Understanding how women's and girls' health is problematized and prioritized in the Sustainable Development Goals (SDGs) and what it means for health policy

Alua Kulenova

Department of Family Medicine

McGill University, Montreal

April 2024

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Master of Science

TABLE OF CONTENTS

List of Figures, Tables, and Abbreviations

List of figures

CHAPTER 2:

CHAPTER 3:

List of tables

CHAPTER 2:

CHAPTER 3:

List of abbreviations:

UN – United Nations

SDGs – Sustainable Development Goals

MDGs – Millennium Development Goals

SRH – sexual and reproductive health

ABSTRACT

Globally, women and girls are a priority population with specific health needs. Women's and girls' health is shaped by complex social, cultural, biological, and economic factors. Policy is a means for ameliorating the unique challenges that women and girls face in achieving good health but if poorly conceived can contribute significantly to health inequity. The Sustainable Development Goals (SDGs) are designed to inform the national policy of governments and establish global norms for action. Given the power of the SDGs to shape policy, it is crucial to know which issues in women's and girls' health are prioritized and how associated problems and solutions are represented within the SDGs. This thesis draws from and contributes to fields of international development, global health, feminist studies, policy analysis, and implementation research. This thesis examines how issues of women's and girls' health are conceptualized and prioritized within the SDGs, the ideas and processes that inform problem conceptualization and prioritization, and the implications of for women's and girls' health. This thesis includes a scoping review and a qualitative study using interview data. The scoping review analyzed conceptions of women's and girls' health in United Nations (UN) documents associated with the Millennium Development Goals and the SDGs. The qualitative study involved interviews with participants working with the UN and its agencies to understand how problems of women's and girls' health are identified and prioritized within the SDG agenda. Together these studies illustrate that problem framing for women's and girls' health is shaped by entrenched structures of gender inequality, political forces, and tensions between the norms and goals of the UN system, its member states, and the wider global system.

RÉSUMÉ

Dans le monde entier, les femmes et les filles constituent une population prioritaire ayant des besoins spécifiques en matière de santé. La santé des femmes et des filles est déterminée par des facteurs sociaux, culturels, biologiques et économiques complexes. La politique est un moyen d'améliorer les défis uniques auxquels les femmes et les filles sont confrontées pour être en bonne santé, mais si elle est mal conçue, elle peut contribuer de manière significative à l'inégalité en matière de santé. Les objectifs de développement durable (ODD) sont conçus pour éclairer la politique nationale des gouvernements et établir des normes d'action mondiales. Étant donné le pouvoir qu'ont les ODD de façonner les politiques, il est crucial de savoir quelles questions relatives à la santé des femmes et des filles sont prioritaires et comment les problèmes et les solutions associés sont représentés dans les ODD. Cette thèse s'inspire des domaines du développement international, de la santé mondiale, des études féministes, de l'analyse des politiques et de la recherche sur la mise en œuvre, et y contribue. Elle examine la manière dont les questions relatives à la santé des femmes et des filles sont conceptualisées et hiérarchisées dans les ODD, les idées et les processus qui sous-tendent la conceptualisation et la hiérarchisation des problèmes, ainsi que les implications pour la santé des femmes et des filles. Cette thèse comprend une étude exploratoire et une étude qualitative utilisant des données d'entretiens. L'étude exploratoire a analysé les conceptions de la santé des femmes et des filles dans les documents des Nations unies associés aux objectifs du Millénaire pour le développement et aux objectifs du Millénaire pour le développement. L'étude qualitative a consisté en des entretiens avec des participants travaillant avec l'ONU et ses agences afin de comprendre comment les problèmes de santé des femmes et des filles sont identifiés et classés par ordre de priorité dans l'agenda des ODD. L'ensemble de ces études montre que la formulation des problèmes de santé des femmes et des filles est façonnée par des structures bien ancrées d'inégalité entre les sexes, par des forces politiques et par des tensions entre les normes et les objectifs du système des Nations unies, de ses États membres et du système mondial au sens large.

ACKNOWLEDGEMENTS

Firstly, I want to express my immense gratitude for my supervisor, Dr. Raphael Lencucha. Our time working together in the past three years has had a tremendous impact on my life. I am exceedingly lucky to feel such support under your mentorship and to have always felt respected as a budding academic. Your belief and faith in me are what made this thesis possible and has set me on a career trajectory I did not expect when I first started my undergrad at McGill – thank you for cultivating my interest at the intersection of political science and health (and beyond). Your advice and guidance have been of immeasurable value to me, and it has always been expressed with the utmost kindness, understanding, and patience. Applying to work with you as a Global Health Scholar is one of the best decisions I've ever made.

To my thesis committee, Dr. Alayne Adams and Dr. Kathleen Rice – thank you for your truly thoughtful engagement with this thesis and dedication to supporting my growth as a scholar, a student, and a person. You helped me feel at home in the Family Medicine department and I feel lucky to have learned under your tutelage.

To the GHER Lab and the formerly-known-as Wednesday Crew of Raphael's lab – your friendship and support have guided me through thick and thin, and I will forever be grateful to have met you all. I couldn't ask for a better group of people to talk about global health or share nourishing snacks with. Thank you for always showing me kindness and laughing with me, even with all the sassy banter that could easily be misconstrued as disdain in any other environment.

To the lifelong friends I've made at McGill and in Montreal – I thank you for the greatest friendships anyone could ever ask for and for empowering me to undertake this endeavour. I hope I can cherish the memories of the special times we shared together here forever, and I look forward to celebrating all your successes in the years to come. Bryan, thank you for always making me tea and making sure I was cozy during the countless couch writing sessions. I love you all deeply.

To my family; Mama, Papa, and Sanzhar, I dedicate this thesis to you. You have always encouraged me to achieve my goals, and with complete faith in me doing so, an act of unconditional love that is ingrained in all that I do. Thank you for your unwavering support and

providing me with the invaluable comfort of knowing that there will always be people in my corner.

And to my beloved dog, Jasper – you may not have been able to read, or understand academia, but I know you would have celebrated this thesis with me in the best way you knew how – cuddles on the couch. I miss you.

EPIGRAPH

“Definitions are vital starting points for the imagination. What we cannot imagine cannot come into being. A good definition marks our starting point and lets us know where we want to end up.”

- bell hooks

CONTRIBUTION OF AUTHORS

Chapter 2: Conception and design of review: AK, RL. Acquisition of data: AK; analysis and/or interpretation of data: AK, RL. Draft manuscript preparation: AK; Revision of manuscript: AK, RL, AA, KR. All authors read and approved of the final manuscript.

Chapter 3: Conception and design of study: AK, RL. Creation of interview guide for data collection: AK, RL, AA. Acquisition of data: AK; analysis and/or interpretation of data: AK, RL. Draft manuscript preparation: AK; Revision of manuscript: AK, RL, AA, KR. All authors read and approved of the final manuscript.

AK wrote the remaining parts of the thesis with approval and edits from RL, AA, and KR.

CHAPTER 1: INTRODUCTION

Globally, women and girls are a priority population with specific health needs resultant from complex underlying social, cultural, biological, and economic determinants of health. (Pederson et al., 2015). Women and girls worldwide face barriers to good health resulting from complex social, cultural, biological, and economic determinants (Davidson et al., 2011; Veas et al., 2021). Examples of health inequities that affect women and girls include, but are not limited to, endemic infectious disease (e.g., 77% of new HIV infections among adolescents aged 10-19 worldwide occurred among girls (UNICEF Data, 2021)) or complex health emergencies (e.g., 75% increase in maternal mortality in Ebola- affected countries (Davies et al., 2016)).

Health, Equity, and Policies

Given the myriad of equity concerns facing women and girls' health, it is crucial that policy is informed by the conditions that shape equity. While policy is a key instrument to address inequity, policy that does not attend to the needs of populations can exacerbate or perpetuate inequities. This thesis uses the terms inequity, inequality, and disparities to describe the social, economic, and political contexts that create barriers to good health. SDG 5 is focused on gender *equality* – this thesis positions gender *equity* as promoting processes necessary for achieving equality. Conversely, gender and health inequities are barriers to equality. This thesis defines gender as a social construct which interacts with other social and physiological determinants across all levels of social, cultural, and institutional structures (Manandhar et al., 2018).

Women and girls face unique barriers to good health due to the pervasive nature of gender inequities across societies (Marmot et al., 2008; Davidson et al., 2011, Veas et al., 2021). Disparities in the location and distribution of power and resources, societal or cultural norms and values, and biases in the way that policies and programs are structured may impact the health of millions of girls and women around the world. For example, a lack of access to quality education in childhood, a result of gender inequality, can shape many aspects of the remainder of a girl's life that can directly impact health – economic independence, career development, health literacy, and self-empowerment (Unterhalter, 2023). Additionally, these disparities interact with sociocultural experiences of gender that are inherently impacted by social and political contexts,

of which often privilege men over women (Johnson et al., 2009). The power of public policy informs the need to critically analyze how the problems associated with women and girls' health are conceptualized and prioritized (Marmot et al., 2008).

A prominent challenge facing the realization of global health goals is the need to coordinate across sectors and levels to promote population health (Meslin & Garba, 2016). To address this diffuse governance context, the United Nations' Sustainable Development Goals (SDGs), the successor to the Millennium Development Goals (MDGs), aims to establish a common agenda to inform the actions and policies of agencies and governments around the world. The SDGs play a prominent role in the global agenda on gender equity and have been described as a powerful tool for "leveraging transformative change in the way governments make development decisions" (Bigg, 2016, p.1). In many countries, the SDGs guide how issues in women's and girls' health are addressed (Sand & Widegren, 2019). Given the influence of the UN's agenda (namely the SDGs in the current era) in shaping development policies globally and impacting population health, it is important to know how issues of women's and girls' health are conceptualized and how associated problems and solutions are represented within UN documents (Sand & Widegren, 2019; Cartsensen & Schmidt, 2016; Schmidt 2010). These representations as identified on paper can hold consequences for women's and girls' health both theoretically and in implementation. It is similarly relevant to understand how these problems and solutions have changed since the introduction of the MDGs in 2000 into the present day to gain a better understanding of future possible trajectories in development policy to refine approaches to realizing gender and health equality. Despite the pertinence of this knowledge for enacting appropriate policies across countries, we do not yet know comprehensively which women's health issues are prioritized in the SDGs, how conceptualizations of women's and girls' health issues are presented and how they have changed over time, and the processes that underly health and gender policy conceptualization and implementation across UN agencies.

The SDGs consist of 17 goals and 169 targets (United Nations, 2015). These goals and their targets are interdependent and inextricably linked to one another (Breuer et al., 2019). The health of women and girls is inherently a global issue that requires global cooperation across all levels of governance (Davidson et al., 2011). The structures of inequity that impact women's and girls' health and status are prevalent worldwide, across different sociocultural contexts

worldwide – efforts to ameliorate these structures must thus be cooperative. Given the global reach of the issue, it is apparent that the SDGs, which are based on the consensus of governments and designed to inform the actions and policies of international agencies and governments around the world, can shape health outcomes for women and girls worldwide (Manandhar et al., 2018). Given the range of determinants of health across sectors that coalesce together to shape the health of women and girls globally, cross-sectoral policy coherence is crucial for implementing the SDGs (Breuer et al., 2019; Morgan et al., 2020; Singh Thakur et al., 2021). Furthermore, while there are specific goals pertaining to either gender or health (SDGs 3 and 5, respectively), the intersectional nature of determinants of gender inequity highlights the need to mainstream issues of gender equity across each of the 17 goals and 169 targets (Morgan et al., 2020). Integrating an intersectional perspective into policy work on gender is necessary as key determinants and experiences that shape pervasive inequity are entwined throughout several dimensions of both one's identity and greater society. This carries implications for policy priority-setting among nations striving to fulfill the SDGs by 2030 (Bennett et al., 2019).

Individual-level health interventions must be complemented by efforts to shape the social, physical, and economic conditions that in turn influence the health of women and girls – these are structural factors which shape the context in which individuals can act (Braveman et al., 2011; Katz, 2009). Inequalities of all kinds can be perpetuated by social policies that reinforce disparities (Braveman et al., 2011; Béland & Katapally, 2018; Brownson et al., 2009). Due to the impact of policy on population health outcomes, particularly in vulnerable demographics, it is imperative to examine the processes shaping policy development. Priority setting in health policy and in development agendas such as the SDGs must fully consider and contextualize the unique barriers that women and girls face. For example, one study in Ghana suggested that women's health funding was dominantly allocated to breast cancer while researchers noted that local politics shaped the decision to focus on breast cancer away from funding needs in the area of sexual and reproductive health (SRH). The researchers noted that local politics and stigma associated with SRH outweighed the scientific and epidemiological evidence – leading to limited resources for cervical cancer which at the time was the leading cancer in Ghanaian women (Nartey et al., 2016). This example illustrates that priority setting can

have “unforeseen equity and social implications” and be shaped by factors outside of direct needs of women and girls (Reichenbach, 2002, p.1).

Framing and Prioritizing Policy Issues

Different actors will often compete to identify, frame, and prioritize problems and associated policy solutions (Schmidt, 2010; Cartsensen & Schmidt, 2016). There are many kinds of policy actors ranging from experts to interest groups – a “policy entrepreneur” is a powerful type of political and social actor who articulates specific problems that move in, out, or between ranks of priority within the policy agenda (Béland & Katapally, 2018). Within the global health agenda, policy entrepreneurs exert influence within social, political, or economic contexts, guiding which problems receive priority (Sibbald et al., 2009; Béland & Katapally, 2018; Widdig et al., 2022). Actors in different disciplines offer perspectives on what successful priority setting should be based on, often reflecting competing values (Sibbald et al., 2009). However, discipline-specific approaches to priority-setting frameworks can aid in navigating abstract goals, such as evidence-based medicine (EBM) (Sibbald et al., 2009). The gradient of social, political, and economic contexts that guide actors’ decisions in priority setting within the SDGs is of particular interest in relation to the global health agenda due to the systemic, interconnected nature of the SDGs and their role in the global health policy landscape (Weitz et al., 2018). These diverse contexts can present unique tensions in priority setting in the women and girls’ global health agenda that can lead to disparate health outcomes across targets (Peters et al., 2016). Given the limited research into priority setting within global agendas of women and girls’ health or even the broad landscape of health policies and the largely unexplored potential for unintended population heath consequences as a result of priority setting (Bennett et al., 2020; Byskov et al., 2019), there is an opportunity to expand existing knowledge on gendered health inequities and establish a base for further research related to gender-informed health policy.

The literature on problem representation and priority setting has illuminated important dynamics in how health policy is developed. Take, for example, the tendency to conflate sexual and reproductive health (SRH) with the entirety of women’s health – and the consequences borne from health policies that obscure consideration for the impacts of gender on health across the life course. Since 2000, SRH has been the top priority in the global policy-making agenda for

women's health, largely due to its emphasis within the Millennium Development Goals (MDGs), the predecessor to the SDGs (Peters et al., 2016). While SRH remains an unfinished concern that requires sustained efforts, more women die annually from non-communicable diseases (NCDs) than from any other cause (Peters et al., 2016; Temmerman et al., 2015; Vogel et al., 2021). Globally, one-third of women die of CVD (Kuehn, 2021). There has been distinct stagnation in the reduction of cardiovascular disease burden in women in the past decade (Peters et al., 2016; Vogel et al., 2021). Women are susceptible to underdiagnosis and inappropriate clinical decisions due to the widely underestimated risk burden of CVD, highlighting the need for policymakers to increase attention to gender and sex-specific disparities (Peters et al., 2016; Mocumbi, 2021). While no single goal in the SDGs encompasses all SRH, aspects of SRH are diffused throughout targets such as maternal mortality (SDG 3.1) and family planning (SDG 3.8) (Yamin, 2019). The broad span of SRH contrasts with a complete absence of mention of the gendered dimensions of NCDs across a total of 8 targets relevant to NCDs in the SDGs (Singh Thakur et al., 2021; Bonita & Beaglehole, 2014). In addition, a women's health agenda that focuses exclusively on women of childbearing age may exclude the non-SRH related needs of women who do not have children and older women who are no longer of reproductive age (Peters et al., 2016). To this end, a broadened definition of women's health that includes greater consideration for NCDs as well as a life-course informed approach can lead to improved health outcomes in women and their communities around the world (Peters et al., 2016; Bonita & Beaglehole, 2014). These types of issues reflect the need to critically evaluate targets in the health of women and girls within global policy agendas like the SDGs against the backdrop of clinical evidence.

Overview of Thesis

This thesis is composed of two papers: Chapter 2, a scoping review focused on UN documents, and Chapter 3, a qualitative interview study conducted with participants employed at UN agencies. Together, these papers seek to illustrate how problem and solution representation can shape policy approaches to gender health inequity, advancing theoretical understandings belying the field of health policy and informing the practical implementation of the SDGs. Therefore, this qualitative study will address the following question: what problems in women's and girls' health are prioritized within the SDGs and what are the potential implications for

global health outcomes? The theoretical contributions of this study involve enhancing knowledge of the underlying logics of global health policy found within the SDGs. This research also aims to promote the inclusion of a gendered lens in the analysis in health policy research. In identifying key variables of the prioritization process, the linkages between the variables, and why these linkages exist, this study will contribute to health development and policy theory (Ebneyamini and Moghadam, 2018). In terms of practice, this research will inform SDG implementation efforts globally by encouraging critical analysis of problems of health and gender in policy as well as establishing a base for further research in health policy. This project will provide an opportunity for relevant actors to cross-reference the ways that problems and solutions are presented in the documents against the perspectives of those working in the field view. This approach can identify problems that need to be addressed, in addition to proposed solutions, that have not yet been addressed in the SDG agenda and engage in a discourse that is informed by the logic informing the problems represented in the SDGs. In other words, this analysis can contribute to not only shifts in priorities and the addition of new topics, but also a conversation about the assumptions and processes that guide policy development of policy in this area. Ultimately, this project aims to inform future policy initiatives and will return research findings to study participants and relevant agencies.

The first manuscript, a scoping review, examines and interrogates problem conceptualization and identified contributing factors of women's and girls' health as they are presented in documents published by the UN related to the MDGs and SDGs. The findings from analyses performed in the first manuscript informed and refined our approach to the second manuscript, an interview analysis carried out to gain valuable insight into the problem identification and priority-setting process from key informants involved with UN agencies, and by extension, involved in achieving the SDGs.

This thesis draws from and contributes to fields of international development, global health, feminist studies, policy analysis, and implementation research. The two studies completed for this thesis aim to improve understanding and highlight the linkages between: 1.) problem conceptualization related to women's and girls' health within the SDGs and 2.) the processes that inform the priority-setting frameworks within the UN system.

References (CHAPTER 1)

Béland, D., & Katapally, T. R. (2018). Shaping Policy Change in Population Health: Policy Entrepreneurs, Ideas, and Institutions. *International Journal of Health Policy and Management*, *7*(5), 369–373. https://doi.org/10.15171/ijhpm.2017.143

Bennett, S., Jessani, N., Glandon, D., Qiu, M., Scott, K., Meghani, A., El-Jardali, F., Maceira, D., Javadi, D., & Ghaffar, A. (2020). Understanding the implications of the Sustainable Development Goals for health policy and systems research: Results of a research priority setting exercise. *Globalization and Health*, *16*(1), 5. https://doi.org/10.1186/s12992-019-0534-2

Bigg, T. (2016). *Reconceiving the SDGs as a political force for change*. International Institute for Environment and Development. https://www.jstor.org/stable/resrep16687

Bonita, R., & Beaglehole, R. (2014). Women and NCDs: Overcoming the neglect. *Global Health Action*, *7*, 10.3402/gha.v7.23742. https://doi.org/10.3402/gha.v7.23742

Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, *32*, 381–398. https://doi.org/10.1146/annurev-publhealth-031210-101218

Breuer, A., Janetschek, H., & Malerba, D. (2019). Translating Sustainable Development Goal (SDG) Interdependencies into Policy Advice. *Sustainability*, *11*(7), 1–20.

Brownson, R. C., Chriqui, J. F., & Stamatakis, K. A. (2009). Understanding Evidence-Based Public Health Policy. *American Journal of Public Health*, *99*(9), 1576–1583. https://doi.org/10.2105/AJPH.2008.156224

Byskov, J., Maluka, S., Marchal, B., Shayo, E. H., Blystad, A., Bukachi, S., Zulu, J. M., Michelo, C., Hurtig, A.-K., & Bloch, P. (2019). A systems perspective on the importance of global health strategy developments for accomplishing today's Sustainable Development Goals. *Health Policy and Planning*, *34*(9), 635–645. https://doi.org/10.1093/heapol/czz042

Carstensen, M. B., & Schmidt, V. A. (2016). Power through, over and in ideas: Conceptualizing ideational power in discursive institutionalism. *Journal of European Public Policy*, *23*(3), 318–337. https://doi.org/10.1080/13501763.2015.1115534

Davidson, P. M., Mcgrath, S. J., Meleis, A. I., Stern, P., Digiacomo, M., Dharmendra, T., Correa-De-Araujo, R., Campbell, J. C., Hochleitner, M., Messias, D. K. H., Brown, H., Teitelman, A., Sindhu, S., Reesman, K., Richter, S., Sommers, M. S., Schaeffer, D., Stringer, M., Sampselle, C., … Covan, E. K. (2011). The Health of Women and Girls Determines the Health and Well-Being of Our Modern World: A White Paper From the International Council on Women's Health Issues. *Health Care for Women International*, *32*(10), 870–886. https://doi.org/10.1080/07399332.2011.603872

Ebneyamini, S., & Sadeghi Moghadam, M. R. (2018). Toward Developing a Framework for Conducting Case Study Research. *International Journal of Qualitative Methods*, *17*(1), 1609406918817954. https://doi.org/10.1177/1609406918817954

Johnson, J. L., Greaves, L., & Repta, R. (2009). Better science with sex and gender: Facilitating the use of a sex and gender-based analysis in health research. *International Journal for Equity in Health*, *8*(1), 14. https://doi.org/10.1186/1475-9276-8-14

Katz, M. H. (2009). Structural interventions for addressing chronic health problems. *JAMA*, *302*(6), 683–685. https://doi.org/10.1001/jama.2009.1147

Kuehn, B. M. (2021). Urgent Need to Reduce Heart Disease Among Women Worldwide. *JAMA*, *326*(3), 214. https://doi.org/10.1001/jama.2021.11409

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, *96*(9), 644–653. https://doi.org/10.2471/BLT.18.211607

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, *372*(9650), 1661–1669. https://doi.org/10.1016/S0140-6736(08)61690-6

Meslin, E. M., & Garba, I. (2016). International Collaboration for Global Public Health. In D. H. Barrett, L. W. Ortmann, A. Dawson, C. Saenz, A. Reis, & G. Bolan (Eds.), *Public Health Ethics: Cases Spanning the Globe*. Springer. http://www.ncbi.nlm.nih.gov/books/NBK435788/

Mocumbi, A. O. (2021). Women's cardiovascular health: Shifting towards equity and justice. *The Lancet*, *397*(10292), 2315–2317. https://doi.org/10.1016/S0140-6736(21)01017-5

Morgan, R., Dhatt, R., Kharel, C., & Muraya, K. (2020). A patchwork approach to gender equality weakens the SDGs: Time for cross-cutting action. *Global Health Promotion*, *27*(3), 3–5. https://doi.org/10.1177/1757975920949735

Nartey, Y., Hill, P., Amo-Antwi, K., Asmah, R., Nyarko, K., Yarney, J., Damale, N., & Cox, B. (2018). Recommendations for cervical cancer prevention and control in Ghana: Public education and human papillomavirus vaccination. *Ghana Medical Journal*, *52*(2), 94–102. https://doi.org/10.4314/gmj.v52i2.6

Pederson, A., Greaves, L., & Poole, N. (2015). Gender-transformative health promotion for women: A framework for action. *Health Promotion International*, *30*(1), 140–150. https://doi.org/10.1093/heapro/dau083

Reichenbach, L. (2002). The Politics of Priority Setting for Reproductive Health: Breast and Cervical Cancer in Ghana. *Reproductive Health Matters*, *10*(20), 47–58. https://doi.org/10.1016/S0968-8080(02)00093-9

Sand, J., & Widegren, K. (n.d.). *Gender and Sustainability: An International Research Review*.

Schmidt, V. A. (2010). Taking ideas and discourse seriously: Explaining change through discursive institutionalism as the fourth 'new institutionalism.' *European Political Science Review*, *2*(1), 1–25. https://doi.org/10.1017/S175577390999021X

Sibbald, S. L., Singer, P. A., Upshur, R., & Martin, D. K. (2009). Priority setting: What constitutes success? A conceptual framework for successful priority setting. *BMC Health Services Research*, *9*(1), 43. https://doi.org/10.1186/1472-6963-9-43

Singh Thakur, J., Nangia, R., & Singh, S. (2021). Progress and challenges in achieving noncommunicable diseases targets for the sustainable development goals. *FASEB BioAdvances*, *3*(8), 563–568. https://doi.org/10.1096/fba.2020-00117

Temmerman, M., Khosla, R., Laski, L., Mathews, Z., & Say, L. (2015). Women's health priorities and interventions. *BMJ*, *351*, h4147. https://doi.org/10.1136/bmj.h4147

Unterhalter, E. (2023). An answer to everything? Four framings of girls' schooling and gender equality in education. *Comparative Education*, *59*(2), 145–168. https://doi.org/10.1080/03050068.2023.2202374

United Nations. (2015). THE 17 GOALS | Sustainable Development. from https://sdgs.un.org/goals

Veas, C., Crispi, F., & Cuadrado, C. (2021). Association between gender inequality and population-level health outcomes: Panel data analysis of organization for Economic Co-operation and Development (OECD) countries. *EClinicalMedicine*, *39*, 101051. https://doi.org/10.1016/j.eclinm.2021.101051

Vogel, B., Acevedo, M., Appelman, Y., Bairey Merz, C. N., Chieffo, A., Figtree, G. A., Guerrero, M., Kunadian, V., Lam, C. S. P., Maas, A. H. E. M., Mihailidou, A. S., Olszanecka, A., Poole, J. E., Saldarriaga, C., Saw, J., Zühlke, L., & Mehran, R. (2021). The Lancet women and cardiovascular disease Commission: Reducing the global burden by 2030. *Lancet (London, England)*, *397*(10292), 2385–2438. https://doi.org/10.1016/S0140-6736(21)00684-X

Weitz, N., Carlsen, H., Nilsson, M., & Skånberg, K. (2018). Towards systemic and contextual priority setting for implementing the 2030 Agenda. *Sustainability Science*, *13*(2), 531–548. https://doi.org/10.1007/s11625-017-0470-0

Widdig, H., Tromp, N., Lutwama, G. W., & Jacobs, E. (2022). The political economy of priority-setting for health in South Sudan: A case study of the health pooled fund. *International Journal for Equity in Health*, *21*, 68. https://doi.org/10.1186/s12939-022-01665-w

Yamin, A. E. (2019). Power, Politics and Knowledge Claims: Sexual and Reproductive Health and Rights in the SDG Era. *Global Policy*, *10*(S1), 52–60. https://doi.org/10.1111/1758-5899.12598

Chapter 2: PROBLEMATIZING WOMEN AND GIRLS' HEALTH ACROSS THE MILLENNIUM DEVELOPMENT AND SUSTAINABLE DEVELOPMENT GOALS: AN ANALYSIS OF UNITED NATIONS DOCUMENTS

In this chapter, I present a scoping review titled "Problematizing women and girls' health across the Millennium Development and Sustainable Development Goals: An analysis of United Nations documents." This review serves as the literature review for this thesis and provides a foundation for Chapters 3 and 4 to build on the findings and observations made in this paper. The review examines documents published by the United Nations spanning the time period from the introduction of the Millennium Development Goals, Sustainable Development Goals, to the present day. I explore which types of health problems are associated with women and girls, how these problems are conceptualized and framed, and the potential implications for these conceptualization and framings on the health and status of women and girls. This review introduces the "What's the problem represented to be?" framework created by Carol Bacchi, which serves as the overarching framework for this thesis. It is a tool for understanding the underlying assumptions of policy development and highlights the importance of critical examination of policy concerning priority populations such as women and girls.

Problematizing women and girls' health across the Millennium Development and Sustainable Development Goals: An analysis of United Nations documents

Alua Kulenova[1*], Alayne Adams[1], Kathleen Rice[1], Raphael Lencucha[2]

[1]Department of Family Medicine, Faculty of Medicine and Health Sciences, McGill University, 5858 Ch. de la Côte-des-Neiges, Montreal, QC H3S 1Z1, Canada.

[2]School of Physical and Occupational Therapy, Faculty of Medicine and Health Sciences, McGill University, 3630 Promenade Sir William Osler, Montreal, QC H3G 1Y5, Canada.

*Corresponding Author: alua.kulenova@mail.mcgill.ca

Submitted to Social Science and Medicine – under review

Statements and Declarations

This research has received funding from the Canadian Institutes of Health Research

Authors declare no competing interests

Abstract

Globally, women and girls are a priority population with specific health needs. Women and girls' health is shaped by complex social, cultural, biological, and economic factors. The Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) have been designed to inform national policy of countries around the world. Given the power of the SDGs to shape policy, it is crucial to understand how the causes and contributing factors of health issues are framed in relation to women and girls. It is similarly valuable to understand how problem framing has changed between the MDGs and SDGs. While gender inequity is recognized as a pertinent issue across the SDGs, there is a need to examine the ideas and assumptions that are represented in the formal discourse pertaining to global development goals. We have reviewed documents produced by UN agencies with the aim of comparing and examining the underlying assumptions associated with health issues identified across the two sets of development goals (i.e., MDGs and SDGs). Our framework-informed analysis has identified some changes in how women and girls' health is represented across the two sets of goals while identifying that the instrumentalization of women's health in relation to community well-being, economic prosperity, and child-rearing remains prominent. This review also finds that discussions of the structural drivers of women and girls' health remain inconsistent and often absent. Future work in gender-informed health and development research can draw from our analysis to better understand how problem conceptualization and representation can impact key populations prioritized in certain policy spheres and to further examine effective ways to advance health and gender equality.

KEYWORDS: Women's health, Development policy, Millennium Development Goals, Sustainable Development Goals

1. Introduction

Globally, women and girls are impacted by patterns of inequity that shape their health outcomes (Pederson et al., 2015). Women and girls worldwide face particular health vulnerabilities resulting from complex social, cultural, biological, and economic determinants (Davidson et al., 2011; Veas et al., 2021). Gender has been identified as a mediating factor in an individual's health through its influence on health behaviours and in how it shapes the response of a health system (i.e. access to quality, gender-sensitive care) (Manandhar et al., 2018).

Examples of health inequity affecting women and girls can be found across all health domains including, but not limited to, endemic infectious disease (e.g., 77% of new HIV infections among adolescents aged 10-19 worldwide occurred among girls (UNICEF, 2021)) and complex health emergencies (e.g., 75% increase in maternal mortality in Ebola- affected countries (Davies et al., 2016). Initiatives designed to address these inequities range from advocacy for cross-sectoral changes from agencies dedicated to fighting HIV/AIDS, to the *Ebola Gender Mainstreaming Strategy* launched by UN Women and regional UN team in Sierra Leone. With this understanding, the trajectory of gender equity in development is frequently changing both in theory and implementation. The language and rhetoric used to describe issues of gender in health provides a key source of charting these changes. To this end, the ways in which problems of women and girls' health are conceptualized and consequently framed, including root causes, contributing factors, and solutions attributed to health issues associated with women and girls, can have a major impact on how these issues are addressed in policy and practice.

The interconnected nature of the social determinants of health that impact priority populations such as women and girls present a complex landscape for development organizations to grapple with. One example of the compounding health effects across social, political, and economic realities includes a girls' access to education, which is commonly identified across policy arenas as a key influence in determining opportunities for career development, economic independence, and empowerment (Unterhalter, 2023). Several tensions exist in the conceptualization of issues of women's and girls' health, likely reflective of the complex determinants of health across aspects of the life course and the inability to fully address any given problem with action in only one dimension of society. Such tensions include grappling with issues of practicality (given finite resources) versus transformative agendas that seek to challenge structural roots of gender inequality. Examples of complex health determinants include structural factors that may impact access to healthcare (i.e. lack of financial independence), cultural orientations that favour the framing and priority of certain issues, or the power of particular groups in setting the agenda related to women's and girls' health (Mucciaroni, 2011). These tensions help rationalize the creation of certain framings regarding women's and girls' health to make sense of the most viable approaches to promoting their health and advancement, as they are conceived by the UN and its agencies – in that framing processes in themselves draw

attention to diverse ideas on key topics (Joachim, 2003). Consideration of problems of inequity have made women's health and empowerment a key topic across development agendas, namely that of the United Nations (UN) and its two flagship sets of development goals, the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs).

The Millennium Declaration adopted by the UN General Assembly in 2000 brought the eight MDGs forward to the global stage, pursuing an ambitious development agenda that intended to harmonize global efforts (United Nations, 2000). Goal 3 of the MDGs sought to promote gender equality and empower women and established standalone Target 3A of eliminating gender disparities in primary and secondary education. The MDGs have been criticized for their reductionist view of gender equality and lack of comprehensive objectives targeting asymmetries of power such as material control of resources or patriarchal gender dynamics (Mariano and Molari, 2022; Langford, 2013; Subrahmanian, 2005; Mohindra and Nikiema, 2010). In terms of explicitly clinical health-related goals, Goal 5 of the MDGs was designed to improve maternal health and included two primary targets: a 75% reduction of the global maternal mortality ratio and universal access to reproductive health. Neither of these targets were achieved by 2015. Given that the predictors of good reproductive health are socially patterned, and the highly preventable nature of maternal mortality, failure to achieve Goal 5 has been linked to similar criticisms of the omission of equity and rights-based discussions such as consideration for tenets like non-discrimination and participation for marginalized communities, and notably a commitment to protect rights pertaining to sexual and reproductive health (Mariano and Molari, 2022). Certain successes were observed with the MDGs, including the reduction of poverty – however, these benefits were unequal across sectors, regions, and populations (Fehling et al., 2013).

The Sustainable Development Goals were introduced to build on the ideas of the MDGs and to highlight the interconnectedness of different sectors to promote an equitable future (DESA, 2015). In the context of gender equality, the SDGs brought increased efforts of gender mainstreaming, which refers to the integration of gendered perspectives across different areas of development (Meier, 2006; United Nations, 2002).

The 17 goals and 169 targets of the 2030 Agenda for Sustainable Development were adopted in 2015 and put forth to address cross-sectoral barriers to development, including those related to improving the health of women and girls. The SDGs have been said to represent a new recognition of the indispensable role of women in development goals and renewed commitment to gender equality (Filho et al., 2022). The wording of Goal 5 of the SDGs is more encompassing of gender equality compared to the MDGs, in that it seeks to "achieve gender equality and empower all women and girls." Mariano and Molari highlight two important advances in this wording, particularly in reference to "all" women, paying due attention to the diversity of women and their experiences, as well as the mention of girls in overcoming what they describe as the "vice of gender policies guided by adult-centrism" (2022, p. 835). Furthermore, a total of 45 targets and 54 indicators are explicitly related to gender across all 17 SDGs, including Goal 3 related to health and well-being for all (Filho et al., 2022). Despite the advances made in integrating greater consideration of the impacts of gender across the domains of the SDGs, Manandhar and colleagues have criticized the SDGs for a narrow concept of gender that positions women in limited roles, such as caregivers and victims – creating implications for the underlying power relations that shape women's health (2018, p.650).

Given the influence of the UN's agenda (namely the SDGs in the current era) in shaping development policies globally and impacting population health, it is important to examine which issues of women's and girls' health are prioritized and the ideas and assumptions that inform the representation of associated health problems and solutions within UN documents (Sand & Widegren, 2019; Cartensen & Schmidt, 2016; Schmidt 2010). These representations have consequences for women's and girls' health is addressed in policy and programming. Schmidt (2008) describes the power of ideas in influencing the terrain of certain policy debates and their ability to mobilize what responses are undertaken (2008, p. 303-326). Similarly, the ideas and corresponding assumptions that inform these policy debates in development spheres has been identified as a key to understanding how these discourses emerge and change (MacArthur et al., 2022).

Recognizing both the depth and breadth of gender inequity as a barrier to population health, it is crucial that development goals and consequent policies align with the unique challenges that women and girls face in achieving good health. The central research question of

this study asks, “how are the causes and contributing factors of health issues framed in relation to women and girls, and how has the problem framing changed between the MDGs and SDGs?” The aim of this scoping review is to critically examine the ways in which problems related to women’s and girls’ health are framed within documents published by UN agencies that pertain to the MDGs and SDGs, and how this framing of causes and contributing factors can impact health and development policy.

2. Conceptual Framework

The analytic portion of this review is guided by the principles of Carol Bacchi’s “What’s the problem represented to be?” (WPR) framework which offers a series of steps to examine the representation of policy problems and how they are shaped (Bacchi, 2019; Archibald, 2020). The WPR framework is situated in a critical paradigm that focuses on the social forces that shape how policy problems are represented and who these representations might benefit or negatively impact (Bacchi, 2019; Archibald, 2020). The framework guides our critical analysis of the assumptions and context in which subject matter is discussed or presented - in our case the framing of women and girls’ health within international development goals - and how language and causal associations are presented. For example, the usage of certain terms and associations can shape the way specific issues are interpreted – such as using the word “mothers” instead of “women” to describe issues that are not restricted only to those who are pregnant or have children.

Bacchi (2016) emphasizes the importance of issue framing in shaping social and political realities (Mol 1999; Bacchi & Rönnblom, 2014). Health is inherently shaped by social and political realities, and in the context of the UN and the SDGs, it is crucial to critically investigate the framing that informs the problems the goals aim to ameliorate (CSDH, 2008; Kickbusch, 2015). In Bacchi’s words, “problematizations thus become part of how we are governed. That is, governing takes place through the ways in which “problems” are constituted in policies. Put in other words, we are governed through problematizations, rather than through policies, signaling the importance of critically interrogating problem representations.” (2016, p. 9)

The WPR framework will be applied to examine how the representation of problems of women’s and girls' health has changed between the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs). Structured by 6 guiding questions (figure 1), the

WPR framework seeks to identify "rationales for the proposal, deep-seated presuppositions underpinning the proposed change, possible silences in the understanding of what needs to change, and the effects that are likely to accompany this particular understanding of the "problem"' (Bacchi, 2009, p. x).

Using these six guiding questions, the types of health issues associated with women can be identified and the causes or contributing factors associated with these health issues can be better discerned. The questions also help expose the rationale and changes in the way these issues are presented overtime. This allows for flexibility in cases where some identified causes and contributing factors may remain the same between development goals, but the description of the health issues themselves may have changed, for example due to shifts in commonly accepted terminology.

The six guiding questions of the WPR framework are as follows:

1.) What is the problem represented to be in a specific policy?
2.) What presuppositions underpin the representation of this problem?
3.) How has this representation of the 'problem' come about?
4.) What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5.) What effects are produced by this representation of the 'problem'?
6.) How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced? (Bacchi, 2012).

Figure 1. The six guiding questions of the WPR framework

3. Methods

We conducted a document review to determine if and how issues in women's and girls' health have changed between the SDGs and the MDGs and how the causes and contributing factors of these health issues are framed in United Nations' documents. We drew from the

scoping review methodology that allows for the definition of the conceptual boundaries of a broad topic or field, such as women and girl's health in development agendas (Peters et al., 2015). We employ Arksey and O'Malley's methodological framework (Arksey and O'Malley, 2005) which includes 5 stages: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing, and reporting the results (Arksey and O'Malley, 2005).

3.1 Research question

Our review was guided by the following question: "How are the causes and contributing factors of health issues framed in relation to women and girls, and how has the problem framing changed between the MDGs and SDGs?" This research question guides our examination of if and how women's and girls' health issues have changed across the two sets of goals, and how the framing of causes and contributing factors are represented in relation to the Goals.

3.2 Search strategy

The United Nations Digital Library (UN Digital Library) was searched to identify relevant documents. As defined by the parameters of the research question, only documents published by the United Nations were included in this review. The UN Digital Library contains electronic versions of publications held in the Dag Hammarskjöld Library, the primary depository for UN documents, and carries a broad range of types of publications such as meeting records, statistical data, and reports.

The team identified search terms with the help of online correspondence with a UN Digital Library librarian, designed to suit the broad objectives of the research criteria while adhering to the inclusion criteria. These terms include "women's health", "Sustainable Development Goals/SDGs", and "Millennium Development Goals/MDGs." Usage of the terms women's health contributed to a broad review of what the documents say about the field as opposed to selecting and examining specific health issues. Notably, although "girls' health" was omitted as its own search term, the documents that were found with the term "women's health" fielded text related to children's health, specifically that pertaining to girls, allowing us to

capture documents related to girls. Thus, girls' health remained a key topic of exploration as per the research question. This wide-net approach helped us to better understand what problems were broadly being explored in the documents and aided in the problem categorization process later in analysis. The UN Digital Library search tool allows the user to specify the search with Boolean operators and toggling between full text or title searches. We used the Boolean operator "AND" to search for the phrases "women's health" and "SDGS/MDGs" in full text to ensure that all relevant documents were being identified.

The determined range for included articles was September 2000 to May 2023 to reflect the introduction of the Millennium Development Goals which were adopted in September 2000. At the end of the MDGs 15-year timeline, the SDGs were adopted by UN member states in 2015.

The search was conducted between May and June of 2023. Selected documents were saved into Zotero, a referencing software, and categorized based on year and whether the document focused on the SDGs, MDGs, or in the case of some documents, both.

See figure 2 for a table of inclusion and exclusion criteria.

3.3 Selecting studies

A total of 2319 articles were identified for initial title and summary screening and imported into Rayyan; 798 for the SDGs and 1521 for the MDGs. Duplicates were identified given the overlap between the SDGs and MDGs in the "transitional years" between the SDGs first introduction in 2012 and its eventual transition to the UN's flagship set of goals.

Given the absence of abstracts in these non-academic documents, we opted to screen the document title and summary instead. Additionally, screening included using command-F to search for the above listed terms within the document to ensure that the terms "women's health" and "SDGs/MDGs" were covered at length rather than mentioned briefly (i.e. on the first page of a document covering the mandate of a specific organization as opposed to the focus of the document itself), and that the subject matter of the document fell under the research question, meaning that its primary focus revolved around women's health and/or the advancement of gender equity.

Post-hoc criteria were developed after the search was initially conducted, which led to the exclusion of documents that were country-specific, draft resolutions, comments on resolutions, and quadrennial reports. The decision to exclude was based on the rationale that these types of documents either did not appropriately address the research question given their foci or were informal information that were not meant to be officially espoused by the United Nations. It is important to note that for the purposes of this review, country-specific is not conflated with region-specific, as many included documents focus on regions such as Sub-Saharan Africa or Latin America. Development agendas are often context specific based on region rather than on one country alone and the details of country-level analyses including types of governments, cultures, norms, and population health concerns were considered too specific for the purposes of this review.

544 documents were identified as fulfilling inclusion criteria. These documents advanced onto full text review, resulting in 304 included documents by the end of June 2023.

3.3 Charting the data

Data was charted by first author AK using an Excel spreadsheet. The following data were extracted from the collected documents:

- UN agency of publication
- Year of publication
- Region (if applicable)
- Document title
- Whether it is related to the SDGs or MDGs, or both
- MDG or SDG goals mentioned or addressed
- Identified health issue
- Identified causes or contributing factors

3.4 Data analysis

Following extraction, data was analyzed and organized into thematic categories of types of health issues, such as inequitable healthcare access or pregnancy and maternal mortality. These categories of issues were then imported into a new Excel spreadsheet compiling the relevant identified causes from the extracted data as well as the six questions of the WPR

framework analysis (see figure 3 for an example chart for one issue and the supplementary materials for the full table). 15 thematic categories of health issues were identified across 304 included documents. These categories were created based off a working list of identified health issues that was developed as documents were read. The categories were formed inductively based on content found in the documents that referred to health issues, such as "pregnancy complications" including maternal mortality or obstetric fistula.

WPR analysis focuses on identifying and analyzing the assumptions made in the process of problem identification and solution proposal. This stage required interpretive and critical analysis of the data to "construct" a rendering of how problems are framed, who contributes to this framing, what assumptions underlie the framing, what types of information are used to support the framing, and what points of tension exist in the different ways that causes and contributing factors are presented in association with one health issue.

As noted above, the WPR framework seeks to identify "rationales for the proposal, deep-seated presuppositions underpinning the proposed change, possible silences in the understanding of what needs to change, and the effects that are likely to accompany this particular understanding of the "problem"' (Bacchi, 2009, p. x). The analysis used the six guiding questions of the WPR framework.

3.5 Consideration of positionality

The research question, topic of inquiry, themes developed, and analysis of their meaning reflect the combined disciplinary expertise (e.g., anthropology, primary care, health policy, political science) and interests of the research team (e.g., policy analysis, social determinants of health, women and gender, critical health studies). We employed a series of checks on aspects of analysis and writing to surface these different interpretations and perspectives. AK discussed emerging interpretations of the data with RL frequently throughout the review, especially during the analysis. Aspects of these discussions included justifications of interpretation as well as critiques. Additionally, themes and drafts of the manuscripts were reviewed by authors AA and KR, allowing the ideas to be evaluated and edited by several people. All identified themes, arguments, and key points of discussion formed from personal interpretations received feedback from several reviewers and discussed at-length.

3.6 Bibliometric analysis

A bibliometric analysis was conducted to complement the WPR framework analysis which involved counting the number of times source material (in our case, identified categories of issues) were referenced across collected documents. Following initial analysis and identification of key health issues, bibliometric analysis was used to explore questions such as: "how many documents explore a given issue? How has this changed overtime between the MDGs and SDGs?" This involved counting the number of documents that referred to each issue to determine the frequency of certain conceptualizations within our review. This process was conducted using Python code that scanned all included PDF documents for key terminology assigned to a scan associated with a certain category. As many documents have different topics, there were no limitations to the number of categories a document could fall under. This process does not include the number of references to each problem within the documents, but rather contextualizes the extent to which each issue is discussed across the documents by counting the number of documents that discuss each issue.

Inclusion Criteria	Exclusion Criteria
• Published literature United Nations departments and agencies related to the MDGs and SDGs • Published between September 2000 and May 2023 • Reference to women and girls • Documents including all SDGs that discuss women's and girls' health in relation to a particular goal • English • Reference to health issues associated with women and girls	• Publications that are not produced by United Nations departments or agencies • Any documents outside of September 2000 and May 2023 • All languages except English • Documents that address issues associated with women and girls without specific reference to health (concept of health can be determined post-hoc?) • Documents covering SDGs exclusive of 3 and 5 (gender and health) • Health policy or health outcomes related ONLY to men

Figure 2. Inclusion and exclusion criteria

Identified Issue	Identified Cause(s)
Barriers to care	underrepresentation of women, lack of attention to women's health needs, lack of gendered perspectives, segregation and discrimination in healthcare, discrimination causing inadequate access to care (i.e. lack of financial independence)

Example of WPR Framework Application to "barriers to care"	
Question 1: What's the problem represented to be in a specific policy or policies? (e.g. economic development, global warming, etc)	Women have difficulty accessing gender-specific, relevant, and appropriate healthcare
Question 2: What deep-seated presuppositions or assumptions (conceptual logics) underlie this presentation of the 'problem'	That women would benefit from gender specific care, that it is a necessity for good health, and that it is discriminatory to not be offered such care
Question 3: How has this representation of the 'problem' come about?	The idea of gender specific care had to be introduced as well as broad acknowledgement of gender specific health needs. Primary health care for all (Alma-Ata Declaration) likely revitalized or triggered this conversation
Question 4: What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualized differently?	A specific focus on issues that are not sexual or reproductive health -- this is often characterized as the main difference between men and women so often remains a focal point. Should integrate a cultural intersectional view as well
Question 5: What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?	Could feed into the opposite effect it intends to have -- further perpetuating an idea of women as complicated or needy, which is a stereotype that affects patient-provider relations and other healthcare experiences
Question 6: How and where has this representation of the 'problem' been produced, disseminated, defended? How has it been and/or how can it be disrupted and replaced?	Produced by development policy rhetoric, disseminated to NGOs and states, defended by health equity advocates. The representation of the problem can be disrupted by consideration for intersectionality, or dependent on region

Figure 3. Extracted table depicting a single issue to provide an example of the WPR framework analysis

4. Results

4.1 Overview of documents

Of the 304 included documents, 142 documents (46.7%) were written and published in the era of the Millennium Development Goals (MDGs) and contained a significant reference to the MDGs, which we define as the presentation of information framed as important to fulfilling the MDGs, as opposed to merely mentioning the MDGs as the predecessor to the SDGs. The MDGs were introduced in September 2000 and completed in 2015 and the SDGs were first introduced in June 2012 with a planned initiation year of 2015 with a deadline of 2030. 41

documents (13.4%) were written and published after June 2012 and before 2016. Documents in the range between 2012 and 2015 are transitional in nature and may contain reference to both the MDGs and the early iterations of the SDGs, often referenced to as "post-2015 goals" or the "2030 Agenda."

The SDGs were officially adopted in September 2015 and brought into force in January 2016. 121 documents (39.8%) were written and published after January 2016. After this date, documents began to reference the SDGs (as per our provided definition) instead of the MDGs, though the MDGs are often mentioned to highlight its role as the previous goals or as a metric for measuring progress made since 2000.

4.2 Identified categories of health issues

As shown in Table 1, fifteen categories of health issues were identified across 304 included documents. Each category is described, and identified causes were compiled iteratively. Some causes were attributed to more than one category.

Category	**Description**	**Causes**
Barriers to care and reduced access to resources	Women have difficulty accessing appropriate and quality care due to lack of decision-making power or lack of control over health resources	underrepresentation of women in health research, lack of attention to women's health needs, lack of gendered perspectives in healthcare, segregation and discrimination in healthcare, social determinants causing inadequate access to care
Disproportionate risk of HIV/AIDS	Women are at an increased risk of infection from HIV/AIDS as well as poorer outcomes beginning at onset of disease and lasting throughout illness	ignorance of disease and effects, lack of sexual and reproductive health education, increased physiological and social vulnerability, prevalence of female sex work, unequal power balance between

		women and men, biology of the reproductive tract, a lack of gendered perspective in HIV/AIDS programming, and sexual and intimate partner violence
Gendered dimensions of environmental health concerns	Women are at greater risk of and have a higher incidence of adverse health consequences from environmental exposures rooted in gender roles	air pollution, lack of affordable energy, poverty, domestic gender roles, unequal power relationships, girls taken away from education, and the vulnerability of women and children in slums
Gender-based violence, rape, trafficking	The prevalence of gender-based violence, rape, and trafficking disproportionately targeting women is ubiquitous across cultures and nations	a lack of education for men at risk of committing violence, a lack of protection of children (young girls), power imbalances and frequent age gaps, lack of worldwide social and cultural progress in gender equity, and biases against women
Poor nutrition	Nutrition is a fundamental part of ones' health, and women experience unique barriers to good nutrition	poverty, lack of access to resources and basic social services, discrimination and discriminatory practices, vulnerability in family structures, cultural traditional practices, and poor literacy
Noncommunicable diseases	Women may present different symptoms of noncommunicable disease that are under-observed and under-researched in clinical settings and experience different circumstances that can exacerbate or improve likelihood of developing disease	an increased risk of cardiovascular disease from smoking, stigma related to NCD presentation in women, inaccessible healthcare due to lack of social or economic autonomy, limited access to physical activity, and a lack of nutritious food

Gendered division of domestic labour	Traditional gender roles maintain highly disproportionate and unregulated domestic labour expectations for women, which acts as a determinant for various health outcomes	unequal gender roles and expectations, cyclical effects of a lack of education, poverty, power imbalances, and vulnerability in family structures
Female genital mutilation (FGM) or female genital cutting (FGC)	The widespread and increasingly medicalized practice of FGM/C is a violation of children's rights and carries short-term and lifelong consequences for girls	cultural and social status, a familial fear of social isolation by going against social norms, fear of loss of status, and the prescribed inferiority of women
Unintended pregnancy	Pregnancy is a life-altering reproductive choice yet nearly half of all pregnancies worldwide annually are unintended, which carries consequences for girls, women, and populations	gender-based discrimination, limited access to birth control, poor access to quality healthcare (abortion, prenatal, emergent care i.e. c-sections), violence, and societal expectations to carry children
Maternal mortality and pregnancy complications	Preventable maternal mortality and other complications such as obstetric fistula and preeclampsia remains staggeringly high, primarily in low-and-middle-income countries – even in instances of survival, mothers and their children can be left with lifelong complications	gender-based discrimination, limited access to birth control, and poor access to quality healthcare
Increased vulnerability in conflict and disaster	In times of crises, structural inequities impact women and girls differently, experiencing increased rates of violence, rape, restricted mobility, and domestic or caregiving responsibilities	a lack of education during emergencies (when basic needs are not met), lack of international intervention and implementation of wartime norms, and the exclusion of women from peace negotiations

Substance abuse	Women are affected by different risk profiles as well as different experiences in instances of substance abuse and/or addiction that can worsen health outcomes	gender biases, the belief that girls are less valuable than boys (i.e. provide less to the family) and that girls are more of a burden to families, as well as the pressure to conform to societal or cultural expectations
Access to education	There is a persistent gender parity in primary educational enrolment worldwide – beyond access to education, girls must feel safe and empowered to pursue aspirations	engrained social gender biases, domestic labour expectations, expectations of starting a family earlier, and the disproportionate impacts of poverty on women and girls
Prenatal sex selection	In families with a distinct son preference, baby girls can be abandoned or killed – those who survive are often treated poorly in a hostile environment as they grow up	gender biases, the belief that girls are less valuable than boys (i.e. provide less to the family) and that girls are more of a burden to families, as well as the pressure to conform to societal or cultural expectations.
Child marriage	Marrying under the age of 18 frequently leads to adolescent pregnancy (increasing the risk of complications), limits opportunities for young girls, and perpetuates ideas of women as property	patriarchal notions, gender-based violence, separation from family in times of disaster, lack of access to education, and lack of consolidated social support or protections for young girls in maintaining the practice of child marriage worldwide

Table 1. Health issues identified in the document analysis

NOTE: Poor mental health was not included as an independent topic as it is most frequently described as a consequence of the following thematic categories.

4.3 Bibliometric analysis comparing references to each cause

Each thematic category was analyzed using bibliometrics to count the number of documents referencing each theme as well as the division of counts between the MDG and SDG eras to identify any contrasts. The numerical findings were used to provide some indication of the importance or priority given to each health issue.

Health Issue	**Number and Percent of Documents Referencing**	**Number in MDG era (pre-2016)**	**Number in SDG era (post-2016)**
Barriers to care	302 (99.3%)	191	111
Disproportionate risk of HIV/AIDS	282 (92.8%)	185	97
Gendered dimensions of environmental health concerns	166 (54.6%)	106	60
Gender-based violence, rape, trafficking	280 (92.1%)	170	110
Poor nutrition	243 (79.9%)	166	77
Noncommunicable diseases in women	70 (23.0%)	41	29
Division of domestic labour	155 (51.0%)	70	85
Female genital mutilation (FGM)	131 (43.1%)	84	47
Unintended pregnancy	92 (30.3%)	58	38

Maternal mortality and pregnancy complications	193 (63.5%)	130	63
Increased vulnerability in conflict and disaster	248 (81.5%)	155	93
Substance abuse	59 (19.7%)	37	22
Access to education	298 (98.0%)	189	109
Prenatal sex selection	62 (20.4%)	48	14
Child marriage	124 (40.7%)	57	67

Table 2. Bibliometric results for each health issue identified

4.4 Thematic findings in problem representation

When the WPR framework was applied across the presentation of women's health issues in the documents we reviewed, three overarching themes emerged related to problem representation in women's health. The themes include 1) justifying efforts to promote women's health by framing it as beneficial to their families and their communities, 2) perpetuating the idea that women are inherently vulnerable yet simultaneously largely responsible for their well-being, and 3) a lack of critical interrogation into why structures of inequality that underlie health issues continue to persist. This section will explore how the framing of the identified causes of health issues contribute to these three themes, as well as how these representations have changed between the Millennium Development Goals and the Sustainable Development Goals eras.

4.4.1 Women's health as beneficial to others

Women are frequently identified as caregivers for not only their immediate families but as the backbones of the communities to which they belong. They have been described to be harbingers of development since the introduction of the Millennium Development Goals.

> "Promoting gender equality and women's empowerment in its broader scope is a key objective of the Millennium Declaration… education contributes to better health, and better education and health increase the productivity that leads to economic growth. Growth then generates resources that finance improvements in people's health and education, further raising productivity. Gender equality is central in these synergies because women are agents of development." (UNDP, 2003, p.7)

In more recent years, notions of women's health promotion as an end in and of itself has become more common, however, discussion continues to highlight the utility of women's health for the greater good of societies.

> "Investments in the health of girls and women have the potential to speed up a country's demographic transition and to increase the size of the demographic dividend… one of the main reasons for this is that the income effect of higher male productivity tends to raise fertility, delaying a demographic transition. In contrast, investments in women's health—specifically reproductive health—may lower fertility rates." (UNFPA, 2018, p. 49)

The framing of many issues and their causes are informed by this rhetoric. The idea that promoting women's health, as well as their social and economic equality, is useful or worthwhile primarily because of their potential to improve societies worldwide is in sharp contrast with arguments that center their inherent right to health and justice.

Some health issues illustrate a degree of dissonance when it comes to this specific type of issue representation. For example, concerns about the unequal division of domestic labour focus on the consequence of women's disproportionate responsibility for the wellbeing of family and community members. In many countries, women assume a "triple burden" that includes the care of children, elderly, and the sick, spending hours gathering water and fuel, and working on farms or other family enterprises for no income (Sachs & UNDP, 2005, p.6 & p.64).

A commonly identified underlying cause for unequal domestic labour division are unequal gender roles and expectations and power imbalances in the family dynamic. These imbalances often manifest as unilateral household decision-making of the family patriarch (Sachs & UNDP, 2005, p.86). The 2003 Human Development Report characterizes inequality in decision making as a hinderance to development – "When women have no say in household

decision-making, the synergies between productivity, health and education are hobbled. Gender equality is thus more than social justice—it promotes development" (2003, p.18). The dissonance of this overarching idea about women as leaders in their community can be summarized as such: the role of acting as a community leader is identified as a potential source of health consequences for women yet is simultaneously positioned as a necessary tool for sustainable development. The document "World survey on the role of women in development: gender equality and sustainable development" (2014) acknowledges this dissonance, referring to women as "sustainability saviours", thus reinforcing women's roles as community leaders (p.13). However, the document goes on to describe that "such responses often add to women's already heavy unpaid work burdens without conferring rights, resources and benefits. Power imbalances in gender relations determine whether women's actions and work translate into the realization of their rights and capabilities" (UNWomen, 2014, p.13).

Framing women as influential community leaders adds another layer to women's disproportionate burden due to the affiliated expectations of contributing both unpaid domestic labour within the household, and social capital that others in the community can benefit from. While their contributions to community may be beneficial, in the context of unequal domestic roles these contributions may come at their expense. Domestic labour may also present specific and gendered health consequences for women due to its unregulated nature, and potential limitations on women's economic independence (UNECE, 2020; OHCHR, 2016). As described above, the unequal burden of domestic labour often assigns women to a specific role that *may* allow for concurrent pursuit of education and/or employment, but frequently does not. This perpetuates an ongoing cycle wherein a lack of education is identified as a reason for women's involvement in domestic labour, even across generations – the World Development Report in 2012 reported that a high maternal income has a stronger link to increases in young girls' schooling than high paternal income (2012, p.111). The framing of these benefits may place an undue expectation on women as essential to development, while condemning them to the same structures that keep them marginalized.

Women and children's health are often conceptually and practically grouped together due to women's role as mothers to children. Exemplifying this conflation between women and children is the example of poor nutrition. A 2013 Food and Agriculture Organization (FAO) document

identifies improving the economic status of women as a priority for improving poor nutritional outcomes in both women and children, highlighting the role of poverty and lack of access to resources as key determinants of nutrition (FAO, 2013). A passage from the same document, seems to position women's health and opportunity for nutritional improvement as secondary to their children; "Increasing women's control over resources and incomes has been shown to benefit their children's health, nutrition and education, as well as their own health and nutritional status" (FAO, 2013, p. 29). This type of framing posits the need to improve women's health as contingent on its ability to also improve the health of their children. Additional examples of this framing can be found even in more recent documents, up to 2022; "When women spend most of their waking hours working […] they may compromise caring and feeding practices of themselves and their children, which may contribute to deterioration of their own nutritional status and that of their children" (WFP, 2022, p.45). Throughout the document "Global Report on Food Crises" (2022), national case studies are presented and defined by a header that lists the number of children and pregnant or lactating women who are malnourished and/or wasting, obscuring women without children from consideration. When this population is mentioned, they are defined as "women of reproductive age". This highlights the emphasis placed on women's nutrition as defined by the impact it could potentially have on their future or current children.

Within the conceptual understanding of women as caregivers, issues of women's health are often linked to their roles as mothers to children – this can hinder attention to other aspects of women's health. In our examination of "barriers to care," examples of associated causes of poor-quality healthcare include a lack of perspective into women's health needs as well as the underrepresentation of women in health research (Andrea and Fergusson, 2008; WHO, 2016). Barriers to care are described as difficulties in accessing appropriate and quality care due to lack of decision-making power or lack of control over health resources (DESA, 2006, p.149). However, the centering of reproductive and sexual health (SRH) when discussing women's healthcare needs risks obscuring considerations of how gender shapes health and well-being beyond SRH. As a document from 2016 states: "Richer countries have sound health and education systems in general, but still have to deliver fully on commitments to sexual and reproductive health and rights, protection against violence, and norms that undercut girls' self-value, among other issues." (UNFPA, 2016, p.80). This quote does not highlight the need for health and education systems to facilitate access to high-quality, holistic care that considers

gender outside of SRH, though it does acknowledge the role of norms in shaping determinants of health. The following excerpt from the MDG era in 2005 provides another example of the disproportionate concern for gender biases in SRH: “Common are gender biases in public investment and social and economic policies, maternal health, and sexual and reproductive health… throughout the developing world and even in middle-income countries, maternal mortality ratios remain appallingly high.” (Sachs & UNDP, 2005, p.45). Gender biases persist outside of SRH clinical spheres, and access to any sort of healthcare can be hindered by unique barriers for women – however, SRH services tends to be the identifying factor in discussion of women’s healthcare access: “Traditional harmful practices hinder equitable access of women and girls to comprehensive and affordable quality primary health-care services, in particular reproductive health services.” (UN Secretary General, 2005, p. 9). Although equitable SRH care is undoubtedly important for advancing the status of women, it is not the only dimension of healthcare that impacts women.

In identifying risk factors for HIV/AIDS infection, women who choose to carry children are also uniquely identified by their ability to transmit the infection to their babies. This is evident in both the documents themselves and in the policies the documents explore. As noted in one document, the “criminalization of vertical HIV transmission marks women living with HIV as potential offenders, and further marginalizes women who are vulnerable as a consequence of poverty, lack of education, absence of health promotion and services, and gender inequality” (Joint UN Programme on HIV/AIDS, 2012, p.37). Reflecting further on these issues, the authors’ state: “Services for the prevention of mother-to-child transmission are important for HIV testing…yet it is essential that treatment scale-up does not focus entirely on these settings; women have the right to access treatment outside maternal health settings and should be supported to access it for their own health.” (Joint UN Programme on HIV/AIDS, 2012, p.39)

A few documents from both MDG and SDG eras incorporate a more holistic consideration of women’s health, for example, acknowledging that non-communicable diseases (NCDs) are the leading cause of death for both men and women (DESA, 2010, p. viii; DESA, 2023, p. 41) However, neither of these documents explicitly advocate for the implementation of gender-specific healthcare outside of SRH needs. Rather, discussions tend to revolve around the rising prevalence of NCDs in women due to differences in risk factors and social determinants

between men and women. Regarding tobacco use, women's risk is uniquely characterized by the additional risk smoking can carry if they are pregnant: "Smokers have elevated rates of serious health problems… there is evidence that women may be more vulnerable than men to tobacco-related health consequences. About one in five pregnant women smoke and smoking during pregnancy can be detrimental to the foetus" (UN Office on Drugs and Crime, 2004, p. 68). Often, the key differentiating factor in these discussions revolves around women and their ability to carry children and their role as mothers – a theme prevalent across the health issues identified in this review.

4.4.2 Dynamics of framing women as vulnerable

Women are often situated as inherently vulnerable, both due to social structures and biological and physiological differences. Using the example of women's increased vulnerability to HIV/AIDS, social structures are the inequities that place women at a higher risk such as a lack of access to sexual and reproductive health education leading to ignorance of the disease and its effects, gender-based violence, the prevalence of women engaging in sex work, and gendered power dynamics (Joint UN Programme on HIV/AIDS, 2017). Physiological differences refer to the biology of the female reproductive tract that makes women especially vulnerable to infection. An additional key determinant of HIV risk in women is sexual violence, which can occur domestic/familial or broader social contexts (Joint UN Programme on HIV/AIDS & Global Coalition on Women and AIDS, 2006, p. 10).

However, descriptions of power dynamics within sexual encounters rarely capture the idea that the root causes of consensual, safe sexual encounters relate to underlying issues of power and social norms. Rather, there is a tendency to focus on the outward manifestations of these underlying factors, such as inequities in access to education. For example, one document notes that "It is no coincidence that many of the countries with the largest gender gaps in education also have relatively high levels of fertility and rapid population growth." (DESA, 2021, p.79) The framing in this specific quote implies that the onus of the problem is the gender gap in education, effectively attributing high fertility to women who are not receiving an adequate education. This places an unspoken responsibility on women for their own reproduction and situations whereby they may fall pregnant even if the circumstances that bely their vulnerability are not their creation. Furthermore, reference to gender *gaps* in education tends to

underplay the reality of education for men worldwide, and in particular, a lack of attention to transformative learning that places responsibility on men to mitigate the harmful effects of gendered power dynamics. The paragraph goes on to identify patriarchal culture and traditions as one factor responsible for this dynamic: "Changing traditional attitudes about the status and roles of women in society can help women and girls to exercise their right to education" (DESA, 2021, p.79). In another section of the same document, fertility and rapid population growth are overarchingly defined by a lack of autonomy and opportunity among women and girls, and it is important to consider who is being held responsible for these factors that create these circumstances for women and girls in problem framing and representation.

This rhetoric can shift depending on the context in which education is being described and in general, we see a more holistic perspective on the role of men and boys in the years since the introduction of the SDGs. "The State of the World Population" is the UN's Population Fund's annual publication – in 2016, the document explained the role of men and boys in becoming allies of girls' empowerment and the socialization of gender roles that keep men in power and control (2016, page 75.) This signifies the endorsement of a gender transformative framework that seeks to challenge how the implicit biases held against women in holding them accountable for their marginalization.

4.4.3 The need to act on structures and norms

Across almost all the documents reviewed was an acknowledgement that key health issues affecting women are embedded in gender inequality that is in and of itself deeply entrenched across social, economic, and political structures that shape the health of women and people everywhere. At the same time, there is a paucity of significant, critical interrogation into *why* these structures continue to persist beyond accepting that gender inequality is ubiquitous.

Prenatal sex selection is an example of a health issue that exemplifies the cyclical nature of gender inequity throughout the life course, and the challenges in targeting specific areas of action in the context of broader gender inequity. Prenatal sex selection refers to the preference of a baby boy over a baby girl, often resulting in either the termination of the pregnancy once the sex is known, abandonment at birth, or sex-selective neglect (Hesketh, Lu & Xing, 2011). This phenomenon carries lifelong consequences for girls who grow up in societies heavily biased against them for their gender (UNFPA, 2005; Hodgkin & Newell, 2002). In countries with

prevalent sex selection, girls are believed to be less socially valuable than boys. They are also seen as economic liabilities for families due to "low expected contributions to family income or large dowries" (UNFPA, 2005, p. 67). Families that are economically limited by single-income households where women are not formally employed are pressured by economic as well as sociocultural expectations to participate in prenatal sex selection (UNFPA, 2005). These underlying causes are fundamentally rooted in structures of inequity and are largely self-perpetuating, and all are engrained in a bias against women. For example, a country's sex balance is an indicator of a nations' well-being as imbalance can increase the risk of trafficking of women for marriage and sex work (UNFPA, 2005). Worrisome in the latter document, are implicit references to women as a commodity in statements such as "the shortage of women and girls in some Asian countries has potentially alarming social repercussions" (p.67, 2005). The term "shortage" evokes an image of products that are difficult to acquire or in short supply, and in the context of this example, seems to objectify women in their roles as companions to men. This type of idea promotes an underlying rhetoric that is fundamental to gender inequity, such as reifying power dynamics that lead men to believe they are entitled to sexual or romantic relationships with women.

Several documents point to the structural nature of gender inequity. Take, for example, an excerpt from a 2014 document: "[Women's] involvement in policy interventions aimed at sustainability does not automatically mean greater gender equality, particularly when the structural foundations of gender inequality remain unchanged." (UN Women, 2014, p.13) This understanding is implicit in the conceptualization of many issues and their causes identified in this analysis, particularly when causes are related to power imbalances and gender roles – which are often characterized as an implicit facts to be condemned, yet accepted as unavoidable in the context of historical and present-day narratives: "The 2030 Agenda's commitment to gender equality is comprehensive, yet inequalities among women and girls remain pervasive." (WHO, Joint UN Programme on HIV/AIDS, UNFPA, UNICEF, UN Women & World Bank, 2018, p.32) Acknowledgement of pervasive inequity, particularly when it is framed as unavoidable, does not instigate change, and can even continue to normalize its presence. As such, efforts should be focused on identifying factors that can lead to advances in gender and other forms of social equity.

Recent documents, such as "State of the World Population" (2020), provide deeper insight into the structures that underlie the causes of harmful practices against women and girls, including the issues of female genital mutilation, child marriage, and prenatal sex selection. Such text includes descriptions of the persistence of inequality despite progress: "The broader backdrop to gender discrimination is one of globally rising inequalities and intensifying exclusion […] they sustain and worsen gender inequalities, even as a deliberate pushback against gender equality is gaining ground." (p.11) This document argues that the entrenchment of root causes within structures of inequality will hinder true progress: "Gender equality is more visible in public discourse than ever before, from social media campaigns to high-profile cases against sexual misconduct. Yet when it comes to actually getting the job done, the shortfalls are stark." (UNFPA, 2020, p.116) While the report calls for linking actions to ending harmful practices with achieving gender equality, the reports fails to lay out what actions are needed: "elaborating a full menu of options to achieve gender equality goes far beyond the scope of this report (2020, p.117). A more comprehensive perspective that explicitly positions efforts towards gender inequality as being opposite and incompatible with underlying structures of discrimination can help strengthen the link between ideas and actions to promote equity and justice.

5. Discussion

We identified the following themes through our analysis; 1) the influential role of communication in conveying problem representation of health issues, 2) the tendency of documents to instrumentalize women as agents of development, and 3) potential consequences of current modes of problem representation. The SDGs are a powerful tool for shaping the development agenda (Bigg, 2016). The SDGs derive their normative and global influence from the force of consensus of participating governments, and they are inherently designed to guide the actions of governments worldwide. This highlights the value of examining problem framing within the Goals.

5.1 Implications of problem framing for health policy

The act of undertaking, and ultimately succeeding in the goal of reaching a shared sense of meaning and understanding "underscores the salience of language and symbolic action in the policy process" (Edelman, 1988; Koon, Hawkins and Mayhew, 2016, p.802). In the context of

this review, the processes that inform the creation and communication of development policy objectives across the MDGs and SDGs are of particular interest given that women and girls are a priority population for advancing health equity. Our analysis has highlighted that UN documents are highly diverse in how they consider and represent inequality in discussions of women's and girls' health. At times, the entrenched features of gender inequality have led to the incidental replication of these very same inequities in problem framing and representation. One example from our results includes framing the improvement of nutrition in women as primarily beneficial to their children rather than beneficial for the pursuit of good health in and of itself – a framing that promotes gendered expectations of caregiving and motherhood and highlights the unique role that women play in their communities across the world (FAO, 2013, p. 29).

Key points to consider in this discussion are the influential yet behind-the-scenes (i.e. largely unpublicized) work of the United Nations and the observation that published documents do not wholly represent the consensus view of the UN body, nor the actions that agencies undertake. This review considers the wide range of ways in which UN agencies present their concerns within official documents. In particular, we assess what information these agencies choose to disseminate (and more particularly, *how* they communicate this information) and the influence this has on shaping stakeholders' and the public's understanding of the issues they choose to present. In our results, we present how different ideas were framed and conveyed throughout the documents we reviewed, and how the persistence of underlying inequities was acknowledged. As previously described, prevalent across these documents was a repudiation of gender inequality, but an implicit or explicit view that it is unavoidable. Many articulated goals, targets, or other ambitions towards gender equality are framed in this way. This suggests an implicit acceptance of persistent and supposed 'natural' inequality. This creates a complex dynamic between goals that can be reasonably (and technically) achieved and ideas that fundamentally challenge structures of inequality.

A complex example is female genital mutilation (FGM) and its associated SDG, Goal 5.3, which seeks to eliminate such harmful practices. This topic is frequently explored in-depth across the documents we reviewed, and proposed actions are seldom straightforward. This is partially due to the entrenchment of cultural values surrounding the purity of girls and the honour of their families (Khosla et al., 2017). With this example, we note tensions between what is being

articulated (i.e. FGM/C is a human rights violation) and the ideas being incidentally expressed (i.e. the contexts in which the practice of FGM/C is encouraged are unavoidable). A 2007 document from the UN Secretary General writes that "the Committee on the Elimination of Discrimination against Women identified the practice of female genital mutilation as the result of entrenched patriarchal attitudes and deep-rooted stereotypes and cultural norms," however, the proposed action items do not seem to challenge the presence of these attitudes (UN Secretary General, 2011, p.8). Referencing these social norms, the 2012 World Development Report states "with female genital cutting, for instance, the universality itself shapes beliefs by preventing a comparison of the sexual morality of cut and uncut women" (p.174). Another section of the document reflects on the slow-changing nature of social reform but situates existing gender bias as the rigid status quo:

> "'Incremental' reforms may not be enough to overcome the path dependence and institutional rigidities that result in persistent gender inequality. Bold government action with "transformative" reforms may be necessary to alter social dynamics and move to a more equitable equilibrium. In choosing between incremental and transformative policies as part of gender reforms, the challenge for policy makers is to balance the pace of change with the risks of reversal. Incremental policies will bring about change only slowly. But transformative policies can risk a backlash" (p. 36).

Decades of efforts have failed to substantially curb the number of girls subjected to FGM/C (Khosla et al., 2017). UNICEF estimates 200 million women and girls alive today have undergone FGM/C, and while numbers are declining, the pace of decline has been markedly uneven and progress has stagnated in many countries (UNICEF, 2023). The challenge of problem and solution framing is apparent in the different ways in which FGM is communicated and addressed across the documents reviewed. Of note is the tension between what is practical and what is transformative. Key to overcoming this tension is bridging the two - successfully communicating an intention to tackle entrenched structures of inequity can invigorate efforts to mobilize those intentions into implementable policies. Esquivel (2016) analyzes the SDGs through a feminist lens that assesses the extent to which structural power relations are either challenged or reinforced. She argues that poor policy coherence across the goals and an over-emphasis on quantitative indicators may exacerbate inequitable dynamics between gender, class,

and other social structures. Examples of structural power relations include political participation and economic empowerment. For the former, Esquivel and others are critical of the SDGs' lack of acknowledgement of the material resources and conditions that must be met for participation such as money, time, confidence, and education (Goetz & Jenkins, 2016). For the latter, Esquivel is wary of equating gender equality as the equality of opportunity between women and men as this does not secure livelihoods and fails to recognize the reality of women's economic lives in "informal work, pervasive gender wage gaps, and occupational segregation" (2016, p.17). These concerns echo a key issue in messaging regarding the complex realities of gender inequality that has been identified by many organizations and authors in the field such as the Consortium on Gender, Security and Human Rights and Gupta & Vegelin (2016), among others.

5.2 *Women as instruments of development*

Our findings suggest that women are often characterized as instrumental agents of development and improved child health within UN documents. The description of goals pertaining to women's health often come with an explanation that highlights the extrinsic value of gender equality and improved population health of women. We find that this framing includes positioning women as uniquely capable of enacting change in their communities because of their role as mothers and/or caregivers. The value that UN agencies have attributed to women and their capabilities has helped to advance gender equity (Filho et al., 2022). While this attribution is positive because it acknowledges the value that women bring to their communities and advocates for the dire need to involve women in development planning, a more critical perspective signals two concerns. First, is the assumption that gender equality resonates only in relation to the benefits it offers for the greater society, and second, that this characterization is an oversimplification of root structural causes of inequity.

Our findings support the arguments of Dubrowolsky (2007) whose essay explains that, across different sectors of policies, "women are also used in highly instrumental ways that reinforce gendered inequalities," namely inequalities related to human capital, economic independence, and domestic expectations (p. 829). The 'sustainability saviour' idea has been described by Leach and colleagues in a 2016 UN Women discussion paper – wherein women and girls are essentialized as carers of nature and their communities and their voluntary labour is

drawn on and instrumentalized (Leach et al., 2016). The authors highlight a need to recognize their knowledge, rights, and capabilities in tandem with control over relevant resources and decision-making power (2016, p. 2.) Labour can be instrumentalized in a variety of ways, including economically (informal domestic labour as well as increased participation in the paid labour market) or their social capital and relationships (which is relied on for household and community survival) (Gonzalez de la Rocha, 2007). Authors like Kabeer (1994), Connell (1987), and Goetz (1995) note the underrecognized salience of gender across the divisions between public, domestic, and private institutions, whose associated conceptions of gender (i.e. division between women who participate in domestic labour *versus* the labour market) may create a false dichotomy between the types of barriers women face, when they are in fact rooted in the same structures. Chant and Sweetman (2012) illustrate this instrumental logic by pointing to a statement made in a 2011 World Bank report, that "gender equality matters for development – it is smart economics. An instrument for development." While women deserve to be celebrated for their ability to uplift their communities and bring unique value to implementation efforts, this kind of messaging risks perpetuating gender roles that place a disproportionate burden of domestic responsibility on women (Braunstein & Houston, 2015).

The SDGs' conceptualization of gender has been similarly criticized by Manandhar et al. (2018):

> "It can be argued that SDG 5's concept of gender is narrow, referring mainly to women and focusing on limited roles: as mothers, as caregivers and as victims of violence. There is little incentive therefore for countries to adopt a more holistic, gender-equal and progressively universal approach. Outdated understandings of gender fail to explicitly acknowledge and address the underlying power and hierarchy relations between men and women that shape their health through a complex interplay of health determinants, behaviours and health-system responses." (p. 650)

The characterization of women and girls as agents of change is, in many ways, an easily digestible 'selling point' for development initiatives promoting empowerment while advancing

economic goals that benefit the entire population. Scholars have observed that in many cases economic relations rely on reproducing gender inequalities, primarily by exploiting the unpaid labour of women and girls (Braunstein & Houston, 2015; Berik & Rodgers, 2008). The link between empowerment and economic goals is illustrated in a document published by the UN Economic and Social Commission for Asia and the Pacific advocating for increased attention towards gender-specific participation in development: "if women had access to and control of the same resources as men, their contributions would increase food production by 2.5–4 per cent, which would be enough to move 150 million people out of hunger and poverty across the developing world" (ESCAP, 2017, p. iii). In another section it notes "in our collective quest for a more balanced development strategy that propels economic growth, protects the environment and advances social development, we must ensure half of the population is not left behind" (p.iv). Chant and Sweetman (2012) highlight the title of a chapter of the World Bank's 1995 gender-focused publication *Enhancing Women's Participation in Economic Development*: "The Pay-offs to Investing in Women", as well as other statements within the document, to emphasize the perceived "'social goods' that are gained by investing in women" (2012, p.519). As argued by Chant and Sweetman, many of the ideas cited in this 1995 World Bank document reflect the sentiments of today's development agenda such as: income controlled by women leading to better outcomes for children (Whitehead, 1984) or the association between education and lower fertility rates (Jeffrey & Jeffrey, 1998). Chant and Sweetman explain that labelling the investment in women as empowerment is part of a 'smart economics' paradigm, which falls short of advocating for systemic change in social norms and political engagement (MacArthur et al., 2022). 'Smart economics' is the process of rationalizing investing in women and girls to improve development outcomes. This corresponds to our finding that efforts to improve health outcomes in women and girls are frequently justified by highlighting the benefits it brings to other populations or structures (Chant, 2012).

We approach this analysis with the understanding that women and girls should not be the sole bearers of responsibility to transform systems that create conditions of inequality. In emphasizing agency and individual empowerment, often in the context of economic participation, root causes of inequity are overshadowed and implicitly characterized as the individual's responsibility to overcome. This perspective can overlook consideration of the structures that affect women and girls' health throughout the life-course and how they might be

overcome (Chant and Sweetman, 2012; Moser, 2020). Our results highlighted that placing responsibility on women to overcome their contexts, and forgoing consideration of the role of men, boys, and entrenched structures, risks perpetuating inequality (Cornwall & Anyidoho, 2010). Many of the documents of the SDG era are in fact aware of the 'sustainability saviour' narrative; exemplified by the work of Leach and colleagues being disseminated through a UN Women document as well the introduction of the 2014 World Survey on the Role of Women in Development, also published by UN Women. It nonetheless remains a narrative that future development agendas must be mindful of to support the intrinsic and material advancement of women and girls.

5.3 Expanding conceptions of gender and health

A disproportionate focus on women's sexual and reproductive health and rights (SRHR) versus other identified health issues, such as non-communicable disease or mental health, was apparent across the reviewed documents. This was also apparent in the bibliometric analysis. In advocating for a broadened understanding of women's health beyond SRHR in development policies, Bustreo et al. succinctly write: "It is time for priorities in women's health to be set in accordance with the unfolding demographic and epidemiologic transition and with breakthroughs in public health and medicine." (2012, p.478). If we look to the SDGs themselves, five out of six gendered indicators within Goal 3 of health for all are related to SRHR, though Goal 5 touches on determinants of health related to advancing gender equality (Manandhar et al., 2018). SRHR is a forefront issue of both development and women and girl's health – it is a function of human rights, human health, and population dynamics (Barragués, 2020). Promoting SRHR is integral to advancing the status of women and girls worldwide. However, SRHR is not the only dimension of health that is important to women and girls. While many UN documents highlight the diversity of experiences and determinants of health for women and girls worldwide, SDG targets remain predominantly focused on SRHR topics.

Take, for example, non-communicable diseases (NCDs). More women worldwide die annually from NCDs than any other cause (Peters et al., 2016; Hallam et al., 2022). While NCDs account for a large burden of disease across the entire world population irrespective of gender, both the physiological characteristics of sex and sociocultural functions of gender can significantly impact disease presentation, outcomes, risk factors, and experiences with healthcare

systems (Hallam et al., 2022; Mauvais-Jarvis et al., 2020). The broad span of SRHR topics in the MDGs and SDGs is contrasted by a complete absence of mention of the gendered dimensions of NCDs across a total of 8 targets relevant to NCDs in the SDGs (Singh Thakur, Nangia, & Singh, 2021). Bonita & Beaglehole (2014) juxtapose the poorly recognized gendered impact of NCDs, to the focus on SRHR: "there is a strong and persistent view that only health-related issues of importance to women are defined through their reproductive capacity, yet two thirds of all deaths and disabilities in women relate to chronic diseases, violence, and other injuries. This myth, reflects, in part, a gender bias" (p. 1). We find that the UN documents we reviewed perpetuate this gender bias. SRHR has historically and continues to dominate discussion of gender and health in UN documents, which can potentially obscure consideration of other health issues that may be mediated by gender.

Another key point of discussion in the literature on gender, health, and development is intersectionality. In our analysis, we noted the need to incorporate an intersectionality approach to further expand conceptions of health and well-being in policy documents. This implies moving beyond singular characteristics assigned to one identity (i.e. motherhood), and expanding understanding about how multiple identities can coalesce to shape the health experience. In our review, we found that intersecting aspects of one's life and identity, such as race, disability, or class, were seldom explored. We noted, for example, that the first and only UN report to explore disability within the context of the SDGs, including its intersection with gender, was published in 2018.

Several scholars in the field have reflected on the consequences of privileging gender over other identities that can significantly impact ones' life, which can include incomplete understandings of how health is formed and shaped (Jacobs & George, 2023; Mariano & Molari, 2022; Hankivsky et al., 2010). If equitable health for all is the ultimate pursuit of sustainable development, conceptions of gender and health must integrate consideration for intersecting identities and their potential impacts on wellbeing. Scholars have noted that intersectionality has become an integral aspect of gender transformation: a paradigm and practice that aims to alter gender dynamics through challenging norms, redistributing resources and expectations, and focusing on the socially constructed impacts of gender (MacArthur et al., 2022).

5.4 Gender transformation in policy over time

A brief analysis of the history of gender and development as an approach is useful for understanding how policy and its relevant framing responds to social, economic, and political forces over time. Attempts to integrate women as a population that provides valuable perspective and utility into development agendas began around 1975 at the beginning of the UN Decade for Women (Beck, 2016). In this period, an approach referred to as Women in Development (WID) emerged. WID emphasized the microlevel benefits of women's individual contributions to labour and development, particularly that of economic development - the role of women as agents in these processes had been historically overlooked and there had been a near-exclusive focus on men's productivity (Beck, 2017; Kanji, 2003). A movement challenging WID was spearheaded by scholars and activists primarily from low-and-middle-income countries, who sought to highlight the ways women are impacted by structures beyond the economy (Beck, 2017). WID was thus criticized for its inability to address root causes of inequity and its inadequacy at improving material conditions, even when women's involvement in economic life and labour was encouraged (Beck, 2017; Mariano and Molari, 2022). This spurred a transition to Gender and Development (GAD), facilitated by social movements driven by civil society as well as development agencies such as the UN (Beck, 2017). GAD aimed to mainstream consideration for gender in policy analysis and to interrogate the dynamics between men, women, and social structures (Beck, 2017). GAD emerged alongside the objectives laid out in the 1995 Beijing Declaration and Platform for Action, a landmark declaration for the UN and its commitment to advancing the status of women, mirroring developments in gender theory at the time (MacArthur et al., 2017; Cornwall and Rivas, 2015).

The GAD approach of the present day, and thus associated with both the MDGs and SDGs, has been criticized for diluting the radical ideas that initially informed the approach, such as challenging resource and power distribution and addressing underlying structures of inequity (Odera et al., 2020; Hillenbrand et al., 2015). Some have found the technical goals of sustainable development to be reductionist in nature because they tend to simplify the complex realities of gender inequality in service of establishing technical goals. Overlooking the fundamental changes necessary to reshape gender roles and expectations can further consolidate patterns of poor health (Jaquette, 2017; Kabeer, 2005). An example of this risk is apparent in Target 5.A of

the SDGs which aims to: "Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws" (UN High Commissioner for Human Rights, 2015). Jaquette (2017) makes the point that this characterization falls short of concretely "improving the actual conditions under which women participate in the labour market" and that their participation in projects seeking to improve the economic status of women must be integrated from their inception, citing Rai's (2003) idea of gender democratization (p. 252).

The MDGs received criticism for its insufficient coverage of gender targets and oversimplified view of gender equality (Kabeer, 2005; Fehling et al. 2013; Odera & Melusa, 2019). MDG 3 on gender equality and the empowerment of women was particularly criticized for conflating decreasing gender disparities in areas like education with ending gender inequality, leaving substantive power asymmetries noticeably unaddressed (Kabeer, 2005; Subrahmanian, 2005). Our analysis of the SDG documents suggests that some of these shortcomings still exist. There seems to be certain omissions in the interrogation of the structural features of inequities. Instead, we noted a tendency towards focusing on what can be reasonably done to improve the metrics of development (i.e. girls' enrolment in school) within the boundaries of what is understood to be unavoidable inequity (i.e. patriarchal expectations of women that persist despite education). Some of the criticisms of the MDGs helped formulate the SDGs (Mariano and Molari, 2022). The 17 goals and 169 targets of the SDGs signified a broader and more interconnected development agenda that sought to address the complex structures of inequity, including those associated with gender. Examples of these advances include a broad commitment to *achieve* gender equality in Goal 5, changing terminology from *promoting* equality in Goal 3, and an increased focus on issues of gender-based discrimination in the form of nine targets concerning gender-based violence, unpaid work, and SRHR. However, despite the advances made by the SDGs in integrating consideration for gender throughout the domains of the SDGs, scholars have criticized the SDGs for a narrow concept of gender that positions women in limited and attributed roles, such as caregivers and victims – obscuring a call for action against power relations and structures of inequity that shape women's health, echoing critiques similar to that of the MDGs (2018, p.650). Our results find support for these criticisms,

finding that gender inequality is often positioned within the documents as inevitable, and that there is a profound lack of action linking gender transformative ideas and their proposed actions.

In this discussion, we have sought to contextualize key themes emerging from analysis of women's health as depicted in MDG and SDG related UN documents, by drawing on related literature and connecting concepts. We noted a cross-cutting tendency to instrumentalize women as agents of development, and identified the need and opportunity for UN agencies to continue the necessary work of recognizing the unique capabilities of women in uplifting those around them, but also in advocating for these gains to be meaningfully and materially reciprocated to truly advance gender equity. We also found, through engaging with various perspectives in the field of gender and development, potential consequences of current modes of problem representation and framing in UN documents. These consequences range from lost opportunities to mobilize greater resources towards expanded concepts of gender and health beyond SRHR to entrenching harmful stereotypes about women and girls. Emerging understandings of the role of framing and problem representation have provided an opportunity to engage with the information disseminated by institutions like the UN and its agencies and identify areas of improvement across analyses, theories, policies, and in implementation.

6. Limitations

This study used publicly available documents published by United Nations agencies to identify which issues of health were associated with women and girls, how these problems were framed, and contextualized within official documents. However, these documents do not provide an entirely comprehensive view of the underlying processes and dynamics of power and institutions that lead to the types of framing presented in the documents we reviewed (Townshend, 2007). This study does not incorporate detailed consideration or consultation with feminist theories that have shaped many of the criticisms and calls to action observed through our engagement with the relevant literature in this field (Antrobus, 1995). The addition of these theories could potentially add an analysis of power and promote research that follows calls for action towards a gender transformative framework. In treating gender as a binary, the experiences of gender diverse people and members of the LGBTQIA2S+ community have been

obscured from the consideration of this paper, despite their significance as a determinant of health.

7. Conclusion

The findings of this document review highlight the implications of problem framing and representation in global development agendas on advancing the health and status of women and girls. The SDGs' goals to achieve gender equality and to promote health and well-being for all must involve critical engagement with problem framing and representation and the inclusion of perspectives from the populations they aim to support. The UN's ambitious goals have made strides in advancing gender equality among its member states and many have devoted their time, resources, and knowledge to improving the status of women. This dedication to gender equality has invigorated rich discourse that aims to continually develop the understanding of gender and health in development spheres. In exploring the consequences of certain types of framing in UN documents on gender and health, we have identified areas of concern such as the instrumentalization of women as tools for development and opportunities for improvement in expanding conceptions of women's and girls' health and reaffirming a commitment to transforming the structures of gender inequality. It is crucial for actors involved in development policy, from creation to implementation, to critically examine the profound effects that framing and representation can carry for key priority populations such as women and girls.

References

Archibald, T. (2020). What's the Problem Represented to Be? Problem Definition Critique as a Tool for Evaluative Thinking. American Journal of Evaluation, 41(1), 6–19. https://doi.org/10.1177/1098214018824043

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. International Journal of Social Research Methodology, 8(1), 19–32. https://doi.org/10.1080/1364557032000119616

Antrobus, P. (1995). United Nations' Conferences: A Framework for Feminist Research and Action. *Caribbean Studies*, *28*(1), 21–29.

Bacchi, C. (2009). *Analysing Policy*. Pearson Higher Education AU.

Bacchi, C., & Rönnblom, M. (2014). Feminist Discursive Institutionalism—A Poststructural Alternative. NORA - Nordic Journal of Feminist and Gender Research, 22(3), 170–186. https://doi.org/10.1080/08038740.2013.864701

Barragués Fernández, A. (2020). Accountability for sexual and reproductive health and rights in development practice: Building synergies. Sexual and Reproductive Health Matters, 28(1), 1848399. https://doi.org/10.1080/26410397.2020.1848399

Beck, E. (2017). What a Feminist Curiosity Contributes to the Study of Development. *Studies in Comparative International Development*, *52*(2), 139–154. https://doi.org/10.1007/s12116-017-9243-0

Berik, G., Rodgers, Y. (2008) *Engendering Development Strategies and Macroeconomic Policies | 1 | Wh*. (n.d.). Retrieved January 14, 2024, from https://www.taylorfrancis.com/chapters/edit/10.4324/9780203892602-1/engendering-development-strategies-macroeconomic-policies-g%C3%BCnseli-berik-yana-van-der-meulen-rodgers?context=ubx&refId=095be120-4417-4f8a-bb89-3a67337f20b1

Bigg, T. (2016). *Reconceiving the SDGs as a political force for change*. International Institute for Environment and Development. https://www.jstor.org/stable/resrep16687

Bonita, R., & Beaglehole, R. (2014). Women and NCDs: Overcoming the neglect. *Global Health Action*, *7*, 10.3402/gha.v7.23742. https://doi.org/10.3402/gha.v7.23742

Braunstein, E. and M. Houston. 2015. “Pathways towards Sustainability in the Context of Globalization: A Gendered Perspective on Growth, Macro Policy and Employment”.

Bustreo, F., Knaul, F. M., Bhadelia, A., Beard, J., & Araujo de Carvalho, I. (2012). Women’s health beyond reproduction: Meeting the challenges. *Bulletin of the World Health Organization*, *90*(7), 478-478A. https://doi.org/10.2471/BLT.12.103549

Carstensen, M. B., & Schmidt, V. A. (2016). Power through, over and in ideas: Conceptualizing ideational power in discursive institutionalism. Journal of European Public Policy, 23(3), 318–337. https://doi.org/10.1080/13501763.2015.1115534

Chant, S. (2012). The disappearing of ‘smart economics’? The World Development Report 2012 on Gender Equality: Some concerns about the preparatory process and the prospects for paradigm change. *Global Social Policy*, *12*(2), 198–218. https://doi.org/10.1177/1468018112443674

Chant, S., & Sweetman, C. (2012). Fixing women or fixing the world? ‘Smart economics’, efficiency approaches, and gender equality in development. *Gender & Development*, *20*(3), 517–529. https://doi.org/10.1080/13552074.2012.731812

CSDH. 2008. *Closing the gap in a generation: Health equity through action on the social determinants of health—Final report of the commission on social determinants of health*. https://www.who.int/publications-detail-redirect/WHO-IER-CSDH-08.1

Cornwall, A., & Anyidoho, N. A. (2010). Introduction: Women’s Empowerment: Contentions and contestations. *Development*, *53*(2), 144–149.

Cornwall, A., & Rivas, A.-M. (2015). From ‘gender equality and ‘women’s empowerment’ to global justice: Reclaiming a transformative agenda for gender and development. *Third World Quarterly*, *36*(2), 396–415. https://doi.org/10.1080/01436597.2015.1013341

Davidson, P. M., Mcgrath, S. J., Meleis, A. I., Stern, P., Digiacomo, M., Dharmendra, T., Correa-De-Araujo, R., Campbell, J. C., Hochleitner, M., Messias, D. K. H., Brown, H., Teitelman, A., Sindhu, S., Reesman, K., Richter, S., Sommers, M. S., Schaeffer, D., Stringer, M., Sampselle, C., … Covan, E. K. (2011). The Health of Women and Girls Determines the Health and Well-Being of Our Modern World: A White Paper From the International Council on Women’s Health

Issues. Health Care for Women International, 32(10), 870–886. https://doi.org/10.1080/07399332.2011.603872

Davies, S. E., & Bennett, B. (2016). A gendered human rights analysis of Ebola and Zika: Locating gender in global health emergencies. International Affairs, 92(5), 1041–1060. https://doi.org/10.1111/1468-2346.12704

DESA. (2006). *Achieving gender equality, women's empowerment and strengthening development cooperation: Dialogues at the Economic and Social Council /: ECOSOC, Office of Support and Coordination*. UN,. https://digitallibrary.un.org/record/3799635

DESA. (2015). *Transforming our World: The 2030 Agenda for Sustainable Development | Department of Economic and Social Affairs*. https://sdgs.un.org/publications/transforming-our-world-2030-agenda-sustainable-development-17981

DESA. (2023). *Leaving no one behind in an ageing World: World Social Report.: 2023 /: UN, DESA*. UN,. https://digitallibrary.un.org/record/4000104

Dobrowolsky, A. (2007). (In)Security and Citizenship: Security, Im/migration and Shrinking Citizenship Regimes. *Theoretical Inquiries in Law*, *8*(2), 629–662. https://doi.org/10.2202/1565-3404.1163

ESCAP, U. (2017). *Gender, the environment and sustainable development in Asia and the Pacific.: 2017*. UN, ESCAP,. https://digitallibrary.un.org/record/1319142

Esquivel, V. (2016). Power and the Sustainable Development Goals: A feminist analysis. *Gender & Development*, *24*(1), 9–23. https://doi.org/10.1080/13552074.2016.1147872

Fehling, M., Nelson, B. D., & Venkatapuram, S. (2013). Limitations of the Millennium Development Goals: A literature review. *Global Public Health*, *8*(10), 1109–1122. https://doi.org/10.1080/17441692.2013.845676

Leach, M., Mehta, L., Prabhakaran, P. (2016*). Discussion Paper Gender Equality and Sustainable Development: A Pathways Approach .https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2016/DPS-Gender-equality-sustainable-development.pdf*

FAO. (2013). *Food systems for better nutrition*. FAO.

Filho, W., Kovaleva, M., Tsani, S., Țîrcă, D.-M., Shiel, C., Dinis, M. A. P., Nicolau, M., Sima, M., Fritzen, B., Lange Salvia, A., Minhas, A., Kozlova, V., Doni, F., Spiteri, J., Gupta, T., Wakunuma, K., Sharma, M., Barbir, J., Shulla, K., … Tripathi, S. (2022). Promoting gender equality across the sustainable development goals. *Environment, Development and Sustainability*, 1–22. https://doi.org/10.1007/s10668-022-02656-1

Goetz, A. M. (2006). Institutionalising Women's Interests and Accountability to Women in Development (Introduction). *IDS Bulletin*, *37*(4), 71–81. https://doi.org/10.1111/j.1759-5436.2006.tb00289.x

Goetz, A. M., & Jenkins, R. (2016). Agency and Accountability: Promoting Women's Participation in Peacebuilding. *Feminist Economics*, *22*(1), 211–236. https://doi.org/10.1080/13545701.2015.1086012

González de la Rocha, M. (2007). The Construction of the Myth of Survival. *Development and Change*, *38*, 45–66. https://doi.org/10.1111/j.1467-7660.2007.00402.x

Gupta, J., & Vegelin, C. (2016). Sustainable development goals and inclusive development. *International Environmental Agreements: Politics, Law and Economics*, *16*(3), 433–448. https://doi.org/10.1007/s10784-016-9323-z

Hallam, L., Vassallo, A., Pinho-Gomes, A.-C., Carcel, C., & Woodward, M. (2022). Does Journal Content in the Field of Women's Health Represent Women's Burden of Disease? A Review of Publications in 2010 and 2020. *Journal of Women's Health*, *31*(5), 611–619. https://doi.org/10.1089/jwh.2021.0425

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health*, *9*(1), 5. https://doi.org/10.1186/1475-9276-9-5

Hesketh, T., Lu, L., & Xing, Z. W. (2011). The consequences of son preference and sex-selective abortion in China and other Asian countries. *CMAJ : Canadian Medical Association Journal*, *183*(12), 1374–1377. https://doi.org/10.1503/cmaj.101368

Hillenbrand, E., Karim, N., Mohanraj, P., Wu, D. (2015). *Measuring gender-transformative change: A review of literature and promising practices*. (n.d.). Retrieved January 8, 2024, from https://digitalarchive.worldfishcenter.org/handle/20.500.12348/248

Hodgkin, R., Newell, P., & UNICEF. (2002). *Implementation handbook for the Convention on the Rights of the Child /: Prepared for UNICEF by Rachel Hodgkin and Peter Newell*. UNICEF,. https://digitallibrary.un.org/record/488256

Jacobs, T., & George, A. S. (2023). How gender is socially constructed in policy making processes: A case study of the Adolescent and Youth Health Policy in South Africa. *International Journal for Equity in Health*, *22*(1), 36. https://doi.org/10.1186/s12939-022-01819-w

Jaquette, J. S. (2017). Women/Gender and Development: The Growing Gap Between Theory and Practice. *Studies in Comparative International Development*, *52*(2), 242–260. https://doi.org/10.1007/s12116-017-9248-8

Jeffrey, P., Jeffrey, R. (1998). SILVER BULLET OR PASSING FANCY?: Girls' schooling and population policy In *Feminist Visions of Development*. Routledge.

Joachim, J. (2003). Framing Issues and Seizing Opportunities: The UN, NGOs, and Women's Rights. *International Studies Quarterly*, *47*(2), 247–274.

Joint UN Programme on HIV/AIDS, H. G. C. (2006). *Keeping the promise: An agenda for action on women and AIDS*. https://digitallibrary.un.org/record/618794

Joint UN Programme on HIV/AIDS. (2012). *Women out loud: How women living with HIV will help the world end AIDS*. Joint United Nations Programme on HIV/AIDS (UNAIDS), https://digitallibrary.un.org/record/3951246

Joint UN-Programme on HIV/AIDS. (2017). *When women lead, change happens :* (n.d.). Retrieved March 4, 2024, from https://digitallibrary.un.org/record/3946214?ln=en

Kabeer N. (1994). *Reversed realities : gender hierarchies in development thought*. Verso.

Kabeer, N. (2005). Gender Equality and Women's Empowerment: A Critical Analysis of the Third Millennium Development Goal. *Gender and Development*, *13*(1), 13–24.

Kabeer, N., & Subrahmanian, R. (1996). *Institutions, relations and outcomes: Framework and tools for gender-aware planning*. IDS.

Kanji, N. (2003). *From Women in Development (WID) to Gender and Development (GAD)* (Mind the Gap, pp. 3–10). International Institute for Environment and Development. https://www.jstor.org/stable/resrep18134.5

Khosla, R., Banerjee, J., Chou, D., Say, L., & Fried, S. T. (2017). Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards. *Reproductive Health*, *14*(1), 59. https://doi.org/10.1186/s12978-017-0322-5

Kickbusch, I. (2015). The political determinants of health—10 years on. *BMJ (Clinical Research Ed.)*, *350*, h81. https://doi.org/10.1136/bmj.h81

Koon, A. D., Hawkins, B., & Mayhew, S. H. (2016). Framing and the health policy process: A scoping review. *Health Policy and Planning*, *31*(6), 801–816. https://doi.org/10.1093/heapol/czv128

Langford, M. (2013). A Poverty of Rights: Six Ways to Fix the MDGs. In *Health and Human Rights in a Changing World* (3rd ed.). Routledge.

MacArthur, J., Carrard, N., Davila, F., Grant, M., Megaw, T., Willetts, J., & Winterford, K. (2022). Gender-transformative approaches in international development: A brief history and five uniting principles. *Women's Studies International Forum*, *95*, 102635. https://doi.org/10.1016/j.wsif.2022.102635

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, *96*(9), 644–653. https://doi.org/10.2471/BLT.18.211607

Mariano, S., & Molari, B. (2022). Gender equality from the MDGs to the SDGs: A feminist analysis. *Revista de Administração Pública*, *56*(6), 823–842. https://doi.org/10.1590/0034-761220220124x

Mauvais-Jarvis, F., Bairey Merz, N., Barnes, P. J., Brinton, R. D., Carrero, J.-J., DeMeo, D. L., De Vries, G. J., Epperson, C. N., Govindan, R., Klein, S. L., Lonardo, A., Maki, P. M., McCullough, L. D., Regitz-Zagrosek, V., Regensteiner, J. G., Rubin, J. B., Sandberg, K., & Suzuki, A. (2020).

Sex and gender: Modifiers of health, disease, and medicine. *Lancet (London, England)*, *396*(10250), 565–582. https://doi.org/10.1016/S0140-6736(20)31561-0

Meier, P. (2006). Implementing Gender Equality: Gender Mainstreaming or the Gap between Theory and Practice. In S. K. Hellsten, A. M. Holli, & K. Daskalova (Eds.), *Women's Citizenship and Political Rights* (pp. 179–198). Palgrave Macmillan UK. https://doi.org/10.1057/9780230502901_10

Mohindra, K. S., & Nikiéma, B. (2010). Women's health in developing countries: Beyond an investment? *International Journal of Health Services: Planning, Administration, Evaluation*, *40*(3), 543–567. https://doi.org/10.2190/HS.40.3.i

Mol, A. (1999). Ontological Politics. A Word and Some Questions. The Sociological Review, 47(1_suppl), 74-89. https://doi.org/10.1111/j.1467-954X.1999.tb03483.x

Moser, C. (2020). *From gender planning to gender transformation: Positionality, theory and practice in cities of the global South | International Development Planning Review*. (n.d.). Retrieved December 20, 2023, from https://www.liverpooluniversitypress.co.uk/doi/10.3828/idpr.2020.9

Mucciaroni, G. (2011). Are Debates about "Morality Policy" Really about Morality? Framing Opposition to Gay and Lesbian Rights. *Policy Studies Journal*, *39*(2), 187–216. https://doi.org/10.1111/j.1541-0072.2011.00404.x

Odera, J. A., & Mulusa, J. (2020). SDGs, Gender Equality and Women's Empowerment: What Prospects for Delivery? In M. Kaltenborn, M. Krajewski, & H. Kuhn (Eds.), *Sustainable Development Goals and Human Rights* (pp. 95–118). Springer International Publishing. https://doi.org/10.1007/978-3-030-30469-0_6

OHCHR (2008). *Human Rights, Health and Poverty Reduction Strategies*. (n.d.). Retrieved March 4, 2024, from https://www.ohchr.org/en/publications/policy-and-methodological-publications/human-rights-health-and-poverty-reduction

Pederson, A., Greaves, L., & Poole, N. (2015). Gender-transformative health promotion for women: A framework for action. Health Promotion International, 30(1), 140–150. https://doi.org/10.1093/heapro/dau083

Peters, S. A. E., Woodward, M., Jha, V., Kennedy, S., & Norton, R. (2016). Women's health: A new global agenda. *BMJ Global Health*, *1*(3), e000080. https://doi.org/10.1136/bmjgh-2016-000080

Rodgers, G. B., Yana van der Meulen. (2008). Engendering Development Strategies and Macroeconomic Policies: What's Sound and Sensible? In *Social Justice and Gender Equality*. Routledge.

Sachs, J., Earthscan, & UNDP. (2005). *Investing in development: A practical plan to achieve the Millennium Development Goals /: Jeffrey D. Sachs, director*. Earthscan,. https://digitallibrary.un.org/record/564468

Sand, J., & Widegren, K. (2019). *Gender and Sustainability: An International Research Review*.

Schmidt, V. A. (2008). Discursive Institutionalism: The Explanatory Power of Ideas and Discourse. *Annual Review of Political Science*, *11*(Volume 11, 2008), 303–326. https://doi.org/10.1146/annurev.polisci.11.060606.135342

Schmidt, V. A. (2010). Taking ideas and discourse seriously: Explaining change through discursive institutionalism as the fourth 'new institutionalism.' *European Political Science Review*, *2*(1), 1–25. https://doi.org/10.1017/S175577390999021X

Secretary-General, U. (2005). *Enhanced participation of women in development: An enabling environment for achieving gender equality and the advancement of women, taking into account, inter alia, the fields of education, health and work : report of the Secretary-General*. https://digitallibrary.un.org/record/566220

Secretary-General, U. (2007). *Ending female genital mutilation: Report of the Secretary-General*. https://digitallibrary.un.org/record/614657

Secretary-General, U. (2011). *Ending female genital mutilation: Report of the Secretary-General*. https://digitallibrary.un.org/record/719163

Simon-Kumar, R., MacBride-Stewart, S., Baker, S., & Saxena, L. P. (2018). Towards North-South Interconnectedness: A Critique of Gender Dualities in Sustainable Development, the Environment and Women's Health. *Gender, Work & Organization*, *25*(3), 246–263. https://doi.org/10.1111/gwao.12193

Singh Thakur, J., Nangia, R., & Singh, S. (2021). Progress and challenges in achieving noncommunicable diseases targets for the sustainable development goals. *FASEB BioAdvances*, *3*(8), 563–568. https://doi.org/10.1096/fba.2020-00117

Subrahmanian, R. (2005). Gender equality in education: Definitions and measurements. *International Journal of Educational Development*, *25*(4), 395–407. https://doi.org/10.1016/j.ijedudev.2005.04.003

World Bank. (2012). *The disappearing of 'smart economics'? The World Development Report 2012 on Gender Equality: Some concerns about the preparatory process and the prospects for paradigm change—Sylvia Chant, 2012*. (n.d.). Retrieved January 9, 2024, from https://journals.sagepub.com/doi/10.1177/1468018112443674

Townshend, J. (2007). Power, A Radical View. *Contemporary Political Theory*, *6*(3), 372–374. https://doi.org/10.1057/palgrave.cpt.9300291

UNDP (2003). Human Development Report 2003. In *Human Development Reports*. United Nations. https://hdr.undp.org/content/human-development-report-2003

UNECE. (2021). *Guidance for Measuring Intra-household Power and Decision-making*. United Nations. https://doi.org/10.18356/9789210055451

UNFPA. (2005). *State of world population.: 2005*. UNFPA,. https://digitallibrary.un.org/record/564853

UNFPA. (2016) *State of World Population 2016*. (n.d.). Retrieved March 4, 2024, from https://www.unfpa.org/publications/state-world-population-2016

UNFPA. (2018) *State of World Population 2018 | United Nations iLibrary*. (n.d.). Retrieved March 4, 2024, from https://www.un-ilibrary.org/content/books/9789210474108

UNFPA. (2020). *State of world population.: 2020,: Against my will : defying the practices that harm women and girls and undermine equality*. UNFPA,. https://digitallibrary.un.org/record/3928823

UN High Commissioner for Human Rights (2015). *Realization of the right to work: Report of the United Nations High Commissioner for Human Rights*. https://digitallibrary.un.org/record/820853

UNICEF (2023). *Female Genital Mutilation (FGM) Statistics*. (n.d.). UNICEF DATA. Retrieved January 18, 2024, from https://data.unicef.org/topic/child-protection/female-genital-mutilation/

United Nations. (2000). *United Nations: Millennium declaration*. (n.d.). United Nations. Retrieved March 4, 2024, from https://www.un.org/en/development/devagenda/millennium.shtml

United Nations. (2002). *Gender mainstreaming: An overview—UNESCO Digital Library*. https://unesdoc.unesco.org/ark:/48223/pf0000132947

Unterhalter, E. (2023). An answer to everything? Four framings of girls' schooling and gender equality in education. *Comparative Education*, *59*(2), 145–168. https://doi.org/10.1080/03050068.2023.2202374

UN Office on Drugs and Crime (2004). *Substance abuse treatment and care for women: Case studies and lessons learned*. UN,. https://digitallibrary.un.org/record/618074

UN-Women. (2014). *World survey on the role of women in development: Gender equality and sustainable development*. UN,. https://digitallibrary.un.org/record/3926998

United Nations Statistics Division, U. S. (2010). *The world's women 2010: Trends and statistics*. UN,. https://digitallibrary.un.org/record/691826

WFP (2022). *Global Report on Food Crises—2022 | World Food Programme*. (2022, May 4). https://www.wfp.org/publications/global-report-food-crises-2022

Whitehead, A. (1984). 'I'm hungry, mum': The Politics of Domestic Budgeting. In *Of Marriage and the Market*. Routledge.

WHO (2008). Commission on Social Determinants of Health. (Closing the gap in a generation: Health equity through action on the social determinants of health : final report of the commission on social determinants of health. *Combler Le Fossé En Une Génération : Instaurer l'équité En Santé En Agissant Sur Les Déterminants Sociaux de La Santé : Rapport Final de La Commission Des Déterminants Sociaux de La Santé*, 247.

WHO, Joint United Nations Programme on HIV/AIDS, UNFPA, UNICEF, UN-Women, & World Bank (2018). *Survive, Thrive, Transform: Global Strategy for Women's, Children's and*

Adolescents' Health (2016–2030) — 2018 monitoring report: current status and strategic priorities. https://digitallibrary.un.org/record/3945602

WHO. (2016). *World health statistics 2016: Monitoring health for the SDGs*. WHO,.https://digitallibrary.un.org/record/3868811

Veas, C., Crispi, F., & Cuadrado, C. (2021). Association between gender inequality and population-level health outcomes: Panel data analysis of organization for Economic Co-operation and Development (OECD) countries. EClinicalMedicine, 39, 101051. https://doi.org/10.1016/j.eclinm.2021.101051

CHAPTER 3: "WE HAVE TO LOOK DEEPER INTO WHY": PERSPECTIVES ON PROBLEM IDENTIFICATION AND PRIORITIZATION OF WOMEN'S AND GIRLS' HEALTH ACROSS UNITED NATIONS AGENCIES

Chapter 3 of this thesis presents a qualitative interview study investigating the process of problem identification and priority-setting pertaining to women's and girls' health within the SDGs. Interviews were conducted with key informants involved with UN agencies. The analysis in Chapter 2 highlights that UN documents often frame promoting women's health as being beneficial to their communities, leading to their instrumentalization, position women as inherently vulnerable yet responsible for their well-being, and demonstrate a lack of interrogation into why structural inequality continues to persist. The interviews drew from these findings and sought to explore the process and interactions involved in engaging with the SDGs within and across UN agencies. Research into problem framing and representation is crucial to advance understanding of the ways that inequity is structured and how equity is sought within the UN system. This work also serves to identify areas of improvement across each step of the policy process, including critical examination of theoretical or conceptual underpinnings that inform the process. Chapter 3 builds on the understanding and evidence described in Chapter 2 regarding the role of problem framing in policy-guiding documents, continuing to draw from the analytic framework of Carol Bacchi's "What's the Problem Represented to Be?" framework. Chapter 3 expands on the findings of Chapter 2 by highlighting the foundational role of problem framing in the policy process and contextualizing the results of our analysis of UN documents by drawing from the perspectives UN employees, with particular attention towards the impact of framing on problem prioritization in sustainable development. The findings from Chapter 3 thus provide insight into the role of political forces in influencing policy, the challenges of resource constraints, the roles and tensions associated with expectations of certain types of scientific evidence and data, and the purpose of differentiated mandates across the UN agencies. Together, the findings from both chapters highlight the ways that women and girls continue to be stereotyped and/or instrumentalized in development policy and how the deep-rooted conditions that shape inequalities demand a greater integration of critical and gendered analysis throughout the policy-making process. The project of advancing women's and girls' health has historically

been developed, and continues to develop, from the work of advocates that push for the dismantling of structural inequalities and powerful collective action.

"We have to look deeper into why": Perspectives on problem identification and prioritization of women's and girls' health across United Nations agencies

Alua Kulenova[1*], Alayne Adams[1], Kathleen Rice[1], Raphael Lencucha[2]

[1]Department of Family Medicine, Faculty of Medicine and Health Sciences, McGill University, 5858 Ch. de la Côte-des-Neiges, Montreal, QC H3S 1Z1, Canada.

[2]School of Physical and Occupational Therapy, Faculty of Medicine and Health Sciences, McGill University, 3630 Promenade Sir William Osler, Montreal, QC H3G 1Y5, Canada.

*Corresponding Author: alua.kulenova@mail.mcgill.ca

Submitted to Globalization and Health

Statements and Declarations

This research has received funding from the Canadian Institutes of Health Research

Authors declare no competing interests

Abstract

Eliminating gender inequality and promoting population health are stand-alone goals in the Sustainable Development Goals (SDGs). Our research examines the process of problem and solution representation, priority setting, and factors that shape the policymaking process concerning women and girls within the UN system in relation to the SDGs. Data for this study were collected from semi-structured one-on-one interviews with participants who have work experience within the United Nations (UN) (n = 9). The analysis was informed by a qualitative descriptive methodology and Bacchi's "What's the problem represented to be?" framework. Our findings identify the role of political forces in influencing policy, the challenges of limited and tied financial resources, the role of scientific evidence and data, and the purpose of differentiated mandates across agencies. It is crucial to understand the processes that take place in establishing policies aimed at promoting gender and health equality given the entrenched and structural natures of these inequalities. Strengthening understanding of the influence of political forces can reinvigorate a commitment to promoting norms of gender equality and dedicate more resources towards discerning effective and ethical methods of doing so. It is also important for stakeholders interested in developing policies related to gender and health to better understand the role of finite financial resources through the perspectives of UN employees across the system, member states, and local organizations to spur innovation and efficiency. Identification of the types of knowledge, evidence, and data that drive and are given preference in policy creation and development can highlight shortcomings and strengths of current modes of policy development and implementation. Key stakeholders and future research in health and development policy spheres may draw from our findings to gain insight into problem representation and prioritization. This will help identify underlying assumptions that may have profound implications for women's and girls' health, such as those concerning their role in society. These assumptions may lead to inadequate attention towards structural and societal drivers of inequality as well as certain key topics that impact women and girls – for example, non-communicable disease risks as they are mediated by gender.

1. Introduction

Stark inequalities across social, political, and economic structures continue to affect women and girls worldwide. Due to the role of gender as a key social determinant of health,

women and girls have unique health needs (Miani et al., 2021). Gender as a social construct interacts with other social and physiological determinants (such as sex) to create patterns of inequity that can shape health outcomes across the life course. These interactional processes are found at the micro level in interpersonal contexts and range all the way to the macro level of wider society and institutional structures such as the state and the economy (Manandhar et al., 2018). Despite considerable progress in improving the status of women and girls worldwide, gender inequality continues to be globally pervasive and carries consequences that are connected to, and extend beyond, health – such as limited access to social and economic opportunities and education (Belingheri et al., 2021). Eliminating gender inequality and improving population health is a global task, given the interconnected nature of the social determinants of health (Braveman & Gottleib, 2014; Davies et al., 2019). For example, cultural norms and practices related to the status and role of women and girls vary worldwide and may conflict with the UN's norms and frameworks. Furthermore, the far-reaching impacts of inequality across the life course, for example access to education from a young age determining future economic independence and access to healthcare, can complicate the methods and resources that policymakers utilize to address these inequalities.

Promoting gender equality across the relevant social determinants of health has been identified as essential to realizing 'better health for all' (Kuhlmann & Annandale, 2015). Professionals, researchers, and policymakers spanning health and development spheres have recognized the profound and far-reaching impacts of gender-based inequities on population health worldwide (Östlin et al., 2006). For example, non-communicable diseases (NCD) are the leading cause of death worldwide – gender and sex are both highly mediating variables in NCD outcomes and a startling example of inequity across dimensions of research, diagnosis, and chronic disease management (Woodward, 2019; Carcel et al., 2024). In striving to improve the status of priority populations around the world while recognizing the complex and interconnected nature of health and well-being, the United Nations have created two sets of goals since the turn of the century: the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs). The SDGs succeeded the MDGs in 2016, significantly expanding on the goals, targets, and indicators of its predecessor (de Jong & Vijge, 2021). In current development discourse, the SDGs garner significant attention due to their ambitious agenda of realizing all 17 Goals by 2030. The SDGs' comprehensive approach to recognizing the

interconnectedness of the complex issues facing sustainable development has cemented its place as the framework for the future of development (Sianes et al., 2022). To this end, the SDGs provide a particularly rich source of guidance for improving the status of women and girls worldwide.

Achieving gender equality and improving the outcomes of health issues mediated by gender is a well-established policy concern for the United Nations (UN) and organizations across the world. The entrenched nature of gender inequality across structures that shape policy may inadvertently reify inequity in policy development and implementation. Gender inequality and its accompanying biases are highly pervasive and, at times, unconscious – biases may be integrated at each step of the policy process, beginning with problem conceptualization and framing all the way into its implementation (Kulenova et al., under review). For these reasons it is crucial to understand how agencies working in these arenas approach the conceptualization and framing of problems related to women's and girls' health and the subsequent prioritizations of these problems. This is especially crucial when these agencies are setting and implementing goals and policy that are meant to shape country policy globally as the SDGs aim to do. Prioritization may be shaped by resource constraints and population needs, or other social, historical, or political factors (Terwindt et al., 2016). Priority-setting processes in public health are complex – furthermore, in a global development context, the relevant considerations to make well-informed policy decisions can vary widely based on the region and population (Bloom et al., 2018). Similarly, the considerations that must be balanced in striving to achieve the SDGs may vary between UN agencies and the regions that they serve. Identifying the processes and factors that shape problem framing and prioritization can serve to inform discussions of which problems are being left out, why and with what implications for women and girls' health. This is an important knowledge gap that health policy research can fill.

The impetus for this study revolves around the understanding that health is situated in social and political realities. It is important to critically analyze the framing that informs the perspectives of those who aim to improve the conditions of populations worldwide (CSDH, 2008; Kickbusch, 2015). In Carol Bacchi's words, "problematizations thus become part of how we are governed. That is, governing takes place through the ways in which "problems" are constituted in policies. Put in other words, we are governed through problematizations, rather

than through policies, signaling the importance of critically interrogating problem representations." (2016, p. 9). Thus, we sought to investigate the perspectives and experiences of those who work within the UN system and are involved in achieving the SDGs. We hope to advance practical implementation efforts for the SDGs within health policy by offering a critical analysis of problem and solution representation, priority setting, and factors that exercise influence on the policy-making process.

This study is informed by the following question: "How are problems identified and associated with women's and girls' health conceptualized across UN agencies?" The goal of this research question is to gain insight into how certain problems are identified and given priority, what processes inform and supports the choice of these problems over others, and how causes and contributing factors are conceptualized. This question was also motivated by the goal of understanding to what extent these conceptualizations and priorities are aligned across UN agencies and to better understand the nature of inter-agency work in striving to achieve the highly interconnected SDGs related to improving the health of women and girls.

2. Methods

We utilized Bachi's "What's the problem represented to be?" or WPR framework to inform the data collection and analysis approach used in the study. Additionally, we drew from the qualitative descriptive (QD) methodology for its flexibility in adapting a conceptual framework, which 'allows researchers to place their study findings within a larger context' to develop knowledge on the topic (Sullivan-Bolyai & Bova, 2021; Anfara & Mertz, 2006; Miles et al., 2014). QD emphasizes low-inference presentation of qualitative findings, attending to the perspectives provided by participants. We followed this principle to ensure that participants perspectives were foregrounded in the analysis and used the WPR framework to guide our analysis. Bradshaw, Atkinson & Doody (2017) explain that a variety of methods can be utilized in QD as long as they demonstrate alignment with the purposes of the research and ensure its rigor (p.3). To this end, we incorporated the Framework method described by Gale et al. (2013) to inform the methodology of thematic analysis process and the WPR framework to guide the creation of the research questions, interview guide, and ultimately our understanding of the identified themes.

The WPR framework is grounded within a critical paradigm that focuses on the role of social influences in how policy problems are represented, who is advancing these representations and how these representations shape discourse and action or inaction (Bacchi, 2019; Archibald, 2020). The framework is oriented to interrogating the assumptions that inform participants perspectives on women's health and the context in which interview participants carry out their work. An example of the kind of assumptions that inform language choices includes using certain terms and their associations, which can shape the way specific issues are interpreted, such as describing women's health exclusively within the parameters of sexual and reproductive health. In this example, women's health is often associated with sexual and reproductive health only, as seen across policy, clinical, or scientific spheres (Hallam et al., 2022). The WPR framework's six guiding questions helped us formulate our interview questions. See figure 1 for a list of these questions.

The Six Guiding Questions of the WPR Framework

1.) What is the problem represented to be in a specific policy?
2.) What presuppositions underpin the representation of this problem?
3.) How has this representation of the 'problem' come about?
4.) What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5.) What effects are produced by this representation of the 'problem'?
6.) How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

Figure 1

2.1 Data collection

Data was collected through key informant interviews (KIIs) with 9 participants. The interviews ranged from 35 minutes to 1 hour and 10 minutes, averaging 56 minutes. Interviews were conducted online using Zoom and were audio recorded, de-identified, and transcribed. AK, RL, and AA developed a semi-structured interview guide together according to the research objectives and the WPR framework, with a view to identifying participants' perspectives on the impacts of problem identification and concurrent solutions within the SDG's women's health policy. Semi-structured interviews were specifically chosen for this research context given their ability to facilitate participants' perspectives and experiences (Green & Thorogood, 2018). The semi-structured approach to the interviews allowed the interviewer to ask additional questions, including follow-up questions, based on the conversation.

2.2 Interview Guide

The interview guide was comprised of 20 open-ended questions that aimed to elicit the perspectives of participants regarding which health issues are associated with women and girls, how certain issues are given priority, and the perceived impacts of priority setting processes on health outcomes and policy. The final set of questions were organized into categories that correspond with the WPR framework and the research question. See appendix for a table of the interview guide questions organized by category.

2.3 Sample and recruitment strategy

We used purposive and snowball sampling to recruit participants. This was done to "achieve a sample that includes ideal representatives from the target population" – in our usage, participants were selected based on their ability to provide a detailed description about their experiences and perspectives on processes underlying problem identification and priority setting within UN agencies (Sullivan-Bolyai & Bova, 2021, p. 10). Participants were recruited based on the following inclusion criteria: 1.) currently employed or have been employed with the UN and 2.) are involved in SDG implementation explicitly related to gender and health. Examples of organizations participants were recruited from include, but are not limited to, UN Women, the World Health Organization, and the United Nations Population Fund. These categories were generated to 1.) gain an understanding of the ways in which gender informs policy across

different UN agencies and 2.) gain insight into the process of problem conceptualization in global women and girls' health. This study recruited a final sample of 9 participants with experience across a range of UN agencies and consulting bodies who work with the UN. This diverse representation ensured a wide range of perspectives from participants working in multiple agencies and topic areas, but with some mandate around women and girls' health, across the UN. Diverse representation is important when examining different institutional conditions that may shape problem identification to solution proposals. The agencies within the United Nations may differ in their emphasis, but each is oriented broadly around the SDGs. Participants recruitment took into account the career duration in the UN systems and the extent of involvement in the SDGs. The recruitment process for each participant was initiated with an IRB approved recruitment email, with an additional letter of information distributed once interest in participating was confirmed. Some participants were identified and recruited through snowball sampling through the networks of relevant participants (Campbell et al., 2020; Parker et al., 2019).

2.4 Data analysis

The qualitative data from the KIIs were transcribed verbatim and transcripts were stored in Microsoft Word and NVivo. Data were analyzed using the Framework Method as described by Gale et al. (2013). The analysis used a deductive-inductive coding method that drew thematically from the WPR framework, while allowing for the identification of novel themes. We followed the five steps of the Framework Method (Gale et al., 2013) to facilitate this effort during the coding process, which utilized the flexibility of the Framework matrix to identify and analyze key themes while retaining the context of each participant's view (Crowe et al., 2011; Gale et al., 2013).

Following an initial process of transcribing the first 4 interviews and becoming familiarized with the data, initial rough codes were applied to interview transcripts stored on Word. Deductive coding followed ideas that were established early on based on scoping review results as well as interview guide questions. An example of an idea that was established in the early stages of the study and eventually coded in the final analysis include understanding which types of information were most important to policymaking. Inductive coding allowed for new

ideas to be developed from the data. Authors AK and RL compared codes on one transcript to ensure that similar ideas were being identified before a guiding framework analysis would be applied to the remaining interviews. NVivo was employed to assist with data management and analysis, and codes were revised from their Word iterations when processed into NVivo as nodes. For example, a code that was initially a long sentence was simplified into fewer words to improve clarity as well as ensuring the applicability of the core idea to a wider set of relevant quotes. An initial working analytical framework, as described by Gale et al. (2013) was developed by grouping the codes into categories which allowed for the additional interviews to be flexibly analyzed under this framework – however, the framework was not finalized until the final transcript was coded in order to allow for additional codes to be developed based on analysis of the data. This type of flexibility is associated with QD and allows for the effective description of participant experiences based on the data provided (Bradshaw, Atkinson & Doody, 2017).

The interview data was then charted into a codebook. Throughout the process, several iterative themes and subthemes were developed, which were repeatedly discussed and honed by the authors as additional transcripts were analyzed. QD can involve either qualitative content analysis or thematic analysis, and the goals of our study were better fulfilled using thematic analysis. The data was analyzed through an iterative process where understanding develops with each consecutive interview following the creation of the initial working analytical framework suggested by Gale et al. (2013). The entire process of coding and developing the working framework allowed for the eventual definition and naming of final themes described in our results (Braun & Clarke, 2006; Sullivan-Bolyai & Bova, 2021). Notes on ideas, themes, and early interpretations of the interviews were kept and consulted throughout, including emerging insights shaped by the guiding questions of the WPR framework. Eventually, following completion of the analysis, a set of themes were agreed upon by the authors once comprehensive review of the charted data and relevant quotes was complete.

2.5 Ethical considerations

The study received clearance from the McGill Faculty of Medicine and Health Sciences Institutional Review Board. Audio recordings from the Zoom calls were saved to a password-

protected computer and titled with pseudonyms that would not identify the name of the research participant to an external party, nor were their real names mentioned in the recordings or transcripts. Names of transcripts were further de-identified and were titled simply using the numbers of the order in which interviews were completed. Any files linking the identities and names of participants to their associated recording are stored on a password protected computer that can only be accessed by AK. Any additional identifying information present in the transcripts, such as details of employment, will not be shared in the results of this paper. Pseudonyms were assigned to each participant and any identifiers, including agency, were removed. Research records were stored confidentially – documents linking pseudonyms assigned to participants and their names are password protected and stored on a password protected computer.

2.6 Rigor and reflexivity

Researchers considered the influence that their positionality, ontological, and epistemological assumptions have on their work at all stages of the research process (Holmes, 2020). A self-reflective and reflexive approach, complemented by collaborative work that ensured that subjective ideas were discussed with other people, was adopted to approach this qualitative project with an open mind. During the data collection process, including during the interviews themselves, author AK was conscious of staying close to the data and limiting extrapolative interpretation, using the advice of Sullivan-Bolyai & Bova (2021) for best practice in QD and ensuring that certain quotes and data were directly linkable to proposed themes. This 'self-check' process required asking oneself if certain codes accurately reflected the sentiment of its associated quote or if one was reading too far beyond what was shared. A similar process needed to be maintained throughout the iterative thematic analysis. Throughout the data analysis process, supervising author RL reviewed and provided feedback on working ideas, codes, and ultimately themes as they were developed. The perspective and comments of authors AA and KR helped to ensure that conclusions reached in the analysis were strongly supported by data and that subjective interpretation did not lead to unsupported assertions.

3. Results

We identified 4 primary themes that represent the process of problem identification and prioritization associated with women's and girls' health across UN agencies: 1.) the influence of political forces, 2.) the challenge of finite financial resources and funding, 3.) the role of scientific evidence and data, and 4.) the purpose of differentiated scopes of work. To capture perspectives on these interconnected concepts, we will describe each theme using descriptions and insights provided by the participants.

Table one illustrates the general topic that their work focuses on. This table is meant to assist in contextualizing the presentation of direct quotes while maintaining the anonymity of participants.

Participant #	Agency Topic Area
One	Population health
Two	Maternal health
Three	Infectious disease
Four	Health policy
Five	Infectious disease
Six	Human rights
Seven	Environmental health
Eight	Human rights
Nine	Financing

Table 1. Participant topic areas

3.1 The influence of political forces

Participants described the effects of political forces across subnational, national, and international levels and the influence that they exert on problem identification and prioritization processes. By political forces, we mean processes or dynamics that are linked to the actions of local or state governments and international relations between states that have the capability to shape or determine the creation and implementation of the global development agenda. Several participants noted that these political forces included member state agendas including normative

frameworks related to health and gender, stalled progress towards established goals due to their status as lower priority, and the feeling that the UN is transitioning through a period of change that is being shaped by changing norms on a global scale, which was noted as resulting in oft-perceived pushback against policy interventions (i.e., policy related to reproductive health rights).

3.1.1 Member State Agendas

Member state agendas were identified as a key force in determining global agendas. Participant 4 shared their perspective on the impact of different ideas on their work: "*the member states that provide the ideas, they also have different internal policies, foreign policies. So of course, that influences the discourse and our work."*

Participant 5 reflected on examples of these discourses: "*We will need to do better on... Predicting, understanding and disrupting the forces of resistance that are increasingly consolidated, they're increasingly better organized, that are rolling back grand progress on sexual reproductive health and rights, gender rights, including the rights of gender and sexual minorities*." This participant also noted that: *"It used to be that the multilateral system was a hotbed for a lot of this dialogue at the place for grant negotiations to take place, for vigorous dialogue and push back and forth to happen. It feels as though these conversations have now skipped the multilateral system entirely and have been taken down to the ground in the member states, and so you find that communities are now having conversations about things that typically in the past have been very obvious and not controversial."*

Most participants reflected on the relationship between their UN agency, as well as the wider UN system, and the member states in which they serve: Participant 8 shared that "*We're a UN agency - we work with the government, so whatever is happening politically has definitely to fit into our work… I mean, they are the ones getting the strategic vision*."

The role of normative frameworks related to both gender and health in shaping the work of UN agencies was frequently discussed across the interviews. These frameworks include a changing understanding of women's and girls' health (i.e. moving beyond focus on sexual and reproductive health and considering the impact of gender on multiple facets of health) and the

subsequent identified priorities of the global health agenda, with Participant 2 explaining that: "*The whole agenda of women's global health let's say it is still evolving. I think that everyone has a different perspective on it and I feel that... that maybe till now, there's been too much focus on reproductive health issues as women's health issues, as if that's the only thing that matters to women."* Participant 4 follows this sentiment reflecting on the tendency to focus on women and their status as mothers rather than their inherent right to good health, and how doing so hinders meaningful progress for women who are not mothers: *"Yet we're not talking about women who are not pregnant or who are not breastfeeding. We're still in the realm when we're talking about women as a bearer of children, right. So, it's more about the child than the woman herself. We're not talking about all those women who are beyond reproductive age or at reproductive age, but not willing or not able to have a baby."* The interview guide did not explicitly reference sexual and reproductive health, but most interviewees discussed it immediately when asked about gender and health, and continually did so throughout the interview. This may be explained by some of the participants' employment or expertise background, but a notable observation, nonetheless.

3.1.2 Structures + Bias + Low Priority = Slow Progress

Many participants reflected on frustration with the slow pace of progress due to perceived political constraints and other barriers related to social, cultural, or economic factors. These constraints ranged from being more broadly related to persistent inequity worldwide to concerns about their impact on the concrete work of the UN. Participant 4 shared:

> "*I feel like it's more about the structures we are finding ourselves in that are not conducive to change. And unless we look into what that is, what the biases are, that are institutional biases or systemic barriers… Until we address those, I think it will be a kind of one person battle or a couple of persons battle against the system rather than something more coherent*"

Participant 6 noted the impact of global poly-crises on the pace of progress and the challenges they present externally and internally: "*You know, we thought we would get there at some point, but now with COVID, the wars, the, you know, global economic downturn, climate crisis, it seems that we are not going to get there in terms of addressing, you know, harmful practices."*

This participant went on to add: "*But at this point in time, Member States are grappling with their own internal situations, if you will. So, their collaboration with the UN in terms of contributions has been impacted*".

Reflecting on the social contexts that uniquely shape the health of women and girls, Participant 4 reiterated that, *"even with all the elevation of the importance of addressing transformative norms, there is a severe lack of focus on the underlying issues leading to inequality*". This participant went on to add that progress is slow and noted their unhappiness.

Participant 7 shared an example of their experiences of actions not reflecting the work of advocates, echoing frustrations about misplaced priorities creating barriers to what they and advocates in their field would perceive as progress: "*This* [referring to appeasing lobbyists] *is where the priorities are being set, but they're not matching what is happening and what is being discussed among advocates."*

Participant 8 shared their input on the 'push and pull' of norms in their field of work in relation to the context of the states they work with: "*So the issue is staggering […] there's that push and pull of our work in the programmatic non-profit sector, but then there's influence within the social spheres of the population by traditional leaders or religious leaders telling them otherwise. So there really needs to be that cooperation."*

Multiple participants situated these frustrations and concerns in relation to a broader regression in women and girls' health governance. Participant 5 shared: *"It feels as though something in the tone and tenor of our public debate changed. It's not a Global North phenomenon. It's a fully global phenomenon."* Participants 5 and 4 felt that this period of change is marked by regression in the agenda around women and girls' health: *"There is a lot more convergence* [of politicization of health and equality] *in a terrible way… there's a way that these conversations are all converging and that is not a mistake. It's not an error. There are specific institutions and forces that are advancing specific agendas"* and *"With the turnover of, I don't know, political party power, we could see a big shift in foreign policy on women's rights, gender equality, what countries think and what they say in the international sphere. So... the sort of rollback is so quick."*

Participant 3 captured this situation noting that the "*The health issues attended to is political will."* The findings on the politics of agenda setting and slow progress being observed was intertwined with resource allocation and financing, another key dimension of the problem identification and prioritization process.

3.2 The challenge of limited funding

A few key ideas emerged when discussing the effects of financing and allocation decisions with participants. These include: the notion that funding often comes with strings attached, the desire to ensure high programmatic efficiency within resource constraints, the recognition that finite resources and decisions made based on priority allocation will determine the degree to which nations can adopt certain initiatives, and the tensions between priorities self-identified by countries and those identified by donors.

Participant 5 expressed concern for the changes in priorities and initiatives that can occur with insufficient funding, and if these changes will limit the realization of gender equality:

> "*We are paying attention to principles of efficiency in a time of scarce global funding. Increasingly, we are hyper sensitized to the need to have coherent responses to the present and critical concerns of our time, one of these being the worrying trend of reversals and stagnation and threats to girls and women's rights, their gender rights, their sexual and reproductive rights globally*."

Concerns about 'strings attached' funding were expressed across several interviews. Participant 1 shared their thoughts on donors creating stipulations for their financial support:

> *"If it's a donor, who says, because you'll get our funds, for example, you're told – 'our interest is in family planning or abortion or so on and so forth'. Let's say OK, but the priorities that have been identified by the countries are to reduce maternal death […] OK, the donor wants to do this and then the country may say yeah, just give us the money then, if those are the conditions."*

This description, along with anecdotes from other participants' experiences, highlight the entwined role of financing in shaping agendas related to women's and girls' health within state and international boundaries. Agencies, states, and community organizations are limited by what resources they are given, and powerful countries with predetermined agendas for advancing development can reify a power dynamic of wealth and influence on an international scale. Participant 1 adds:

> *"We are an agency that depends on donor funds. And so, what's available for us to perform the work is driven by… we're given funds… but a lot of times they give funds with clear very clearly, articulated preferences of what they want their money to do […] for many countries that don't have funds to invest in their own health, or who don't invest enough in their own health, and they accept what comes from elsewhere -- they're going to have to toe the line and do what the donor wants, because then you have to report. And if you don't, if you're not doing well, you're blacklisted and all those things."*

Participant 1 expressed their agency's interest in preserving the self-identified priority of a member state when they are offered funding, if they are at odds with what has been stipulated:

> *"I mean, in a sense, we also try to ensure that what our communities have said is their priority does not get ignored, so there will be situations where the funds that are available are as they are, and where governments are strong, they will say 'we don't want that money'."*

Reflecting on the slow progress of eliminating HIV/AIDS in children, Participant 3 shared their insight on the role of limited funding across key priority problems:

> *"Preventing HIV in children, you've got the same problem preventing malaria in children, got the same problem in preventing malnutrition -- there's so many, you know why prioritize just this one problem? And so catching the attention of, you know, very, very limited and very, very stretched health spending budgets is a major setback."*

Participant 9 shared that their organization is largely concerned with preserving the priorities of the state government by financially supporting their self-identified needs: *"I've seen questions like 'Why can't you support this organization and country?' And the answer is always, generally, because we are bound by our mandate where we have to bend to governments. We cannot. You*

know, we cannot work with specific agencies, and it has to be the government." P9 went on to elaborate on the case of a country having to address an underlying structural issue before receiving support from a financing agency: *"I can see how that might look as 'strings attached', but again there are issues that are underlying, structural issues that really need to be addressed, I wouldn't say it's particularly without reason."*

Certain kinds of evidence can influence which issues receive funding and which issues are identified as the greatest priorities, as Participant 8 shared: *"I think if our topics are relegated or stagnating and are not prioritized, it might be because they might be seen as less urgent."* To this end, several participants noted the importance of evidence and data in policymaking and agenda development.

3.3 The role of scientific evidence and data

There is an established expectation across the UN system to undertake extensive data collection and measurement and/or to base policy decisions on existing evidence. Participant perspectives shared insights into the values assigned to these types of data. Some participants described the expectations for member states to commit to data collection and measurement, and that these expectations are at times difficult to meet depending on the circumstances of a country. Participants noted that on one hand it can be difficult to collect data in countries and on the other the challenge collecting the right data to drive agendas forward.

One example of how biases or barriers manifest is the example of sex-disaggregated data and the perceived lack of gender-specific reports that include sex-disaggregated data where relevant. This highlights the systemic exclusion of women and girls from consideration in research and policies. This discussion in particular highlighted frustration with other agencies with more technical foci, with P4 asking: "*Why don't we publish this data? Why is it not regularly published in this [annual technical report]?*" and noting the juxtaposition against frequent male-centric reports. Participant 1 echoed the importance of data disaggregation by gender and age but did not necessarily attribute its inadequate measurement to institutional barriers.

Participant 4 reflected on the heightened emphasis on evidence and scientific standards for policymaking, such as randomized controlled trials:

> *"Sometimes, it's a curse. Sometimes it's a blessing. Curse in the sense that… we always get asked, what's your evidence? Or did you do the randomized control, you know, things like that or like, we need to see change in six months and they can only show us in five years."*

In providing an alternative to rigorous data-based research, this participant described the community-engagement strategies of their agency and the value they identified within it:

> *"We invested in training and going hand in hand with communities so they can talk to their peers and get their hands on information and then analyze it in a way that speaks to them. And then we created the spaces and facilitated spaces for them to disseminate the findings, and I think that was closer to our heart as more being the advocate, rather than researchers."*

Participant 2 highlighted the issue of member states being expected to collect and measure data and the tensions of practicality and utility: "*we are creating more and more indicators to be monitored while we at the same time also know that let's say many systems will not be able to actually implement it."* The same participant shared personal experiences working with member states, reflecting on pushback against measurement policies:

> *"I think the interest in measurement is very much a global obsession […] I think the pushback […] at a country level, let's say the pushback has always been, oh, there's way too many indicators, and that we [the UN agency] should identify a core set of 25 indicators that the Ministry of Health [of member state] should monitor and that's it."*

However, the importance of data in gaining a clearer picture of areas for improvement as well as indicators of success is well-established, further highlighting the tension between practical, reasonable expectations and perceived standards of accountability and sustainability:

> *"If we want to support ministries and at the same time be able to hold ministries accountable for what they are doing, we need to have a basic set of indicators and targets. That will allow us to a.) to plan in order to achieve those targets and b.) allow them to be able to be held accountable"*

Furthering this idea and the utility of data for driving agendas forward, Participant 6 highlighted the role of data and evidence in gaining the crucial support of member states: *"Our interventions are informed by what happens in a particular country context, and that basically deals with data and evidence […] then we present the data and evidence to policymakers, to the government and try and get government buy-in into the process because anything that we at the country level has to be in collaboration with a particular countries government. We cannot just work in a vacuum, the UN, any UN agency, cannot work in a vacuum."*

Participant 5 expressed that data quantifies gender inequality in a powerful way: "*The data speaks loudly, it speaks volumes and there is no complaining or misunderstanding what is happening to women and girls in all contexts."* However, a different participant, Participant 7 was critical of where data comes from, and whether they are being evaluated closely enough:

> *"I think that we see it a lot within this field at the UN specifically, like a statistic will be picked up and then like reported by like a million different places. And there's not really like a deep dive into like where that's coming from. How did you get this and where is this coming from?"*

3.4 Differentiated scopes of work

The final theme was associated with the complementary work being conducted across agencies. Almost all participants described that the mandates of different agencies are well-established and designed to work together in complementary ways. Participants described this as a means to generate a system of accountability as well as provide opportunities for different agencies to invest resources in their specific field of work.

The purpose of differentiated scopes of work was described as allowing agencies to identify priority issues within their field and share their findings with other agencies in hope of collaborating and finding policies or initiatives that can address the greatest number of high-priority issues efficiently. According to Participant 3, *"each of the constituent agencies, the constituent agencies bring to the table…. their respective focus expertise."* Participant 5 reflected on the role of the whole system in ensuring the rights of women and girls collaborative: "*if we are doing our job as a system, every single one of us is defending girl's sexual reproductive health and rights in every context*".

Different agency mandates, goals, and technical responsibilities allow for cross-agency enhancement to better achieve goals. Participant 5 explained "*We are committed to the principle of working as one. Making sure that we are able to enhance each other's mandate without duplicating responsibilities*." In a similar way Participant 1 shared that "*all UN agencies at the highest level are aligned to the SDGs*".

Agency mandates shape the problem representation and prioritization process throughout the UN system, with different agencies contributing different dimensions of this process. Participant 6 shared that "*WHO is overall responsible for the health agenda, if you will, of the UN. So, there's a complementary of efforts here. We do a lot of work with UN Women, because UN Women in a way is responsible for doing the policy level work when it comes to women's rights issues, including at the UN, and it's got a normative agenda. While again, we have the implementation agenda."*

Collaboration was highlighted as a key process in each agency's line of work, whether it involved units of one agency, inter-agency work, or cross-sectoral collaboration with the academic, private, and public sectors. On collaborating with other agencies daily, Participant 4 shared: "*To explain, it's not like a single meeting. It's like daily work of mine. We have different levels of meetings*." Participant 5 described the different teams involved in daily work and their collaborative nature: "*There are regional support teams, and there are country support joint teams, you know as part of that, as well as a regional specialist and as a country specialist… we really have a changing, dedicated team of specialists."*

Participants commonly spoke about agencies other than the one they worked or had previously worked within with respect and admiration and many participants echoed sentiments about a united goal or vision to achieve the SDGs and other overarching goals such as eliminating HIV/AIDS globally. Participant 3 shared:

> "*They're all [other agencies] impressive and they're all impressive in what they do, and in the, you know, in the contribution to the SDGs we have, we have joint planning, which always, always sticks close to the SDGs*"

Participant 3 added that there is accountability in the HIV/AIDS strategy: "*For the most part, there is a common accountability for goals that are set strategy and that's a global AIDS strategy*."

The common vision across UN agencies facilitates collective action and inspires the need to act on key issues affecting women and girls while shaping conceptualizations of the women and girls' global health agenda.

4. Discussion

The UN and the SDGs are highly influential in shaping the global health and development agenda concerning women and girls (Widegren & Sand, 2019; Bigg, 2016). To this end, the UN system is an important institution to research to better understand how the interests and rights of priority populations such as women and girls are conceptualized and protected worldwide. In gaining perspectives from key informants on the processes that drive their agencies' agenda and decision-making, this qualitative study has identified the following themes: 1.) the influence of political forces, 2.) the challenge of finite financial resources and funding, 3.) the role of scientific evidence and data, and 4.) the purpose of differentiated scopes of work. The insights gained from this research will highlight gaps between knowledge and implementation, key areas for improvement with a view to improving outcomes for relevant populations benefitting from the SDGs and encourage the inclusion of a gendered lens in health policy research inside and outside of development spheres.

4.1 (Re)framing women's health

Actors across the multilateral international systems such as the UN are highly influential in reshaping conceptions of women's health. Our interview data as well as a multitude of literature such as Kulenova et al. (under review), Peters et al. (2016) and Raymond et al. (2005) highlight a concerningly narrow definition of women's health, wherein women's health is almost entirely equated with sexual and reproductive health (SRH). SRH is an integral component of women's health – it is particularly entwined with gender equality and human rights, necessitating due action and research (OHCHR, n.d.). However, narrowing the scope of women's health to near exclusively SRH has several risks such as limiting the scope of research pertaining to

women and girls to SRH and reinforcing harmful norms about women. The latter point is expressed in a recent article published in The Lancet which described the implications of equating women's health to reproductive health to include risking "reinforcing outdated and potentially harmful stereotypes about women's roles in society as well as neglecting the full spectrum of women's health" ("A Broader Vision for Women's Health", 2023, p.1).

A narrow perspective on women's health can worsen outcomes for other relevant health conditions that may uniquely impact women based on characteristics related to both sex and gender (Peters et al., 2016; Carcel et al., 2024). As Raymond et al. (2005) explain, the allocation of health services and resources should ideally be "aligned with the epidemiological realities" of threats to women's health, which is a broad spectrum of issues not limited to reproductive health (p.1144). Davies et al. (2019) situate the need for a more comprehensive definition of women's health within the wider global health context and at institutional and operational levels by advocating for a feminist research agenda, which can challenge the deep structural gender inequities related to power and resources – such a lens is useful particularly for interrogating underlying assumptions behind a myopic focus on SRH, including the equivocation of women with reproductive capabilities and motherhood (Bustreo et al., 2012).

When women and girls' health is narrowly conceived as SRH, it is easily politicized to the detriment of health and gender equality (Sommer and Forman-Rabinovici, 2020). Several participants noted feeling that the women's health agenda integral to their day-to-day work is regressing or facing significant threat from heavy politicization across domestic, state, and international levels, a finding reflected in the literature (Allotey & Denton, 2020). SRH is a key issue that continues to require coordinated efforts to protect the rights of women and girls everywhere, especially amid the threat of severe regression. In tandem with these efforts, widening the scope of women's health within policy spheres may provide some protection against the politicization of reproductive health and address underlying needs and structures that contribute to stark inequalities across the life course. Several study participants noted the shifting framing around women's health in their agency's work, remarking that the agenda and definition is changing and moving beyond purely SRH to encompass other key issues related to gender and health. Several participants also highlighted opportunities for improvement to continue these

changes. Advocating for a broadened conception of women's health that is inclusive of, but not limited to SRH, is necessary to advance both gender and health equality.

4.2 Health, human rights, and norms

The UN has played an instrumental role in solidifying the linkage between human rights and global health (Meier & Gostin, 2019). Human rights law and the consolidation of norms that privilege principles of justice and equity with global health have become an international framework over the past 70 years and helped to articulate health as a human right (Meier & Gostin, 2019, p. 200). Throughout the interviews, multiple participants noted the challenge of balancing the interests and priorities of member states while striving to advance norms that improve the health and well-being of women and girls – two priorities that are at times at odds with one another across various local, national, and international contexts. UN agencies mediate the push and pull between promoting global norms such as human rights and member state preferences and/or differing conceptions of norms (UNITAR, 2019).

In the early 1990s, UN agencies adopted human rights-based approaches to health, moving away from a focus purely on the right to health (Hunt, 2016). Hunt explains that "although the right to health is extensive, it is narrower than a human rights-based approach," and that the wider "lens" of a human rights-based approach may help devise a more comprehensive and effective strategy, since the latter encompasses all relevant human rights (2016, p.110). Hunt describes the operationalizing of human rights within UN agencies:

> "UN agencies have adopted increasingly detailed guidance on how to operationalize human rights, for example, in relation to HIV/AIDS, tuberculosis, maternal mortality, under-five mortality, contraceptive information and services, and clinical management of female genital mutilation. This has required agencies to interpret and apply treaties, general comments, and other jurisprudence, sometimes weighing the available evidence as part of their interpretative process." (2016, p.110).

In one key example illustrating the challenging of promoting its norms, the UN has situated female genital mutilation/cutting (FGM/C) as a gross violation of human rights and fundamentally discriminatory based on sex, gender, and age (UN, 2024; OHCHR, 2019). Khosla et al. (2017) explain that due to social, cultural and community norms related to gender, "efforts to resist and eradicate FGM require multi-sectoral, gender- and culturally-sensitive response that works across sectors, communities and generations" (p.7). Here lies the question of the extent to which UN agencies can influence norm creation and consolidation processes on its member states while promoting them internationally, what the potential consequences may be for both the advancement of gender equality, as well as implications for states receiving aid and policy guidance. A portion of participant data describe the deference of UN agencies to its member states and the perception that their role is to serve member states, especially in agencies or units with a specific regional mandate, while simultaneously advancing the rights-based agenda of gender and health. At the same time, they are seeking to advance norms and have a vision for what states should strive for – and seek to implement change within the context of the regions and states they work with. Comprehensively answering this question is outside of the scope of this study but highlights the need for further research and interrogation on the impact and capabilities of the UN to mediate this 'push and pull' of norms across the development agenda.

A United Nations Institute for Training and Research (UNITAR) book published in 2019 delineates the challenges and contributions of the SDGs. In contemplating the legal dimensions of establishing norms in sustainable development in a chapter of this book, Liesa (2019) writes that sustainable development as a legal concept "would not regulate the conduct of its subjects nor be directed towards them, but rather operate between primary norms with the aim of changing their scope and effects and establishing new relations between them" (p.55). Furthermore, the SDGs are "expected to provide guidance and resolve normative conflicts, institutional fragmentation and policy complexity" (Biermann et al., 2022, p.797).

The UN, its agencies, and the SDGs are aligned to a certain set of normative values that, in terms of implementation, may be applied differently based on the diverse sociocultural contexts of member states. Nonetheless, the SDGs themselves are committed to promoting its framework for development including the advancement of gender equality and human rights. The epistemological challenges of this endeavour will be explored in greater depth later in this

discussion. In terms of the extent of impact the SDGs demand for norm creation and consolidation, Liesa (2019) explains:

> "The measures to be taken to achieve the SDGs also mean a qualitative transformation of how the international society functions. It is a challenge that, if reached, will mean that development is compatible with the environment and human rights. It is an integrated and indivisible challenge that requires policies that are conceived entirely under this coordinated perspective." (p. 52)

Biermann et al. (2022) found that the impact of the SDGs on global development has largely been discursive and has mostly affected conceptions of and communication about sustainable development from key actors. Discourse concerning the SDGs is rooted in the largely universal understanding that the Goals are not a panacea for the global shortcomings it aims to ameliorate – highlighting the role and often oppositional force of embedded norms and structures against advancing gender equality among other areas of social development. However, discourse is a valuable tool in reshaping norms and challenging perceptions on key topics related to gender and health equality and is an agent for social change (Hassen, 2015). Take, for example, the changes observed between the MDGs and SDGs, designed to incorporate criticisms of the MDGs and to recognize the interconnected and complex nature of inequity (Mariano and Molari, 2022; Kulenova et al., under review).

4.3 Feasibility, resource constraints, and operations

Our interview data highlights the complexities of striving towards an ambitious agenda of human development within resource and financing constraints as well as feasibility concerns about the practicality of aligning the interests of all member states. Weitz et al. (2018) and Bandari et al. (2022) explain that key barriers to implementation of the SDGs include opposition from key stakeholders (such as national governments), limited budgets and human resources, a lack of collaboration between states and relevant actors, as well as limited transparency. Furthermore, Saxena et al. (2021) highlight that primary criticisms of the SDGs include: not accounting for restrictive forces that impede on the realization of the goals, having obligations limited to key stakeholders, as well as ambiguous financial investment expectations.

Priority-setting is a key mechanism of the policymaking and implementation process, especially in striving to achieve an ambitious set of goals such as the SDGs. Priority-setting is made necessary by financial and resource constraints and is identified as an important tool for the SDGs (Weitz et al., 2018). Saxena et al. (2021) note that the SDGs have been subject to some criticism for their broadly spanning agenda, wherein some characterize the lack of clear priorities within the SDGs as signalling that nothing is a priority. Clark & Horton (2019) are critical of the UN system's incongruence between its optics and its actions given their broad commitment to gender equality, but its lack of prioritization in specific sects of development, specifically global health, that require attention and action:

> "WHO consistently states gender equality to be a cross-cutting feature of its work. Gender is ubiquitous in the UN system: UN Women, UNFPA, UNICEF, and the sustainable development agenda. On the other hand, it's nowhere. Not in the universal health coverage plans, not among WHO's ten priority global health threats, and not tied to governance or the accountability of organisational and government leaders" (p.2368)

To this end, priority-setting decisions carry significant implications across the policy development process. A few study participants voiced concern about certain policy decisions leading to a reduced ability for some member states to adhere to the Goals, a stark concern within the articulated ambition of "leaving no one behind" (UNSDG, n.d.). In the context of the UN system, the importance of differentiated scopes and mandates across UN agencies was highly emphasized throughout the interviews. It is a key tool for allocating human and financial resources to dedicate to specific sects of the ambitious agenda and retaining programmatic efficiency while adhering to a shared vision of achieving the Goals. However, there may be challenges related to priority-setting both within and between agencies, potentially hindering coherent approach to women's and girls' health – further research and studies may be necessary to fully discern the 'hierarchies' within the UN system, and whose decisions carry the strongest influence in deciding which issues receive the greatest resources. Interview data from several participants provide valuable information on the standards of evidence expected for measurement and implementation, which provides insight into the priority-setting, decision-making, and evaluation processes of the UN system.

4.4 Evidence, epistemology, and ethics

A key point of critical discussion that is necessary for research concerning development policy are the power asymmetries embedded across the institutions shaping the assumptions underlying the creation and implementation of these policies. The ideas that scaffold principles of progress and advancement are not universal across cultures and nations, creating challenges for global development spheres to create agendas that do not perpetuate epistemic injustices. Epistemic injustice in global health is described by Bhakuni and Abimbola (2021) as being rooted in the "structural exclusion from marginalised producers and recipients of knowledge" and highly prevalent across all dimensions of academic global health (p.1).

Epistemic injustice may become particularly prevalent in the practical ways that countries are expected to integrate or adhere to the SDGs. Our results illustrate that there is often disconnect between the self-identified needs of member states and the attributed priorities from external actors such as high-income donor states or organizations. Several participants were concerned that member states did not have the freedom to allocate received funding as they saw fit and were subject to several stipulations that reflected the interests and preferences of foreign actors rather than their own. This can create tension in situations where agencies wish to respect state autonomy and must decide how to proceed when states are not implementing direly needed policies to protect women and girls' rights and health. Epistemic injustice is entwined throughout this process as agendas are shaped by knowledge that has been created and reproduced by privileged populations, excluding the perspectives of those from historically marginalized countries and regions – these agendas are then used as frameworks for institutions both in the public and private sectors, who finance and/or implement policies in states worldwide (Bhakuni and Ambiola, 2021; Pratt and Vries, 2023; Keshri and Bhaumik, 2022). To this end, certain states have the power to pursue their own agendas and embed these very same agendas within global goals. Instances wherein self-identified state priorities do not entirely align with that of a donor and states asked to bend to stipulations can be harmful in multiple ways: in the sense that it continues a cycle of epistemic injustice, in its potential to be inefficient and/or harmful for relevant populations, and in the uncertainty of whether or not structural and normative changes will be appropriately or ethically addressed (Banks et al., 2015; Harbour et al., 2021; Sundberg, 2018; Schmidt, 2020).

Study participants were asked to reflect on the types of information and data that were integral to the programming at their agency. A notable dichotomy between quantitative, scientific data and qualitative information divulged from methods like community engagement emerged. Though not mutually exclusive, research in the field highlights that the latter may be more conducive to incorporating diverse epistemologies, particularly those that are local to contexts of implementation (Pantelic et al., 2022; MacQueen et al., 2015). Interview data revealed that some participants felt that an overemphasis on scientific, technical evidence was obscuring consideration for knowledge and perspectives that are crucial for effective and ethical policy-making, an assertion shared by the likes of Adabanya et al. (2023) and Adhikari (2019).

A key theme we identified in our study data was the importance of evidence and data to create informed initiatives towards realizing the SDGs. It is crucial to understand what types of knowledge inform policies within the UN system, how this knowledge is created, and who (and who does not) create this knowledge. Studying these questions helps situate the contexts in which the SDGs are created and implemented and helps to identify opportunities to improve future iterations of sustainable development agendas as well as implementation for the remainder of the 2030 Agenda. Understanding what types of knowledge inform goal and policy planning is crucial for advancing equity and justice as well as shaping better outcomes.

5. Limitations

This study may be limited by its sample size, however we achieved broad representation across agencies. Participants who responded to emails and chose to participate in the study created a specific sample population that does not comprehensively reflect the thoughts and experiences of all UN employees, though our sampling methods were designed to maximize variety across agencies and experience. Future studies in this field would benefit from a larger sample size to gain more perspectives. It would be interesting to combine perspectives of those working at the global level with those working at national and sub-national levels, which our study did not do. The insights on international-national dynamics may have enriched the perspective on how problems are represented and prioritized. Additionally, the interviews were conducted in English – while English and French are the working languages of the UN, ideas (particularly pertaining to local contexts) could potentially be communicated differently in other languages spoken by interviewees and divulge different meanings.

6. Conclusion

This qualitative study has provided insight into how certain problems related to women's and girls' health are identified and subsequently prioritized, what processes inform and support the choices made, and how causes and contributing factors to identified health problems are conceptualized within the UN system. Key findings derived from the interviews include the role of political forces in influencing policy decisions, limited and tied financial resources, the role of scientific evidence and data in shaping policy, and the purpose of differentiated mandates across agencies. This paper has contextualized study findings within a wider body of literature to highlight opportunities for improving equity and encouraging discourse about the role of the SDGs and the UN in establishing norms related to gender and health equity. Further examination of the policy process will divulge a clearer understanding of what improvements can be made to increase the efficacy and impact of policy as it pertains to women and girls, a necessary step forward in advancing health equity globally.

References

Adabanya, U., Awosika, A., Moon, J. H., Reddy, Y. U., & Ugwuja, F. (n.d.). Changing a Community: A Holistic View of the Fundamental Human Needs and Their Public Health Impacts. *Cureus*, *15*(8), e44023.

Adhikari, B., Pell, C., & Cheah, P. Y. (2020). Community engagement and ethical global health research. *Global Bioethics*, *31*(1), 1–12. https://doi.org/10.1080/11287462.2019.1703504

Allotey, P., & Denton, F. (2020). Challenges and priorities for delivering on the Beijing Declaration and Platform for Action 25 years on. Lancet (London, England), 396(10257), 1053–1055. https://doi.org/10.1016/S0140-6736(20)32004-3

Archibald, T. (2020). What's the Problem Represented to Be? Problem Definition Critique as a Tool for Evaluative Thinking. American Journal of Evaluation, 41(1), 6–19. https://doi.org/10.1177/1098214018824043

Anfara, V. A., & Mertz, N. T. (2006). Theoretical Frameworks in Qualitative Research (0 edition). Sage Publications.

Bacchi, C. (2009). *Analysing Policy*. Pearson Higher Education AU.

Bandari, R., Moallemi, E. A., Lester, R. E., Downie, D., & Bryan, B. A. (2022). Prioritising Sustainable Development Goals, characterising interactions, and identifying solutions for local sustainability. *Environmental Science & Policy*, *127*, 325–336. https://doi.org/10.1016/j.envsci.2021.09.016

Banks, N., Hulme, D., & Edwards, M. (2015). NGOs, States, and Donors Revisited: Still Too Close for Comfort? *World Development*, *66*, 707–718. https://doi.org/10.1016/j.worlddev.2014.09.028

Basile, G. (2022). Towards a Health from the South: A decolonial and health sovereignty epistemology. *Social Medicine*, *15*(2), Article 2.

Belingheri, P., Chiarello, F., Fronzetti Colladon, A., & Rovelli, P. (2021). Twenty years of gender equality research: A scoping review based on a new semantic indicator. *PLoS ONE*, *16*(9), e0256474. https://doi.org/10.1371/journal.pone.0256474

Bhakuni, H., & Abimbola, S. (2021). Epistemic injustice in academic global health. *The Lancet Global Health*, *9*(10), e1465–e1470. https://doi.org/10.1016/S2214-109X(21)00301-6

Biermann, F., Hickmann, T., Sénit, C.-A., Beisheim, M., Bernstein, S., Chasek, P., Grob, L., Kim, R. E., Kotzé, L. J., Nilsson, M., Ordóñez Llanos, A., Okereke, C., Pradhan, P., Raven, R., Sun, Y., Vijge, M. J., van Vuuren, D., & Wicke, B. (2022). Scientific evidence on the political impact of the Sustainable Development Goals. *Nature Sustainability*, *5*(9), 795–800. https://doi.org/10.1038/s41893-022-00909-5

Bloom, D. E., Cadarette, D., Dayalu, R., & Sullivan, J. (2018). Introduction: Priority setting in global health. *Cost Effectiveness and Resource Allocation : C/E*, *16*(Suppl 1), 49. https://doi.org/10.1186/s12962-018-0115-x

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a Qualitative Description Approach in Health Care Research. *Global Qualitative Nursing Research*, *4*, 2333393617742282. https://doi.org/10.1177/2333393617742282

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101.

Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*, *129*(Suppl 2), 19–31.

Bustreo, F., Knaul, F. M., Bhadelia, A., Beard, J., & Araujo de Carvalho, I. (2012). Women's health beyond reproduction: Meeting the challenges. *Bulletin of the World Health Organization*, *90*(7), 478-478A. https://doi.org/10.2471/BLT.12.103549

Carcel, C., Haupt, S., Arnott, C., Yap, M. L., Henry, A., Hirst, J. E., Woodward, M., & Norton, R. (2024). A life-course approach to tackling noncommunicable diseases in women. *Nature Medicine*, *30*(1), 51–60. https://doi.org/10.1038/s41591-023-02738-1

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. Journal of Research in Nursing: JRN, 25(8), 652–661. https://doi.org/10.1177/1744987120927206

Clark, J., & Horton, R. (2019). A coming of age for gender in global health. *The Lancet*, *393*(10189), 2367–2369. https://doi.org/10.1016/S0140-6736(19)30986-9

Cochrane, M. (n.d.). *Unpacking Power Dynamics in International Development: A Causal Layered Analysis*.

Crowe, S., Cresswell, K., Robertson, A. *et al.* The case study approach. *BMC Med Res Methodol* **11**, 100 (2011). https://doi.org/10.1186/1471-2288-11-100

CSDH. 2008. *Closing the gap in a generation: Health equity through action on the social determinants of health—Final report of the commission on social determinants of health*. https://www.who.int/publications-detail-redirect/WHO-IER-CSDH-08.1

Davies, S. E., Harman, S., Manjoo, R., Tanyag, M., & Wenham, C. (2019). Why it must be a feminist global health agenda. *The Lancet*, *393*(10171), 601–603. https://doi.org/10.1016/S0140-6736(18)32472-3

Davies, S. E., & True, J. (2022). Follow the money: Assessing Women, Peace, and Security through financing for gender-inclusive peace. *Review of International Studies*, *48*(4), 668–688. https://doi.org/10.1017/S0260210522000122

de Jong, E., & Vijge, M. J. (2021). From Millennium to Sustainable Development Goals: Evolving discourses and their reflection in policy coherence for development. *Earth System Governance*, *7*, 100087. https://doi.org/10.1016/j.esg.2020.100087

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology, 13(1), 117. https://doi.org/10.1186/1471-2288-13-117

Gostin, L. O., Meier, B. M., Thomas, R., Magar, V., & Ghebreyesus, T. A. (2019). 70 years of human rights in global health: Drawing on a contentious past to secure a hopeful future. *Lancet (London, England)*, *392*(10165), 2731–2735. https://doi.org/10.1016/S0140-6736(18)32997-0

Green, J., & Thorogood, N. (2018). *Qualitative Methods for Health Research*. SAGE Publications.

Gupta, G. R., Oomman, N., Grown, C., Conn, K., Hawkes, S., Shawar, Y. R., Shiffman, J., Buse, K., Mehra, R., Bah, C. A., Heise, L., Greene, M. E., Weber, A. M., Heymann, J., Hay, K., Raj, A., Henry, S., Klugman, J., & Darmstadt, G. L. (2019). Gender equality and gender norms: Framing the opportunities for health. *The Lancet*, *393*(10190), 2550–2562. https://doi.org/10.1016/S0140-6736(19)30651-8

Hallam, L., Vassallo, A., Pinho-Gomes, A.-C., Carcel, C., & Woodward, M. (2022). Does Journal Content in the Field of Women's Health Represent Women's Burden of Disease? A Review of Publications in 2010 and 2020. *Journal of Women's Health*, *31*(5), 611–619. https://doi.org/10.1089/jwh.2021.0425

Hassen, R. (2015). Discourse as Medium of Knowledge: Transmission of Knowledge by Transmission of Discourse People Live. *Journal of Education and Practice*.

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., … Gupta, G. R. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, *393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E., Hawkes, S., Heise, L., Henry, S., Heymann, J., Klugman, J., Levine, R., Raj, A., & Gupta, G. R. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. *The Lancet*, *393*(10189), 2440–2454. https://doi.org/10.1016/S0140-6736(19)30652-X

Holmes, A. G. (2020). Researcher Positionality—A Consideration of Its Influence and Place in Qualitative Research—A New Researcher Guide. *Shanlax International Journal of Education*, *8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Horner, R. (2020). Towards a new paradigm of global development? Beyond the limits of international development. *Progress in Human Geography*, *44*(3), 415–436. https://doi.org/10.1177/0309132519836158

Hunt, P. (2016). Interpreting the International Right to Health in a Human Rights-Based Approach to Health. *Health and Human Rights*, *18*(2), 109–130.

Keshri, V. R., & Bhaumik, S. (2022). The feudal structure of global health and its implications for decolonisation. *BMJ Global Health*, *7*(9), e010603. https://doi.org/10.1136/bmjgh-2022-010603

Khosla, R., Banerjee, J., Chou, D., Say, L., & Fried, S. T. (2017). Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards. *Reproductive Health*, *14*(1), 59. https://doi.org/10.1186/s12978-017-0322-5

Kickbusch, I. (2015). The political determinants of health—10 years on. *BMJ (Clinical Research Ed.)*, *350*, h81. https://doi.org/10.1136/bmj.h81

Kuhlmann, E., & Annandale, E. (2015). Gender and Healthcare Policy. In E. Kuhlmann, R. H. Blank, I. L. Bourgeault, & C. Wendt (Eds.), *The Palgrave International Handbook of Healthcare Policy and Governance* (pp. 578–596). Palgrave Macmillan UK. https://doi.org/10.1057/9781137384935_35

Kulenova, A., Adams, A., Rice, K., & Lencucha, R. Submitted, in review.

MacQueen, K. M., Bhan, A., Frohlich, J., Holzer, J., Sugarman, J., & Network, the E. W. G. of the H. P. T. (2015). Evaluating community engagement in global health research: The need for metrics. *BMC Medical Ethics*, *16*. https://doi.org/10.1186/s12910-015-0033-9

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, *96*(9), 644–653. https://doi.org/10.2471/BLT.18.211607

Mariano, S., & Molari, B. (2022). Gender equality from the MDGs to the SDGs: A feminist analysis. *Revista de Administração Pública*, *56*(6), 823–842. https://doi.org/10.1590/0034-761220220124x

McBride, B., Hawkes, S., & Buse, K. (2019). Soft power and global health: The sustainable development goals (SDGs) era health agendas of the G7, G20 and BRICS. *BMC Public Health*, *19*(1), 815. https://doi.org/10.1186/s12889-019-7114-5

Meier, B. M., & Gostin, L. O. (2019). Human Rights for Health across the United Nations. *Health and Human Rights*, *21*(2), 199–204.

Miani, C., Wandschneider, L., Niemann, J., Batram-Zantvoort, S., & Razum, O. (2021). Measurement of gender as a social determinant of health in epidemiology—A scoping review. *PLoS ONE*, *16*(11), e0259223. https://doi.org/10.1371/journal.pone.0259223

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). Qualitative Data Analysis: A Methods Sourcebook. Third Edition. In SAGE Publications Ltd (CA). SAGE Publications.

National Academies of Sciences, Engineering, and Medicine, Division of Behavioral and Social Sciences and Education, Health and Medicine Division, Committee on Law and Justice, Board on Children, Youth, and Families, Board on Global Health, & Forum on Global Violence Prevention. (2018). *Addressing the Social and Cultural Norms That Underlie the Acceptance of Violence: Proceedings of a Workshop—in Brief*. National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK493719/

Nations, U. (n.d.). *Message*. United Nations; United Nations. Retrieved March 27, 2024, from https://www.un.org/en/observances/female-genital-mutilation-day/message

Östlin, P., Eckermann, E., Mishra, U. S., Nkowane, M., & Wallstam, E. (2006). Gender and health promotion: A multisectoral policy approach. *Health Promotion International*, *21*(suppl_1), 25–35. https://doi.org/10.1093/heapro/dal048

OHCHR (2019). *Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019) on harmful practices*. (n.d.). OHCHR. Retrieved March 27, 2024, from https://www.ohchr.org/en/documents/general-comments-and-recommendations/joint-general-recommendation-no-31-committee

OHCHR (n.d.) *Sexual and reproductive health and rights*. (n.d.).. Retrieved March 26, 2024, from https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights

Parker, C., Scott, S., & Geddes, A. (2019). Snowball Sampling. *SAGE Research Methods Foundations*. http://methods.sagepub.com/foundations/snowball-sampling

Pantelic, M., Steinert, J. I., Ayala, G., Sprague, L., Chang, J., Thomas, R. M., Nininahazwe, C., Caswell, G., Bach-Mortensen, A. M., & Bourne, A. (2022). Addressing epistemic injustice in HIV research: A call for reporting guidelines on meaningful community engagement. *Journal of the International AIDS Society*, *25*(1), e25880. https://doi.org/10.1002/jia2.25880

Peters, S. A. E., Woodward, M., Jha, V., Kennedy, S., & Norton, R. (2016). Women's health: A new global agenda. *BMJ Global Health*, *1*(3), e000080. https://doi.org/10.1136/bmjgh-2016-000080

Pratt, B., & Vries, J. de. (2023). Where is knowledge from the global South? An account of epistemic justice for a global bioethics. *Journal of Medical Ethics*, *49*(5), 325–334. https://doi.org/10.1136/jme-2022-108291

Raymond, S. U., Greenberg, H. M., & Leeder, S. R. (2005). Beyond reproduction: Women's health in today's developing world. *International Journal of Epidemiology*, *34*(5), 1144–1148. https://doi.org/10.1093/ije/dyi121

Sand, J., & Widegren, K. (n.d.). *Gender and Sustainability: An International Research Review*.

Saxena, A., Ramaswamy, M., Beale, J., Marciniuk, D., & Smith, P. (2021). Striving for the United Nations (UN) Sustainable Development Goals (SDGs): What will it take? *Discover Sustainability*, *2*(1), 20. https://doi.org/10.1007/s43621-021-00029-8

Schmitt, C. (2020). External Actors and Social Protection in the Global South: An Overview. In C. Schmitt (Ed.), *From Colonialism to International Aid: External Actors and Social Protection in the Global South* (pp. 3–18). Springer International Publishing. https://doi.org/10.1007/978-3-030-38200-1_1

Sianes, A., Vega-Muñoz, A., Tirado-Valencia, P., & Ariza-Montes, A. (2022). Impact of the Sustainable Development Goals on the academic research agenda. A scientometric analysis. *PLoS ONE*, *17*(3), e0265409. https://doi.org/10.1371/journal.pone.0265409

Sommer, U., & Forman-Rabinovici, A. (2020). The Politicization of Women's Health and Wellbeing. Sustainability, 12(9), Article 9. https://doi.org/10.3390/su12093593

Strategizing national health in the 21st century: A handbook. (n.d.). Retrieved March 7, 2024, from https://www.who.int/publications-detail-redirect/9789241549745

Sullivan-Bolyai, S., & Bova, C. (2021). *Qualitative Description: A "How-To" Guide*. https://doi.org/10.13028/8VWE-XC61

Sundberg, M. (2019). Donors dealing with 'aid effectiveness' inconsistencies: National staff in foreign aid agencies in Tanzania. *Journal of Eastern African Studies*, *13*(3), 445–464. https://doi.org/10.1080/17531055.2019.1628384

Terwindt, F., Rajan, D., Soucat, A., Schmets, G., & Kadandale, S. (2016). Strategizing national health in the 21st century: A handbook. *Geneva: World Health Organization*.

The Lancet. (2023). A broader vision for women's health. *The Lancet*, *402*(10399), 347. https://doi.org/10.1016/S0140-6736(23)01570-2

United Nations Institute for Training and Research (UNITAR) (2019). *SDGs, Main Contributions and Challenges* (N. Seth, C. M. Díaz Barrado, & P. Durán Y Lalaguna, Eds.). UN. https://doi.org/10.18356/55c2bdbe-en

UNSDG | Leave No One Behind. (n.d.). Retrieved March 27, 2024, from https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind, https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind

Weitz, N., Carlsen, H., Nilsson, M., & Skånberg, K. (2018). Towards systemic and contextual priority setting for implementing the 2030 Agenda. *Sustainability Science*, *13*(2), 531–548. https://doi.org/10.1007/s11625-017-0470-0

Woodward, M. (2019). Cardiovascular Disease and the Female Disadvantage. *International Journal of Environmental Research and Public Health*, *16*(7), 1165. https://doi.org/10.3390/ijerph16071165

CHAPTER 4: DISCUSSION

This thesis has sought to explore problem conceptualization related to women's and girls' health within the SDGs and the processes that inform priority-setting frameworks within the UN system. Chapter 2, a scoping review titled *Problematizing women and girls' health across the Millennium Development and Sustainable Development Goals: An analysis of United Nations documents* utilized Bacchi's WPR framework to examine problem framing and representation related to women's and girls' health across UN documents. I analyzed the potential implications of problem framing and representation and highlighted the particular importance of identifying underlying assumptions when working with priority, marginalized populations, including women and girls. Problem framing and representation inherently shapes policy decisions and are informed by often implicit assumptions and biases, resource constraints, and often complex social, political, and economic contexts. To this end, Chapter 3, a qualitative study titled "*We have to look deeper into why": Perspectives on problem identification and prioritization of women's and girls' health across UN agencies* generated insight into what these factors are and how they impact UN agencies' work in implementing the SDGs as they relate to gender and health equality.

A key overarching exploration of this thesis is how women's and girls' health is represented in, and positioned in relation to, the SDGs. To this end, it has demonstrated the need to examine the role of the SDGs in shaping policy affecting the health of women and girls worldwide as well as critically examining problem framing and priority-setting processes in the SDGs and across UN agencies. The role of the SDGs is to mobilize policy and programmatic change by channelling resources, attention, and strategies towards key issues needed to foster global development (Grainger-Brown and Malekpour, 2019). This characterization was echoed in the narratives of study participants in Chapter 3. Given the overarching influence of the SDGs to shape development agendas around the world, it important to critically analyze the messaging communicated in the SDGs. This is especially important given the absence of strict implementational guidelines to ensure that harmful stereotypes or preconceptions about women's role in society are not perpetuated and thus potentially consolidated in interventions implemented by member states. It is equally as important to promote equitable approaches to policy and programming. Opportunities for doing so are highlighted in both Chapters 2 and 3, such as

expanding the conception of women's and girls' health to include all gender-mediated dimensions of health across the life course.

de Leeuw et al. (2014) argue that policy is not an intervention in and of itself but helps to drive the development and implementation of interventions – to this end, the authors write that it is crucial to understand policy processes and their underlying theories in order to enact policy change – as this thesis has sought to do for SDGs and global health. With the introduction of the SDGs in 2016, Esquivel and Sweetman (2016) contemplated the potential role of the SDGs, writing that

> "The SDGs will form a significant element in the constellation of international agreements which will shape the world for women in the next decade and a half. They should offer an entry point to movements fighting for rights and social justice, including women's movements, and to all involved in fighting economic inequality and poverty" (p.2)

Acknowledging that the "strong aspirational" documents will not solve inequalities on their own, Esquivel and Sweetman (2016) go on to explain that international agreements have historically been "hugely important in directing policy decisions and resource flows to social goods" as well as "influencing the cultural and social norms which we all live by" (p.2). Glass and Newig (2019) describe the SDGs as particularly special due to their "broad acceptance and commitment of the international community," and position the goals as a response to "global problems emerging in the wake of globalization processes and increasing global interconnectedness" (p.1). In identifying issues of gender and health equality as inherently global, the SDGs provide a particularly useful vantage point and orientation for policies seeking to impact the health and well-being of girls and women worldwide.

The influence of the UN can be demonstrated through the lens of the Beijing Declaration and Platform for Action of 1995 and the strides made towards gender equality since its adoption into the UN agenda, while underlining a similar optimism for the future as we approach the conclusion of the 2030 Agenda. The Beijing Declaration was frequently cited as a landmark and historical turning point for gender equality by study participants in Chapter 3. Allotey and

Denton (2020) characterize the progress in gender equality in the past 30 years as undeniably positive, given that many countries worldwide have been able to achieve impressive results on the indicators associated with the Declaration, including violence against women, access to sexual and reproductive health services, improved access to education, reduction in maternal morbidity and mortality, and an increased recognition of the importance of considering gender in healthcare provision.

Part of Chapter 2's research objectives involved examining the evolution of the UN's sustainable development agenda between the MDGs and SDGs. The MDGs received criticism for insufficient coverage of gender targets, an oversimplified view of gender equality, and leaving substantive power asymmetries noticeable unaddressed (Kabeer, 2005; Fehling et al. 2013; Odera & Melusa, 2019). As to the value and necessity of addressing power asymmetries and entrenched structures of inequality, Allotey and Denton (2020) caution that progress achieved since the Declaration, in the eras of both the MDGs and the SDGs, is fragile. They attribute this to an absence of "real political, societal, and cultural transformation in the past 25 years, and transformation that recognises the need for redistribution of power and privilege across all aspects of life and that would impact on health and wellbeing" (p.1053). Both chapters of this thesis have sought to bring attention to the shortcomings of both the SDGs and MDGs in ameliorating the concerns of Allotey and Denton (2020) and Kabeer (2005). Such findings include a demonstrated lack of interrogating underlying structures of inequality in UN documents and the perpetuation of stereotypes of women's role in society. Chapter findings also emphasize problem representation analysis as a constructive opportunity to enact change on identified issues, positively shifting the practical implementation of the SDGs and sustainable development agendas moving forward.

Chapter 2 of this thesis has elucidated the types of framing and representation that occur across UN documents in discussion surrounding issues of women's and girls' health. The linkage between problem framing and its implications for policy and programs related to women's and health will be further discerned in this discussion. In identifying key categories of health issues and the ways they are represented in UN documents spanning the MDGs and SDGs, Chapter 2 identified potential consequences of current modes of framing, which include: reduced mobilization of resources towards a broadened concept of gender and health and the further

consolidation of harmful stereotypes about women and girls. The perspectives of study participants in Chapter 3 similarly contribute to this thesis' understanding of policy consequences.

Shiffman and Shawar (2022) cite the work of Benford and Snow (2000) and Stone (1989) to explain that:

> "Frames commonly encompass beliefs about an issue's causality, including what and who is to blame for its existence; its solutions, including who is responsible for solving it; and its import, especially why it merits public action." (2022, p. 1978).

Framing is thus key to comprehending policy and its intentions and implications, given the impact has on the policy. It is well-documented and understood that like the complex and expansive topic landscape of the SDGs, gender equality is a complex and multifaceted problem on a global scale (Hawkes et al., 2020; Clark & Horton, 2019). At the global level, the task of advocating for specific framings of problems is complicated by factors explored in Chapter 3, such as member state relations and international norms related to gender and health. Head (2022) explains that "complex policy problems often involve conflicting interests and divergent perceptions among various stakeholder groups," and that disagreements about problems and subsequent policy often stem from diverse backgrounds in "material interests, socio-cultural values, and political (dis)trust" (p.7). This phenomenon leads to equally diverse expressions of problem and solution framing, which occur through "the language of economic benefits, ideological outlooks, group values and political loyalties" (Head 2022, p.7).

Reconceptualizing this phenomenon of divergent interests as an opportunity for policy may be useful, especially for complex problems such as the multifaceted issue of health and gender inequality. This would involve approaching potential policy implementation and intervention with the understanding that diverging opinions are an unavoidable feature of the process. This approach would direct important resources towards research similar to this thesis that identifies and interrogates underlying assumptions. It would also prioritize community engagement processes that encourage and attend to the perspectives and knowledge of a diversity of stakeholders impacted by a certain intervention, including their involvement in problem

framing and implementation. While these initiatives do not necessarily simplify the framing process, they may help encourage transparency, awareness, accountability, and collaborative action towards ensuring quality, context-dependent, and equitable policy (de Weger et al., 2022; Lewis et al., 2019).

A central finding of Chapter 2 is the tendency of problem and solution framing in characterizing women in terms of what they can/should provide to others, such as their children, families, or communities. As clarified in Chapter 2, recognizing the capability of women in supporting others is not negative in and of itself – indeed community-oriented policy and practice is central to sustainable development (Filho et al., 2022). It is thus necessary to recognize the unique capabilities of women and the immense value they bring to their communities. However, positioning efforts towards gender equality as primarily beneficial for others (i.e., children, families, and communities) may hinder the accountability that is necessary to achieve meaningful and material reciprocation for the benefits women provide to their communities. To combat this instrumental framing of women's health, it is important to emphasize an individual rights-based approach to health that recognizes the inherent right to good health for all rather than a means to improving different facets of society – such as improving social welfare or economic growth, as is often the case in development policy literature. As described earlier using the work of Head (2022) and in Chapter 2, problem framing often takes on a practical role of convincing stakeholders that a certain problem is worth pursuing for the benefits its resolution may provide, or the ability to tackle many birds with one stone. This is a necessary consideration in the scope of a complex agenda such as the SDGs which emphasizes interconnectedness and the need to act on many issues at once. However, it may prove worthwhile to be mindful of how these investments and gains in women's and girls' health are portrayed, moving towards a reconceptualization that recognizes the need to improve their status irrespective of any social or economic justification.

Chapter 3 noted a key concern expressed by several study participants, who identified a flaw in the logic of equating women's health with maternal and/or reproductive health – in that not all women will become mothers, and that their health is inherently valuable outside of their reproductive capabilities. This concern, echoed in Chapter 2 and shared by scholars like Bustreo et al. (2012), is interconnected with an emerging call to broaden conceptions of women's health

beyond sexual and reproductive health to include consideration for the other dimensions of health that can be mediated by gender. Reconceptualizing women's health as holistically impacted by sociocultural dimensions of gender, which can interact with physiological characteristics of the body, is key to meaningfully enacting policy changes that can improve the status of women and girls across the social determinants of health (Langer et al., 2015).

Future research at the intersection of health, gender, and development, could benefit from incorporating other frameworks to analyze key parts of the policymaking and implementation process, including underlying theories. Applying complementary frameworks and theories to future document reviews or interview studies can provide additional insights into information and processes that impact policy and enhance its success in advancing health and gender equality. Examples of frameworks include: the Multidimensional Inequality Framework created by the Atlantic Fellows in Social and Economic Equity Programme, which provides a systematic approach to measuring and conceptualizing inequalities across many dimensions, Kabeer's (1994) Social Relations Approach, which focuses on the interrelated dimensions of gender inequality, and/or Walt and Gilson's policy triangle.

A further exploration and application of feminist and intersectional theories as they relate to country-level implementation of the SDGs can shed necessary light onto the ways in which gender can compound other parts of one's identity. For example, the experiences of gender and sexual minorities were not well-explored in this thesis. In a report written by O'Malley et al. for the UNDP, the authors explain that "sexual and gender minorities are often among the most marginalized and, as such, require specific inclusion and attention in order to drive forward the vision of the SDGs" (2018, p.9). Further research focusing on these populations may benefit from similar methods of analysis as those used in this thesis to understand how framing and underlying assumptions impact or exclude gender and sexual minorities from relevant policies. Gender inequality is harmful to people of all genders, and the ways in which gender interacts with sexual orientation highlight the importance of intersectional and collective action towards dismantling structures that disadvantage certain populations (O'Malley et al., 2018; Becker, 1999). Intersectional approaches are crucial for understanding how multiple parts of one's identity can coalesce to shape one's health, emphasizing the need for integrated action that promotes equality across determinants mediated by race, ethnicity, class, religion, sexual

orientation as well as gender identity. Yam et al. (2021) explains that "the deep wellspring of learnings [intersectionality] affords remains underused in mainstream initiatives on gender and global health," highlighting an opportunity for future research to consider the findings of this thesis in conjunction with similar framework analyses for other priority populations in global health research.

The health of older women is a key issue identified across the literature on women's health and by several key informants in Chapter 3. Advocating for greater attention to be paid to the unique health determinants impacted by gender across the life course involves advocating for specialized research dedicated to improving the health and well-being of older women, an oft-overlooked sub-population within an already neglected population (Vibha and Laskar, 2011; Bustreo et al. 2013; Myatra et al. 2021; Peters et al., 2016). Research focused on the health of older women is crucial when considering the rapidly increasing global burden of non-communicable diseases, of which risk is partially determined by health behaviours throughout life but typically onsets later in life, and the complex policy responses necessary to mitigate their burden (Ngowi et al., 2023; Bonita & Beaglehole, 2014).

References (CHAPTER 4)

Allotey, P., & Denton, F. (2020). Challenges and priorities for delivering on the Beijing Declaration and Platform for Action 25 years on. *Lancet (London, England)*, *396*(10257), 1053–1055. https://doi.org/10.1016/S0140-6736(20)32004-3

Becker, M. (1999). *Patriarchy and Inequality: Towards a Substantive Feminism*.

Benford, R., & Snow, D.A. *Framing Processes and Social Movements: An Overview and Assessment. Annual Review of Sociology, 26, 611–639. http://www.jstor.org/stable/223459*

Bonita, R., & Beaglehole, R. (2014). Women and NCDs: Overcoming the neglect. *Global Health Action*, *7*, 10.3402/gha.v7.23742. https://doi.org/10.3402/gha.v7.23742

Bustreo, F., de Zoysa, I., & Araujo de Carvalho, I. (2013). Policy directions to improve women's health beyond reproduction. *Bulletin of the World Health Organization*, *91*(9), 712–714. https://doi.org/10.2471/BLT.12.109785

Bustreo, F., Knaul, F. M., Bhadelia, A., Beard, J., & Araujo de Carvalho, I. (2012). Women's health beyond reproduction: Meeting the challenges. *Bulletin of the World Health Organization*, *90*(7), 478-478A. https://doi.org/10.2471/BLT.12.103549

Clark, J., & Horton, R. (2019). A coming of age for gender in global health. *The Lancet*, *393*(10189), 2367–2369. https://doi.org/10.1016/S0140-6736(19)30986-9

de Leeuw, E., Clavier, C., & Breton, E. (2014). Health policy – why research it and how: Health political science. *Health Research Policy and Systems*, *12*(1), 55. https://doi.org/10.1186/1478-4505-12-55

De Weger, E., Drewes, H. W., Van Vooren, N. J. E., Luijkx, K. G., & Baan, C. A. (2022). Engaging citizens in local health policymaking. A realist explorative case-study. *PLoS ONE*, *17*(3), e0265404. https://doi.org/10.1371/journal.pone.0265404

Esquivel, V., & Sweetman, C. (2016). INTRODUCTION: Gender and the Sustainable Development Goals. *Gender and Development*, *24*(1), 1–8.

Fehling, M., Nelson, B. D., & Venkatapuram, S. (2013). Limitations of the Millennium Development Goals: A literature review. Global Public Health, 8(10), 1109–1122. https://doi.org/10.1080/17441692.2013.845676

Glass, L.-M., & Newig, J. (2019). Governance for achieving the Sustainable Development Goals: How important are participation, policy coherence, reflexivity, adaptation and democratic institutions? *Earth System Governance*, *2*, 100031. https://doi.org/10.1016/j.esg.2019.100031

Grainger-Brown, J., & Malekpour, S. (2019). Implementing the Sustainable Development Goals: A Review of Strategic Tools and Frameworks Available to Organisations. *Sustainability*, *11*(5), Article 5. https://doi.org/10.3390/su11051381

Hawkes, S., Allotey, P., Elhadj, A. S., Clark, J., & Horton, R. (2020). The Lancet Commission on Gender and Global Health. *Lancet (London, England)*, *396*(10250), 521–522. https://doi.org/10.1016/S0140-6736(20)31547-6

Head, B. W. (2022). Debates in Public Policy—Problem Framing, Knowledge and Interests. In B. W. Head (Ed.), *Wicked Problems in Public Policy: Understanding and Responding to Complex Challenges* (pp. 7–19). Springer International Publishing. https://doi.org/10.1007/978-3-030-94580-0_1

Kabeer N. (1994). *Reversed realities : gender hierarchies in development thought*. Verso.

Kabeer, N. (2005). Gender Equality and Women's Empowerment: A Critical Analysis of the Third Millennium Development Goal. *Gender and Development*, *13*(1), 13–24.

Langer, A., Meleis, A., Knaul, F. M., Atun, R., Aran, M., Arreola-Ornelas, H., Bhutta, Z. A., Binagwaho, A., Bonita, R., Caglia, J. M., Claeson, M., Davies, J., Donnay, F. A., Gausman, J. M., Glickman, C., Kearns, A. D., Kendall, T., Lozano, R., Seboni, N., … Frenk, J. (2015). Women and Health: The key for sustainable development. The Lancet, 386(9999), 1165–1210. https://doi.org/10.1016/S0140-6736(15)60497-4

Leal Filho, W., Levesque, V., Sivapalan, S., Salvia, A. L., Fritzen, B., Deckert, R., Kozlova, V., LeVasseur, T. J., Emblen-Perry, K., Azeiteiro, U. M., Paço, A., Borsari, B., & Shiel, C. (2022). Social values and sustainable development: Community experiences. *Environmental Sciences Europe*, *34*(1), 67. https://doi.org/10.1186/s12302-022-00641-z

Lewis, S., Bambra, C., Barnes, A., Collins, M., Egan, M., Halliday, E., Orton, L., Ponsford, R., Powell, K., Salway, S., Townsend, A., Whitehead, M., & Popay, J. (2019). Reframing "participation" and "inclusion" in public health policy and practice to address health inequalities: Evidence from a major resident-led neighbourhood improvement initiative. *Health & Social Care in the Community*, *27*(1), 199–206. https://doi.org/10.1111/hsc.12640

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization*, *96*(9), 644–653. https://doi.org/10.2471/BLT.18.211607

Myatra, S. N., Tripathy, S., & Einav, S. (2021). Global health inequality and women – beyond maternal health. *Anaesthesia*, *76*(S4), 6–9. https://doi.org/10.1111/anae.15431

Ngowi, J. E., Munishi, C., Ndumwa, H. P., Njiro, B. J., Amani, D. E., Mboya, E. A., Mloka, D., Kikula, A. I., Balandya, E., Ruggajo, P., Kessy, A. T., Kitambala, E., Kapologwe, N., Kengia, J. T., Kiologwe, J., Ubuguyu, O., Salum, B., Kamuhabwa, A., Ramaiya, K., & Sunguya, B. F. (n.d.). Efforts to Address the Burden of Non-Communicable Diseases Need Local Evidence and Shared Lessons from High-Burden Countries. *Annals of Global Health*, *89*(1), 78. https://doi.org/10.5334/aogh.4118

Odera, J. A., & Mulusa, J. (2020). SDGs, Gender Equality and Women's Empowerment: What Prospects for Delivery? In M. Kaltenborn, M. Krajewski, & H. Kuhn (Eds.), Sustainable Development Goals and Human Rights (pp. 95–118). Springer International Publishing. https://doi.org/10.1007/978-3-030-30469-0_6

Peters, S. A. E., Woodward, M., Jha, V., Kennedy, S., & Norton, R. (2016). Women's health: A new global agenda. *BMJ Global Health*, *1*(3), e000080. https://doi.org/10.1136/bmjgh-2016-000080

Sexual and Gender Minorities. (n.d.). UNDP. Retrieved April 6, 2024, from https://www.undp.org/publications/sexual-and-gender-minorities

Shiffman, J., & Shawar, Y. R. (2022). Framing and the formation of global health priorities. *The Lancet*, *399*(10339), 1977–1990. https://doi.org/10.1016/S0140-6736(22)00584-0

Stone, D. A. (1989). *Causal Stories and the Formation of Policy Agendas*.

Vibha, & Laskar, A. R. (2011). Women's Health: Beyond Reproductive Years. *Indian Journal of Public Health*, *55*(4), 247. https://doi.org/10.4103/0019-557X.92399

Yam, E. A., Silva, M., Ranganathan, M., White, J., Hope, T. M., & Ford, C. L. (2021). Time to take critical race theory seriously: Moving beyond a colour-blind gender lens in global health. *The Lancet Global Health*, *9*(4), e389–e390. https://doi.org/10.1016/S2214-109X(20)30536-2

CHAPTER 5: CONCLUSION

This thesis has provided insight into how problem and solution framing and representation can shape policy approaches to gender health inequity and the role of problem framing in impacting priority setting in development policy. It has fulfilled its research objectives by identifying key categories of health issues associated with women and girls across the MDGs and SDGs, utilizing the WPR framework to examine potential implications of problem framing on health, and gaining insight into the types of information and conceptualizations that shape policy action in UN agencies. Future research in the field of health, development, and policy can build on the findings of this thesis to further explore key issues relevant to improving women's and girls' health. This work could be expanded to interrogate the concept of gender itself as it is presented in documents and policies. Furthermore, the inclusion of additional analytical frameworks such as Walt and Gilson's policy triangle would be highly beneficial in identifying other components of the policy making process that can lend themselves to either exacerbating or improving inequality in development policy. This study has contributed to the fields of international development, global health, feminist studies, policy analysis, and implementation research, and enhanced knowledge of the underlying logics of global health policy within the SDGs. This thesis connects Chapters 2 and 3 to demonstrate the linkages between problem framing, representation, and conceptualization and the processes that inform the priority-setting frameworks within the UN system. In doing so, this thesis has demonstrated the importance of promoting the inclusion of a gendered lens in examining development policy and interrogating the impacts of certain types of information and communication on priority populations. These actionable items offer promising opportunities for improving the health and status of women and girls worldwide, especially in the next iteration of the UN's sustainable development agenda.

APPENDICES

Appendix 1: Interview Guide

Broad questions:

Theme/objective	Ask respondent to	Questions:
Opening questions		Thank you for talking with me! [other opening/ice breaking] Can you describe your position for me? How long have you worked in this position? Can you tell me about your involvement with the SDGs (either the development or since they were adopted)?
Identify which health issues are associated with women and girls	Provide overview of understanding of women/girl's health	Which issues related to women's and girl's health have you seen identified within your agency? What issues do you work on? *what it involves, how it addresses the issue Can you describe an initiative that emerged that pursues or addresses these issues? • Can you describe how you are involved in this/these initiative(s)? Which agencies do you see really pushing the women and girls' health agenda? What are they doing that impresses you? Are these new initiatives? (Probe to gain some historical context) - If there is one, ask *when* these initiatives emerged

Understand the criteria and rationale used to justify and support identified issues	Explore re) ways in which org history, people, politics, agendas and evidence have influenced approach	I'd like to explore your perspectives on 3 levels of criteria or influencing factors on how the global health agenda for women is developed and framed – within your agency, in terms of public discourse, and more broadly within global health and development discourse What do you think informed your agency's decision to address the health issues that you identified previously? • Who have you consulted most closely with in your work on women and girls' health? What do think are some key contributions that these individuals/groups make to your work? Can you provide an example of an interagency meeting or experience where women's health issues were discussed? • Were there any differences in how people thought about and identified which factors contributed to the same problem? For example, if two regional divisions of the WHO were to meet (i.e. African Region and PAHO), how might you describe discussion about the different factors of, for example, gender-based violence? • If so, how were any differences resolved? Which types of information were most important in identifying health issues? For example, was there a particular report that was impactful in helping to identify the issue(s)?

Understand the criteria and rationale used to justify and support identified issues	Explore re) ways in which org history, people, politics, agendas and evidence have influenced approach	Sexual and reproductive health topics like family planning seem to receive a lot of attention inside and outside of policy and clinical spheres. Do you think the attention certain issues receive in media or political debates shapes your work?
Understand the criteria and rationale used to justify and support identified issues	Explore re) ways in which org history, people, politics, agendas and evidence have influenced approach Personal experience	What historic events/agendas have influenced the manner in which WG health is discussed? (Note: important to probe to get details and fill in the historical context)
Follow up questions based on research question		Are there issues that have lagged or have otherwise struggled to see progress? Why do you think this might be the case? Can you share any thoughts on why certain issues receive attention and other do not?
Closing		Is there anything else that we haven't discussed that you think is important for me to understand?
Snowball sampling	Recruit additional participants	Can you think of colleagues with similar experience and expertise in your field?

Appendix 2: Data Extraction Table

Identified Issue	Identified Cause(s)	**Question 1**: What's the problem represented to be in a specific policy or policies? (e.g. economic development, global warming, etc	**Question 2:** What deep-seated presuppositions or assumptions (conceptual logics) underlie this presentation of the 'problem'	**Question 3:** How has this representation of the 'problem' come about?	**Question 4:** What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be conceptualized differently?	**Question 5:** What effects (discursive, subjectification, lived) are produced by this representation of the 'problem'?	**Question 6:** How and where has this representation of the 'problem' been produced, disseminated, defended? How has it been and/or how can it be disrupted and replaced?
Barriers to care	underrepresentation of women, lack of attention to women's health needs, lack of gendered perspectives, segregation and discrimination in healthcare, discrimination causing inadequate access to care (i.e. lack of financial independence)	Women have difficulty accessing gender-specific, relevant, and appropriate healthcare	That women would benefit from gender specific care, that it is a necessity for good health, and that it is discriminatory to not be offered such care	The idea of gender specific care had to be introduced as well as broad acknowledgement of gender specific health needs. Primary health care for all (Alma-Ata Declaration) likely revitalized or triggered this conversation	A specific focus on issues that are not sexual or reproductive health -- this is often characterized as the main difference between men and women so often remains a focal point. Should integrate a cultural intersectional view as well	Could feed into the opposite effect it intends to have -- further perpetuating an idea of women as complicated or needy, which is a stereotype that affects patient-provider relations and other healthcare experiences	Produced by development policy rhetoric, disseminated to NGOs and states, defended by health equity advocates. The representation of the problem can be disrupted by consideration for intersectionality, or dependent on region
Disproportionate risk of HIV/AIDS	ignorance of disease and effects, lack of SH education, increased physiological and social vulnerability, prevalence of sex work (female dominated), fundamental unequal power balance between women and men, reproductive tract biology, lack of gendered perspective in HIV programming, sexual and intimate partner violence	Women have a disproportionately higher risk of contracting HIV/AIDS	HIV/AIDS is an epidemic, that women have a different set of factors (i.e. social, biological, political) that differentiate their baseline risk from that of men	HIV/AIDS was identified as a major threat to development. Women are unique because they can transmit to babies. Disparities in HIV/AIDS epidemic revealed/exacerbated/highlighted the same disparities in health broadly	I find it interesting the rhetoric between HIV/AIDS being characterized as an MSM disease in Western/HIC countries when the reality of the situation on a global epidemic scale tells otherwise -- perhaps silence about cultural differences? Also stigma in general	Stigmatization of sex work, rhetoric of responsibility falling solely or mostly on women to use protection, blame placed on HIV-positive women who give birth to babies despite lack of accessibility to testing (criminalization in certain countries)	See above. The representation of the problem can be disrupted by bringing light to the HIV/AIDS risk and prevalence in women in HICs
Gender specific environmental health concerns	air pollution, lack of affordable energy, poverty, gender roles, unequal power relationships, girls are pulled away from education, vulnerability of women and children in slums	Women are at greater risk of various environmental health concerns (i.e. water borne disease, long-term consequences of exposure to pollution, etc)	That many of the hallmarks of life for those with limited resources present dangerous health risks, and women are placed at greater risk of being negatively affected by these factors due to biological or sociocultural characteristics	Emergent research on the risks of certain environmental exposures, and who bears the greatest cumulative exposures. Based in knowledge that women and girls often fetch water or do all the cooking in the house	Many countries and their economies cannot reasonably switch energy sources or install widespread plumbing that would prevent water-borne diseases for women retrieving - plausible alternatives are left silent *but will review the documents on this when writing analysis*	Path dependency and further consolidating gender roles - addressing the overt exposures without addressing the underlying issues effectively	See above. It can be disrupted by challenging the gender role norms (but again delicate subject [see comment on left cell]
Sexual violence, rape, trafficking	lack of protection of children (young girls), lack of education, power imbalances, frequency of age gaps, lack of social and cultural progress worldwide, biases against women	Women have a disproportionate lifetime risk of suffering sexual violence and abuse	Women are inherently vulnerable because of the social and power dynamics related to gender, which impacts them differently compared to men	Problem may be viewed as a non-issue or part of the cultural or social fabric of some countries or regions - nevertheless, has been accepted as a problem by the United Nations under the precipice that it violates human rights of autonomy and causes great distress	The role of men in perpetuating it, it takes on a bit of a "it's just how it is" rhetoric, is not clear on how these processes continue to be replicated beyond just "it is embedded in culture"	Having to be afforded the "privilege" of not being sexually abused, or recognition of right to autonomy, fundamentally undermines that very right - linked to other ideas of justice theories	This problem has been produced by feminist activists, development policy rhetoric, disseminated to NGOs and states, and defended by feminist/women's rights advocates. This representation can be heavily disrupted depending on region
Poor nutrition	poverty, lack of access to resources and basic social services, discrimination and discriminatory practices, vulnerability in family structures, cultural traditional practices, poor literacy	Women have a different risk profile that creates different outcomes (compared to men) when affected by poor nutrition, that carries different consequences for community structures	Women occupy different roles in community or familial structures that makes the status of their nutrition have a different impact than men	Came about through increased research into the effects of poor nutrition and its distribution globally + making linkages to cultures or regions that typically use a female-centric domestic upkeep model	Reconceptualization of the issue would include focusing on broader structural factors on the interplay between gender roles (i.e. caregiving, domestic support, agricultural support) in both food systems among regions as well as in the facilitation of communities	Perpetuates this idea of responsibility, follows similar rhetoric of women as sole caretakers of family and thus bearing the burden of raising healthy children who become productive adults	See above. Representation can be disrupted by challenging the "ulterior motives" of trying to ameliorate poor nutrition + other gender inequities
NCDs in women	increased risk of CVD from smoking, stigma, inaccessible healthcare due to lack of autonomy, limited access to physical activity, lack of nutritious food	Women are uniquely affected by both different and shared risk factors (compared to men) which are rooted in a different set of determinants	Recognition that there are differences in biology, behaviour, and social determinants of health between men and women, and that women may be at an increased risk of death or disability due to NCDs	Epidemiological research, sex-disaggregated data, gender-based research, and increasing advocacy for gender equity in healthcare experiences	Despite inherently recognizing differences in health status that may contribute to these discrepancies, underlying social inequities are seldom addressed and cannot be adequately resolved in one sector alone	In resource scarce settings, it is certainly a practicality issue of what can be done to address this admist the process of "triaging" but ignoring issue fundamentally places women at again, a level of inequality pervasive throughout society	Relatively new idea in NCD research - reproduced by academic research and health education campaigns, but needs to be disseminated hand in hand with structural overhauls to disrupt the problem
Divison of domestic labour	unequal gender roles and expectations, cyclical effects of lack of education, poverty, power imbalances, vulnerability in family structures	Women bear a disproportionate burden of domestic labour (housekeeping, raising children, etc) and do not possess economic independence, carrying implications for health	Women have a different role in society as caregivers and homemakers, this is applicable to most cultures in the world, and that unpaid labour carries an inherent value	Emergent research on gender dynamics, spearheaded by feminist activism, and driven by development rhetoric looking to involve women in the economy	Potentially does not explore the role of men in family dynamics further, perhaps also encompasses the labour of children (specifically girls), it overlooks cultural factors such as the lack of sanctioned childcare in many countries	This problem has shed light on the unequal division between domestic labour performed versus the economic benefits sowed by the caregivers -- shapes women further as mothers and the "backbones" of their communities	See above. Representation could be altered by including consideration for the question of who might take care of these children and the immense overhaul necessary for cultural norms (i.e. splitting time between parents, leaving children with caretakers, etc)
FGM	cultural and social status, familial fear of social isolation by going against social norms, fear of loss of status, prescribed inferiority of women	FGM is a form of gender-based violence that is culturally embedded in some societies that carries significant psychological and medical problems for victims	Girls are differentiated by the societal expectation to be pure and modest and their sexualities and bodily autonomy are dictated by patriarchal standards	Has been facilitated through human rights activism and emerging recognition of the severe and longlasting consequences	While not necessarily silent, the issue of cultural backlash and social consequences for famillies that do not abide is integral to the issue, and like many human rights offences, is not straightforward in its solutions	The representation of the problem sheds light on the lack of autonomy for girls' bodies, but again characterizes girls as helpless in a way -- also, many women who are older and continue these practices on their daughters as immigrants do not agree with its negative characterization -- othering in a way	See above - it is a big topic within the UN and has been reproduced by its associated human rights or gender rights agencies -- the problem could be disrupted by promoting culturally sensitive approaches to the root problems (like many things here)
Unintended pregnancy	gender-based discrimination, limited access to birth control, poor access to quality healthcare (abortion, prenatal, emergent care such as c-section), pregnancy as a result of violence, societal expectations to carry children	Unintended pregnancy can cause severe and longlasting consequences for mothers	Pregnancy is associated with girlhood/womanhood and inextricably linked to power dynamics that interact to create circumstances in which women encounter unwanted pregnancies as well as perpetuates maternal mortality	Brought on by the advancement of reproductive rights and advent of birth control, family planning methods, gender-based research	Like other issues, it is tied back to complex and embedded power structures in society that generate risk factors for unwanted pregnancy -- what could be left unsaid is that pregnancy does not just have to be pushed back to a later date, or under consensual circumstances, that its ok to not be a mother	In resource scarce settings, it is certainly a practicality issue of what can be done to address this admist the process of "triaging" but ignoring issue fundamentally places women at again, a level of inequality pervasive throughout society - helps to shape public discourse on motherhood	See above. Rhetoric around problem reproduction may differ based on the culture of the region it is being pedalled in -- for example, restrictions on abortion but access to birth control - disruption could include comprehensive sexual education delivery despite barriers in education for women
Maternal mortality + other complications	gender-based discrimination, limited access to birth control, poor access to quality healthcare (abortion, prenatal, emergent care such as c-section),	Maternal mortality is an rampant problem facing many LMICs with limited access to healthcare resources -- and these deaths are largely preventable at each stage through pregnancy and childbirth	Pregnancy is associated with girlhood/womanhood and inextricably linked to power dynamics that interact to create circumstances in which women are in positions of poor maternal heatlh and inaccessibility to healthcare, and that maternal health is a right for child and mother	Maternal mortality had long been a development goal but its underlying motives have evolved overtime - emerged due to staggering numbers, specifically preventable deaths	Maternal mortality is often associated with LMICs and resource-poor settings (since it is often used as an indicator of development), but there is also an element of "global in local" wherein mothers die everywhere + underreporting of maternal deaths	It shapes discourse on maternal mortality and is inextricably linked to measurement of development -- it helps create an interesting tension between the expectation for women to be mothers and the dangerous undertaking it often is for women	See above -- disruption of this problem would be inextricably linked to discourse around unwanted pregnancies as well as societal or cultural expectations of motherhood and discussions around bodily autonomy and the right to healthcare
Increased vulnerability in conflict and disaster	lack of education during emergencies (when basic needs are not met), lack of international intervention + implementation of warcrime norms, exclusion from peace negotiations	Women have a unique risk profile during times of conflict or disaster due to increased vulnerability that exacerbates existing structures of oppression	Times of conflict or disaster means that societies must try to retain their most basic needs + functions (food, water, shelter, safety) -- and that women's rights are often not included in this list of priorities, hence placing women's rights as nonpriority -- assumptions about gender norms	This problem has emerged from research and perspectives into crises and emergencies and the role of gender in emergencies, as well as concurrent discussion on human rights and autonomy	As with many experiences, there is certainly much diversity and variance in experiences, and an unpredictability that is often unique to instability or times of crisis	I think it perpetuates a certain rhetoric of women being inherently vulnerable or weak instead of that being the case due to patriarchy and violation of human rights in war or crises - risk of becoming self fulfilling prophecy that perpetuates probelm	See above -- this problem is reproduced by humanitarian organizations -- problem could be disrupted by challenging the way we conceptualize women's vulnerabilities as well as providing gender specific support in emergency response
Substance abuse	increased stigma around women's usage specifically, different perceptions compared to men, lack of awareness of gender specific risk factors, socialization of SU as a "man's issue", lack of research into sex-specific consequences, barriers to care caused by inequitable distribution of resources	Women are at equal if not greater risk of substance abuse (depending on type) but are also at greater risk of stigma related to substance use	Women have different risk factors for substance abuse as well as different consequences as a result of gender and sex-specific differences, plus that substance abuse is typically stigmatized regardless of cultural context as well as gender	Emerged from research into gender-specific substance abuse, advocacy efforts for gender and sex disaggregated research into health, and women's advocacy	As with many experiences, there is often much intersectionality to be considered in the context of substance abuse - while there are different factors impacting women and men, there may also be different factors impacting women of different backgrounds (i.e. SES or race)	The stigmatization of substance abuse can further alienate certain vulnerable people from their communities, especially in poorly understood populations	See above - reproduced by health advocate and addiction medicine -- problem could be disrupted by further advocating for a holistic approach to substance abuse care, care delivery, and research
Access to education	gender biases, domestic labour expectations, expectations of starting family earlier, disproprtionate impacts of poverty	Girls face gender-based barriers to education that place them at life-long disadvantages compared to boys of the same age	Education is a crucial tool for social and individual development that unlocks opportunities and statuses for women that are difficult to achieve otherwise - empowering	Brought on by developments in children's rights and welfare, gender specific research into the impacts of education on girls, shaped by its role in the MDGs and SDGs	Need to consider not only the accessibility of education but also the quality of education -- while it is necessary to educate women to develop communities, what is the directionality between building the infrastructure for women to be educated if their education is necessary for a nation to flourish?	Rhetoric around girls' education often shapes them as being a benefit to their community, which is true, but it also carries a connation of we educate girls so that they can provide or be better role models for their community as opposed to just education for the sake of education, which is often how its represented for boys	See above - reproduced by education advocates (i.e. UNICEF) and narrative around the right to learn -- could be disrupted by promoting education for the sake of education (see left)
Prenatal sex selection	gender biases, belief that girls are less valuable than boys (i.e. provide less) and are more of a burden to the family, pressure to conform to societal or cultural expectations	Sometimes referred to as "natal inequality" -- many cultures in the world have a distinct preference for sons and reflects the low status of women	That the cultures who partake in this typically have a preference for boys and that there are consequences for demographics and sex ratios in populations	Introduced in family planning spheres and child/human rights advocacy efforts, research around national and sub-national (regional) data on sex ratios for newborns worldwide that indicated preference for boys	There is a recognition of how this data might be stratified across certain social/economic gradients; the socioeconomic struggle and stress of wanting a provider son is not well explored, but this is a two-fold interpretation of patriarchy since women are obscured from opportunity to pursue careers and economic independence	The attention being brought to the subject - while not necessarily the driving force in and of itself, may contribute to a general sense of low sense of self worth or perception of ability to thrive as women in countries where this practice takes place; the pressure to have sons can impede on a mothers' wishes	See above - reproduced by international bodies (such as the UN) particularly interested in human rights, as well as epidemiologists, economists, other population scientists concerned with imbalanced growth rates in certain countries - demands greater call to action for *some* of the underlying factors in this issue i.e. SES
Child marriage	patriarchal notions, gender-based violence, separation from family in times of disaster, lack of access to education, lack of consolidated social support or protections	The practice of marriage involving children is rampant and has consequences for a society	Child marriage is a violation of human rights, a threat to girls' health and well-being, and an obstacle to gender equality and development	Emerged from human and child rights advocacy efforts driven by social progress-- steady decline in the practice in the last decade especially, but persists in all regions of the world	Child marriage is often characterized as a foreign problem abroad, but it persists and manifests in different ways in high income nations - a discussion to be had about the different way violations of autonomy are created across national contexts	The representation of this problem runs the risk of alienating girls vulnerable to child marriage in countries not typically "associated" with the issue, as well as the risk of inadvernently normalizing the practice through complex systems of path dependency in areas where foreign intervention takes place	Above - notably, as mentioned in Q2, HICs often reproduce and represent this problem as a 'foreign' problem; otherwise, rhetoric is reproduced by childrens' rights/human rights/women's rights organizations - problem could be disrupted by challenging the idea that this issue is constrained to certain regions or countries