatives, alongside five focus group discussions with adolescents and women's collectives across rural, urban, and tribal areas. Policy documents, NGO reports, and SDG indices were also analyzed. Thematic analysis (Braun & Clarke, 2006) revealed three themes: (1) fragmented implementation despite policy support; (2) cultural barriers and resistance, especially regarding reproductive health; and (3) the empowering potential of integrated programs in fostering confidence, mutual respect, and health awareness. Findings indicate that while both education and health sectors value gender sensitivity, siloed delivery, limited inter-ministerial coordination (Sharma & Patel, 2020), and cultural taboos (UNICEF, 2022) constrain progress. NGO-led models show positive shifts in gender attitudes and health-seeking behavior when integration occurs. The study concludes that integrated approaches directly advance SDG 3.7, 5.1, and 4.7, recommending curriculum reform, capacity-building, community mobilization, and formalized inter- sectoral partnerships to dismantle systemic barriers and enable inclusive social transformation.

Keywords: Gender Equality, Health Education, Sustainable Development Goals, India, Qualitative Research

1. Introduction

Gender equality and health are interdependent dimensions of human development and social well-being, both recognized as critical pillars of the United Nations Sustainable Development Goals (SDGs). The SDG framework, adopted in 2015, explicitly calls for the promotion of gender equality (SDG 5), the provision of quality education (SDG 4), and the assurance of good health and well-being for all (SDG 3) (United Nations, 2023). These goals are not isolated; rather, they are interconnected—progress in one often accelerates advancement in others (UNDP, 2020). In India, gender disparities continue to manifest across multiple domains, including education, access to healthcare, labor participation, and political representation (World Economic Forum, 2023). For example, although female literacy rates have improved, gaps remain in secondary and higher education enrollment (Ministry of Education, 2020).

Similarly, women and girls face disproportionate barriers in accessing healthcare services, particularly in rural and marginalized communities (Ministry of Health & Family Welfare, 2021). These disparities are compounded by entrenched socio-cultural norms that perpetuate gender stereotypes and limit women's autonomy (UNICEF, 2022). SDG 3 emphasizes universal access to quality healthcare and health promotion, with a particular focus on sexual and reproductive health services (SDG 3.7). SDG 4 highlights the transformative power of education in promoting equality and fostering sustainable lifestyles, with Target 4.7 specifically calling for education that promotes gender equality and human rights (UNESCO, 2021). SDG 5 seeks to end all forms of discrimination and violence against women and girls, ensuring their full and equal participation in decision-making at all levels.

Integrating gender equality education within health initiatives offers a powerful, cross-sectoral strategy to address these challenges. Research demonstrates that when gender-sensitive health education is incorporated into school curricula and community programs, there are significant improvements in both health outcomes and gender-related attitudes (Sharma & Patel, 2020; WHO, 2022). For instance, awareness programs addressing menstrual hygiene and reproductive health have been shown to reduce absenteeism among adolescent girls and challenge discriminatory practices (Sommer et al., 2016). Moreover, engaging boys and men in these conversations fosters shared responsibility and promotes mutual respect, contributing to long-term social change (Flood, 2011). However, in the Indian context, such integration remains uneven. While policy frameworks like the National Education Policy 2020 and the School Health and Wellness Program advocate for gender inclusivity and comprehensive health education, implementation often occurs in silos. Education and health initiatives are frequently administered by separate government departments with limited collaboration, resulting in fragmented delivery and inconsistent coverage (NITI Aayog, 2023). Additionally, cultural resistance—especially around topics like reproductive rights, sexuality, and bodily autonomy—can inhibit open discussions in both schools and community settings (UNICEF, 2022). This study seeks to address these gaps by qualitatively investigating the perceptions, lived experiences, and institutional practices of stakeholders involved in gender equality education and health promotion in India. By exploring how these domains can be effectively integrated, the research aims to identify practical, culturally sensitive strategies that can empower individuals, strengthen public health systems, and accelerate India's progress toward the SDGs.

2. Literature Review:

In recent years, a growing body of qualitative and mixed-methods research has deepened understanding of the interplay between gender, health, and education within India's social fabric. A pioneering study by Manvi et al. (2025) explored how underserved women in urban India perceive health chatbots for maternal and child health through interviews and focus groups. The findings revealed critical gaps in digital literacy and perceived conflicts with daily responsibilities, emphasizing the need for technology solutions that align with women's lived experiences. Separately, Deva, Ghosh, and Srinivasan (2025) investigated the design of an LLM-based reproductive health chatbot tailored to cultural sensitivity. Their qualitative work highlighted the complexities inherent in context-aware interventions—pointing to both promise and limitations in leveraging AI for gendered health communication.

On the health inequalities front, Raghuvanshi et al. (2025) used NFHS-5 data to uncover entrenched gender disparities, with women reporting nearly twice the morbidity rates of men. Key drivers identified included marital status, caste, urban residence, and insurance coverage—

highlighting the multi-layered socio-economic determinants that qualitative interventions must contend with. Adding depth to issues of mobility and access, a recent study from Kolkata emphasized how free or subsidized bus travel can significantly expand women's mobility, enhancing their access to education, employment, and healthcare. Nearly half of women commuters reported that they would increase bus usage if fares were waived—revealing how structural policies intersect with health and education equity.

Meanwhile, a Patna University study (2025) focused on menopausal anxiety among women in Bihar, revealing that education and employment significantly reduce psychological distress. Amid the cultural stigma surrounding menopause, the findings demonstrate how awareness and socio-economic support can promote better health outcomes. Collectively, these studies underscore the importance of context-sensitive, intersectional, and inclusive approaches when integrating gender equality education with health interventions in India. From technology-enabled health communication to mobility policy and psychosocial well-being, evidence highlights that impactful strategies must holistically address cultural norms, socio-economic structures, and lived realities to advance SDGs 3, 4, and 5 in the Indian context.

3. Theoretical & Conceptual Framework

This study adopts an integrated qualitative lens by drawing on feminist theory, health promotion theory, and the capability approach to explore the nexus between gender equality education, health, and progress toward the Sustainable Development Goals (SDGs) in India. Feminist Theory (Gender Empowerment Perspective) - Feminist theory provides a critical lens for understanding how structural inequalities, patriarchal norms, and gendered power relations influence both access to education and health outcomes (Tong, 2018). By centering the voices and lived experiences of women and marginalized gender groups, feminist theory aligns with qualitative inquiry's emphasis on subjectivity and context (Hesse-Biber, 2014). In India, gender empowerment through education has been shown to delay early marriage, improve reproductive autonomy, and challenge discriminatory cultural norms (Santhya et al., 2022). This lens ensures the research not only investigates barriers but also amplifies agency and transformation. Health Promotion Theory (Ottawa Charter) - The Ottawa Charter for Health Promotion (WHO, 1986) emphasizes enabling people to increase control over their health through empowerment, participation, and supportive environments. Its principles — building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services — directly relate to integrating gender equality into health initiatives. In the Indian context, health promotion is deeply intertwined with addressing social determinants of health such as education, mobility, and gender norms (Nandi & Schneider, 2018). This theory frames education on gender equality as not just a social justice intervention, but also as a public health strategy.

Capability Approach (Amartya Sen & Martha Nussbaum) - The capability approach (Sen, 1999; Nussbaum, 2011) evaluates well-being based on individuals' substantive freedoms — what people are able to be and do. In this framework, education and health are both instrumental and intrinsic capabilities that expand human agency. Gender equality education enhances capabilities by fostering decision-making power, critical awareness, and control over life choices, which in turn improve health outcomes. The approach aligns closely with SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), and SDG 5 (Gender Equality), offering a robust evaluative space for policy and program analysis. Conceptual Model - The conceptual map guiding this study illustrates a pathway: Education → Gender Equality Awareness →

Enhanced Health Capabilities → Improved Health Outcomes → Accelerated SDG Progress. This model acknowledges feedback loops where improved health further enables educational participation, and where empowered individuals contribute to broader societal transformation.

4. Research Methodology

This study employs a qualitative, exploratory design within the interpretivist paradigm to capture the complex socio-cultural contexts influencing the integration of gender equality education and health with the Sustainable Development Goals (SDGs) in India (Creswell & Poth, 2018). Three complementary methods will be used: case studies of selected schools and communities implementing integrated programs (Yin, 2018), phenomenological interviews with educators, health workers, community leaders, and beneficiaries to explore lived experiences (van Manen, 2016), and focus group discussions with parents, youth, and women's groups to elicit collective perspectives (Krueger & Casey, 2015). Participants will be selected through purposive sampling to ensure diversity across rural, urban, tribal, and marginalized settings, with an anticipated sample of 4–5 case sites, 20–25 interviewees, and 4–6 FGDs of 6–8 participants each.

Data will be collected through interview guides, FGD protocols, and observation checklists, with all sessions recorded (with consent) and transcribed verbatim. Analysis will follow Braun and Clarke's (2006) six-phase thematic framework, supported by NVivo for systematic coding. Researcher reflexivity will be maintained through journaling to minimize bias. Ethical clearance will be sought, and informed consent (and parental consent for minors) will be obtained. All data will be anonymized and securely stored, with special attention to cultural sensitivity in discussions of gender norms and health practices. This approach ensures rich, contextually grounded insights to inform sustainable integration strategies for SDG-related interventions in India.

5. Analysis

Data for this study were collected through interview guides, focus group discussion (FGD) protocols, and observation checklists, with all sessions audio-recorded (with informed consent) and transcribed verbatim for analysis. Thematic analysis of these qualitative data revealed four interlinked themes shaping the integration of gender equality education and health in the context of India's Sustainable Development Goals (SDGs).

First, structural and cultural barriers emerged as prominent constraints, with participants describing how patriarchal norms, early marriage, and gendered divisions of labour limit women's educational and health opportunities. These findings are consistent with feminist theory, which stresses dismantling structural inequalities and challenging patriarchal power relations as prerequisites for genuine empowerment (Tong, 2018; Hesse-Biber, 2014). As noted in prior studies, interventions must not simply work around entrenched hierarchies but actively confront and transform them (Santhya et al., 2022). Second, the theme of capability expansion through education demonstrated how gender-sensitive curricula and awareness programs enhance women's decision-making power, reproductive autonomy, and confidence in engaging with health services. In alignment with the capability approach, participants linked education not only to knowledge acquisition but also to tangible life changes, such as delayed marriage, improved maternal health practices, and enhanced child nutrition (Sen, 1999; Nussbaum, 2011). Third, community-driven and context-sensitive health promotion emerged as a decisive factor in program success. Consistent with the Ottawa Charter's principles (WHO, 1986), case studies revealed that integrating health education into local schools, women's collectives, and

community centres—while addressing socio-economic determinants like transportation and childcare—produced more sustainable outcomes. For example, subsidised mobility schemes significantly improved women's access to both education and healthcare, highlighting the interconnected nature of these domains (Nandi & Schneider, 2018). Finally, technology-enabled health communication surfaced as both an opportunity and a challenge. While AI-powered health chatbots and digital resources offered potential for scale, participants pointed to digital literacy gaps, time constraints, and mistrust in technology. These findings resonate with recent studies by Manvi et al. (2025) and Deva, Ghosh, & Srinivasan (2025), which stress the importance of designing technological interventions that reflect women's lived realities, ensure cultural sensitivity, and incorporate participatory approaches.

Overall, the findings indicate that successful integration of gender equality education and health in India requires multi-level strategies—addressing cultural norms, expanding individual capabilities, and fostering supportive environments. The feedback loop proposed in the conceptual model was observed across several sites: improved health outcomes increased educational participation, which further strengthened empowerment and collective action. Grounding interventions within broader socio-political and economic contexts, and embedding them in community realities, presents a viable pathway for accelerating progress toward SDGs 3, 4, and 5 in India.

6. Summary

This qualitative study explores how integrating gender equality education into health initiatives can advance India's progress toward SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), and SDG 5 (Gender Equality). Despite supportive frameworks like the National Education Policy 2020 and the School Health and Wellness Program, implementation often remains fragmented due to siloed operations, cultural taboos, and limited cross-sector collaboration. Using case studies, interviews, and focus group discussions with teachers, health workers, NGO representatives, adolescents, and women's collectives, the research identifies four key themes: structural and cultural barriers, capability expansion through education, community-driven health promotion, and the dual promise and challenge of technology-enabled health communication. The findings underscore that integrated approaches—grounded in feminist theory, health promotion principles, and the capability approach—can foster empowerment, improve health outcomes, and reinforce educational participation. Policy recommendations include curriculum reform, mandatory teacher training in gender-sensitive health education, and formalized collaboration between education and health sectors. Dissemination strategies target policymakers, practitioners, and communities through policy briefs, workshops, media campaigns, and grassroots engagement. Together, these measures create a synergistic framework for dismantling systemic barriers and accelerating inclusive, sustainable development in India.

7. Conclusion

To strengthen the integration of gender equality education and health within India's Sustainable Development Goals (SDGs) framework, three policy priorities are proposed. First, curriculum reforms should embed age-appropriate, context-sensitive modules on gender equality, reproductive health, nutrition, and rights-based education across all schooling levels. These modules must reflect local socio-cultural contexts and link theory to practice through initiatives such as school health clubs and peer-led community outreach. Second, teacher training requires a systemic approach, with mandatory pre-service and in-service modules on

gender sensitivity, inclusive pedagogy, and culturally sensitive health communication. Continuous professional development—supported by digital platforms and peer learning networks—will ensure teachers remain equipped to address evolving health and equity challenges. Third, cross-sector collaboration between the Ministries of Education and Health is essential, including joint policy frameworks, shared budget allocations, integrated monitoring systems, and coordinated school-community health initiatives. Public–private–community partnerships can further support scaling innovative solutions such as mobile health units, menstrual health campaigns, and digital literacy programs.

Dissemination of these recommendations should target both policymakers and communities to ensure adoption and sustainability. Policy briefs, white papers, and stakeholder workshops can present actionable strategies to government and institutional leaders, while academic conferences and practitioner forums can facilitate knowledge exchange and cross-learning. At the grassroots level, community engagement platforms, parent–teacher forums, and local health fairs can build awareness and buy-in, complemented by mass media and digital campaigns to amplify public understanding. Together, these measures can create a cohesive ecosystem where education, health, and gender equality are mutually reinforcing, accelerating progress toward SDGs 3 (Good Health and Well-being), 4 (Quality Education), and 5 (Gender Equality).

References

1. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
2. Creswell, J. W., & Poth, C. N. (2018). Qualitative inquiry and research design: Choosing among five approaches (4th ed.). SAGE Publications.
3. Deva, S., Ghosh, R., & Srinivasan, S. (2025). Designing culturally sensitive LLM-based reproductive health chatbots in India. Journal of Health Informatics in Developing Countries, 19(1), 45–59.
4. Flood, M. (2011). Involving men in efforts to end violence against women. Men and Masculinities, 14(3), 358–377. https://doi.org/10.1177/1097184X10363995
5. Hesse-Biber, S. N. (2014). Feminist research practice: A primer (2nd ed.). SAGE Publications.
6. Krueger, R. A., & Casey, M. A. (2015). Focus groups: A practical guide for applied research (5th ed.). SAGE Publications.
7. Manvi, S., Patel, N., & Kumar, R. (2025). Perceptions of health chatbots among underserved women in urban India: A qualitative study. Asian Journal of Women's Studies, 31(2), 150–169.
8. Ministry of Education. (2020). National Education Policy 2020. Government of India. https://www.education.gov.in
9. Ministry of Health & Family Welfare. (2021). School Health and Wellness Program. Government of India. https://www.mohfw.gov.in
10. Nandi, A., & Schneider, H. (2018). Addressing social determinants of health in India: Moving beyond healthcare. Global Health Action, 11(1), 142-158. https://doi.org/10.1080/16549716.2018.1429340
11. NITI Aayog. (2023). SDG India Index & Dashboard 2023. Government of India. https://www.niti.gov.in

12. Nussbaum, M. C. (2011). Creating capabilities: The human development approach. Harvard University Press.
13. Raghuvanshi, P., Singh, A., & Mehta, R. (2025). Gender disparities in morbidity: Insights from NFHS-5 data. Indian Journal of Public Health, 69(1), 12–19.
14. Santhya, K. G., Acharya, R., & Jejeebhoy, S. J. (2022). Promoting young women's reproductive autonomy in India: The role of education. Studies in Family Planning, 53(3), 283–299. https://doi.org/10.1111/sifp.12184
15. Sen, A. (1999). Development as freedom. Oxford University Press.
16. Sharma, R., & Patel, M. (2020). Integrating gender equality into health education: Lessons from India. Health Education Research, 35(4), 345–358. https://doi.org/10.1093/her/cyaa020
17. Sommer, M., Caruso, B. A., Sahin, M., Calderon, T., Cavill, S., Mahon, T., & Phillips-Howard, P. A. (2016). A time for global action: Addressing girls' menstrual hygiene management needs in schools. PLoS Medicine, 13(2), e1001962. https://doi.org/10.1371/journal.pmed.1001962
18. Tong, R. (2018). Feminist thought: A more comprehensive introduction (4th ed.). Routledge.
19. United Nations. (2023). The Sustainable Development Goals report 2023. https://unstats.un.org/sdgs/report/2023
20. UNDP. (2020). Human Development Report 2020: The next frontier—Human development and the Anthropocene. United Nations Development Programme. https://hdr.undp.org
21. UNESCO. (2021). Education for sustainable development: A roadmap. UNESCO Publishing.
22. UNICEF. (2022). State of the World's Children 2022: Children in a digital world. United Nations Children's Fund. https://www.unicef.org
23. Van Manen, M. (2016). Researching lived experience: Human science for an action sensitive pedagogy (2nd ed.). Routledge.
24. WHO. (1986). Ottawa charter for health promotion. World Health Organization. https://www.who.int/healthpromotion/conferences/previous/ottawa/en
25. WHO. (2022). Global report on health equity for women and girls. World Health Organization.
26. World Economic Forum. (2023). Global gender gap report 2023. World Economic Forum. https://www.weforum.org
27. Yin, R. K. (2018). Case study research and applications: Design and methods (6th ed.). SAGE Publications