Globalization and Health

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"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], Kathleen Rice[1], Alayne Adams[1] and Raphael Lencucha[2*]

Abstract

Eliminating gender inequality and promoting population health are stand-alone goals in the Sustainable Development Goals (SDGs). It is crucial to understand goal setting and policy making processes aimed at promoting gender and health equality given the entrenched and structural natures of these inequalities. 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. 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 different mandates across agencies. Political forces were found to shape the work of UN agencies, often hindering advancement of the SDG agenda. At the same time participants noted how they navigated opposition or what they considered regressive approaches to women and girls' health in order to pursue a more progressive agenda. Finite financial resources were also noted to play an important role in shaping SDG implementation pertaining to women and girls' health. 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 can draw from our findings to gain insight into problem representation and prioritization. This will help identify underlying assumptions that inform work on women's and girls' health and how they shape policy agendas.

Keywords Women's Health, Sustainable Development Goals, Girls Health, Millennium Development Goals, WPR Framework, Policy Analysis

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 [1]. 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

*Correspondence:
Raphael Lencucha
raphael.lencucha@mcgill.ca
[1] Department of Family Medicine, Faculty of Medicine, 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

processes are found at the micro level in interpersonal contexts and at the macro level of wider society and institutional structures such as the state and the economy [2]. Despite considerable progress in improving the status of women and girls worldwide, 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 [3]. While gender has a broad scope for consideration, we have focused on the category of 'women and girls', a prominent emphasis of the UN development agenda. Eliminating gender inequality and improving population health is a global task, given the interconnected nature of the social determinants of health [4]. 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' [5]. Professionals, researchers, and policymakers working in health and development have recognized the profound and far-reaching impacts of gender-based inequities on population health worldwide [6]. 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 [7, 8]. 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 has 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 [9]. 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 [10]. 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 [11, 12]. For these reasons it is crucial to understand how agencies working in these arenas approach the conceptualization and framing of problems related to women 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 [13]. 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 [14]. 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 study begins with 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 [4, 15]. 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. In other words, we are governed through problematizations, rather than through policies, signaling the importance of critically interrogating problem representations" [12] (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 interagency work in striving to achieve the highly interconnected SDGs related to improving the health of women and girls.

Methods

We drew from Bacchi'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 [16]. 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, while at the same time we were explicit about the theoretical and analytic frameworks used to organize and assess the perspectives of participants. Bradshaw, Atkinson & Doody [17] 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. [18] to inform the 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 [12, 19]. 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 [20]. The WPR framework's six guiding questions helped us formulate our interview questions. See Fig. 1 for a list of these questions. Our study deviated from a 'pure' WPR analysis by incorporating other qualitative approaches. The framework was used to inform a more thematic analysis of the perspectives of participants.

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 [21]. The semi-structured approach to the interviews allowed the interviewer to ask additional questions, including follow-up questions, based on the conversation.

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?

Fig. 1 The Six Guiding Questions of the WPR Framework

Interview guide

The KII 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.

Sample and recruitment strategy

We used purposive and snowball sampling to recruit participants. Actors were mapped using Google search terms reflecting key areas of work in the UN, such as "gender and health", leading to several human resources web pages providing lists of potential participants. Participants were filtered for recruitment using agency, department, job title, seniority, and work experience. This was done to "achieve a sample that includes ideal representatives from the target population" – for our purposes, this involved selecting participants 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 [22], 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. The topic area of a participant's department was closely evaluated together with the overarching agency's topic area – for example, a department may have a specific focus on gender and health under a broader agency, however, both were considered in recruitment. 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 of inclusion 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's 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. Participant selection also took into account the career duration in the UN systems, and 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. Not all prospective participants responded to the invitation to the study. Some participants were identified and recruited through snowball sampling through the networks of relevant invited participants [19, 55].

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. [18]. 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 5 steps of the Framework Method [18] which included data familiarization, identifying a thematic framework, indexing/coding, charting, and interpretation.

Following an initial process of transcribing the first 4 interviews, becoming familiar with the data, and drawing on concepts in the WPR framework, preliminary codes were applied to interview transcripts. Deductive coding followed ideas that were established early on based on scoping review results and as well as interview guide questions. 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 coding the remaining interviews. NVivo was employed to assist with data management and analysis. Aided by the WPR, an initial working analytical framework, as described by Gale et al. [18] 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.

Throughout the analysis process, iterative themes and subthemes were identified, discussed and honed by the authors. These themes were charted in data displays to facilitate analysis across participants, while retaining the context of each participant's view.

Notes on ideas, themes, and early interpretations of the interviews were kept in a journal and consulted throughout the analysis process, including emerging insights on the guiding questions of the WPR framework. Eventually, following completion of the analysis, a set of themes were agreed upon by the authors a once comprehensive review of the charted data and relevant quotes was complete.

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.

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 [23]. 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 [24] 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.

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 1 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.

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. Political forces were characterized by actions of local or state governments and international relations between states that had 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).

Member State Agendas

Member state agendas were identified as a key force in determining global agendas. Participant 4 shared their

Table 1 Participant topic areas

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

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, entrenching gender roles, 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.

$$Structures + Bias + Low\ Priority = Slow\ Progress$$

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.

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.

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. 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 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?"*

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 differentiated scope 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's and girls' global health agenda.

Discussion

The UN and the SDGs provide a normative basis for a global health and development agenda concerning women and girls [25]. 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 represented 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.

(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 Peters et al. [26] and Raymond et al. [27] 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. 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" [13] (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 [8, 26]. As Raymond et al. [27] 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. [28] 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 [29]. Furthermore, framing women's health as their involvement or participation in gender roles such as having children reflects underlying structures shaping our societies. UN agencies must consciously challenge these notions through their work and continue to critical assess how prevailing assumptions are structured to perpetuate gender inequalities.

When women and girls' health is narrowly conceived as SRH, it is easily politicized to the detriment of health and gender equality [30]. 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 [31]. 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.

Health, human rights, and norms

The UN has played an instrumental role in solidifying the linkage between human rights and global health [32]. 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 [32], 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 [33].

In the early 1990s, UN agencies adopted human rights-based approaches to health, moving away from a focus purely on the right to health [34]. 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 [34] (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 [35]. Khosla et al. [36] 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. Participants note the deference paid by UN agencies to its member states and their role in serving member states, especially in agencies or units with a specific regional mandate, while simultaneously working to uphold and advance transnational human rights norms associated with gender and health. Comprehensively answering this question is outside of the scope of this study but our findings highlight 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 [33]. In contemplating the legal dimensions of establishing norms in sustainable development in a chapter of this book, Liesa [37] 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" [38], 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 37 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. [38] 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 [11]. 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 [39]. Participant 4 shared that they felt that their agency and the wider UN could not confidently say that they are "really look[ing] into intersectionality, the interconnectedness between the SDGs; the real root causes of what's happening to women in the health realm." In classifying gender and health issues as separate domains, the goals and targets of the SDGs risk overlooking the inherent intersectionality within topics pertaining to gender and health such as race, class, and disability, among others. The overlapping and compounding nature of these facets have created complex forms of discrimination which require a commitment to encompassing intersectionality in all efforts to improve

equality globally, including the SDGs. The SDGs' current limitations in doing so have affected the ability of agencies to pursue global norms that address the needs of women and other priority populations.

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. [7] and Bandari et al. [40] 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. [41] 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. These constraints can affect the efficiency and timeliness of addressing key issues of women's and girls' health across the world.

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 [7]. Saxena et al. [41] 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 [42] 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. Furthermore, the non-binding nature of the SDGs means that progress on gender and health equity is dependent on political will and the voluntary efforts of governments striving to achieve the Goals, rather than dependent on legal obligations to do so. Countries prioritize issues related to gender and health equity differently, leading to variable progress on key issues throughout the world. To this end, a lack of accountability from states when it comes to evaluating measurement and implementation can impact the ability of the SDGs to influence norm-setting globally. However, interview data from several participants provides 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. This information can lay the framework for future research to identify barriers and facilitators to the efficiency of the SDGs in addressing gender and health inequity.

Evidence, epistemology, and ethics

The power asymmetries embedded across the institutions shaping the assumptions underlying the creation and implementation of these policies are a key point of discussion in development policy. 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 [43] 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 [43–45]. 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 [46], Harbour et al., 2021, [47, 48]. Striving to address epistemic injustices will offer greater opportunities for policies to encompass intersectionality in the overarching goal of achieving health equality across social structures including, but not limited to, gender, race, class, and disability.

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 [49, 50]. 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 [51] and Adhikari [52].

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 identify opportunities to improve future iterations of sustainable development agendas and their 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.

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. Our analysis also charted the key themes associated with pursuing women and girls' health informed by the WPR framework. A more thorough analysis of problem representation would be beneficial as we did not focus as much on what informed problem representation as much as on how problems were identified and the factors that shaped efforts to advance the agendas associated with women and girls' health.

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 policy processes 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.

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Authors' contributions
A.K. conceptualized the study in conversation with R.L., A.A., and K.R. A.K. and R.L. developed the interview guide in conversation with A.A. and K.R. A.K. recruited and interviewed participants. A.K. conducted the analysis with the support of R.L., A.A., and K.R. A.K. wrote the first draft of the manuscript. R.L., A.A., and K.R. edited and contributed to subsequent drafts. All authors approved the final draft.

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Data availability
Data is held by the first author and is available upon reasonable request.

Declarations

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