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GENDER INEQUALITY IN HEALTHCARE: HOW SEXISM SHAPES WOMEN'S HEALTH OUTCOMES IN WESTERN HEALTHCARE SYSTEMS

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Abstract

The aim of this article is to examine gender inequality in healthcare as a sociological issue, analysing how women's health has been historically marginalised and continues to be shaped by sexist practices and norms. The study explores how this historical exclusion influences contemporary Western healthcare systems and women's health outcomes. While gender bias and health disparities are acknowledged in academic literature, in practice they are often dismissed or addressed as technical issues rather than outcomes of sexist social structures. This paper provides a sociological perspective by examining how gender inequality in healthcare is produced and sustained through gendered norms and research practices that influence the quality of women's healthcare. The study combines a literature review with case-based examples documented in academic literature to examine historical and contemporary trends in women's healthcare, their impact on female patient safety and quality of care. Examples from multiple Western countries, including delayed diagnoses of women's pain-related and reproductive health conditions, are used to illustrate patterns of dismissal. The article reveals that contemporary Western healthcare systems continue to operate on male-default model, resulting in unequal care practices, dismissal of women's health concerns, incorrect or delayed diagnoses. Although overt discrimination has diminished in many Western healthcare contexts, inequality persists through research frameworks and clinical practices. This study relies on secondary data and published sources. Future research could incorporate empirical qualitative data, including interviews with patients, healthcare professionals and researchers, as well as comparative analyses across healthcare systems.

Keywords**:** *women's health; gender bias; health disparities; quality of care.*

Introduction

Despite major progress in the field of gender equality in the Western world, gender-based disparities persist across many social fields. For example, UN Women and United Nations Department of Economic and Social Affairs (2023) identify 17 separate areas in which women continue to face unequal treatment due to their gender, including instances of poverty, access to clean water, food, safe housing and others.

Research in sociology and gender studies shows that these disparities are shaped by historically embedded sexist structures and cultural norms that continue to influence contemporary societies and healthcare systems in Western countries are no exception (Hay et al., 2019; Merone et al., 2021). While modern healthcare is often presented as neutral and evidence-based, academic research and case examples demonstrate that healthcare practices have historically been shaped and sustained through gendered norms and research practices. Those patterns continue to influence contemporary Western healthcare systems and women's health outcomes.

The aim of this article is to examine gender inequality in healthcare as a sociological issue, analysing how women's health has been historically marginalised and continues to be shaped by sexist practices and norms. The study explores how this historical exclusion influences contemporary Western healthcare systems and women's health outcomes.

The article addresses the following objectives: 1) To analyse the historical background of gender inequality in healthcare; 2) To examine sociological perspectives of gender bias in contemporary healthcare systems; 3) To evaluate practical implications of gender inequality for women's health outcomes.

While gender bias and health disparities are acknowledged in academic literature, in practice they are often dismissed or addressed as technical issues rather than outcomes of sexist social structures.

Methodology

The study uses a literature review analysis to examine historical and contemporary trends in women's healthcare and their impact on female patient safety and quality of care. Case-based examples documented in academic literature from multiple Western countries, including delayed diagnoses of women's pain-related and reproductive health conditions, are used to illustrate patterns of dismissal.

The study relies on secondary data obtained from publicly available scientific publications and institutional reports. Sources were identified through searches of publicly available academic databases and search engines, using combinations of the following keywords: „gender bias in healthcare", „women's health", „sexism in medicine", „diagnostic bias" and „obstetric violence". The inclusion criteria were: 1) peer-reviewed scientific articles; 2) publications examining situations in Western countries; 3) studies published between 2015

and 2025. The final sample consists of 18 scientific articles and 2 institutional reports.

The literature was examined to identify patterns and examples related to the historical marginalisation of women's health and gender bias in healthcare, and the consequences of these inequalities for women's health outcomes and quality of care.

No human participants and/or respondents were involved and no personal data were collected. Thus, formal ethics considerations were not required.

Historical Background

The development of modern healthcare has been vastly influenced by historical sexist practices and norms and in turn women's health has long been marginalised within medical research and clinical practice. Scholars argue that these historical inequalities continue to shape modern healthcare systems, influencing women's health outcomes and the quality of the care they receive (Merone et al., 2021). Similarly, Liu et al. (2016) suggest that the historical exclusion of women from clinical research has produced gaps in medical knowledge regarding female health. Merone et al. (2021) refer to healthcare systems as patriarchal institutions that have historically focused women's health exclusively on reproductive organs, reflecting the notion that reproduction was the primary social function of women. Merone et al. (2021) also highlight that in past medical literature the female body was often seen as one of the "small male", ignoring biological differences between the sexes beyond reproductive organs. Historical medical discourse also illustrates how women's symptoms were often psychologised rather than medically treated. The diagnosis of "hysteria" widely used in earlier medical practice, demonstrates that women's pain and illness were interpreted through psychological lens while other medical explanations were overlooked (Merone et al., 2021).

The psychologicalisation of women's health is a reoccurring theme in medical history. Tasca et al. (2012) explain that women were historically perceived as weak and their symptoms of pain or illness were frequently dismissed as "uterine melancholy" or attributed to a lack of a normal sex life.

The pattern to interpret women's illness or pain as psychological problems contributed to more serious consequences in the history of women's healthcare – the disproportionate use of psychosurgery. The first lobotomy in the United Stated of America was performed on a woman, Alice Hammatt, who suffered from depression, it is also noted that the criteria for a lobotomy, recognised by the public at the time included "female gender" and other non-medical factors like "non-obedience" (Porfyri et al., 2025). Tone and Koziol (2018) detail the emergence of lobotomy procedures in the early twentieth century and highlight that most lobotomised patients were women, even though most institutionalised psychiatric patients at the time were men. In many cases, lobotomies were performed with the goal of making women more compliant, allowing them to return to socially expected domestic roles.

However, gender biases have existed not only in clinical treatment, but also in medical research. Liu et al. (2016) explain that earlier researchers viewed women as problematic subjects due to fluctuating hormones and as more expensive to study than the „norm" population. Liu et al. (2016) also discuss the U.S. Food and Drug Administration's 1977 guideline that banned women of child-bearing age from early-phase research to protect them from potential reproductive harm, a policy now viewed as problematic. Liu et al. (2016) emphasise that excluding women from clinical research has led to gaps in medical knowledge, for example, in understanding how the female body responds to certain medical drugs.

In conclusion, the historical background and development of women's healthcare reveal how gender bias has shaped clinical practice and medical research. Women's symptoms were frequently dismissed, ignored or psychologised. The diagnosis of hysteria, the disproportionate use of lobotomy procedures and the exclusion of women from clinical research illustrate the historical marginalisation of women's health. While many of these overt practices have been abandoned in contemporary Western healthcare systems, their legacy continues to influence women's health outcomes and the quality of care female patients receive.

Theoretical Background

Historical sexism and gender bias have shaped the practices of healthcare systems and their impact continues to have influence on women's health outcomes. A report by European Institute for Gender Equality (2025) highlights several instances of this impact – one in four women in the European Union believe that men are provided with better treatment by medical staff. The report also details that women report poorer self-perceived levels of health than men. Although women have a higher life expectancy, they spend a larger portion of their lives in poorer health than men. The gap between the genders also exists in mental health instances, as women report experiencing worse mental health than men. One of the main factors impacting this disparity is the disproportionate caregiving responsibilities women carry within their family structures due to existing gender norms.

Research by Samulowitz et al. (2018) argues that chronic pain care is influenced by gendered expectations in the patient and healthcare provider encounter. Gendered norms affect men and women, but in different ways. Men are expected to be "stoic" and "tough", which can lead to delays in seeking treatment and minimising pain. The flip side to this is that women are more often perceived as "emotional" and "complainers", which results in their pain being more frequently psychologised and less likely to be legitimised (Samulowitz et al., 2018). A paradox is described – although women represent most of the chronic pain diagnoses, their pain is taken less seriously and treated less adequately than that of men.

These biases have important consequences for treatment outcomes. Women with chronic pain report feeling that they are misunderstood by their doctors and are less likely to

receive effective pain relief, they are prescribed fewer opioid medications and they are more frequently referred for mental health treatment. In some cases, a woman's appearance also influences the outcome of their treatment – if a woman looks "too healthy", her pain may be dismissed (Samulowitz et al., 2018).

Research by Hay et al. (2019) supports the notion that women's pain is more frequently interpreted as psychological, leading to symptoms being dismissed or treated as lower priority. Women are also being perceived through their reproductive roles, which results in broader aspects of women's health receiving less attention. However, Hay et al. (2019) correspondingly argue that gender inequality is also reflected in the structure of the healthcare workforce. Women are concentrated in lower-status and lower-paid care roles, which contributes to the devaluation of care work and increases the risk of burnout among female healthcare workers. These conditions ultimately affect the quality of care provided to patients, who are more often women.

Looking at the contemporary field of medical research, the pattern of dismissing women and their health concerns persists. Merone et al. (2022) note that even in modern research, only 6% to 38% of medical studies analyse the results by sex, examples of problematic research practices, including modern studies that use female attractiveness as a proxy for health, are also highlighted. In one of the illustrated cases, physicians were asked to rate the "attractiveness" of women with endometriosis, with the implication that attractiveness influenced more severe forms of illness (Merone et al., 2022). In addition, women remain unrepresented in clinical trials related to heart and coronary disease, due to the perception that these conditions are "male" diseases, despite being leading causes of death for women (Merone et al., 2022; Al Hamid et al., 2024).

In summary, the literature illustrates that gender bias and inequality remain embedded in contemporary healthcare systems and continue to affect the quality of women's healthcare. Women's symptoms are more often dismissed or psychologised, influencing the way conditions are treated. Gender inequality is also noticed in healthcare workforce and in medical research, where women remain underrepresented. These factors show that gender inequality operates within multiple levels of healthcare systems and continues to affect the diagnosis, treatment and the general health of women.

Practical Implications

The dismissal of women's health and the sexism in healthcare systems have major consequences for women's health outcomes (Samulowitz et al., 2018; Hay et al., 2019; Merone et al., 2022). Case-based examples documented in academic literature from multiple Western countries illustrate recurring patterns of delayed diagnosis and dismissal of women's pain-related and reproductive health conditions.

Reproductive and gynaecological health represents one of the main areas where gender inequality in healthcare becomes visible. Factors such as menstrual stigma,

normalisation of women's symptoms and sexist structures within medical practice contribute to the dismissal of women's health concerns. This results in delayed diagnoses and poor treatment, leading to negative reproductive and gynaecological health outcomes for women, especially for those living with conditions such as endometriosis (Li et al., 2025; Karavadra et al., 2025; De Corte et al., 2025).

The case of delayed diagnosis of endometriosis is not uncommon and is linked to the normalisation and dismissal of dysmenorrhea (painful menstruation). This results in increased symptom severity and negative reproductive health outcomes. If left untreated due to diagnostic delays, endometriosis can lead to infertility, damage to internal organs and reduced quality of life. The social acceptance of painful menstruation as the norm prevents and discourages women from seeking medical treatment early, further contributing to delayed diagnosis (Li et al., 2025).

Similar findings about social biases contributing to delayed diagnosis are detailed by Karavadra et al. (2025). Their study describes that the sexual and psychosocial impacts of endometriosis are often overlooked in medical settings unless specifically addressed. As a result, delays in recognizing symptoms affect women's physical, psychological and sexual health. Karavadra et al. (2025) also highlight that in some cases women's symptoms are only taken seriously when a male partner is present and is a "witness" of their pain. This illustrates broader sexist structures within healthcare systems that influences the dismissal, minimization and questioning of the legitimacy of women's experiences of pain.

The previous authors' findings are further supported by De Corte et al. (2025), whose work describes delayed diagnosis as a catalyst for worsening gynaecological symptoms and reduced quality of life. The normalisation of symptoms by both healthcare providers and patients, often due to existing social norms, is identified as a major reason for the failure to recognise symptoms and delayed diagnosis. Research on delays in diagnosis of endometriosis shows that although women with this condition seek medical treatment and present symptoms, such as painful menstruation, pelvic pain and infertility, the average time to diagnosis can range from 8 to even 14 years (De Corte et al., 2025; Li et al., 2025). These findings demonstrate how gender bias, social norms and stigma interact to delay the treatment of illness, ultimately contributing to poorer health outcomes in women.

The case of obstetric violence is yet another manifestation of gender inequality in healthcare. Obstetric violence is described as the disrespect and abuse experienced by women during pregnancy, childbirth and postpartum, as perpetrated by healthcare staff. This issue is becoming recognised as a violation of women's human rights (Karabulut et al., 2025; Reyes-Amargant et al., 2025). Research argues that the case of obstetric violence is rooted in sexist social structures and unequal power dynamics between patients and healthcare providers (Ferrão et al., 2022). Women often experience a loss of autonomy in instances of childbirth, including procedures being performed without medical necessity or consent. Scholars also describe obstetric violence as forms of physical and verbal abuse during childbirth, denial of pain medicine, humiliating treatment, interventions without consent and communication failures about procedures (Karabulut et al., 2025; Reyes-Amargant et al.,

2025). These practices are often normalised within healthcare staff, partly due to staff shortages, overwork and burnout, which can reduce empathy and negatively affect the quality of care. The consequences of obstetric violence extend beyond the experience of giving birth. Research links obstetric violence to postpartum depression, post-traumatic stress disorder, as well as to physical complication such as increased risks of vaginal injuries, haemorrhage and caesarean sections (Ferrão et al., 2022). This demonstrates that reproductive healthcare remains an area where gender inequality continues to and manifest in direct and harmful ways.

Pain conditions and their management represent another area in which gender bias is visible in healthcare. Research shows that female patients are significantly less likely than male patients to receive pain medication for the same or similar complaints, even when reported pain scores and other clinical variables are comparable. The disparity is particularly seen in cases of severe pain, where clinical guidelines recommend administering pain medications to all patients, yet deviations from these guidelines occur more often when treating women. Additional discrepancies are noticed in clinical practices of nursing personnel – nurses are around 10% less likely to document pain scores for female patients. Moreover, women spend thirty minutes longer on average in emergency rooms than male patients. Interestingly, the mentioned bias is noticed among both male and female healthcare providers, who are similarly less likely to prescribe pain medication to women. This pattern is attributed to existing social norms and stereotypes that portray women as emotional or more prone to exaggerating their pain, which leads healthcare providers to view women's pain reports as less credible. These biases have serious implications for women's health outcomes and the quality of care they receive. Inadequate treatment and management of pain conditions can lead to chronic suffering, medication dependency and a declined overall quality of life (Guzikevits et al., 2024; Samulowitz et al., 2018).

Diagnostic bias is another manifestation of gender inequality and sexism in contemporary healthcare systems. These problematic social structures translate directly into diagnostic disparities in clinical practice, where women are more likely to be misdiagnosed, receive fewer diagnostic tests and experience delays in receiving treatment. Al Hamid et al. (2024) report that women are approximately 50% more likely to be misdiagnosed during a heart attack because the symptoms experienced (nausea, fatigue, abdominal discomfort) are often labelled as atypical compared to the traditionally male-centred clinical symptom of chest pain. As a result, women are offered fewer diagnostic tests in the cases of suspected heart attacks. Similarly, research by Westergaard et al. (2019) reports that women are usually diagnosed at an older age than men for most disease categories and experience longer diagnosis-free intervals, which leads to conditions progressing further without being detected. Diagnostic bias is also influenced by the gender of the healthcare provider. Greenwood et. al. (2018) argue that female patients treated for heart attacks by male healthcare providers had higher mortality rates compared to those who were treated by female medics.

The consequences of diagnostic bias contribute to higher morbidity and mortality rates, particularly in cardiovascular disease, which remains one of the leading causes of death

among women globally (Al Hamid et al., 2024). These findings illustrate that diagnostic bias is a serious issue within healthcare systems and has direct consequences for women's health outcomes.

In summary, the examples provided demonstrate that gender inequality in healthcare has direct consequences for the quality of women's health and care, which can ultimately contribute to morbidity and mortality rates. Patterns of dismissal and unequal treatment are not isolated events but are evidence of broader systematic inequalities that influence clinical encounters, institutional practices and medical treatment. Gender biases manifest across many fields of medicine and contribute to women's suffering and reduced quality of life. Addressing these disparities requires greater awareness of these issues and efforts to be made to recognise women's health issues as legitimate. Without significant changes, women will continue to experience unequal treatment in healthcare, even in a contemporary world.

Discussion

The findings presented in this article support previous literature that suggests gender inequality remains embedded in contemporary Western healthcare systems. They also align with the indication that healthcare systems have historically been structured around male-centred medical models that were deemed standard (Merone et al., 2021; Westergaard et al., 2019). The cases described in this study also reflect sociological perspectives on gender bias in healthcare interactions. Gender stereotypes influence how patient symptoms are interpreted and often affect the credibility attributed to women's health concerns. As a result, women's symptoms are more likely to be dismissed or deprioritised in clinical settings, which contributes to serious health consequences, including increased morbidity and mortality (Samulowitz et al., 2018; Hay et al., 2019; Guzikevits et al., 2024).

Importantly, the dismissal of women's pain and symptoms should also be viewed as a matter of patient safety and quality of care (Samulowitz et al., 2018; Al Hamid et al., 2024). Moreover, when a significant portion of the population does not receive safe medical attention, the issue extends into the realm of human rights and access to adequate healthcare. Gender inequality in Western healthcare persists despite formal legal equality, since it continues to be reproduced through historically rooted norms, clinical practices and institutional structures.

It is also important to acknowledge that this study relies on secondary data and published sources. Future research could incorporate empirical qualitative data, including interviews with patients, healthcare professionals and researchers, as well as comparative analyses across healthcare systems.

Conclusions

Gender inequality continues to shape contemporary Western healthcare systems and has serious implications for women's health outcomes. The findings of this study demonstrate that gender bias in healthcare reflects historical, institutional and social structures that influence how women's health concerns are treated.

Firstly, the historical background illustrates the marginalisation of women's health within medical research and clinical practice. Earlier medicine positioned men as the clinical standard, while women's symptoms were dismissed, psychologised or reduced to reproductive functions. The diagnosis of hysteria, disproportionate use of lobotomy procedures on women and the historical exclusion of women from clinical research demonstrate how gender bias became embedded in medical practice.

Secondly, sociological research describes that gender stereotypes influence interactions between patients and healthcare providers, even in modern times. Women's pain and illness are more likely to be interpreted as emotional or exaggerated, which results in delayed diagnoses, poor treatment and unequal access to medical care.

Thirdly, contemporary case examples across medical fields show that gender biases persist in practice. Delayed diagnosis of endometriosis, obstetric violence during childbirth, disparities in pain management and diagnostic bias in cardiovascular disease illustrate how gender bias directly affects women's quality of care and long-term health outcomes.

Overall, the findings of this study suggest that gender inequality in healthcare represents not only a social issue but also a patient safety concern. Addressing these disparities requires awareness of gender bias in medical practice and changes within healthcare systems that prioritise appropriate and safe care for all patients.

References

Scientific research:

Al Hamid, A., Beckett, R., Wilson, M., Jalal, Z., Cheema, E., Al-Jumeily Obe, D., Coombs, T., Ralebitso-Senior, K., & Assi, S. (2024). Gender Bias in Diagnosis, Prevention, and Treatment of Cardiovascular Diseases: A Systematic Review. *Cureus*, 16(2), e54264. https://doi.org/10.7759/cureus.54264

De Corte, P., Klinghardt, M., von Stockum, S., & Heinemann, K. (2025). Time to Diagnose Endometriosis: Current Status, Challenges and Regional Characteristics-A Systematic Literature Review. *BJOG: an international journal of obstetrics and gynaecology, 132*(2), 118–130. https://doi.org/10.1111/1471-0528.17973

Ferrão, A. C., Sim-Sim, M., Almeida, V. S., & Zangão, M. O. (2022). Analysis of the Concept of Obstetric Violence: Scoping Review Protocol. *Journal of personalized medicine, 12*(7), 1090. https://doi.org/10.3390/jpm12071090

Greenwood, B. N., Carnahan, S., & Huang, L. (2018). Patient-physician gender concordance and increased mortality among female heart attack patients. *Proceedings of the National Academy of Sciences of the United States of America, 115*(34), 8569–8574. https://doi.org/10.1073/pnas.1800097115

Guzikevits, M., Gordon-Hecker, T., Rekhtman, D., Salameh, S., Israel, S., Shayo, M., Gozal, D., Perry, A., Gileles-Hillel, A., & Choshen-Hillel, S. (2024). Sex bias in pain management decisions. *Proceedings of the National Academy of Sciences of the United States of America, 121*(33), e2401331121. https://doi.org/10.1073/pnas.2401331121

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., Kharel, C., Gender Equality, Norms, and Health Steering Committee (2019). Disrupting gender norms in health systems: making the case for change. *Lancet (London, England), 393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8

Karabulut, K., & Unutkan, A. (2025). A phenomenological study on the traces of obstetric violence in women's birth experiences. *BMC pregnancy and childbirth, 25*(1), 1210. https://doi.org/10.1186/s12884-025-08426-x

Karavadra, B., Thorpe, G., Morris, E., & Semlyen, J. (2025). Exploring delay to diagnosis of endometriosis, a healthcare professional perspective. *BMC health services research*, 25(1), 1483. https://doi.org/10.1186/s12913-025-13536-5

Li, W., Feng, H., & Ye, Q. (2025). Factors contributing to the delayed diagnosis of endometriosis-a systematic review and meta-analysis. *Frontiers in medicine, 12*, 1576490. https://doi.org/10.3389/fmed.2025.1576490

Liu, K. A., & Mager, N. A. (2016). Women's involvement in clinical trials: historical perspective and future implications. *Pharmacy practice, 14*(1), 708. https://doi.org/10.18549/PharmPract.2016.01.708

Merone, L., Tsey, K., Russell, D., & Nagle, C. (2021). Sex and gender gaps in medicine and the androcentric history of medical research. *Australian and New Zealand journal of public health, 45*(5), 424–426. https://doi.org/10.1111/1753-6405.13139

Merone, L., Tsey, K., Russell, D., & Nagle, C. (2022). Sex Inequalities in Medical Research: A Systematic Scoping Review of the Literature. *Women's health reports (New Rochelle, N.Y.), 3*(1), 49–59. https://doi.org/10.1089/whr.2021.0083

Porfyri, G. N., & Tarantili, V. (2025). A historical overview on the rise and downfall of psychosurgery. *European Psychiatry, 68* (Suppl 1), S1053. https://doi.org/10.1192/j.eurpsy.2025.2130

Reyes-Amargant, Z., Fuentes-Pumarola, C., Roqueta-Vall-Llosera, M., Garre-Olmo, J., Ballester-Ferrando, D., & Rascón-Hernán, C. (2025). Obstetric violence: perspectives from mothers, midwives, and obstetricians. *Frontiers in global women's health, 6*, 1609632. https://doi.org/10.3389/fgwh.2025.1609632

Samulowitz, A., Gremyr, I., Eriksson, E., & Hensing, G. (2018). „Brave Men" and „Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and

Gendered Norms towards Patients with Chronic Pain. *Pain research & management, 2018*, 6358624. https://doi.org/10.1155/2018/6358624

Tasca, C., Rapetti, M., Carta, M. G., & Fadda, B. (2012). Women and hysteria in the history of mental health. *Clinical practice and epidemiology in mental health: CP & EMH, 8*, 110–119. https://doi.org/10.2174/1745017901208010110

Tone, A., & Koziol, M. (2018). (F)ailing women in psychiatry: lessons from a painful past. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne, 190*(20), E624–E625. https://doi.org/10.1503/cmaj.171277

Westergaard, D., Moseley, P., Sørup, F. K. H., Baldi, P., & Brunak, S. (2019). Population-wide analysis of differences in disease progression patterns in men and women. *Nature communications, 10*(1), 666. https://doi.org/10.1038/s41467-019-08475-9

Other sources:

European Institute for Gender Equality. (2025). *Gender Equality Index 2025: sharper data for a changing world*. https://data.europa.eu/doi/10.2839/1693233.

UN Women & United Nations Department of Economic and Social Affairs. (2023). *Progress on the Sustainable Development Goals: The gender snapshot 2023*. https://www.unwomen.org/sites/default/files/2023-09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2023-en.pdf