Distribution Agreement

In presenting this thesis as a partial fulfillment of the requirements for a degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis in whole or in part in all forms of media, now or hereafter now, including display on the World Wide Web. I understand that I may select some access restrictions as part of the online submission of this thesis. I retain all ownership rights to the copyright of the thesis. I also retain the right to use in future works (such as articles or books) all or part of this thesis.

Jahnavi Chamarthi April 7, 2025

Intersecting Identities: Evaluating the Impact of SC/ST Women in Indian State Legislative Assemblies on Legislative Commitment to Healthcare and Education for SC/ST Women

by

Jahnavi Chamarthi

Beth Reingold
Adviser

Political Science

Beth Reingold

Adviser

Kiela Crabtree

Committee Member

Rachel Harmon

Committee Member

2025

Intersecting Identities: Evaluating the Impact of SC/ST Women in Indian State Legislative Assemblies on Legislative Commitment to Healthcare and Education for SC/ST Women

By

Jahnavi Chamarthi

Beth Reingold
Adviser

An abstract of
a thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Political Science

2025

Abstract

Intersecting Identities: Evaluating the Impact of SC/ST Women in Indian State Legislative Assemblies on Legislative Commitment to Healthcare and Education for SC/ST Women

By Jahnavi Chamarthi

This research investigates how the intersection of caste and gender informs political representation in India by examining the presence of Scheduled Caste (SC) and Scheduled Tribe (ST) women in state legislatures. It asks whether and how the descriptive representation of SC/ST women shapes substantive legislative commitment, primarily through proposed budget allocations and passed legislation, to addressing the needs of similarly marginalized communities, particularly in the domains of healthcare and education. Drawing on theories of intersectionality and political representation, the study considers how shared identity and lived experience may influence legislative behavior, while also recognizing the institutional constraints that shape what legislators can meaningfully accomplish. Situated within India's decentralized governance structure, where social policy falls largely under state authority, this research contributes to broader scholarly conversations about the relationship between identity, representation, and the distribution of political attention.

Intersecting Identities: Evaluating the Impact of SC/ST Women in Indian State Legislative Assemblies on Legislative Commitment to Healthcare and Education for SC/ST Women

By

Jahnavi Chamarthi

Beth Reingold
Adviser

A thesis submitted to the Faculty of Emory College of Arts and Sciences
of Emory University in partial fulfillment
of the requirements of the degree of
Bachelor of Arts with Honors

Political Science

2025

Acknowledgements

I am deeply grateful to my advisor, Dr. Reingold, who was the first to encourage me to pursue a thesis and whose mentorship has profoundly shaped both this project and my academic journey. Her unwavering support, thoughtful guidance, and deep commitment to the study of political representation inspired the questions at the heart of this research.

I am also thankful to Dr. Harmon and Dr. Crabtree, whose encouragement and generous feedback pushed me to sharpen my arguments and expand my thinking. I've been incredibly fortunate to learn from all three of my committee members—not just as scholars, but as mentors I've had the opportunity to form meaningful connections with.

I also want to express my sincere gratitidude to Dr. Das Acevedo, whose teaching and mentorship have been a lasting source of inspiration. Her approach to scholarship shaped the way I thought about this project and continues to shape the way I think about my future academic and professional path.

Lastly, to my family and friends—thank you for your patience, encouragement, and understanding throughout this process. Your support made all the difference.

Table of Contents

I. Introduction

Research has shown that when women and marginalized groups hold at least 30% of legislative seats, legislative priorities are more likely to address a wide range of issues affecting these populations (UN Women 2024). Among these priorities, healthcare and education emerge as critical foci for the allocation of medical and educational resources, the development of local health and education infrastructure, and the responsiveness of health and education systems to marginalized populations (Pollack Porter, Rutkow, and McGinty 2018; Chattopadhyay and Duflo 2004).

The intersections of where caste and gender meet may be especially influential in understanding how legislative actions address the compounded vulnerabilities faced by marginalized communities. In India, first, where caste and gender play pivotal roles in shaping individuals' experiences within the healthcare and education systems and, second, where the composition of the legislative assembly is deeply influenced by caste and gender, the presence of intersecting identities in government may have far-reaching implications for these sectors. Against this backdrop, this research investigates how the intersecting identities of caste and gender in Indian state legislatures influence legislative commitment, primarily through proposed budget allocations and passed legislation for Scheduled Caste (SC) and Scheduled Tribe (ST)[1] women's healthcare and education, using these measures as quantitative indicators of legislators' substantive representation of women from SC and ST communities.

[1] Scheduled Castes and Scheduled Tribes are classifications within Indian society that identify groups historically subjected to social and economic discrimination. Scheduled Castes, often referred to as Dalits, fall outside the traditional four-tier varna caste system and have been marginalized as "Untouchables." They have typically faced severe restrictions on their rights, including limitations on access to public services and education. Scheduled Tribes encompass India's various indigenous communities, many of which have been reduced to small communities that live in largely remote areas. The term "schedule" is derived from both groups' inclusion in one of the twelve schedules of the Indian Constitution for the purpose of affirmative action and political representation.

India offers fertile grounds for this research primarily because of its introduction of gender quota systems and its implementation of caste quota systems. These provisions aim to promote the representation of women and individuals from marginalized caste backgrounds in political institutions by reserving a third of seats for these groups in legislative bodies. While the gender quota system for state legislative assemblies and the Parliament has yet to be implemented—contingent upon the next delimitation process—the reservation of seats for SCs and STs is implemented based on their proportion of the population in each state, as determined by the latest Census. This process is overseen by the Delimitation Commission of India, which identifies the constituencies for reservation, focusing on areas with significant SC or ST populations. Although the process theoretically allows for rotation to ensure reserved seats are periodically redistributed across different constituencies, in practice, constituencies with consistently high SC or ST populations often remain reserved over time (Cassan and Vandewalle 2021).

The quota system presents a unique opportunity for this research to examine the effectiveness of already implemented caste quota legislation and potential necessity of introduced—but not yet implemented—gender quota legislation by exploring whether ensuring the representation of women from lower-caste backgrounds in government (descriptive representation) leads to greater advocacy for provisions that genuinely address the specific needs and concerns of the communities they come from (substantive representation).

The underexplored question of whether women from these backgrounds, once elected, successfully demonstrate legislative commitments that benefit similarly marginalized groups represents a critical gap in political representation literature. This study contributes to that literature by comparing legislation and budget proposals across varying Indian states,

investigating the implications of caste and gender quotas in state legislatures and how they could impact the formulation of policies and budgetary schemes aimed at improving healthcare and education, particularly for the women of marginalized communities.

II. Literature Review

Previous scholarship has primarily considered the "single-axis" impact (Crenshaw 1989) of citizens' gender *or* caste on healthcare and education access (Daher et al. 2021; Hickey and Stratton 2007; Morgan et al. 2017; Sabharwal et al. 2014), and explored the political contexts, specifically decentralization, party priorities, and structural barriers such as financial constraints, family background, and socio-cultural factors that underpin disparities in health and education policy implementation (Smith 2014; Kumar 2023). While these studies provide valuable insights, when they do consider intersectionality, they typically do so from only one side of the equation—either the recipients of policy or the policymakers themselves. This limited dialogue inspires an important question: *How do the caste and gender identities of legislators simultaneously shape their policymaking and impact constituents of the same background through measures like policy adoption and budget allocation?* This research seeks to answer this question by first, leveraging intersectional theory, which posits that individuals' experiences are shaped by the interconnected nature of various social identities and systems of power. Second, this research intends to contribute to the underexplored relationship between descriptive and substantive representation by examining intersectionality on both sides—the intersectional identity of the legislators and their policy making impact on intersectionally marginalized groups.

Intersectionality theory, coined by Kimberlé Crenshaw (1989), emphasizes the ways in which overlapping identities—such as gender, race, and class—and structures of inequality create unique experiences of marginalization. In the Indian context, these identities intersect in ways that severely limit the socioeconomic mobility of women from SC/ST backgrounds, compounding their exclusion from both social and political life (Chatterjee 2010; Arya and Rathore 2020). While India's constitutionally mandated SC/ST quota systems have sought to increase representation in political spaces, as Raghuram (2019) argues, the intersecting identities of SC/ST women mean that they continue to face significant barriers to accessing and influencing political power. As these women often share the dual burdens of caste or tribe, and gender-based discrimination, their ability to successfully push for funding that addresses their communities' healthcare and educational needs is challenged. This multi-layered oppression affects their political leverage and limits their access to networks of power, complicating their capacity to enact substantive healthcare and education reforms.

At the same time, caste and gender-based hierarchies in India shape the quality and access to public resources and services for recipients of both the healthcare and education systems. For instance, the literature has established caste and gender as key factors contributing to unmet healthcare needs and disparities in healthcare access for lower-caste women, in large part because economic disadvantage—often intensified by gender and caste—leaves marginalized groups with limited options (Singh et al. 2023; Mahapatro et al. 2021; Yadav & Jena 2020; Thapa et al. 2021). Similarly, economic disadvantage constrains women's and marginalized communities' access to education, reinforcing cycles of inequality across both sectors. In rural areas, SC/ST girls face barriers to formal schooling, including economic constraints, social stigma, and household responsibilities, which often prevent them from

attending school (Hickey & Stratton 2007; Mohanty & Nandakumar 2005). Discriminatory practices within medical and educational institutions, societal stigmas against SC/ST women, and economic barriers create significant challenges, affecting not only the likelihood of prioritizing and seeking these services in the first place but also the quality of healthcare and education received. This exclusion from both quality services and timely intervention reinforces cycles of poor health and education outcomes in SC/ST communities, disproportionately impacting SC/ST women (Hickey and Stratton 2007; Kumar 2019; Singh et al. 2023; Mahapatro, James, and Mishra 2021).

This research highlights that marginalized women, particularly SC/ST women, encounter dual layers of oppression. This dual marginalization—rooted in both caste-based discrimination and gendered social norms—directly impacts their ability to access healthcare and education, often leading to worse health outcomes and lower educational attainment. These insights provide an opportunity to explore if—and how—SC/ST women legislators, who face barriers accessing and navigating political systems, successfully advocate for budget allocations and policies that address healthcare and educational disparities for their constituents, who face similar barriers accessing and navigating these systems.

This discussion lends itself well to the concepts of descriptive and substantive representation, both of which play crucial roles in this analysis. *Descriptive representation* refers to the numerical presence of legislators who share key social identities with their constituents, such as caste, gender, or ethnicity. The premise is that legislators who embody these identities are more likely to reflect the lived experiences and specific interests of their constituents in legislative decisions. *Substantive representation* goes beyond shared identity to encompass the actual advocacy and implementation of legislative actions that materially benefit these

marginalized groups.[2] Together, these concepts suggest that when SC/ST women are elected to legislative bodies, they may be particularly attuned to the social and structural barriers their communities face, making them more likely to pursue policies that address these issues directly.

Several studies underscore the positive impact of descriptive and substantive representation on policy outcomes for marginalized communities. Reingold and Smith (2012), Reingold, Widner, and Harmon (2019), and Cassan and Vandewalle (2021) collectively argue that legislators who share intersecting identities with marginalized groups—such as women of color in the United States or lower-caste women in India—are often more responsive to these groups' needs than legislators who do not share identities with their constituents. This responsiveness manifests in tangible policy priorities, including healthcare, social welfare, and education, where policymakers advocate for resources and reforms aligned with the needs of their constituencies. For example, women of color in U.S. state legislatures have shown distinct tendencies to champion health and welfare policies that serve racial and gender-based minority groups, demonstrating the unique role that intersectional identity can play in legislative decision-making.

Similarly, Barnes, Beall, and Holman (2020) examine the role of pink-collar legislators—women from traditionally low-status, feminized occupations—who, like SC/ST women in India, share lived experiences with economically and socially marginalized communities. Their analysis of U.S. state legislatures finds that women from pink-collar backgrounds are more likely to jointly advocate for increased budget allocations for education and social services, underscoring how occupational identity, alongside gender, influences

[2] Political representation is composed of three related dimensions: descriptive, substantive, and symbolic representation (Pitkin 1967). While this study emphasizes substantive representation, it is distinct from symbolic representation, which refers to the expressive or psychological value of seeing members of one's social group in positions of power, regardless of policy outcomes. Symbolic representation can shape perceptions of legitimacy, inclusion, and political efficacy among marginalized communities. Though not the primary focus of this study, this could be an avenue that future research could productively explore.

institutional legislative priorities. Their findings reinforce the broader argument that shared experiences of structural marginalization—whether based on caste, class, or occupation—translate into institutional-level policymaking trends that reflect how legislators prioritize policy interventions for disadvantaged communities.

Empirical evidence supports the link between descriptive and substantive representation within India's caste system, as well. Clots-Figueras (2005) finds that women legislators in Indian state assemblies shape budgetary allocations in ways that reflect their constituents' needs, particularly in education and infrastructure. Notably, SC/ST women legislators prioritize capital investments in lower tiers of education, irrigation, and other essential services, while upper-caste women legislators show no significant impact on redistributive policies. This distinction underscores the importance of considering how intersecting caste and gender identities influence legislative priorities. This research takes Clots-Figueras (2005) as inspiration and builds on this foundation by focusing specifically on SC/ST women and examining how their representation affects not just general sectoral spending, but targeted allocations and legislation in healthcare and education for SC/ST women. In doing so, this study extends the insights of Clots-Figueras by further disaggregating spending patterns and capturing a more precise measure of substantive representation for intersectionally marginalized groups.

Another example of this dynamic in the Indian context (and notably, one of the few that examines intersectionality on both sides of the equation) can be seen in Halim, Yount, and Cunningham's (2016) study on education, which examines how the representation of SC/ST women in state legislatures impacts educational outcomes for SC/ST girls. Recognizing the intersecting caste and gender identities of these legislators, the study hypothesizes that SC/ST women legislators may feel a strong sense of solidarity with SC/ST girls and support legislative

policies that benefit them. To test this hypothesis, the authors analyzed district-level data from 2000 to 2004, drawing from the Indian Election Commission, the 2004/5 India Human Development Survey, and the 2001 Indian Census. Their findings reveal that districts with a higher proportion of SC/ST women legislators were positively associated with SC/ST girls' primary school grade completion and age-appropriate grade progression, though not with their primary school performance. While this study connects descriptive representation to educational outcomes, my research attempts to explore a closer link between legislators' intersectional identities and their policymaking actions, particularly in healthcare and education resource allocation.

This model suggests that SC/ST women legislators, grounded in the lived realities of caste-based marginalization, hold the potential to influence budget allocations and legislation that address the specific challenges faced by lower-caste women. By advocating for increased funding for healthcare and educational programs, equitable resource distribution, and improvements in the quality of provisions, these legislators may help bridge existing gaps in healthcare and education services for marginalized women. These theoretical and empirical insights support the hypothesis that the presence of SC/ST women in legislative roles could drive transformative budgetary and policy decisions in healthcare and education, providing substantive representation that reflects the intersectional needs of their communities.

III. Theory

This section theorizes how the presence of SC/ST women in state legislative assemblies influences budgetary and legislative commitment to healthcare and education programs targeting SC/ST women. The central argument is that when women from historically marginalized caste

groups are descriptively represented in legislative bodies, they are more likely to drive substantive representation for their communities—especially in policy domains like health and education, where the effects of caste and gender-based exclusion are acutely felt. This theory builds on established work linking descriptive and substantive representation and is grounded in the idea that lived experiences and shared group identities can shape budgetary and legislative priorities. While the full causal mechanism is discussed in detail after the variables are introduced, it is important to frame this section with the broader theoretical claim that increased SC/ST women's representation in state legislatures should lead to greater attention to the policy needs of SC/ST women through targeted budgetary allocations and legislative activity.

This state-level focus is especially important in the Indian context, where health and education are constitutionally defined as subjects on the State List[3]. As such, state governments hold primary authority over budget allocations, program implementation, and legislative decision-making in these sectors. This decentralization makes state legislatures the most relevant arena for evaluating how political representation influences outcomes in health and education policy.

The dependent variable (DV) is the legislative commitment to healthcare and education aimed at addressing the needs of women from SC/ST communities, measured through aggregate state-level metrics. The DV will be two-pronged: the first prong will examine the proportion of the assembly term's budget allocated to healthcare and education, specifically for women from SC/ST populations, while the second will analyze the number of bills, acts, and ordinances passed during a given assembly term that specifically pertain to healthcare and education for women from SC/ST communities. Together, these measures provide a comprehensive

[3] Also known as List II in the Seventh Schedule of the Indian Constitution, the State List grants state governments exclusive power to legislate on 61 specific matters.

understanding of state-level legislative commitment, capturing both policy creation and resource allocation. This approach will allow for an analysis of variations across states with differing levels of SC/ST women's representation in the legislature.

The selection of legislative commitment to healthcare and education for SC/ST women as the dependent variable in this study is intentional and critical. Healthcare policies for SC/ST women not only recognize the gendered experience of pregnancy, childbirth, and reproductive health, but also tackle the systemic caste-based discrimination that limits access to adequate medical services, prenatal and postnatal care, contraception, and child health interventions for SC/ST women. Without these interventions, SC/ST women and children face higher rates of maternal and infant mortality, malnutrition, and preventable diseases, reinforcing intergenerational cycles of disadvantage (Ahmed and Mahapatro 2023; Jungari and Chauhan 2017).

Similarly, education is not just a crucial policy issue for SC/ST girls and women but also for mothers, making it an essential area of legislative focus. For women, access to education directly correlates with economic independence, political participation, and improved health outcomes, offering a pathway out of systemic marginalization (Reshi, Sudha, Dar 2022). For mothers, education is key to ensuring better health and educational outcomes for their children, as research consistently shows that maternal education is one of the strongest predictors of child survival, nutritional status, and school enrollment (Vikram and Vanneman 2020). Further, research consistently shows that mothers play a central role in decisions about their children's schooling, as they advocate for enrollment, retention, and access to quality education. (Avvisati, Besbas, and Guyon 2011; Banerji, Berry, and Shotland 2017). However, while mothers value education, structural barriers such as poverty, lack of accessible schools, and caste-based

discrimination limit their ability to prioritize it, particularly in low-income SC/ST households, where education competes with immediate survival needs (Bhagavatheeswaran et al. 2016). For instance, research indicates that SC/ST households are significantly less likely to spend on education compared to other social groups and that being from an SC/ST background statistically and significantly reduces the probability of household spending on education across all economic groups (Prakasam 2021; Prakasam 2023). These barriers make education policy a pressing concern for SC/ST women, both as voters and as potential legislators, as they navigate a system that often restricts their ability to secure better educational opportunities for themselves and for their children.

By centering healthcare and education, this study highlights legislative action in two of the most critical domains where caste and gender intersect to shape women's and children's well-being, agency, and long-term opportunities. Together, these policy areas offer a direct mechanism for SC/ST women legislators to influence the structural barriers that affect their constituents, making them a crucial lens for examining substantive representation.

The independent variable (IV) is the presence of SC/ST women legislators in state legislative assemblies. This presence is measured by the percentage of all legislators who are SC/ST women within a specific state's assembly during a specific legislative term.

The causal mechanism linking the IV to the DV, at the *individual* legislator level, is grounded in two aspects of descriptive representation that drive substantive representation. First, legislators who share key social identities with their constituents, such as SC/ST women legislators with SC/ST women constituents, possess insight into the potential neglect and mistreatment experienced by their communities. This insight comes from lived experiences and firsthand knowledge of the systemic barriers to accessing healthcare and education services, such

as discrimination and lack of infrastructure (Lowande, Ritchie, and Lauterbach 2019). As a result, SC/ST women legislators are more likely to recognize gaps in sectors, in which lower-caste women face heightened disparities.

The second mechanism is the motivation drawn from shared experiences and common history. Legislators with a deep sense of identification with their constituents are likely to feel a heightened sense of responsibility to advocate for policies that benefit their communities. This shared group identity fosters a personal commitment to addressing issues that affect the collective well-being of the group (Lowande, Ritchie, and Lauterbach 2019). For SC/ST women legislators, this means they are not only informed by their lived experiences but also motivated by a sense of duty to push for policies and budgets that specifically address the needs of marginalized lower-caste women. These dual mechanisms—insight into neglect and motivation from shared identity—constitute the link between descriptive and substantive representation in this research.

The causal mechanism at the individual level forms the basis for understanding how representation of SC/ST women in the legislature can affect healthcare and education legislative action catered towards SC/ST women at the *aggregate level*. First, the presence of SC/ST women legislators can reshape institutional norms and influence budgetary decisions through increased parliamentary deliberation and advocacy. Research highlights how descriptive representation fosters institutional attention to marginalized groups' needs, often through formal discussions and proposals that elevate the visibility of systemic disparities (Mechkova 2024). Further, Clayton and Zetterberg (2018) demonstrate that substantial increases in women's parliamentary representation ("quota shocks") are associated with greater government spending on public health, and suggest that this is a result of an increased legislative focus on social welfare issues.

Additionally, the authors also theorize that the presence of more women in legislatures signals a reorientation of policy priorities, leading both quota and non-quota legislators to pay greater attention to public health and social services, further institutionalizing these policy shifts. SC/ST women legislators, by emphasizing the compounded disadvantages faced by lower-caste women, are able to frame healthcare and education as urgent state priorities, leading to higher budget allocations for these sectors at the institutional level.

Second, their advocacy within legislatures often involves forming coalitions with like-minded colleagues, leveraging their collective influence to overcome institutional resistance and secure targeted funding for healthcare and educational services (Hessami and Lopes da Fonseca 2020).

Finally, increased representation of SC/ST women legislators can generate symbolic effects that reinforce accountability and long-term institutional change. Their presence signals a commitment to addressing intersectional inequities, which can pressure state governments to prioritize these issues in response to public demand. This dynamic is consistent with findings that link higher representation of marginalized groups to greater public accountability in resource distribution and policymaking (Mechkova 2024). These mechanisms highlight how SC/ST women's descriptive representation at the state level influences substantive outcomes in budgetary and policy proposals, ensuring that healthcare and education receive the funding and legislation necessary to address the needs of women from marginalized populations.[4]

[4] Generalizability is a core principle of political science scholarship, as it allows theoretical frameworks to extend beyond specific case studies and contribute to broader understandings of political behavior and institutional dynamics. While this study focuses specifically on SC/ST women, the underlying mechanisms linking descriptive to substantive representation can be extended to other manifestations of political underrepresentation. Legislators who identify with marginalized groups—such as individuals with disabilities, LGBTQ+ representatives, or members of religious or ethnic minorities—can similarly draw on lived experiences and group-based motivations to shape legislative priorities. These parallels suggest that the causal mechanisms theorized in this paper are not unique to caste and gender intersections but are broadly applicable across diverse forms of identity-based representation, making this framework a useful foundation for understanding how marginalized voices shape policy across multiple contexts.

IV. Research Methodology

This research employs state-legislative session as its unit of analysis. The healthcare budgetary data includes all 28 states and 3 of the Union Territories (UT)—National Capital Territory (NCT) of Delhi, Jammu and Kashmir, and Puducherry.[5] While Union Territories are federally administered regions, these entities still possess their own state-like legislatures that oversee policy decisions. The education budgetary dataset includes 27 states—excluding Arunachal Pradesh due to data unavailability—and the 3 UTs mentioned above. The budgetary datasets analyze (1) the proportion of the *total* state budget allocated to healthcare specifically for SC/ST women in a given fiscal year, (2) the proportion of the *total* state budget allocated to education specifically for SC/ST women in a given fiscal year, and (3) the proportion of the total *healthcare* budget designated for healthcare specifically for SC/ST women in a given fiscal year, and (4) the proportion of the total *education* budget designated for education for SC/ST women in a given fiscal year.

Using both total budgets and sector-specific budgets as denominators provides a comprehensive perspective on fiscal prioritization. Examining allocations as a share of the total state budget allows for an assessment of how much priority SC/ST women's healthcare and

---

Let me know if you'd like to cite any specific generalizability debates or scholars like King, Keohane, and Verba, or extend this to comparative politics!

[5] While Union Territories are federally administered regions, these entities still possess their own state-like legislatures that oversee policy decisions, making them suitable for inclusion in this research.

education receive relative to all government expenditures, shedding light on broad policy commitments. Meanwhile, using sector-specific budgets as denominators isolates how funding is distributed within healthcare and education, capturing whether SC/ST women's needs are emphasized within constrained sectoral budgets. This research finds both of these perspectives to be meaningful in understanding the link between descriptive and substantive representation, and therefore, considers both in its analysis.

The fiscal year selected typically corresponds to the final year of the legislative session, ensuring that the allocation reflects the legislator's tenure in office. However, since legislative sessions that begin after 2019 will not yet have available data for the final fiscal year of that session, the most recent fiscal year with available data is used instead. By focusing on the last year of the session, this approach offers a test of policy prioritization, as it captures whether a state prioritizes these allocations even when approaching the end of its term. In other words, if a government does not push for these budgets in the final year, it may indicate a lack of sustained commitment to SC/ST women's healthcare and education. Conversely, if funding is maintained or increased, it suggests that these issues hold significant policy importance, regardless of electoral incentives or political timing.

Additionally, this study does not only examine the static relationship between the percentage of SC/ST women legislators and the proportion of the budget allocated to healthcare and education but also measures changes in both over time. Specifically, it will also assess whether an increase (or decrease) in the proportion of SC/ST women in the legislature corresponds to an increase (or decrease) in the proportion of budgetary allocations for healthcare and education targeting SC/ST women. Examining changes over time will help mitigate the influence of confounding variables by controlling for state-level fixed effects that do not change

across legislative sessions, such as historical political culture, long-standing institutional biases, or baseline economic development levels. By focusing on within-state changes rather than cross-sectional differences between states, this method can isolate the effect of SC/ST women's legislative presence from broader structural factors.

The legislation dataset includes all 28 states and two Union Territories: the NCT of Delhi and Puducherry. It examines the number of health and education acts, bills, and ordinances passed between 2020 and 2023 that specifically target SC/ST women. Rather than treating each year as an individual data point, the dataset assigns one data point per legislative session, capturing the legislative output as an average of each session.

If a state has one legislative session spanning 2020–2023, the dataset first records the total number of relevant legislative measures passed in each year and then calculates the average across those years, representing the session as a single data point. If a state has two legislative sessions within this period, the dataset records a separate data point for each session, with each data point representing the average of the total number of relevant legislative measures passed per year within that session. This approach allows for a standardized measure of legislative commitment to SC/ST women's healthcare and education policies while accounting for variations in session length and frequency across states. For instance, calculating the sum of totals would not be appropriate, as some states may have sessions spanning three years within 2020–2023, while others may have only one, leading to inconsistencies in comparisons. By averaging the totals across the years within each session, this method ensures that legislative activity is measured more proportionally rather than skewed by differences in session duration.

By examining the relationship between SC/ST women's political representation and healthcare and education budgets and policy formation, this study tests the following hypotheses:

Health Budget Hypotheses	
H1: SC/ST Women's Health over Total Budget	States with a higher percentage of SC/ST women legislators will allocate a higher percentage of their total state budgets to healthcare specifically addressing SC/ST populations.
H2: SC/ST Women's Health over Health Budget	States with a higher percentage of SC/ST women legislators will allocate a higher percentage of their total state health budgets to healthcare specifically addressing SC/ST populations.
H3: Change in SC/ST Women's Health over Total Budget	An increase in the percentage of SC/ST women legislators is associated with an increase in the percentage of the total state budget allocated to SC/ST women's healthcare.
H4: Change in SC/ST Women's Health over Health Budget	An increase in the percentage of SC/ST women legislators is associated with an increase in the percentage of the state's health budget allocated to SC/ST women's healthcare.
Education Budget Hypotheses	
H5: SC/ST Women's Education over Total Budget	States with a higher percentage of SC/ST women legislators will allocate a higher percentage of their total state budgets to education specifically addressing SC/ST populations.
H6: SC/ST Women's Education over Education Budget	States with a higher percentage of SC/ST women legislators will allocate a higher percentage of their total state education budgets to education specifically addressing SC/ST populations.
H7: Change in SC/ST Women's Education over Total Budget	An increase in the percentage of SC/ST women legislators is associated with an increase in the percentage of the total state budget allocated to SC/ST women's education.
H8: Change in SC/ST Women's Education over Education Budget	An increase in the percentage of SC/ST women legislators is associated with an increase in the percentage of the state's education budget allocated to SC/ST women's education.
Legislative Activity Hypotheses	
H9: Health	A higher percentage of SC/ST women legislators is associated with a greater number of healthcare-related legislative actions for SC/ST women.

H10: Education	A higher percentage of SC/ST women legislators is associated with a greater number of education-related legislative actions for SC/ST women and children.

Table 1: Hypotheses

This study relies on multiple sources to construct a dependent variable that captures both state-level budgetary patterns and legislative actions, and an independent variable that measures descriptive representation of SC/ST women in a given state's legislature.

A. *Independent Variable (IV): Representation of SC/ST Women Legislators*

The independent variable is the proportion of SC/ST women legislators in state assemblies. This data is sourced from the replication files provided by Francesca R. Jensenius as part of her article "Competing Inequalities? On the Intersection of Gender and Ethnicity in Candidate Nominations in Indian Elections", which is derived from her dissertation work (Jensenius 2016). Jensenius compiled comprehensive electoral data on India's national and state elections from 1961 to 2015, based on PDF reports from the Election Commission of India that were scraped, parsed, and cleaned to produce an accessible and structured dataset. This dataset was further updated with election data up to 2024, allowing for a more current and robust examination. Using this appended dataset, the proportion of SC/ST women legislators is calculated for each state assembly term by aggregating constituency-level election results. This variable captures the descriptive representation of SC/ST women legislators and reflects the intersectionality of caste and gender as a key factor influencing policy and budgetary outcomes.

B. *Dependent Variable*

a. Budgetary Data

The first dependent variable at the aggregate level is the percentage of total state *and* intra-sector budgets allocated to healthcare and education programs specifically targeting women

from SC/ST populations.[6] The healthcare budgetary data is sourced from the National Health Mission (NHM), covering fiscal years 2002–2025. NHM publishes detailed Program Implementation Plans (PIPs) annually, which outline state-specific proposed budgets, programs, and priorities for the upcoming fiscal year.

The tentative nature of these budgets is beneficial for this analysis, as it reflects legislators' priorities in allocating resources rather than final spending outcomes. Actual expenditures are determined by executive agencies such as state health departments, finance ministries, and bureaucratic bodies responsible for fund disbursement and program execution. These agencies may adjust allocations based on administrative constraints, implementation challenges, or shifting policy directives, which could introduce additional external factors into the causal chain, making it harder to isolate legislative intent.

To construct this variable, these PIPs are systematically analyzed to identify healthcare programs explicitly aimed at SC/ST women, focusing on initiatives related to maternal health, reproductive health, child health, and infant health tailored specifically for caste-marginalized populations. This identification process involved reviewing budget line items, program descriptions, and stated beneficiary groups within PIPs, ensuring that allocations were explicitly earmarked for SC/ST women rather than broader general healthcare initiatives.

In analyzing state healthcare budget allocations, most budget documents had designated sections for Reproductive and Child Health (RCH) and tribal health programs, which facilitated the identification of intersectional health policies targeting SC/ST women. These structured

[6] Both the intra-sector and total budget variables are calculated using the same method—SC/ST women-specific allocations as a percentage of a broader budget category. The only difference lies in the denominator: for intra-sector allocations, the denominator is taken from the same sources as the SC/ST-specific allocations (as discussed in this section), ensuring internal consistency. In contrast, the denominator for total state spending is sourced from state legislative websites and official budget documents published by state governments. Both total state spending and intra-sector spending denominators are also *proposed* legislative budgets in order to reflect the tentative nature of the independent variable.

sections made it easier to locate and analyze programs explicitly designed to address caste and gender disparities in healthcare access.

Several programs and budget allocations appeared consistently across multiple state legislatures. One of the most common branches of programs was noted as “Integrated Outreach RCH (Reproductive and Child Health) Services”, and was present in most states. Another widely implemented branch of programs was called “Special RCH Plans for Tribal Areas,” which appeared in nearly every state with a significant tribal population, including Andhra Pradesh, Chhattisgarh, Odisha, and Madhya Pradesh. These plans often focused on maternal and infant health, anemia prevention, and incentives for tribal health workers. Similarly, the “Vulnerable Groups RCH program”, found in Assam, Bihar, Haryana, and other states, aimed at providing reproductive health services to socially disadvantaged populations, including SC/ST women. Other common programs included ambulance transport services for tribal areas, which were prioritized in states like Andhra Pradesh and Gujarat, and ASHA worker incentives in tribal districts, seen in Gujarat, Maharashtra, and Madhya Pradesh. These incentives were meant to strengthen community-based health outreach and awareness programs.

While many budget documents followed a similar structure, each state also had unique programs tailored to local demographic needs and governance priorities, and therefore required a more in-depth review. For example, Jharkhand allocated funds specifically for strengthening tribal hospitals and setting up telemedicine units in particularly vulnerable districts, a program not commonly found in other states. Odisha introduced RCH exhibitions at tribal festivals, an outreach approach that leveraged local cultural events to promote reproductive and child health awareness. Himachal Pradesh allocated funding for alternative vaccine delivery systems in hard-to-reach tribal areas, addressing geographical barriers to healthcare access. In Tamil Nadu,

the budget included mobile medical units targeted at tribal populations, ensuring that healthcare services reached communities without permanent health infrastructure. By isolating proposed budgetary allocations targeted toward SC/ST groups within these divisions of healthcare, this variable effectively captures the extent to which legislative priorities align with addressing intersectional inequities in healthcare access and outcomes.

Despite legislative sessions typically lasting five years, they do not always follow a uniform timeline across states. As a result, the healthcare budgetary data for most states spans four legislative sessions within the 2002–2025 timeframe. However, due to specific circumstances, not all states have data for four complete sessions. For instance, Jammu and Kashmir, affected by political instability and its reorganization into a Union Territory in 2019, has data covering only three legislative sessions. Similarly, Telangana, which officially separated from Andhra Pradesh in 2014 has data spanning only two legislative sessions within this period.

The second component of the budgetary dependent variable is the percentage of total state budgets allocated to education programs specifically targeting women and girls from SC/ST populations. The educational budgetary data is primarily sourced from publicly accessible datasets provided by Open Budgets India, which compiles detailed budget information from various sectors, including education, across Indian states. For states whose education budget data were not available through this platform, state legislative websites were directly consulted to retrieve the necessary budget information. Similar to how the health budget variable was constructed, budgets from each state were systematically analyzed to identify educational programs explicitly aimed at SC/ST girls and women, with a particular focus on initiatives designed to promote girls' enrollment, retention, access to higher education, scholarship schemes, and programs addressing early marriage or dropout prevention. For example, many

states allocated funds for scholarships for SC/ST girls, hostel construction to support female students from remote areas, and awareness campaigns in tribal areas to encourage families to educate their daughters.

At the same time, this variable was not limited to education policies targeting SC/ST girls but also accounted for educational programs benefiting SC/ST children as a whole. Recognizing that children's education is an important issue for mothers, the analysis also considered initiatives supporting primary and secondary education for SC/ST students, school infrastructure improvements, and teacher recruitment in tribal and disadvantaged regions. For instance, many states included funding for primary school construction in underserved areas, mid-day meal expansions tailored to SC/ST-majority schools, and vocational training programs aimed at bridging skill gaps for SC/ST youth.

This education-focused data spans fiscal years 2008–2024, encompassing two or three legislative sessions for most states. However, due to variations in legislative terms and differences in data availability, some states diverge from this pattern. For example, Arunachal Pradesh lacked publicly accessible data entirely within this timeframe. Additionally, certain states such as Haryana, Jammu & Kashmir, Kerala, Mizoram, and Nagaland had budget data covering only one legislative session, limiting their representation in the analysis.

This dependent variable—carefully constructed from publicly accessible and reputable research and government institutions—allows for a precise assessment of how the descriptive representation of SC/ST women legislators influences targeted budgetary commitments to healthcare and education. Although variations in data availability across states, due to political changes or limited transparency, create constraints, the method employed here represents the most robust approach possible given these limitations. By systematically analyzing explicitly

targeted budget allocations, this variable captures the extent to which SC/ST women legislators substantively address intersectional inequities in healthcare and education.

b. Legislative Actions

The second dependent variable is the number of legislative measures adopted that specifically address healthcare and education for women of SC/ST backgrounds. Data for this variable is sourced from PRS Legislative Research's Annual State Laws Review reports, published between 2020 and 2023. These reports provide a comprehensive overview of state-level legislative activity, including bills introduced, acts passed, and ordinances issued, which enables a detailed analysis of how these legislative measures address the specific needs of SC/ST women in healthcare and education. To identify these measures, the search initially focused on laws directly concerning healthcare and education. The search was then narrowed to laws that addressed intersectional issues, specifically those that affected both SC/ST communities and women. A law had to address not only the needs of SC/ST or women but also an intersectional issue that impacted both components. For example, a law increasing labor and delivery centers in a district with a significant SC/ST population would meet this criterion.

By analyzing the adoption of policies addressing healthcare and education for women of SC/ST populations, this study captures the extent to which state legislatures institutionalize policies that respond to the needs of intersectionality marginalized groups. This approach allows for an examination of legislative trends across states with varying levels of SC/ST women's representation, offering insights into how descriptive representation influences substantive outcomes in regard to policy outcomes.

D. *Control Variables*

To ensure the robustness of the analysis and accurately isolate the relationship between the presence of SC/ST women legislators and legislative and budgetary commitment to healthcare and education for SC/ST women across these states, this study incorporates thirteen control variables: Inflation Rate, GDP (Per Capita Net State Domestic Product), Poverty Rate, Literacy Rate, Unemployment Rate Among SC and ST Populations, Average of Total Bills Passed within a Legislative Session, Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Percentage of SC and ST Women aged 15-49 yrs with BMI<18.5, Percentage of SC and ST children aged 6-59 months having any anaemia (<11.0g/dl), Percentage of SC and ST women aged 15-49 years having any anaemia (<12.0g/ dl), Percentage of SC/ST Women Population, and Total State Population.

These variables account for economic, healthcare, and demographic factors that could independently influence healthcare and education budget allocations. Some of these variables, such as inflation rate, GDP, and poverty will be used across all analyses, whereas others are specifically collected to serve as controls for either the health budgetary data, the education budgetary data, or the legislative actions data. It is important to note here that all of these control variables, except for one—the average of total bills passed within a legislative session—are time-invariant. This limitation arises due to the lack of regularly updated data for certain variables and the reliance on census data, which is collected only once every 10 years. As a result, many of the control variables remain constant over time, making it difficult to capture more dynamic changes in the population or related factors within shorter time frames. Each variable is discussed below, along with its source, timeframe, and rationale for inclusion.

(1) Inflation Rate[7]

Inflation significantly affects a state's economic stability and its capacity to fund public services. For this study, the inflation rate is measured as the percentage change in the Consumer Price Index (CPI), which reflects the average change over time in the prices paid by urban consumers for a market basket of goods and services. The data is sourced from the Ministry of Statistics and Programme Implementation (MoSPI), specifically from the official CPI data for December 2024.

Including the inflation rate as a control variable helps isolate the effects of SC/ST women legislators proposing funding for intersectional health and education programs from those of broader economic changes. High inflation may erode the real value of fiscal resources, potentially reducing the amount a state can allocate to healthcare services, regardless of the political influence of SC/ST women legislators. By controlling for inflation, the study ensures that the observed differences in healthcare budgets are not merely due to changes in the purchasing power of money, but instead reflect the true impact of political representation.

(2) GDP (Per Capita Net State Domestic Product)

Economic capacity significantly impacts a state's ability to allocate resources to healthcare and education. For this study, GDP is measured as per capita Net State Domestic Product (NSDP) at constant 2004–2005 prices. The data is sourced from the Central Statistics Office (CSO) via the Government of India's Data Portal and corresponds to the fiscal year 2012–2013.

[7] Ideally, the cost of living index would have been used, as it directly reflects changes in the cost of living across regions and would provide a more accurate representation of the financial burden on households. However, due to the unavailability of reliable and up-to-date cost of living data, the inflation rate is used as a substitute.

Including GDP as a control variable is critical for distinguishing the effects of economic capacity from those of descriptive representation. States with higher per capita GDP may allocate larger shares of their budgets to maternal healthcare simply because they have more fiscal resources. Controlling for GDP will strengthen the findings by making certain that observed differences in healthcare budgets reflect the influence of SC/ST women legislators rather than state wealth disparities.

(3) Poverty Rate

For this study, poverty is measured using the headcount ratio, which represents the percentage of the population living below the poverty line. This measure is derived from the Multidimensional Poverty Index (MPI), which accounts for various factors such as income, education, and standard of living. The data for this variable is sourced from the Government of India's official dataset on state-wide multidimensional poverty estimates for the years 2022-23, available on the OGD Platform.

The headcount ratio is a crucial indicator as it helps assess the extent of poverty in each state, reflecting not only the number of people living below the poverty line but also the intensity of their poverty. By including this variable, the study controls for the impact that varying levels of poverty may have on healthcare and education access and quality. States with higher poverty levels may face greater challenges in allocating resources to the healthcare and education sectors, as more individuals are in need of basic services. Conversely, states with more poverty may also propose to spend more on these sectors due to the greater need within these communities. By controlling for the poverty rate, the study helps demonstrate that observed differences in budgets and passed legislation reflect the influence of SC/ST women legislators rather than disparities in poverty levels.

(4) Literacy Rate

Literacy is a significant determinant of both health and education outcomes, as individuals with higher literacy levels are better equipped to access healthcare services and educational opportunities. Drawing from DeWalt et al. (2004), higher literacy rates have been consistently associated with improved health knowledge, greater utilization of preventive services, and better adherence to medical guidance. These findings underscore the role of literacy in fostering an informed and proactive citizenry capable of advocating for public services, including healthcare and education policies that directly impact marginalized communities.

For this study, data on literacy rates is sourced from the 2011 Census of India, the most recent and comprehensive dataset available. By controlling for literacy, this study ensures that observed differences in both healthcare and education budget allocations are not conflated with broader trends in social development, governance quality, or overall education levels. This approach isolates the specific impact of SC/ST women legislators on legislative and budgetary commitments to healthcare and education.

(5) Unemployment Rate Among SC and ST Populations

For this study, unemployment rates of SC and ST communities are included as a control variable, reflecting the percentage of SC individuals and ST individuals, who are actively seeking but unable to find work. This data is sourced from the OGD Platform India for the years 2015–2016, the most recent dataset available with state-wise unemployment estimates specifically for SC/ST communities.

Unemployment is a critical control variable as it affects both healthcare and education access, influencing individuals' ability to afford medical care, invest in education, and navigate bureaucratic systems to access public services. Ideally, all control variables in this study would

be derived from SC/ST-specific datasets to ensure maximum precision. However, due to limited publicly available data on key indicators like state-wise SC/ST literacy rate, incorporating the SC/ST unemployment rate strengthens the robustness of this analysis. By controlling for unemployment within SC/ST populations, this study accounts for structural economic constraints that may independently affect healthcare and education investments, helping isolate the distinct impact of SC/ST women legislators on policy outcomes.

(6) Average of Total Bills Passed

For this study, the average of the total number of bills passed within a given legislative session is included as a control variable to account for structural differences in legislative productivity across states. This measure captures the total number of bills passed in a given legislative session and is sourced from PRS Legislative Research's Annual State Legislative Briefs. Unlike other control variables, this is the only time-variant measure, allowing for a more dynamic assessment of how legislative structures impact policy making trends over time.

This variable is used exclusively in the legislative actions dataset to control for institutional and procedural differences that influence the volume of legislation enacted in each state. Some states inherently pass more bills due to greater legislative efficiency, session length, or political dynamics, while others have more constrained legislative processes. By controlling for the average of the total number of bills passed, the study ensures that variation in the number of healthcare and education bills targeting SC/ST women is not simply a byproduct of a state's overall legislative activity, but rather a reflection of specific policy commitments to marginalized communities.

(7) Infant Mortality Rate (IMR)

Infant mortality, the number of infant deaths per 1,000 live births, is an important indicator of overall healthcare access and quality. Data for IMR is sourced from the Sample Registration System (SRS) and corresponds to 2014, the most recent nationally available data before the study period.

IMR is included as a control variable to account for states' broader healthcare challenges that may influence maternal or child healthcare funding. For example, states with high IMR may prioritize maternal and child health programs to address systemic deficiencies in healthcare delivery.

(8) Maternal Mortality Rate (MMR)

Maternal mortality, measured as the number of maternal deaths per 100,000 live births, is a key indicator of healthcare needs and priorities. Data for MMR is sourced from the Sample Registration System (SRS) and corresponds to the period 2010–2012, and provides a reliable indicator of maternal health conditions, which tend to evolve gradually over time (WHO).

Including MMR as a control variable allows the analysis to account for variations in healthcare budgets and legislation driven by state-specific maternal health challenges. States with higher MMRs may allocate more funding to maternal healthcare as a response to these urgent needs. Controlling for MMR ensures that budgetary allocations and legislative actions are not solely reactive to healthcare crises but reflect the role of SC/ST women legislators in shaping legislative priorities.

(9) Percentage of SC and ST Women aged 15-49 yrs with BMI<18.5, (10) Percentage of SC and ST children age 6-59 months having any anaemia (<11.0g/dl), (11) Percentage of SC and ST women age 15-49 years having any anaemia (<12.0g/ dl)

This study incorporates various health indicators related to SC and ST women and children as control variables. These variables aim to address existing disparities in nutritional status and anemia prevalence, which could separately impact healthcare investments for these groups. Data is obtained from India's Open Government Data (OGD) Platform and is from 2017-18, focusing on state and UT-level nutritional status and anemia prevalence among SC/ST populations.

These controls are included in the health dataset to ensure that differences in maternal and child healthcare funding for SC/ST communities are not simply driven by preexisting disparities in malnutrition or anemia prevalence, which could affect healthcare policy decisions independently of legislative representation. By accounting for both women's and children's health indicators for SC and ST populations, this study strengthens its ability to isolate the specific impact of SC/ST women legislators on healthcare allocations, reducing the likelihood of confounding effects from broader health disparities.

(12) Percentage of SC/ST Women Population and (13) Total Population

Data on the proportion of SC/ST women is sourced from the 2011 Census of India, the most recent and comprehensive dataset available for caste and gender demographics.

Including the SC/ST women population proportion as a control variable is essential because it may impact both the independent and dependent variables. States with larger SC/ST women populations and total populations may naturally see higher representation of SC/ST women legislators, as political systems might respond to demographic demands. Similarly, larger SC/ST women populations could drive increased budgetary allocations for maternal healthcare and children's education, for example, to address caste-based inequities and meet the needs of these prevalent communities. Controlling for these population variables ensures that any

observed relationships between SC/ST women legislators and SC/ST women's healthcare and education funding and legislation are not confounded by constituent-driven representation, but instead are isolating the specific effects of intersectional and descriptive representation.

V. Data Analysis

To test the hypotheses outlined in this study, Ordinary Least Squares (OLS) regression analysis is employed to examine the relationship between SC/ST women's political representation and budgetary and legislative commitments to healthcare and education. This approach allows for a systematic evaluation of whether the proportion of SC/ST women legislators influences state-level budget allocations and legislative activity related to SC/ST women's healthcare and education.

(i) Modeling Budget Allocations

For budget-related hypotheses (H1–H8), the dependent variables are the percentage of total state budgets and sector-specific budgets allocated to SC/ST women's programs. The cross-sectional OLS regression uses the following general model:

$$Y_{it} = \beta_0 + \beta_1 (pctscstleg)_{it} + \beta_2 X_{it}$$

where:

- Y_{it} represents the percentage of the total state budget or sector-specific budget (health or education) allocated to SC/ST women's programs in state *i* during session *t*,
- $pctscstleg_{it}$ is the key independent variable, measured as the percentage of SC/ST women legislators in state *i*'s assembly during session *t*,

- X_{it} is a vector of control variables, including but not limited to, poverty rates, literacy rates, unemployment rates, total bills passed, and health indicators such as anemia prevalence and BMI levels in state *i* during session *t*.

For hypotheses 3, 4, 7, and 8—which focus on changes in budget allocations over time—a first-difference approach will be applied, where the dependent variable is the change in the percentage of budget allocations from one session to the next. This approach helps account for time-invariant state-level factors and ensures that the analysis captures the dynamic effects of increasing SC/ST women's representation on budgetary decisions.

Before understanding the results of this regression, it is important to examine the descriptive statistics of the independent and dependent variables[8]. While a review of the electoral data reveals that SC/ST women seem to be well represented across most state-years, it is important to recognize that many states report 0% SC/ST women representation in the legislature, highlighting the severe underrepresentation of this group in political institutions. This absence of descriptive representation suggests that the regression results likely reflect a conservative estimate of its potential impact, as the lack of variation in the independent variable may limit the model's ability to fully capture its influence.

At the same time, preliminary analysis of the budget data revealed that allocations for SC/ST women's health and education remain a small fraction of both total and sectoral budgets. On average, across the sample states, healthcare for SC/ST women accounts for approximately 0.01% of total state budgets and 0.27% of total health budgets, while education programs for SC/ST women average around 0.18% of total state budgets and 1.2% of total education budgets. These proportions illustrate the narrow slice of overall public expenditure dedicated to the

[8] A complete table of the numerical representation of SC/ST women in state legislatures across the various years included in this study can be found in the Appendix.

intersectional needs of SC/ST women and sets the foundation for this regression that explores how variations in descriptive representation affect both the scale and prioritization of targeted programs.

To contextualize these proportions in absolute terms, consider Andhra Pradesh in 2023, where roughly ₹43 crore (₹432 million) was allocated toward SC/ST women's healthcare initiatives. This amount included programs such as tribal reproductive and child health (RCH), ambulance transport to and from tribal areas, quality assurance infrastructure, and targeted outreach services. While ₹43 crore is a meaningful sum in terms of potential service delivery—capable of funding substantial maternal care, mobile outreach, or healthcare personnel in remote areas—it represents only about 0.31% of the state's ₹13,976 crore health budget that year. This underscores a critical tension: even in states that make relatively large absolute investments in intersectional health, those expenditures remain marginal within the broader sector. This pattern reinforces the importance of investigating how descriptive representation shapes not only whether these allocations exist, but also how much priority they are given within a constrained fiscal landscape.

(ii) Modeling Legislative Activity

For legislative activity-related hypotheses (H9–H10), I will estimate similar OLS regressions with the dependent variable representing the number of legislative actions (bills, acts, ordinances) passed related to SC/ST women's healthcare and education in each legislative session. This model will specifically control for total bills passed along with other socioeconomic indicators, ensuring that observed differences in policy focus are not merely a function of legislative productivity but rather a result of specific policy priorities linked to SC/ST women's representation.

VI. Findings

To evaluate the strength of relationships in the regression analysis, I consider the magnitude of coefficients and their interpretability within the model, as well as statistical significance using conventional thresholds. Since different variables are measured on different scales, their coefficients must be interpreted relative to their units. Some independent variables are percentages ranging from 0 to 100, while others are raw total values, requiring careful attention to ensure comparability.

Some independent variables are raw total values, meaning they are not constrained to a fixed range and can take on very large numbers. These include NSDP, total bills passed, and total state population. Because they are measured in absolute terms, the coefficients associated with these variables appear much smaller compared to those of variables expressed as percentages. This difference in scale is important to keep in mind when interpreting the results, as smaller coefficients do not necessarily indicate weaker relationships—particularly when the variables themselves represent large quantities.

The remaining independent variables, as well as the dependent variable, are measured as percentages, meaning they are bounded between 0 and 100. Using percentages ensures consistency in interpretation across the model and also helps maintain interpretability, especially given the already small size of many coefficients. Expressing variables as percentages avoids introducing further compression that might result from measuring them as proportions, which could make already modest relationships appear even smaller. It is also important to disclaim here that even when coefficients are small—which they often are in the following models—they may still reflect meaningful shifts in policy attention or budgetary commitment as they occur in actuality.

If a model estimates that a one-percentage-point increase in SC/ST women's legislative representation is associated with a 0.05 percentage-point increase in budget share, that may sound minor numerically. But applied to a health budget of ₹20,000 crore, this shift would correspond to an additional ₹10 crore in real allocations, demonstrating how seemingly small coefficients in percentage-point terms can translate into substantial and tangible resource changes on the ground. Taking Andhra Pradesh as an example again, the budget allocated to SC/ST women's healthcare rose from ₹4.5 crore in 2008 to ₹53 crore in 2018—an increase that occurred alongside a rise in the share of the health budget from roughly 0.10% to 0.25%. In this case, a 0.15 percentage-point change, while still relatively higher than the coefficient estimates in the models to follow, resulted in nearly ₹50 crore more in healthcare spending for SC/ST women.

In addition to evaluating the magnitude of coefficients, I also consider statistical significance using conventional thresholds. Relationships are assessed based on p-values, where coefficients with $p < 0.05$ are considered statistically significant, indicating a meaningful association that is unlikely to be due to random chance. Variables with $p < 0.01$ are considered highly significant, while those with $p < 0.1$ may indicate a weaker but potentially important relationship.

Hypotheses 1 and 2:

SC/ST Women's Health Budget		
Variables	**Coefficient Estimates (SE)**	
	H1: SC/ST Women's Health Over Total Budget	**H2: SC/ST Women's Health Over Health Budget**
Constant	-0.038 (0.064)	-2.100 (2.544)
% of SC/ST Women in Legislature	0.003 * (0.001)	0.054 (0.049)
Inflation Rate	-0.001 (0.002)	-0.018 (0.091)
Net State Domestic Product	-0.000 (0.000)	0.000 (0.000)
Poverty Rate	0.001 (0.001)	0.018 (0.021)
Literacy Rate	0.000 (0.001)	0.021 (0.021)
SC/ST Unemployment Rate	0.000 (0.001)	-0.005 (0.023)
Infant Mortality Rate	0.000 (0.001)	0.013 (0.020)
Maternal Mortality Rate	-0.000 ** (0.000)	-0.006 (0.004)
SC/ST Low BMI	0.000 (0.000)	0.008 (0.015)
SC/ST Child Anemia	0.000 (0.001)	-0.001 (0.020)
SC/ST Women Anemia	0.001 + (0.000)	0.013 (0.015)
% of SC/ST Women in Population	0.000 (0.000)	-0.002 (0.004)
Total Population	-0.000 (0.000)	-0.000 (0.000)
Num.Obs.	122	122
R2	0.248	0.095
F	2.742	0.869
RMSE	0.03	1.02

Table 2: Hypotheses 1 and 2 Regression Table

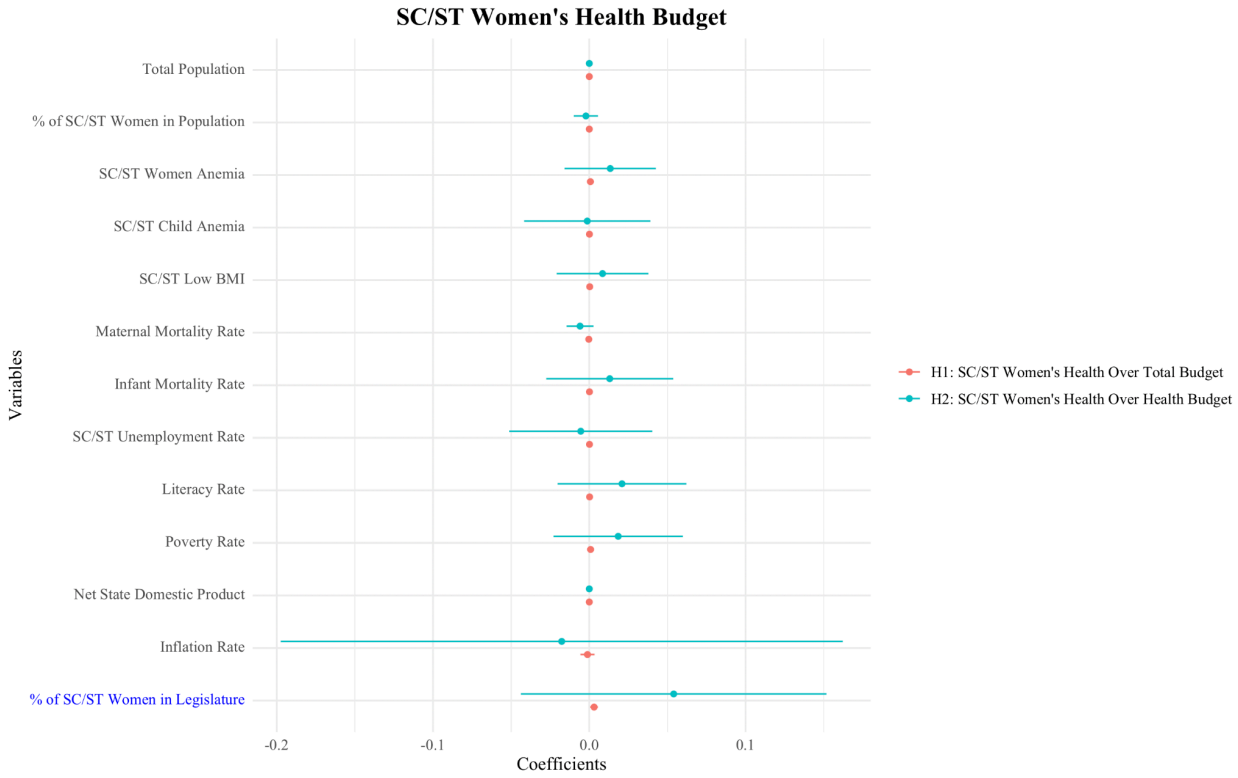

Figure 1: Hypotheses 1 and 2 Plot

H1: *Budget Allocation-SC/ST Women's Health over Total Budget*

The results show a statistically significant relationship between the proportion of SC/ST women in the state legislature and the percentage of the total state budget allocated to healthcare for SC/ST women. This means that states with higher SC/ST women representation tend to allocate a greater share of their total budget to healthcare programs specifically targeting SC/ST women. The relationship is strong enough to indicate that states where SC/ST women hold more legislative seats consistently prioritize healthcare for SC/ST women to a greater extent than states where SC/ST women representation is lower.

H2: *Budget Allocation-SC/ST Women's Health over Health Budget*

The results for H2 show no statistically significant relationship between SC/ST women's representation and the proportion of the healthcare sector's budget allocated to SC/ST women.

This suggests that while states with more SC/ST women legislators allocate more healthcare funding overall, they do not necessarily shift spending priorities within the healthcare sector itself.

Hypotheses 3 and 4:

Change in SC/ST Women's Health Budget		
Variables	**Coefficient Estimates (SE)**	
	H3: Change in SC/ST Women's Health Over Total Budget	**H4: Change in SC/ST Women's Health Over Health Budget**
Constant	-0.019 (0.102)	0.351 (3.375)
Change in % of SC/ST Women in Legislature	0.004 ** (0.001)	0.060 (0.045)
Inflation Rate	0.001 (0.004)	0.020 (0.119)
Net State Domestic Product	-0.000 (0.000)	-0.000 (0.000)
Poverty Rate	-0.001 (0.001)	-0.013 (0.028)
Literacy Rate	-0.000 (0.001)	-0.011 (0.028)
SC/ST Unemployment Rate	-0.000 (0.001)	0.012 (0.030)
Infant Mortality Rate	0.000 (0.001)	-0.009 (0.027)
Maternal Mortality Rate	-0.000 (0.000)	0.002 (0.006)
SC/ST Low BMI	-0.000 (0.001)	-0.008 (0.020)
SC/ST Child Anemia	0.000 (0.001)	0.007 (0.027)
SC/ST Women Anemia	0.000 (0.001)	0.004 (0.019)
% of SC/ST Women in Population	0.000 (0.000)	0.002 (0.005)
Total Population	-0.000 (0.000)	0.000 (0.000)
Num.Obs.	91	91
R2	0.115	0.064
F	0.768	0.403
RMSE	0.03	1.14

Table 3: Hypotheses 3 and 4 Regression Table

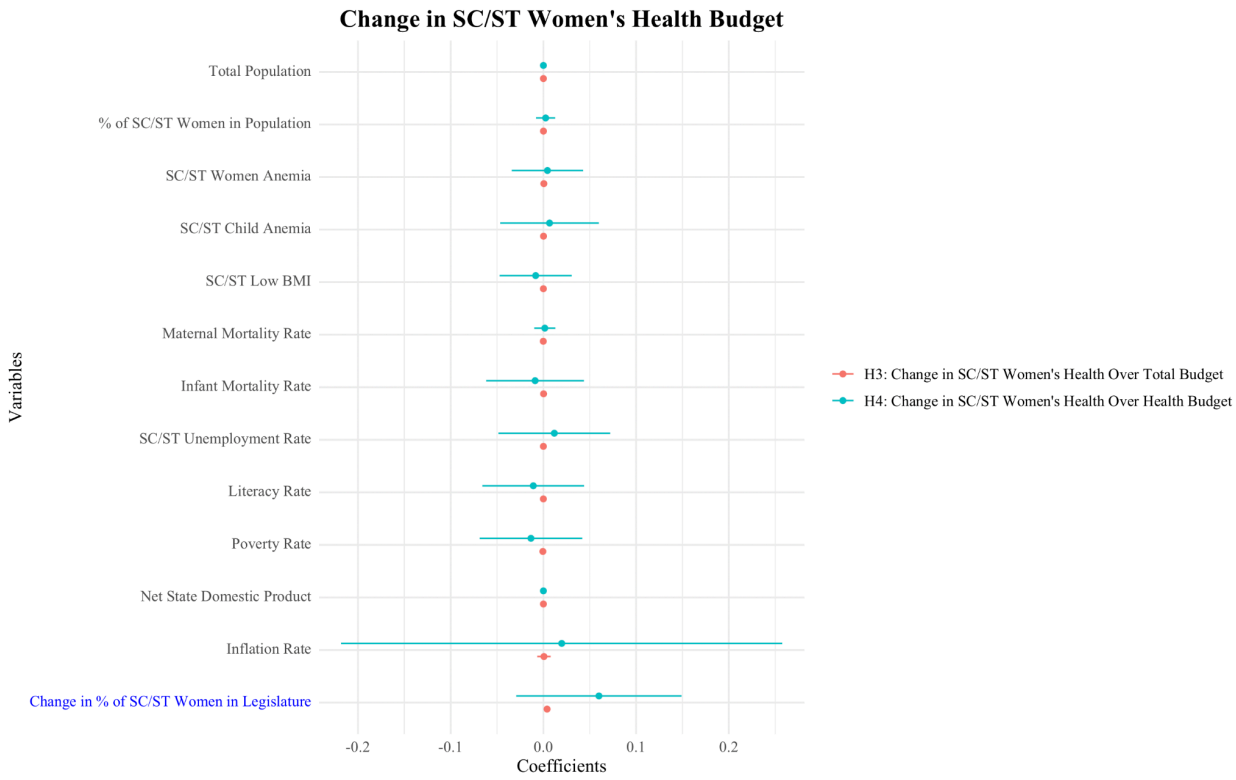

Figure 2: Hypotheses 3 and 4 Regression Plot

H3: *Budget Allocation-Change in SC/ST Women's Health over Total Budget*

The findings for H3 indicate that as SC/ST women's representation increases over time, the total percentage of the state budget allocated to SC/ST women's healthcare also increases in a statistically significant manner. This suggests that greater legislative representation may contribute to gradual increases in healthcare funding for SC/ST women, potentially reflecting the cumulative impact of sustained policy attention and institutional shifts over multiple legislative terms, rather than short-term fluctuations driven by election cycles or isolated political changes.

H4: *Budget Allocation-Change in SC/ST Women's Health over Health Budget*

The results for H4 show no statistically significant relationship, indicating that as SC/ST women's representation increases over time, it does not systematically lead to a greater share of the healthcare sector's budget being allocated to SC/ST women. This suggests that while

healthcare funding for SC/ST women may increase as part of total budgetary shifts (as seen in H3), the proportion of the healthcare budget itself directed toward SC/ST women does not consistently increase in response to growing SC/ST women's representation. This result implies that intra-sectoral budget distribution in healthcare remains relatively fixed, regardless of changes in representation over time.

Hypotheses 5 and 6:

SC/ST Women's Education Budget		
Variables	**Coefficient Estimates (SE)**	
	H5: SC/ST Women's Education Over Total Budget	**H6: SC/ST Women's Education Over Education Budget**
Constant	-0.933 * (0.427)	-7.136 ** (2.673)
% of SC/ST Women in Legislature	0.013 (0.012)	0.212 ** (0.073)
Inflation Rate	-0.019 (0.022)	-0.154 (0.137)
Net State Domestic Product	-0.000 * (0.000)	-0.000 *** (0.000)
Poverty Rate	0.002 (0.005)	-0.006 (0.031)
Literacy Rate	0.014 ** (0.005)	0.102 ** (0.031)
SC/ST Unemployment Rate	-0.007 (0.006)	-0.047 (0.037)
% of SC/ST Women in Population	0.005 *** (0.001)	0.033 *** (0.006)
Total Population	0.000 *** (0.000)	0.000 *** (0.000)
Num.Obs.	73	73
R2	0.366	0.483
F	4.617	7.461
RMSE	0.21	1.32

Table 4: Hypotheses 5 and 6 Regression Table

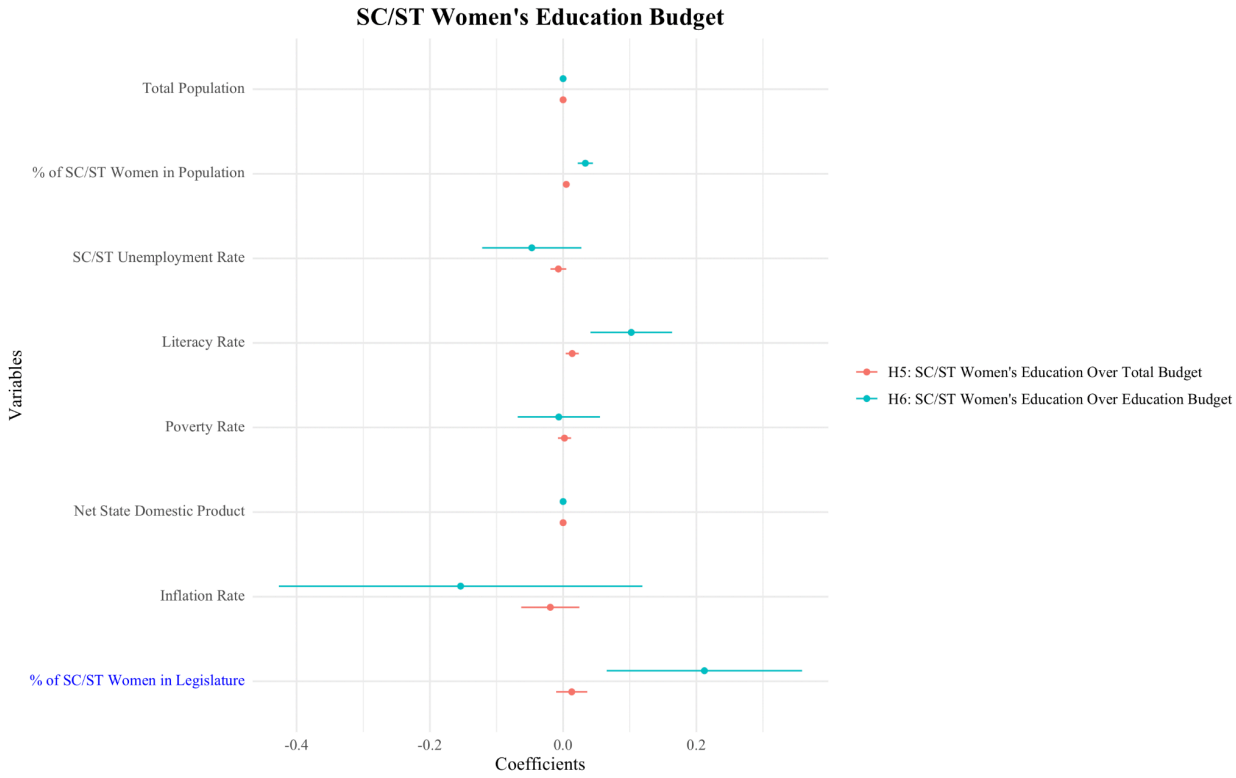

Figure 3: Hypotheses 5 and 6 Regression Plot

H5: *Budget Allocation-SC/ST Women's Education over Total Budget*

For H5, the relationship between SC/ST women's representation and the proportion of the total state budget allocated to SC/ST women's education is positive but not statistically significant. This means that while states with more SC/ST women legislators tend to allocate a larger portion of their overall budget to education for SC/ST women, this effect is not strong enough to conclude that it occurs systematically across states.

H6: *Budget Allocation-SC/ST Women's Education over Education Budget*

For H6, there is a statistically significant positive effect of SC/ST women's representation on the proportion of the education sector's budget dedicated to SC/ST women. This suggests that states with a greater proportion of SC/ST women in their legislature are allocating a greater share of the existing education budget to programs specifically targeting SC/ST women. This indicates

that while representation does not significantly influence total education spending (as seen in H5), it affects how resources within the education sector itself are distributed.

Hypotheses 7 and 8:

Change in SC/ST Women's Education Budget		
Variables	**Coefficient Estimates (SE)**	
	H7: Change in SC/ST Women's Education Over Total Budget	**H8: Change in SC/ST Women's Education Over Education Budget**
Constant	-0.453 (0.764)	-3.851 (5.066)
Change in % of SC/ST Women in Legislature	0.003 (0.013)	0.104 (0.086)
Inflation Rate	0.032 (0.037)	0.180 (0.248)
Net State Domestic Product	0.000 (0.000)	-0.000 (0.000)
Poverty Rate	0.005 (0.008)	-0.042 (0.055)
Literacy Rate	0.003 (0.009)	0.034 (0.059)
SC/ST Unemployment Rate	0.003 (0.011)	-0.006 (0.070)
% of SC/ST Women in Population	0.002 (0.002)	0.023 * (0.010)
Total Population	-0.000 * (0.000)	0.000 (0.000)
Num.Obs.	43	43
R2	0.327	0.260
F	2.065	1.490
RMSE	0.25	1.66

Table 5: Hypotheses 7 and 8 Regression Table

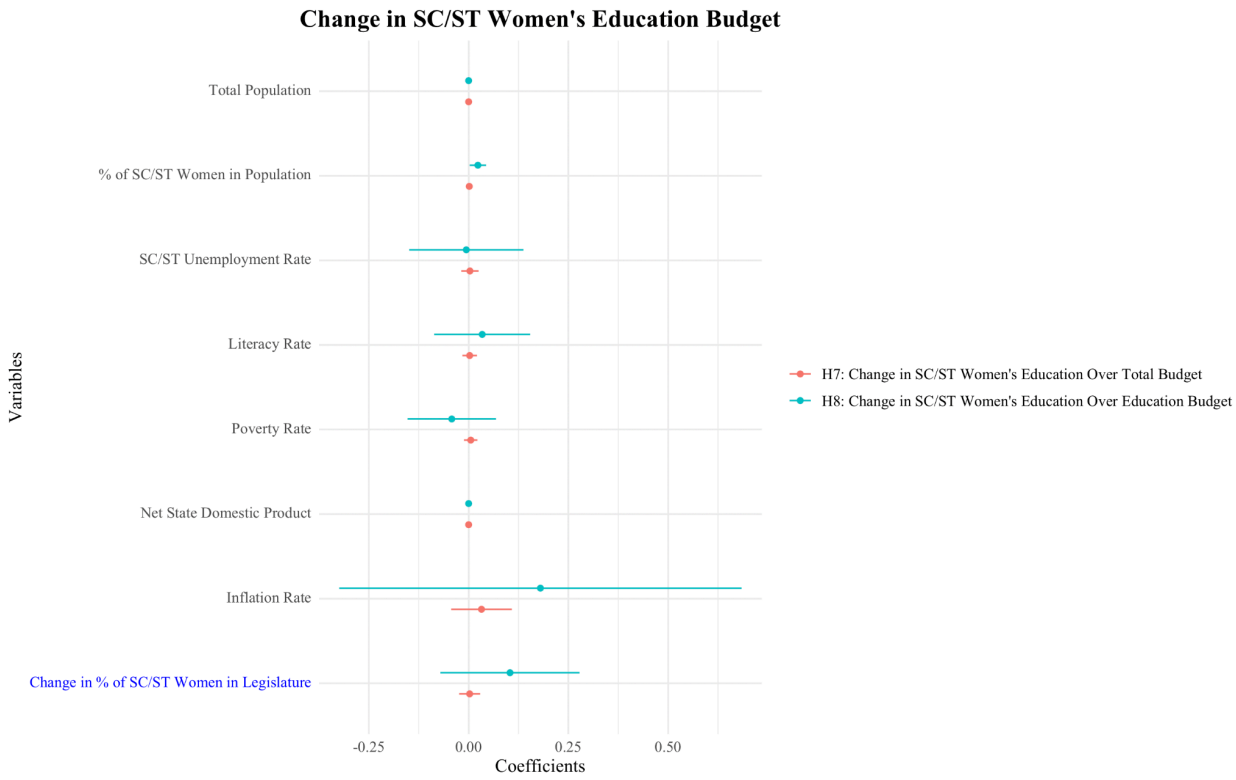

Figure 4: Hypotheses 7 and 8 Regression Plot

H7: *Budget Allocation-Change in SC/ST Women's Education over Total Budget*

For H7, the relationship between increasing SC/ST women's representation over time and the total percentage of the state budget allocated to SC/ST women's education is not statistically significant. This means that even as SC/ST women's representation has grown in some states, there has not been a consistent corresponding increase in the percentage of total education budgets allocated to SC/ST women.

H8: *Budget Allocation-Change in SC/ST Women's Education over Education Budget*

For H8, there is also no statistically significant effect of increasing SC/ST women's representation on the proportion of the education sector's budget allocated to SC/ST women. This reinforces earlier findings that education funding appears to be less responsive to changes in legislative representation than healthcare funding.

Hypothesis 9:

SC/ST Women's Health Legislative Activity	
Variables	**Coefficient Estimates (SE)**
	H9: SC/ST Women's Health Legislative Activity
Constant	1.145 (1.302)
% of SC/ST Women in Legislative Session	-0.008 (0.019)
Average of Total Number of Bills Passed in Term	0.004 (0.004)
Inflation Rate	-0.010 (0.048)
Net State Domestic Product	0.000 (0.000)
Poverty Rate	-0.013 (0.012)
Literacy Rate	-0.017 (0.011)
SC/ST Unemployment Rate	-0.007 (0.013)
Infant Mortality Rate	-0.009 (0.012)
Maternal Mortality Rate	-0.002 (0.002)
SC/ST Low BMI	0.008 (0.008)
SC/ST Child Anemia	0.013 (0.011)
SC/ST Women Anemia	-0.005 (0.007)
% of SC/ST Women in Population	-0.000 (0.002)
Total Population	-0.000 (0.000)
Num.Obs.	51
R2	0.308
F	1.146
RMSE	0.30

Table 6: Hypothesis 9 Regression Table

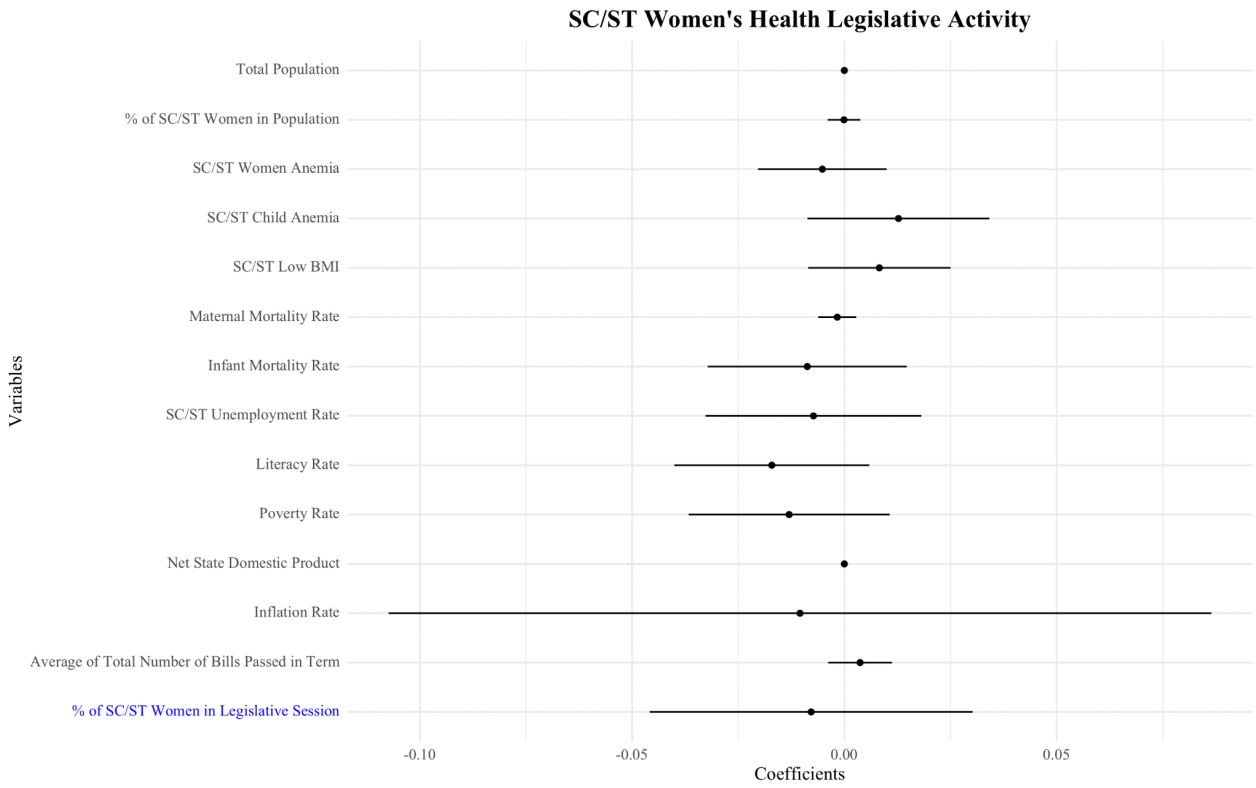

Figure 5: Hypothesis 9 Regression Plot

H9: *Legislative Activity-Health*

The findings for H9 show that there is no statistically significant relationship between SC/ST women's representation and the number of healthcare-related legislative actions (bills, acts, ordinances) introduced. Additionally, the coefficient is negative, meaning that states with higher SC/ST women representation tend to introduce fewer healthcare-related legislative actions, though this effect is not strong enough to be statistically significant. This suggests that SC/ST women legislators are not necessarily driving an increase in healthcare policy making through legislative activity, and other political or institutional factors may play a larger role in determining healthcare legislative output.

Hypothesis 10:

SC/ST Women's Education Legislative Activity	
Variables	**Coefficient Estimates (SE)**
	H10: SC/ST Women's Education Legislative Activity
Constant	-0.599 (1.227)
% of SC/ST Women in Legislative Session	-0.021 (0.027)
Average of Total Number of Bills Passed in Term	0.003 (0.005)
Inflation Rate	0.094 (0.066)
Net State Domestic Product	0.000 *** (0.000)
Poverty Rate	-0.007 (0.016)
Literacy Rate	-0.002 (0.014)
SC/ST Unemployment Rate	0.019 (0.016)
% of SC/ST Women in Population	0.009 ** (0.003)
Total Population	-0.000 (0.000)
Num.Obs.	51
R2	0.767
F	14.968
RMSE	0.51

Table 7: Hypothesis 10 Regression Table

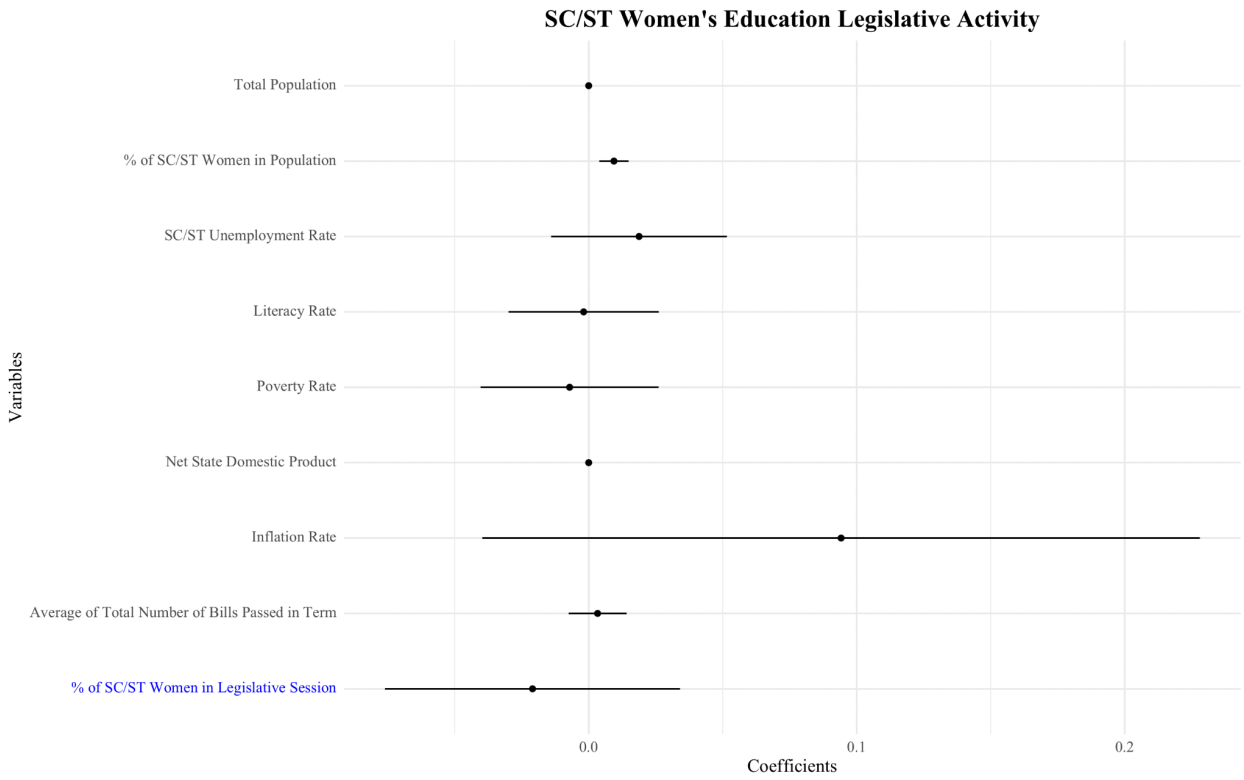

Figure 6: Hypothesis 10 Regression Plot

H10: Legislative Activity-Education

Similarly, the findings for H10 indicate that there is no statistically significant relationship between SC/ST women's representation and the number of education-related legislative actions introduced. The coefficient is also negative, meaning that states with more SC/ST women legislators tend to introduce fewer education-related bills and policies. While this relationship is not statistically significant, the direction of the coefficient suggests that greater SC/ST women's representation does not correspond with an increase in legislative activity in education policy. This could indicate that SC/ST women legislators face structural or political barriers that limit their ability to shape education policy through legislative mechanisms. Since this pattern emerges in both health and education legislation, further investigation into how

institutional constraints impact policy making—while still allowing for shifts in budget allocations—is a valuable avenue for research.

Taken together, the mixed findings in this analysis underscore a crucial point: descriptive representation does not operate in a vacuum. While the presence of SC/ST women in legislatures can influence budgetary allocations, their capacity to do so is deeply shaped by the broader institutional environment in which they are embedded. Policymaking institutions—such as bureaucratic gatekeeping, party hierarchies, legislative rules, and the extent of fiscal decentralization—mediate the extent to which individual legislators can translate political presence into substantive outcomes. Even when legislators are deeply motivated and attuned to the needs of marginalized groups, they must navigate political constraints, such as limited agenda-setting power, resistance from party leadership, or competing policy priorities that dilute their influence.

These institutional constraints help explain why descriptive representation does not always yield uniform effects across sectors or states. In contexts where legislative procedures are opaque, budgets are centrally controlled, or party discipline is particularly strong, even committed legislators may struggle to advance targeted policy proposals. Conversely, more open or responsive policymaking environments may allow greater opportunities for marginalized legislators to shape outcomes. These findings point to the need for future research that treats representation and institutions as mutually constitutive—recognizing that the effectiveness of representation depends not only on who is present, but also on how power is structured and exercised within the political system.

VII. Discussion

The results of this study reveal notable variations across hypotheses, indicating that SC/ST women's representation does not uniformly translate into increased spending or legislative action in all policy areas. While some hypotheses, such as H1, H3, and H6, show strong positive and statistically significant relationships, others, like H2, H4, H5, H9, and H10, either exhibit positive or negative coefficients, but lack statistical significance. Notably, however, none of the hypotheses demonstrate a statistically significant negative coefficient. These mixed findings suggest that SC/ST women legislators may face structural, institutional, or political constraints that shape their ability to influence budgetary and legislative outcomes. This section explores potential explanations for these differences, considering the policy environment, legislative power structures, bureaucratic constraints, and political dynamics that may account for the results.

(i) Why Does SC/ST Women's Representation Affect Overall Healthcare Budgets (H1) but Not Intra-Sector Healthcare Spending (H2)?

One of the most striking differences in the results is between H1 and H2. While H1 finds that states with higher SC/ST women's representation allocate a larger share of the total state budget to healthcare for SC/ST women, H2 finds no statistically significant relationship between SC/ST women's representation and the proportion of the healthcare sector's budget allocated to SC/ST women. This discrepancy suggests that SC/ST women legislators may be able to influence overall budgetary priorities but not necessarily the internal distribution of funds within the healthcare sector.

This difference can be partially explained by the behavior of the denominators in these two measures. In the case of H1, the denominator—total state spending—may not be necessarily

growing in tandem with SC/ST women's healthcare funding. As a result, increases in targeted healthcare allocations stand out more clearly and are picked up in the regression. In contrast, for H2, the denominator—the total healthcare budget—often increases alongside the targeted programs. When both the numerator (e.g., spending on Tribal RCH) and denominator (total health spending) are rising together, the proportion may remain relatively stable, obscuring potential associations with SC/ST women's representation.

This becomes clearer when examining how both SC/ST-targeted health spending (the numerator) and total health budgets (the denominator) evolve over time. In Andhra Pradesh, for example, SC/ST women's health spending increased from approximately ₹4.5 crore in 2008 to ₹53 crore in 2018—a more than tenfold rise. However, during that same period, the total health budget also increased sharply from ₹4,560 crore to ₹48,322 crore. As a result, the intra-sector share of the health budget allocated to SC/ST women's health rose only modestly, from 0.10% to 0.11%. By contrast, when calculated as a share of total state spending, the shift is more visible: SC/ST women's health allocations rose from 0.0089% to 0.0226% of the total state budget—more than doubling in proportion. These differences illustrate that even when real spending increases significantly, intra-sector proportions may remain flat if both the targeted spending and the sectoral budget are growing in parallel.

Moreover, the data supports the interpretation that this growth in absolute spending does not appear to reflect new or diversified programmatic priorities. In states like Andhra Pradesh, while absolute spending on programs such as Tribal RCH, ambulance transport to tribal areas, and quality assurance initiatives has clearly expanded over successive legislative sessions—from just over ₹1,000 lakhs in 2008 to more than ₹10,000 lakhs in 2023—the actual types of programs remain largely consistent across time. Similarly, Jharkhand has seen large-scale investments in

tribal healthcare infrastructure and supplies, but these increases reflect the scaling up of existing priorities rather than the introduction of new ones. In Madhya Pradesh, although there is notable investment in ASHA incentives and antenatal screening in tribal districts by 2022, the overall set of initiatives mirrors previous years, suggesting an expansion of existing schemes rather than the introduction of new ones. Even in West Bengal, where there is a visible rise in proposed spending on integrated outreach services and urban slum-focused interventions between 2010 and 2025, the underlying priorities continue to follow the same template.

This suggests that SC/ST women legislators may be more effective in influencing the overall amount of funding directed toward SC/ST health programs than in initiating entirely new programs, which would allow them to more influentially shape the scale of intra-sectoral allocations. This distinction becomes especially salient when considering how the denominators in each measure behave: while total state budgets tend to remain relatively stable or increase gradually, allowing targeted changes to stand out more clearly, health sector budgets often grow alongside SC/ST-specific spending. As a result, proportional increases may be less visible when calculated against the health budget itself—helping to explain why a significant relationship is observed in H1 but not in H2.

A key explanation for this difference in the denominators is who controls different levels of budget allocation. The total state budget is often determined by elected legislators and executive policymakers, meaning that legislative advocacy can influence these allocations. In contrast, sector-specific budget allocations are typically handled by bureaucrats and health administrators rather than legislators. Research has shown that public health bureaucracies both in India (Sneha et al. 2021) and globally (Kaufman and Nelson 2004) tend to be resistant to direct political interference and often prioritize continuity and stability in funding allocations

rather than responding to shifts in political representation. This may explain why SC/ST women legislators can advocate for a larger total health budget but have limited influence over how that money is divided within the healthcare sector.

Another factor that may contribute to this discrepancy is the relative flexibility of total versus sector-specific budgets. While total budgets can be adjusted annually based on political priorities, intra-sectoral allocations are often governed by long-term funding structures, pre-existing commitments to healthcare programs, and technical assessments of need (Streeck and Thelen 2005). For example, funding for hospitals, medical staff salaries, and drug procurement may be locked into multi-year contracts, limiting the ability of legislators to redirect resources toward SC/ST women's health initiatives.

Additionally, coalitional politics may play a role. If SC/ST women legislators are part of a broader political alliance that supports increased healthcare funding for SC/ST women, they may be able to push for an expansion of this spending without necessarily being able to determine how those funds (and others) are allocated within the healthcare sector. This suggests that while representation matters for broad fiscal priorities, sectoral budget control may require additional mechanisms, such as targeted policymaking authority or greater legislative oversight over bureaucratic decisions.

(ii) Why Does SC/ST Women's Representation Not Affect Overall Education Budgets (H5) but Affects Intra-Sector Education Spending (H6)?

In contrast to the findings for health, the education regressions show an almost inverse pattern. SC/ST women's representation was not significantly associated with education budget shares when measured as a percentage of total state spending, but it was significantly and positively associated with the proportion of the education sector's budget allocated to SC/ST

women. This suggests that, unlike in health—where SC/ST women legislators may have been more successful in expanding overall allocations but not intra-sectoral distributions—education may be a policy area where legislators have greater leeway to influence how existing sectoral funds are allocated rather than how much funding the sector receives overall.

The difference in variation between the two dependent variables helps explain this. The education-over-total budget measure shows limited variation, with a standard deviation of just 0.26, making it harder for representation to show an effect. By contrast, the education-over-education budget variable has a much larger standard deviation of 1.84, indicating greater variability across states and time in how education funds are distributed. This wider spread in the data may have made it easier to detect a statistically significant relationship in the regression. In short, the greater variation in intra-sector education spending may have revealed patterns that are less visible in more constrained or uniform distributions, helping to clarify where and how SC/ST women legislators are able to exercise influence.

(iii) Why Do SC/ST Women's Representation and Legislative Activity in Healthcare and Education Have Negative Correlations (H9 and H10)?

One of the most unexpected findings of this study is that H9 and H10 show negative (though not statistically significant) correlations between SC/ST women's representation and the number of healthcare- and education-related legislative actions. This suggests that states with more SC/ST women legislators tend to introduce fewer healthcare and education bills, acts, and ordinances. While this result is not statistically significant, its direction raises important questions about why increased representation does not lead to greater legislative activity.

A likely explanation for why SC/ST women legislators are able to push for budget allocations but not legislative activity lies in the institutional and political constraints they face

within the policymaking process. Research in India has found that legislators from historically marginalized backgrounds often lack the same level of political capital and institutional support as their upper-caste or male counterparts. For instance, Vatsala (2023), through interviews with national-level women parliamentarians, shows that even when women enter politics, they are often denied key portfolios and excluded from influential party decision-making bodies. Many reported being steered toward marginal ministries like Tourism and Textiles, while male colleagues dominated "key portfolios" like Agriculture and Defense. Respondents also complained that women parliamentarians seldom get an equal time slot in Parliamentary house debates. These patterns suggest that without access to internal party power structures and influential committee roles, SC/ST women legislators may find it more feasible to influence distributive outcomes—such as budget allocations—through informal channels or constituency-level advocacy than to alter legislation itself.

Budget allocations are often determined through negotiations within executive and legislative budget committees, where legislators can exert influence by aligning with broader fiscal priorities or leveraging coalition politics. Women legislators are also often noted for their effectiveness in building coalitions and collaborating across party lines, qualities that may enhance their ability to shape budgetary outcomes even when formal legislative influence is limited (Volden, Wiseman, and Wittmer 2018). While these traits would be beneficial in the legislative process, introducing and passing new legislation also requires access to key legislative committees, policymaking networks, and elite political alliances—resources that SC/ST women legislators may lack unless they hold institutional power, such as leadership positions or membership in a majority party. In many cases, legislative gatekeeping—where party leadership

and senior legislators control which bills advance—limits their ability to successfully push through new policies.

Moreover, budget decisions are often made collectively within party frameworks, allowing SC/ST women legislators to advocate for increased spending as part of a broader fiscal package, whereas proposing and *passing* legislation often requires individual political clout and sustained coalition-building (Blasingame, Hansen, and Witmer 2024; Claessen 2024). These constraints suggest that while SC/ST women legislators may successfully advocate for greater financial commitments within existing policy frameworks, they face structural barriers that prevent them from independently shaping new legislative agendas.

Another factor is the nature of legislative agendas in states with high SC/ST women representation. It is possible that in states where SC/ST women legislators hold more seats, there is already an institutionalized commitment to healthcare and education funding, reducing the need for new legislative actions. In such states, existing laws and programs may already address SC/ST women's needs, meaning that legislators focus more on budgetary oversight rather than introducing new bills. This is supported by previous research showing that women legislators often prioritize implementation and resource distribution over purely legislative activity (Schwindt-Bayer 2010).

Moreover, party politics may limit the ability of SC/ST women legislators to introduce bills. If SC/ST women legislators are part of majority party coalitions, they may be required to support the party's broader legislative agenda, which may not prioritize new healthcare or education policies for SC/ST women. In contrast, if they are members of opposition parties, they may lack the power to successfully introduce bills that require majority approval. Studies on legislative behavior in India suggest that marginalized legislators are often expected to align with

party leadership rather than independently pushing their own policy agendas (Jensenius 2017), which may explain the negative coefficient in H9 and H10.

(iv) Why Does SC/ST Women's Representation Over Time Increase Healthcare Spending (H3) but Not Education Spending (H7)?

The findings for H3 show that as SC/ST women's representation increases over time, the proportion of the total state budget allocated to healthcare for SC/ST women also increases in a statistically significant manner. However, H7 does not find a significant relationship between increasing SC/ST women's representation over time and education spending for SC/ST women. This suggests that healthcare spending may be more politically responsive to changes in representation than education spending.

A major reason for this difference may be the differing political and economic structures of healthcare and education funding. Healthcare funding often includes short-term, discretionary budget items that can be adjusted annually, such as maternal health initiatives, community health worker programs, and vaccination campaigns. In contrast, education budgets are highly structured and long-term in nature, often including multi-year investments in infrastructure, teacher salaries, and curriculum development (Carnoy and Dossani 2013). This means that while legislators can push for increased healthcare spending within a few budget cycles, shifting education expenditures may require prolonged institutional changes that are harder to achieve within a single legislative term.

Additionally, political incentives may differ between healthcare and education policy. Healthcare policies, especially those targeting SC/ST women, often yield visible, short-term benefits, such as improved maternal health outcomes or expanded access to reproductive services. These benefits can be politically advantageous for legislators seeking re-election,

making healthcare spending a more appealing target for advocacy. In contrast, education reforms take longer to produce measurable results, meaning that legislators may have less immediate political incentive to push for education spending compared to healthcare (Lindert 2004).

VIII. Limitations and Future Research

While this study provides valuable insights into the relationship between SC/ST women's legislative representation and budgetary and legislative outcomes in healthcare and education, several limitations should be acknowledged. These limitations highlight opportunities for future research to build upon and refine the findings presented here.

One of the primary limitations of this study is the lack of comprehensive longitudinal data. The analysis was constrained by the availability of budgetary and legislative records for specific years, limiting the ability to observe long-term trends and causal relationships over multiple legislative cycles. Future research could address this gap by employing expanded datasets that span additional legislative sessions, allowing for a more robust examination of how SC/ST women's representation influences policy outcomes over time. A longer time horizon would enable researchers to determine whether the effects observed in this study are temporary fluctuations or sustained policy shifts. Additionally, access to historical budgetary archives and legislative records could provide a clearer picture of how policy changes unfold across different political administrations.

Another key limitation pertains to language barriers in budgetary documents and legislative records. Many official budget reports, policy proposals, and legislative transcripts are written in Hindi or other regional languages, requiring translation for analysis. The process of translating these documents introduces the possibility that nuanced fiscal and legislative details

may have been lost or misinterpreted. Certain technical terms, policy classifications, or legislative intent may not be accurately conveyed in English translations, which might have affected the precision of the dataset. Future research could mitigate this issue by collaborating with linguists, regional policy experts, or employing advanced natural language processing (NLP) techniques to ensure greater accuracy in textual analysis. Additionally, studies that analyze policy documents in their original language could offer deeper insights into how budgetary and legislative priorities are articulated within different linguistic and cultural contexts.

Another promising avenue for future research involves incorporating religion as an analytical variable. While this study focuses primarily on caste and gender, religion and caste in India are deeply interconnected, and religious identity can play a critical role in shaping political representation and policy outcomes (Hertel 1977; Stroope 2012). SC/ST women legislators from different religious backgrounds may face varying levels of political inclusion, social barriers, and policy influence, which could affect their ability to advocate for healthcare and education funding. Future studies could explore how religious affiliation interacts with caste and gender in shaping legislative behavior and budgetary allocations, especially for issues like reproductive health and girls' education. Additionally, examining whether Muslim women legislators, Dalit Christian legislators, or other religious minorities experience similar or distinct patterns of policy influence could provide a more nuanced and meaningful understanding of representation and governance in India.

Beyond these considerations, future research should also investigate the role of political party dynamics and intra-party hierarchies in shaping SC/ST women's legislative impact. While this study examines representation at an aggregate level, individual legislators operate within

party structures that may either amplify or constrain their policy influence. Party leadership, committee assignments, and electoral incentives all play a role in determining whether SC/ST women legislators can effectively advocate for increased healthcare and education spending. Future work could explore how party ideology, leadership support, and coalition politics affect the ability of SC/ST women legislators to drive policy change.

A methodological limitation of this study is the reliance on quantitative budgetary data to infer policy influence. While statistical analyses provide a useful framework for measuring relationships between representation and spending, they do not fully capture the political negotiations, advocacy efforts, and informal mechanisms that legislators use to influence policy. Moreover, the independent variable shows very limited variation, with many states reporting zero representation. This lack of variation constrains the statistical power of the regression model and suggests that the findings likely reflect a conservative estimate of the true relationship. In such contexts, qualitative research, including interviews with SC/ST women legislators, policy analysts, and bureaucrats, could offer richer insights into the challenges and strategies involved in securing healthcare and education funding, and help reveal dynamics that remain invisible in quantitative data alone.[9]

In a similar vein, this study grapples with the broader challenge of translating intersectionality—as a theoretical framework—into empirical measurement. While intersectional theory is essential for understanding how multiple axes of identity operate simultaneously to shape experiences of marginalization, operationalizing this framework using quantitative state-level data is inherently difficult. As a result, these methods may obscure important nuances, failing to fully reflect how SC/ST women experience and respond to exclusion within political

[9] This study originally intended to incorporate interviews with Indian legislators and policymakers to examine how descriptive representation translates into substantive representation at the individual level, but challenges in gaining access to elected officials made this difficult.

institutions. Recognizing this limitation is critical, as it underscores the importance of complimenting statistical models with qualitative approaches that can better capture the lived realities at the heart of intersectional analysis.

Future research should hence prioritize direct engagement with legislators, possibly through collaborations with Indian political organizations or journalist networks, to better understand how SC/ST women navigate legislative constraints, build coalitions, and advocate for policy changes. Ethnographic studies on the lived experiences of SC/ST women legislators could further illuminate the structural barriers they face and the informal networks they leverage to push for policy change. Understanding these individual-level processes is crucial, as the decisions and actions of individual legislators collectively shape aggregate-level policy shifts. Examining representation at the individual level provides a more detailed account of how small-scale political negotiations, legislative behavior, and advocacy strategies accumulate to drive broader systemic change in healthcare and education policy.

In addition to legislative behavior and elite political dynamics, future work should also examine how representation affects outcomes at the implementation level and within communities themselves. Exploring whether increased SC/ST women's representation leads to improved service delivery, greater accessibility of health and education programs, or changes in community-level perceptions of inclusion would offer a fuller picture of the democratic impact of representation. Such an approach would complement institutional and budgetary analyses by grounding them in the everyday experiences of the citizens these policies are meant to serve.

In conclusion, while this study provides important findings on the effects of SC/ST women's representation on budgetary and legislative outcomes, future research should aim to expand the temporal scope, incorporate linguistic and religious dimensions, explore intra-party

dynamics, and employ qualitative methodologies to offer a more comprehensive understanding of the factors that shape political influence and policy outcomes in India.

Appendix A

SC/ST Women's Population Share and Legislative Representation by State and Year

Note: Table shows the percentage of SC/ST women in the state population (taken from the 2011 census) and their representation in state legislatures across selected years.

	State	Year	% of SC/ST Women in State Pop.	% of SC/ST Women in Legislature
1	ANDHRA PRADESH	2009	0.200736679	5.1020408
2		2014		4.0816327
3		2019		0.0000000
4		2024		4.5714286
5	ARUNACHAL PRADESH	2009	0.349368770	3.3333333
6		2014		3.3333333
7		2019		0.0000000
8		2024		5.0000000
9	ASSAM	2006	0.096565210	2.3809524
10		2011		2.3809524
11		2016		2.3809524
12		2021		1.5873016
13	BIHAR	2005	0.082758639	0.0000000
14		2010		1.6460905
15		2015		3.2921811
16		2020		0.0000000
17	CHATTISGARH	2008	0.218524123	0.0000000
18		2013		7.7777778
19		2018		0.0000000
20		2023		16.6666667
21	GOA	2007	0.061121871	0.0000000
22		2012		0.0000000
23		2017		0.0000000
24		2022		0.0000000
25	GUJARAT	2007	0.105558132	3.2967033
26		2012		2.1978022
27		2017		1.6483516
28		2022		3.2967033

29	HARYANA	2005	0.094825261	5.5555556
30		2009		2.2222222
31		2014		4.4444444
32		2019		0.0000000
33	HIMACHAL PRADESH	2007	0.152807111	0.0000000
34		2012		0.0000000
35		2017		2.9411765
36		2022		1.4705882
37	JAMMU AND KASHMIR	2008	0.092159570	0.0000000
38		2014		0.0000000
39	JHARKHAND	2005	0.190123546	0.0000000
40		2009		7.4074074
41		2014		8.6419753
42		2019		0.0000000
43	KARNATAKA	2008	0.119889425	0.0000000
44		2013		0.8928571
45		2018		0.4484305
46		2023		2.6785714
47	KERALA	2006	0.054133919	0.0000000
48		2011		1.4285714
49		2016		1.4285714
50		2021		2.1428571
51	MADHYA PRADESH	2008	0.179424956	0.0000000
52		2013		6.0869565
53		2018		3.9130435
54		2023		6.0869565
55	MAHARASHTRA	2009	0.104145908	1.0416667
56		2014		1.3888889
57		2019		0.0000000
58	MANIPUR	2007	0.219766552	0.0000000
59		2012		0.0000000
60		2017		0.0000000
61		2022		3.3333333
62	MEGHALAYA	2008	0.436258653	1.6666667
63		2013		6.6666667

64		2018		5.0847458
65		2023		5.0000000
66	MIZORAM	2008	0.474142504	0.0000000
67		2013		0.0000000
68		2018		0.0000000
69		2023		7.5000000
70	NAGALAND	2008	0.427063506	0.0000000
71		2013		0.0000000
72		2018		0.0000000
73		2023		3.3333333
74	NCT of Delhi	2008	0.078836887	0.0000000
75		2013		2.8571429
76		2015		1.4285714
77		2020		0.0000000
78	ORISSA	2009	0.200925220	3.4013605
79		2014		3.4013605
80		2019		0.0000000
81		2024		2.7210884
82	PONDICHERRY	2006	0.080782690	0.0000000
83		2011		0.0000000
84		2016		10.0000000
85		2021		3.3333333
86	PUNJAB	2007	0.152119547	1.7094017
87		2012		5.1282051
88		2017		3.4188034
89		2022		2.5641026
90	RAJASTHAN	2008	0.151157641	0.0000000
91		2013		7.5000000
92		2018		5.5000000
93		2023		5.0000000
94	SIKKIM	2009	0.188215409	3.1250000
95		2014		0.0000000
96		2019		0.0000000
97		2024		0.0000000
98		2006		4.2735043
99		2011		2.9914530

100	TAMIL NADU	2016	0.105720041	3.8461538
101		2021		2.9914530
102	TELANGANA	2018	0.281688589	2.5210084
103		2023		3.3613445
104	TRIPURA	2008	0.244707216	0.0000000
105		2013		1.6666667
106		2018		1.6666667
107		2023		10.0000000
108	UTTAR PRADESH	2007	2.006071508	1.9851117
109		2012		3.2258065
110		2017		2.7295285
111		2022		4.9627792
112	UTTARAKHAND	2007	0.005340831	0.0000000
113		2012		1.4285714
114		2017		4.2857143
115		2022		4.2857143
116	WEST BENGAL	2006	0.143596657	3.0612245
117		2011		4.7619048
118		2016		5.1020408
119		2021		4.4217687

References

Ahmed, Shakeel, and Sandhya Mahapatro. “Inequality in Healthcare Access at the Intersection of Caste and Gender.” *Contemporary Voice of Dalit* 15, no. 1_suppl (August 2023): S75–85. https://doi.org/10.1177/2455328X221142692.

Arya, Sunaina, and Aakash Singh Rathore, eds. *Dalit Feminist Theory: A Reader*. Abingdon, Oxon ; New York, NY: Routledge, 2020.

Avvisati, Francesco, Bruno Besbas, and Nina Guyon. “Parental Involvement in School : A Literature Review:” *Revue d’économie Politique* Vol. 120, no. 5 (January 1, 2011): 759–78. https://doi.org/10.3917/redp.205.0759.

Banerji, Rukmini, James Berry, and Marc Shotland. “The Impact of Maternal Literacy and Participation Programs: Evidence from a Randomized Evaluation in India.” *American Economic Journal: Applied Economics* 9, no. 4 (October 1, 2017): 303–37. https://doi.org/10.1257/app.20150390.

Barnes, Tiffany D., Victoria D. Beall, and Mirya R. Holman. “Pink‐Collar Representation and Budgetary Outcomes in US States.” *Legislative Studies Quarterly* 46, no. 1 (February 2021): 119–54. https://doi.org/10.1111/lsq.12286.

Bhagavatheeswaran, Lalitha, Sapna Nair, Hollie Stone, Shajy Isac, Tejaswini Hiremath, Raghavendra T., Kumar Vadde, et al. “The Barriers and Enablers to Education among Scheduled Caste and Scheduled Tribe Adolescent Girls in Northern Karnataka, South India: A Qualitative Study.” *International Journal of Educational Development* 49 (July 2016): 262–70. https://doi.org/10.1016/j.ijedudev.2016.04.004.

Blasingame, Elise, Eric R. Hansen, and Richard C. Witmer. "Are Descriptive Representatives More Successful Passing Group-Relevant Legislation? The Case of Native American State Legislators." *Political Research Quarterly*, November 6, 2024, 10659129241298270. https://doi.org/10.1177/10659129241298270.

Carnoy, Martin, and Rafiq Dossani. "Goals and Governance of Higher Education in India." *Higher Education*, August 24, 2012. https://doi.org/10.1007/s10734-012-9565-9.

Cassan, Guilhem, and Lore Vandewalle. "Identities and Public Policies: Unexpected Effects of Political Reservations for Women in India." *World Development* 143, (July 2021): 105408. https://doi.org/10.1016/j.worlddev.2021.105408.

Chatterjee, Baishali. "Political Theory and Citizenship Discourses: Cast(e) in the Periphery: Understanding Representation of Dalit Women and Politics in India." *Asien*, (February 2022): 50-67. https://doi.org/10.11588/ASIEN.2010.114/115.17230.

Chattopadhyay, Raghabendra, and Esther Duflo. "Women as Policy Makers: Evidence from a Randomized Policy Experiment in India." *Econometrica* 72, no. 5 (September 2004): 1409–43. https://doi.org/10.1111/j.1468-0262.2004.00539.x.

Claessen, Clint. "Accruing Career Capital: How Party Leaders with More Political Experience Survive Longer." *Party Politics* 30, no. 4 (July 2024): 719–35. https://doi.org/10.1177/13540688231170381.

Clayton, Amanda, and Pär Zetterberg. "Quota Shocks: Electoral Gender Quotas and Government Spending Priorities Worldwide." *The Journal of Politics* 80, no. 3 (July 2018): 916–32. https://doi.org/10.1086/697251.

Clots-Figueras, Irma. “Women in Politics.” *Journal of Public Economics* 95, no. 7–8 (August 2011): 664–90. https://doi.org/10.1016/j.jpubeco.2010.11.017.

Crenshaw, Kimberle. “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, *Feminist Theory and Antiracist Policies*.” University of Chicago Legal Forum 1989, no. 1 (1989): 139-167.

Daher, Marilyne, Mahmoud Al Rifai, Riyad Y. Kherallah, Fatima Rodriguez, Dhruv Mahtta, Erin D. Michos, Safi U. Khan, Laura A. Petersen, and Salim S. Virani. “Gender Disparities in Difficulty Accessing Healthcare and Cost-Related Medication Non-Adherence: The CDC Behavioral Risk Factor Surveillance System (BRFSS) Survey.” *Preventive Medicine* 153 (December 2021): 106779. https://doi.org/10.1016/j.ypmed.2021.106779.

DeWalt, Darren A., Nancy D. Berkman, Stacey Sheridan, Kathleen N. Lohr, and Michael P. Pignone. “Literacy and Health Outcomes: A Systematic Review of the Literature.” *Journal of General Internal Medicine* 19, no. 12 (December 2004): 1228–39. https://doi.org/10.1111/j.1525-1497.2004.40153.x.

Dovi, Suzanne. “Preferable Descriptive Representatives: Will Just Any Woman, Black, or Latino Do?” *American Political Science Review* 96, no. 4 (December 2002): 729–43. https://doi.org/10.1017/S0003055402000412.

Halim, Nafisa, Kathryn M. Yount, and Solveig Cunningham. “Do Scheduled Caste and Scheduled Tribe Women Legislators Mean Lower Gender-Caste Gaps in Primary

Schooling in India?" *Social Science Research* 58 (July 2016): 122–34. https://doi.org/10.1016/j.ssresearch.2016.01.002.

Hertel, Bradley R. "Church, Sect, and Congregation in Hinduism: An Examination of Social Structure and Religious Authority." *Journal for the Scientific Study of Religion* 16, no. 1 (March 1977): 15. https://doi.org/10.2307/1386202.

Hessami, Zohal, and Mariana Lopes Da Fonseca. "Female Political Representation and Substantive Effects on Policies: A Literature Review." *European Journal of Political Economy* 63 (June 2020): 101896. https://doi.org/10.1016/j.ejpoleco.2020.101896.

Hickey, M. Gail, and Mary Stratton. "Schooling in India: Effects of Gender and Caste." *Scholarlypartnershipsedu* 2, no. 1 (2007): Article 6.

Kumar, Anil. "Determinants of Barriers in Equal Access to Education in India: An Empirical Study." *VNS Group of Institutions Bhopal, Faculty of Management*. (January 2019).

Jensenius, Francesca R. "Competing Inequalities? On the Intersection of Gender and Ethnicity in Candidate Nominations in Indian Elections." *Government and Opposition* 51, no. 3 (July 2016): 440–63. https://doi.org/10.1017/gov.2016.8.

Jensenius, Francesca R. *Social Justice through Inclusion*. Vol. 1. Oxford University Press, 2017. https://doi.org/10.1093/oso/9780190646608.001.0001.

Jungari, Suresh, and Bal Govind Chauhan. "Caste, Wealth and Regional Inequalities in Health Status of Women and Children in India." *Contemporary Voice of Dalit* 9, no. 1 (May 2017): 87–100. https://doi.org/10.1177/2455328X17690644.

Kaufman, Robert R., and Joan M. Nelson, eds. *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*. Washington, D.C: Woodrow Wilson Center Press, 2004.

Lindert, Peter H. *Growing Public: Social Spending and Economic Growth since the Eighteenth Century*. 1st ed. Cambridge University Press, 2004. https://doi.org/10.1017/CBO9780511510717.

Lowande, Kenneth, Melinda Ritchie, and Erinn Lauterbach. "Descriptive and Substantive Representation in Congress: Evidence from 80,000 Congressional Inquiries." *American Journal of Political Science* 63, no. 3 (July 2019): 644–59. https://doi.org/10.1111/ajps.12443.

Mahapatro, Sandhya R., K.S. James, and Udaya S. Mishra. "Intersection of Class, Caste, Gender and Unmet Healthcare Needs in India: Implications for Health Policy." *Health Policy OPEN* 2 (December 2021): 100040. https://doi.org/10.1016/j.hpopen.2021.100040.

Mechkova, Valeriya. *"When Does Women's Political Representation Lead to Policy Change?" American Political Science Review* (2024).

Mohanty, S., and V. Nandakumar. "Why Our Girls Do Not Go to School." *Gender and Education* (February 2005).

Morgan, Rosemary, Moses Tetui, Rornald Muhumuza Kananura, Elizabeth Ekirapa-Kiracho, and A S George. "Gender Dynamics Affecting Maternal Health and Health Care Access and Use in Uganda." *Health Policy and Planning* 32, no. suppl_5 (December 1, 2017): v13–21. https://doi.org/10.1093/heapol/czx011.

P, Sneha, Neha Sinha, Ashwin Varghese, Avanti Durani, and Ayush Patel. "Bureaucratic Indecision and Risk Aversion in India." *Indian Public Policy Review* 2, no. 6 (Nov-Dec) (November 19, 2021): 55–87. https://doi.org/10.55763/ippr.2021.02.06.004.

Pitkin, Hanna F. *The Concept of Representation*. University of California Press, 1967. https://doi.org/10.1525/9780520340503.

Pollack Porter, Keshia M., Lainie Rutkow, and Emma E. McGinty. "The Importance of Policy Change for Addressing Public Health Problems." *Public Health Reports* 133, no. 1_suppl (November 2018): 9S-14S. https://doi.org/10.1177/0033354918788880.

Prakasam, Geetha R. "Family Spending on Education in India: Pattern and Determinants." *New Delhi: National Institute of Educational Planning and Administration* (2021).

Prakasam, Geetha R. "What Factors Determine Family Spending on Education in India and Does It Vary Across Well-Being Measures?" *Journal of Social Sciences* 19, no. 1 (January 1, 2023): 22–37. https://doi.org/10.3844/jssp.2023.22.37.

Raghuram, Shobha. "Inequalities, Caste, and Social Exclusion: Dalit Women's Citizenship." *Development* 62, no. 1–4 (December 2019): 154–59. https://doi.org/10.1057/s41301-019-00209-0.

Reingold, Beth, Kerry Lee Haynie, and Kirsten Widner. *Race, Gender, and Political Representation: Toward a More Intersectional Approach*. New York: Oxford university press, 2021.

Reingold, Beth, and Adrienne R. Smith. "Welfare Policymaking and Intersections of Race, Ethnicity, and Gender in U.S. State Legislatures." *American Journal of Political Science* 56, no. 1 (January 2012): 131–47. https://doi.org/10.1111/j.1540-5907.2011.00569.x.

Reingold, Beth, Kirsten Widner, and Rachel Harmon. "Legislating at the Intersections: Race, Gender, and Representation." *Political Research Quarterly* 73, no. 4 (December 2020): 819–33. https://doi.org/10.1177/1065912919858405.

Reshi, A. Irshad, Dr T. Sudha, and Shabir Ahmad Dar. "Women's Access to Education and Its Impact on Their Empowerment: A Comprehensive Review." *MORFAI JOURNAL* 1, no. 2 (January 31, 2022): 446–50. https://doi.org/10.54443/morfai.v1i2.760.

Sabharwal, Nidhi S, Sandeep Sharma, Dilip Diwakar G, and Ajaya K Naik. "Caste Discrimination As A Factor in Poor Access to Public Health Service System: A Case Study of Janani Suraksha Yojana Scheme." *Journal of Social Inclusion Studies* 1, no. 1 (December 2014): 148–68. https://doi.org/10.1177/2394481120140110.

Schwindt-Bayer, Leslie A. *Political Power and Women's Representation in Latin America*. Oxford University Press, 2010. https://doi.org/10.1093/acprof:oso/9780199731954.001.0001.

Singh, Sumanjeet, Binod Rajak, Ranjit Kumar Dehury, Swati Mathur, and Akankhya Samal. "Differential Access of Healthcare Services and Its Impact on Women in India: A Systematic Literature Review." *SN Social Sciences* 3, no. 1 (January 13, 2023): 16. https://doi.org/10.1007/s43545-023-00607-9.

Smith, Stephanie L. “Political Contexts and Maternal Health Policy: Insights from a Comparison of South Indian States.” *Social Science & Medicine* 100 (January 2014): 46–53. https://doi.org/10.1016/j.socscimed.2013.10.029.

Streeck, Wolfgang, and Kathleen Ann Thelen, eds. *Beyond Continuity: Institutional Change in Advanced Political Economies*. Oxford ; New York: Oxford University Press, 2005.

Stroope, Samuel. “Caste, Class, and Urbanization: The Shaping of Religious Community in Contemporary India.” *Social Indicators Research* 105, no. 3 (February 2012): 499–518. https://doi.org/10.1007/s11205-011-9784-y.

Thapa, Raksha, Edwin Van Teijlingen, Pramod Raj Regmi, and Vanessa Heaslip. “Caste Exclusion and Health Discrimination in South Asia: A Systematic Review.” *Asia Pacific Journal of Public Health* 33, no. 8 (November 2021): 828–38. https://doi.org/10.1177/10105395211014648.

UN Women. “Facts and Figures: Leadership and Political Participation.” Accessed October 28, 2024. https://www.unwomen.org/en/what-we-do/leadership-and-political-participation/facts-and-figures.

Vatsala, Bhusry. “Women Parliamentarians in India since 1991: Challenges and Opportunities.” *Hatfield Graduate Journal of Public Affairs* 7, no. 1 (May 26, 2023). https://doi.org/10.15760/hgjpa.2023.7.1.4.

Vikram, Kriti, and Reeve Vanneman. “Maternal Education and the Multidimensionality of Child Health Outcomes in India.” *Journal of Biosocial Science* 52, no. 1 (January 2020): 57–77. https://doi.org/10.1017/S0021932019000245.

Volden, Craig, Alan E. Wiseman, and Dana E. Wittmer. “Women’s Issues and Their Fates in the US Congress.” *Political Science Research and Methods* 6, no. 4 (October 2018): 679–96. https://doi.org/10.1017/psrm.2016.32.

World Health Organization. (2024, April 26). *Maternal mortality*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

Yadav, Arvind Kumar, and Pabitra Kumar Jena. “Maternal Health Outcomes of Socially Marginalized Groups in India.” *International Journal of Health Care Quality Assurance* 33, no. 2 (February 28, 2020): 172–88. https://doi.org/10.1108/IJHCQA-08-2018-0212.