AN IMAGINED FUTURE FOR GLOBAL HEALTH RESEARCH, POLICY, AND PRACTICE

AN IMAGINED FUTURE FOR GLOBAL HEALTH RESEARCH, POLICY, AND PRACTICE: CONTRADICTIONS AND CHANGE
A STUDY USING THE EXAMPLE OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN EASTERN SUB-SAHARAN AFRICA

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TITLE: An imagined future for global health research, policy, and practice: contradictions and change. A study using the example of adolescent sexual and reproductive health in Eastern sub-Saharan Africa

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LAY ABSTRACT

There is growing controversy in the field of global health and it is not yet clear how the field will respond and evolve. As the number of critiques grow, responding with new ideas for the future of global health becomes more urgent and yet more difficult. This thesis aimed to address this challenge by examining what an imagined future for global health research, policy, and practice might be, and how it might be achieved. This research focuses on the future of global health and Canada's role in it, particularly regarding adolescent sexual and reproductive health (ASRH) in Eastern sub-Saharan Africa. By reviewing documents and conducting qualitative interviews, this study explores adolescent involvement in ASRH research, Canada's Feminist International Assistance Policy (FIAP) and stakeholder experiences implementing ASRH projects with Canadian funding. Findings emphasize the need for concrete actions to implement the changes proposed by scholars. Further research is encouraged to engage local actors and consider practical ways forward for shifts towards equity and justice in Canadian funding.

ABSTRACT

Ongoing global health inequities have been amplified since the 2020 COVID-19 pandemic and subsequent social movements. Such inequities have resulted in increased literature critiquing the historical roots and current practices in global health. From this literature, questions have emerged about the future of global health and Canada's role in this future. However, there is little research consolidating existing critiques and, based on these critiques, exploring adolescent sexual and reproductive health (ASRH) research and the role of Canadian funding for ASRH. The aim of this dissertation is to consolidate contemporary critiques of global health to develop a conceptual framework for one potential imagined future for global health. It then explores the conceptual framework for an imagined future through an example of global health research, policy, and practice, as it relates to ASRH in Eastern sub-Saharan Africa, to consider the opportunities and challenges of achieving this new potential vision. In this dissertation, I present four unique contributions. The first article presents the conceptual framework for an imagined future that will be used to explore ASRH research, policy, and practice. The second article presents findings from a scoping review on adolescent engagement in ASRH research. The third article presents a review of Canada's Feminist International Assistance Policy (FIAP) and examines the development of the policy in relation to an imagined future. The fourth article presents a qualitative description of stakeholder perspectives who are implementing ASRH projects with Canadian funding and discusses these perspectives in relation to an imagined future. Conclusions suggest that language to support changes towards an imagined future in global health exists although there is

continued opportunity to operationalize the changes. Further research is encouraged to engage local actors and consider practical ways to shift towards equity and justice in Canadian funding for ASRH.

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ABBREVIATIONS

ASRH	Adolescent sexual and reproductive health
BMGF	Bill and Melinda Gates Foundation
CanWaCH	Canadian Partnership for Women and Children's Health
CCIC	Canadian Council for International Cooperation
CIDA	Canadian International Development Agency
CSOs	Civil society organizations
EAC	East African Community
FFP	Feminist Foreign Policy
FIAP	Feminist International Assistance Policy
GAC	Global Affairs Canada
HIC	High income country
IAR	International Assistance Review
LNHO	League of Nations Health Organization
MDG	Millennium Development Goal
NGO	Non-governmental organization
ODA	Overseas development assistance
OECD	Organization for Economic Cooperation and Development
PGE	Policy on Gender Equality
QD	Qualitative description
STI	Sexually transmitted infection
SRH	Sexual and reproductive health

SRHR	Sexual and reproductive health and rights
SDG	Sustainable Development Goals
UN	United Nations
WHO	World Health Organization
WID	Women in Development Strategy
WRO	Women's rights organization
WVL	Women's Voice and Leadership
YLO	Youth led organization

DECLARATION OF ACADEMIC ACHIEVEMENT

This dissertation presents four original research studies (Chapters 2-5), an introductory chapter (Chapter 1) and a concluding chapter (Chapter 6). Chapter 2 has been published in *PLoS Global Public Health.* Each chapter has been written with a number of co-authors who were a part of my dissertation supervisory committee. I, Hanna Chidwick, am the lead author of each chapter and conceived of the research questions, structured the research approach and led data analysis with input from members of my dissertation committee. Chapter 2 is co-authored with Dr. Andrea Baumann, Laura Banfield, Patricia Ogba and Dr. Deborah DiLiberto. Chapter 3 is co-authored with Dr. Lisa Schwartz, Dr. Deborah DiLiberto, Dr. Germaine Tuyisenge and Dr. Andrea Baumann. Chapter 4 and Chapter 5 are co-authored with Dr. Lisa Schwartz, Dr. Deborah DiLiberto, and Dr. Germaine Tuyisenge.

CHAPTER 1. Introduction

This doctoral dissertation has been completed as a "sandwich thesis", consisting of six chapters. Four of these chapter comprise of original research studies that have either been published in academic journals or have been prepared for publication. The aim of Chapter 1, Introduction, is to outline the topic, research question and objectives, explain the main contextual pieces of the thesis, which include adolescent sexual and reproductive health (ASRH), Canadian policy for foreign aid (Canada's Feminist International Assistance Policy (FIAP)), and non-governmental organizations (NGOs), and present an overview and rationale for each study and its methodology.

Brief Background and Overview

There is growing controversy in the field of global health and it is not yet clear how the field will respond and evolve. As the number of critiques grow, responding with new ideas for the future of global health becomes more urgent and yet more difficult. This thesis aimed to address this challenge by examining what an imagined future for global health research, policy, and practice might be, and how it might be achieved.

Global health is a dynamic and evolving field of research and practice[1] that has had significant impact in uniting diverse global stakeholders and disciplines to build equitable

[1] This dissertation acknowledges the complexity of defining global health, and as such, further clarifies the definition of both "field" and "global health" in the Glossary of Key Terms (p. 4) and in Chapter 2.

solutions to health challenges [1–5]. Global health initiatives have worked to improve access to health services and treatment by reducing user costs and increasing availability and quality of services through infrastructure and training [5]. The field has had a positive impact on global disease prevalence and severity of health experiences amongst many marginalized populations [5]. Global health promotes values of equity and justice although it is often described as having historical roots in harmful power structures such as colonialism [4,6–9]. Since the early 1970s, the influence of private organizations has grown more significant, encouraging business and results oriented approaches to improving health (i.e., scalable, efficient, standardized approaches) [9–15]. These approaches have been driven by the priorities usually defined by Western actors including universities, government and non-governmental organizations (NGOs), and philanthropic institutions [6,9]. Over the past 10 years, growing critiques of such approaches and actors have developed, and more recently, been further amplified by the social movements and inequities exposed through the COVID-19 pandemic [11,16,17]. Starting in 2020, the COVID-19 pandemic brought forward existing inequities in global responses to public health challenges [18,19]. The pandemic unequivocally demonstrated inequities experienced by groups already made vulnerable by existing structural factors such as colonialism and racism [18,19]. Since then, contemporary critiques in scholarly literature describe the dominant approaches in global health as colonial, extractive, sometimes exploitative, paternalistic, and top-down, privileging Eurocentric knowledge and understandings of health through a Western biomedical lens [6,7,16,20–23].

This discourse of critiques has prompted questions about if research, policy, and practice in global health should continue, and if so, how? Simultaneous to these questions, critiques appear to be reaching an inflection point, converging around a discourse of reimagining global health as a field that adopts new and alternative approaches/platforms/formats or imagines new ways of using old approaches [24]. The discourse of critiques works to disrupt the legacies of colonial harm by decentralizing the interests and priorities of high-income country (HIC) institutions towards collaborative, reflexive, and equitable growth. This dissertation conceptualizes this convergence of discourse as a potential "imagined future", which explores how ASRH research, policy, and practice, focused on Eastern sub-Saharan Africa, needs to change to redress past transgressions and move towards greater equity and justice in approaches [6,7,29,11,17,20,21,25–28]. While these discourses concerning a potential imagined future are rapidly expanding, the extent to which they can be achieved in reality, through research, policy, and practice, remains unknown.

This thesis will consolidate contemporary critiques to existing dominant paradigms in global health to develop a conceptual framework for one potential imagined future for global health. It will then further explore this conceptual framework for an imagined future for global health through the example of research, policy, and practice, as it relates to ASRH in Eastern sub-Saharan Africa, to consider the opportunities and challenges of achieving this potential vision for global health. In short, I aim to explore what global

health could look like in the future, to build an understanding of what could be preserved, amplified, and changed for greater equity in the field.

In this introductory chapter, I will present, 1) a glossary of key terms; 2) the research question and objectives; 3) implications of the study; 4) context and justification for the main concepts in the thesis, including, ASRH, Canada's FIAP and NGOs; and, 5) the structure of the thesis and justification for its methodological approach. Complimentary to this introductory chapter, Chapter 2 presents background literature for the conceptual framework for an imagined future for global health, which will connect each chapter of the dissertation, and provide a framework of analysis.

Glossary of Key Terms

The glossary of terms has been developed based on the literature synthesized and considered in Chapter 2, as well as background and relevant literature from each subsequent chapter.

Imagined future: An imagined future, based on scholarship from Futures Studies, conceptualizes alternatives to present contexts, based on historical and current societal processes and structures [30,31]. An imagined future for global health, presented in this thesis, is one potential conceptualization of what the future of global health could look like, based on the history, and contemporary critiques, of the dominant paradigm in the field. There are multiple possible futures for global health and therefore, the conceptual framework for this imagined future does not aim to evaluate or predict the future of global health as a field, but rather explore one possible vision of change as it relates to ASRH policy, research, and practice. The conceptual framework for an imagined future

has been developed through an analysis of contemporary critiques, and presents two overarching shifts, 1) shifting the power in how we do global health and, 2) shifting the paradigm in which we think about global health. These shifts can be practically considered in terms of funding, leadership, knowledge production, knowledge history, knowledge justice, and reflexivity (Appendix 2).

Global health: At this point in its history, global health is a relatively new field of research and practice emerging in the 1970s from the field of International Health [3,32–38]. Largely contested, somewhat biased, and difficult to define, as the field spans across many disciplines, consistent themes in literature emphasize that global health is a field of multisectoral and interdisciplinary health focused research and practice, centred on equity and justice [3,32–38]. Based on consistent themes defining the field, in this dissertation I discuss global health as an interdisciplinary field of health related policy, research, and practice, guided by the values of equity and justice. In the background section, global health is referred to more generally, as a field. Subsequent sections of the dissertation refer to global health more specifically as it relates to ASRH policy, research, and practice in Eastern sub-Saharan Africa. The goal of the dissertation is not to make a claim about global health as a field, but rather, discuss the shifts articulated in the rhetoric of critiques of the field (Chapter 2), to explore how these shifts may be possible in reality, as they relate to ASRH (Objectives 2-4). For additional context on this definition see Chapter 2.

Field: A field refers to an area of study, interest or activity [39]. In this thesis, I define global health as a field to capture its inter/trans/multi-disciplinary nature. Although there is contention in defining global health among scholars, a widely accepted definition has been provided by Koplan et al. [2] who state that global health is, “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide” (pp. 1995). To capture this “area for study, research, and

practice", I use the term field, which is commonly used to describe global health amongst scholars and practitioners [1,3,24,40].

Research: Research refers to published, peer-reviewed literature which in this context will focus on literature examining the engagement of adolescents in research on ASRH in Tanzania, Rwanda, Kenya, and Uganda, and what ASRH research approaches currently look like in these four countries.

Policy: Policy in this dissertation refers to Canadian policy for foreign aid, specifically the Feminist International Assistance Policy (FIAP).

Practice: Practice refers to the development and implementation of global health projects by non-governmental organizations (NGOs), specifically, NGOs that are funded through the FIAP, developing, and implementing ASRH projects in Eastern sub-Saharan Africa.

Feminist International Assistance Policy (FIAP): The policy of focus in the Chapter 4 study is the FIAP, which frames Canada's development assistance abroad with a focus on empowering women and girls through a "feminist approach"[41].

Document analysis: Document analysis is a method of qualitative research that consists of analyzing various documents including scholarly articles, policies, and institutional reports [42,43]. Although limited to the data (documents, articles, reports) available, document analysis is an effective approach to consider the historical trajectories that led to the development of policies and processes, aligned with the research question in the Chapter 4 study [42,43].

3-i framework: The document analysis in the Chapter 4 study will be completed using the 3-i framework which asserts that policy development and choices are influenced by actors' interests, ideas, and institutions [44]. The framework is useful for both

retrospective and prospective analysis of policy [44], and offers an opportunity to describe the development of the FIAP through a systematic approach considering the institutions, key government interests, and ideas that influenced the policy.

Methodological approach: The general approach to inquiry in the Chapter 5 study.

Stakeholder analysis: Stakeholder analysis is a process of systematically gathering and analyzing information to determine stakeholder interests, interrelations, intentions, and roles in policy change [45–50]. In general, a stakeholder can be defined as individuals, groups or organizations that share common interests [45,48,50,51]. In this study, key informants are engaged from one stakeholder group: NGOs. Although stakeholder analysis is a technical approach and employed in this dissertation, I acknowledge the colonial history of the term stakeholder. "Stakeholder" in a colonial context refers to "the person who drove a stake into the land to demarcate the land s/he was occupying/stealing from Indigenous territories" [52] (no p.). Recently some have argued to banish the term and replace it with other terms such as '(potentially) interested groups' or 'interest groups' [52,53]. The term stakeholder is used in this dissertation while referring to the approach of stakeholder analysis and when referring to documents that use the term.

Method: The procedures and tools used to gather information and organize into data. Key informant interviews were the method employed in the Chapter 5 study.

Qualitative description (QD): QD is the analytic approach for the Chapter 5 study. The approach aims to describe the who, what, and where of events or experiences, based on a constructivist paradigm which notes perspectives are subjective and specific to social, cultural, and historical context while aiming to be inclusive of all perspectives regardless of existing social power hierarchies [54–56]. Aligned with Sandelowski's view of QD [55,56], the Chapter 5 study will describe, based on key informant interviews, how the FIAP influences ASRH projects, which has not been previously studied.

Research Question & Objectives

The overall question of this thesis is, *What are the challenges and opportunities for moving towards an imagined future for global health research, policy, and practice as it relates to ASRH in Eastern sub-Saharan Africa?*

To answer this question, I develop a conceptual framework for an imagined future for global health which creates a basis for understanding global health and a lens of analysis for the thesis. I use the specific example of ASRH in Eastern sub-Saharan Africa to explore this conceptual framework for an imagined future through three avenues – research, policy, and practice. In this study, research refers to published, peer-reviewed literature examining engagement of adolescents in research on ASRH in four East African countries. Policy was focused on Canadian policy for foreign aid, and as such ASRH, as outlined in Canada's 2017 FIAP. Finally, practice refers to the work of Canadian-based NGOs supporting the development and implementation of ASRH projects in Eastern sub-Saharan Africa funded through the FIAP.

There are four specific objectives,

1. To understand the history and contemporary critiques of global health and develop a conceptual framework for an imagined future for global health to situate the analysis of subsequent objectives (Chapter 2).
2. To understand current approaches to adolescent engagement in ASRH research in Eastern sub-Saharan Africa and how these align with the rearrangements to

research called for in the conceptual framework for an imagined future for global health (Chapter 3).

3. To describe the interests, ideas, and institutions that influenced the development of the FIAP, and consider the extent to which the FIAP supports the realization of renewed approaches to funding in the conceptual framework for an imagined future for global health (Chapter 4).
4. To understand the perspectives of key informants from NGOs on the FIAP and how the policy influences ASRH projects, to subsequently consider how these perspectives relate to the conceptual framework for an imagined future for global health (Chapter 5).

Implications

This dissertation aims to draw conclusions to inform, 1) how Canadian foreign aid can respond to and make rearrangements towards the conceptualized imagined future in the approach to funding ASRH projects in Eastern sub-Saharan Africa, and globally; and 2) what needs to change amongst policy makers, researchers, and practitioners from HICs to actualize the conceptual framework for an imagined future for global health.

Context

There are three main contextual pieces of this thesis, which include ASRH, Canadian policy for foreign aid, and NGOs. The aim of this section is to briefly explain what each aspect of the thesis is, identify the connections between the FIAP, ASRH, and NGOs in

Eastern sub-Saharan Africa, and justify the importance of these contextual pieces in exploring the challenges and opportunities for moving towards an imagined future for global health research, policy, and practice. Further historical context for each aspect of the thesis will be included in each relevant chapter.

Adolescent sexual and reproductive health (ASRH)

Adolescents make up over half of the world's population and represent the largest generation in history [57,58]. Defined by the United Nations (UN), as young people aged 10 to 19 years old, adolescence is a key time influencing the trajectory of individual and community health outcomes [57,58]. Adolescents may start engaging in sexual behaviour around the age of 15 years making their sexual and reproductive health (SRH) an important issue for both their immediate and long-term health outcomes [57,59]. SRH is defined as,

> A wide range of health issues including family planning; maternal and newborn health care; prevention, diagnosis and treatment of sexually transmitted infections (STIs) … [with] services [aiming to prevent] poor SRH, such as … unintended pregnancies, unsafe abortions, [and] complications caused by STIs. [60,61]

In 2019, adolescents in low and middle-income countries (LMICs) were reported to experience an estimated 21 million pregnancies each year, with over 50% of those unintended, demonstrating vast unmet SRH needs [62,63]. Since the COVID-19 pandemic, there has been an increase in unintended pregnancies, gender-based violence and limited access to family planning and youth-friendly SRH services [64,65]. Improving SRH outcomes aligns with Sustainable Development Goals (SDG) 3.7 and 5.6, which aim to ensure universal access to SRH services and rights [60,61]. In sub-Saharan

Africa, and East Africa in particular, progress on achieving SDG targets remains slow, resulting in a continuing burden of STIs, unmet contraceptive needs, and inadequate quality of SRH care amongst adolescents [60,66–73]. For example, by the age of 19, over half of adolescent girls in Tanzania have given birth to a child indicating limited access to SRH information and services [74]. Given the impact of unmet SRH needs and global focus on the issue, ASRH has become the focus of many foreign governments through development assistance.

Canadian policy for foreign aid

Canada has a long history of diplomatic relations and consistent development assistance for countries and projects abroad [41,75–77]. The focus of Canadian development assistance is largely defined by the political party in power and since the 1970s has emphasized women, and further gender, in development [78,79]. The trajectory of Canadian policy for foreign aid has been traced by scholars, where the connection between the present development policy for foreign aid, and past policies, has been discussed [79,80]. To note briefly, Canada first implemented the Women in Development (WID) Strategy in 1976, which shaped subsequent gender equality and feminist approaches to development assistance (i.e., the FIAP), including the funding to support health programs abroad [79–81]. Since 2015, the Liberal Party, has shaped Canada's development assistance priorities and goals, committing about $6.2 billion per year, which is 0.26% of the country's Gross National Income to overseas development assistance (ODA) [77,78]. In 2017, the Liberal Party announced the FIAP, which frames

development assistance and support [41]. The FIAP encourages a specific focus on gender equality and human dignity, which includes SRH [41]. After implementing the FIAP, the government announced $650 million over three years to address gaps in SRH globally, where 95% of all financial support for development initiatives would target and integrate gender equality and empowerment of women and girls by 2022 [41,82–84]. In 2019 as a further part of Canada's FIAP, the Liberal government announced a "10-Year Commitment to Global Health and Rights" investing an additional $1.4 billion each year (for 10 years) to further support the health and rights of women and girls globally [82]. This included a commitment of $700 million each year specifically for SRH [82].

Canadian policy for foreign aid through the FIAP significantly focuses on the region of sub-Saharan Africa, defining it as an area of particular vulnerability and thus, opportunity for support [41,85]. The Canadian government has "cultivated relationships in Africa for more than five decades" (no p.) aiming to provide development assistance and promote democracy, peace and security in the particular region of sub-Saharan Africa [86]. Global Affairs Canada (GAC), under the leadership of the current government, leads the implementation of the FIAP by distributing funding to relevant projects [87,88]. Important to this distribution of funds are organizations, as the FIAP promotes multi-sectoral approaches by engaging global and local civil society, multinational organizations, women's rights organizations, and non-traditional donors [41]. Over the past decades, NGOs have grown into one of the most significant groups of actors influencing development and health globally [77,89,90].

Non-governmental organizations (NGOs)

There are a number of significant global actors important to the field of global health, including, multilateral organizations (mainly United Nations (UN) affiliated organizations), bilateral actors (government to government), and NGOs [91,92]. NGOs are organizations that are independent from any government, including both for-profit and not-for-profit organizations [93]. Over the past decades, NGOs have grown into one of the most valued groups of actors influencing development and health globally [89,90]. The rapid growth in the role of NGOs can be attributed to the increased development assistance from national governments, channeled through NGOs, to countries and specific sectors abroad [89]. NGOs became prominent actors in global relations after the neoliberal shift in policy in the 1970s where governments called upon private actors to facilitate and build public health [10]. Assuming a greater sense of objectivity from non-government entities, NGOs are believed to be more altruistic, objective, connected, and ultimately, effective in providing support to communities in need [89]. Although these assumptions are not entirely true, NGOs have a significant role in Canada's development funding specific to global health [75,78,89,94]. Davis [89] reports that over 990 Canadian NGOs work in the international development sector, which includes health, receiving funds from both the federal government and private donors.

GAC oversees the funding of particular projects, framed under the FIAP, that NGOs, both Canadian and international, lead in the country of focus. This process involves a "call for

proposals" for projects based on government priorities [77]. Government aid has been critiqued in the past as NGOs often shift priorities to match those of the government in order to receive funding [77,78,95]. Through the FIAP priorities, gender and SRH have become central foci of NGO projects [41,79,96]. Almost 50% of projects funded through the FIAP focus in sub-Saharan Africa, where many NGOs working in Eastern sub-Saharan Africa in particular, focus on ASRH [41,76,97,98]. Despite critiques, some argue that NGOs are characterized by misleading assumptions about government connections, dismissing the altruistic endeavours that NGOs engage in [89]. Davis [89] calls for analyses and discussions that more specifically consider individual NGOs and their connection to the Canadian government. This dissertation will consider the role and perspectives of individuals from specific NGOs that receive significant Canadian government funding for ASRH projects.

Justifying the example of ASRH research, policy, and practice

ASRH is an area of global focus and study that has prompted many national governments including the Canadian government to develop policies to improve ASRH outcomes. The priorities of policies such as the FIAP inform ASRH projects which are primarily implemented by NGOs. This dissertation explores an imagined future for global health by identifying the challenges and opportunities for moving towards this future in approaches to global health policy (FIAP), research (ASRH in East Africa), and practice (NGOs developing and implementing ASRH projects in Eastern sub-Saharan Africa).

I use the example of ASRH as it is a significant area of focus in global health, that has been identified by many intersecting actors, such as multilateral organizations (i.e., the World Health Organization (WHO) and UN), national governments, NGOs, and communities as a priority. In my previous work to this PhD in both Canada and Tanzania, I was struck by the Canadian policy focus of ASRH which resulted in significant funding to the topic in research and practice. I saw colleagues I had worked with in global health impact investing, NGOs in East Africa, and researchers in Canada, shift their work to greater focus on SRH, especially among adolescent women and girls. The global (and Canadian focus) on ASRH includes the specific and well supported priority to engage women and girls, which has been named as an effective solution to end poverty, improve health, and move towards health equity [41,61,99]. Although my own values very much align with feminist approaches that engage women and girls equitably and these approaches have been effective, I began to wonder, is this so called "future of global health" through engaging women and girls reflective of a Western, Canadian perspective, or does it reflect the priorities of communities funded by FIAP projects? How do we "do" global health, as it relates to ASRH in a way that balances Western ideals and values of gender, feminism, equity, health etc., with context specific ideals and values? Is it equitable and collaborative for the Canadian government to prescribe such a focus on ASRH when organizations, researchers, and practitioners subsequently expand ASRH as a priority based on this prescribed funding focus (i.e., top down approach)? While asking these questions specific to ASRH, the discourse of contemporary critiques of global health, based on the inequities exposed through the COVID-19 pandemic, became more

prevalent [6,16,26,100–102]. Through continuous reflection and consideration of these critiques, my curiosity about what is possible in this field of global health, as it relates to ASRH and feminist approaches, grew. Based on these reflections, and the knowledge that global health research, policy, and practice significantly focuses on ASRH in this era of the SDGs, ASRH provided a dynamic, complex, and meaningful example to explore what an imagined future for global health could look like and how it is already being actioned.

Dissertation Structure & Methodological Approach

This dissertation includes four chapters that present original research findings, contributing to the existing knowledge on the future of global health policy, research, and practice, specific to ASRH, from a Canadian development sector perspective (see Fig. 1). The four studies presented are connected through a methodological approach that draws on aspects of pragmatism and constructivism. These paradigms inform an approach to this dissertation that is, 1) effective in building comprehensive research designs to explore and answer the research question and objectives; 2) responsive to the values of lead researcher, HC; and, 3) responsive to the context of the research (i.e., COVID-19 and the current debates in how to do global health research).

Pragmatism is a research paradigm that understands the meaning of concepts are imbued with practical implications [103,104]. A pragmatic approach to research encourages using any philosophical orientation while recognizing the existence and importance of multiple different realities (i.e., social, physical, natural etc.) [103–105]. Knowledge is understood

as being both constructed and based on empirical observations of the world [103–105]. Further, pragmatists reject binaries and endorse pluralisms (i.e., multiple different views of topics, experiences etc.) [103–105]. In conjunction to drawing on a pragmatic approach, this research engaged with constructivism. Constructivist approaches emphasize lived experiences by individuals which creates meaning [103]. Further, constructivists understand knowledge as a subjective and relative construction of ideas and meanings between actors [103,106]. The purpose or aim of constructivist research is understanding [103], and, each objective of the dissertation has some aim to "understand" an aspect of a future for global health, the FIAP, and ASRH.

The four original research studies demonstrate an application of various methodologies, methods, and analytical frameworks including, document and literature review, qualitative interviews, stakeholder analysis, Qualitative Description, and various framework analyses. Although pragmatists and realists advocate for mixed-methods research (i.e., uses both qualitative and quantitative approaches to answer a research question), this research uses multiple qualitative methods to answer the research question, sometimes called multiple-strategy research [103–105]. By using multiple method strategies, this research prioritized the idea that reality can be interpreted in multiple different ways and was able to capture the complexity of the topic.

Chapter 2

The first original research chapter, Chapter 2, presents the background and conceptual framework for the dissertation. Through a narrative literature review of the contemporary critiques of global health, I trace the trajectory of global health to develop a conceptual framework for one potential vision for an imagined future in the field. This chapter uses Futures Studies [30,31,107,108] and Foucault's idea of genealogies [109,110] to complete a literature review and framework analysis of contemporary critiques of global health. Literature review, as a method, was chosen as it offered an effective approach to examine the emerging scholarly critiques of global health in an extemporaneous and ongoing way while thematically organizing these ideas. Through this approach, the study both synthesizes historical literature and contextualizes this literature within contemporary critiques of global health. Although the approach may limit the context specificity in applying the conceptual framework and documents may not be representative of all existing literature on the topic, it offered a feasible and comprehensive way to examine the emerging discussion of global health and its future.

The conceptual framework for an imagined future for global health, developed from the literature, calls for two overarching shifts – shifting the paradigm in which we think about global health and shifting power in how we do global health. This conceptual framework is then explored through the example of ASRH research, policy, and practice, specific to Eastern sub-Saharan Africa in subsequent chapters. This paper offers a comprehensive analysis and discussion of a wide breadth of contemporary critiques of global health which had previously not been critically assessed or conceptualized. Major benefits

include the breadth and depth of both contemporary and historical literature to contextualize contemporary critiques along with the methodological approach based in Futures Studies [30,31] that allowed for data collection and analysis within the context of the COVID-19 pandemic. Challenges in writing this chapter included conceptualizing a future for global health before it exists and extemporaneously incorporating the rapidly emerging literature on critiques of global health. The subsequent chapters of original research, Chapter 3, Chapter 4, and Chapter 5, explore the central question through research, policy, and practice, relating to ASRH.

Chapter 3

Chapter 3 presents a scoping review of literature, that examines the extent to which meaningful adolescent engagement in research is achieved in practice and how this influences the evidence available to inform ASRH services. A scoping review approach was chosen in order to examine a wide and comprehensive scope of knowledge on the topic and identify the gaps in knowledge to inform future research [111,112]. We followed the 5-step methodological framework presented by Arksey and O'Malley [111] that allowed for iterative engagement with the current literature on ASRH research in four East African countries. A key strength of scoping review studies, including this study, is that they offer a transparent method for mapping areas of research. However, despite the breadth of literature the study maps, the depth of analysis of this literature could be limited. Further, this study did not engage relevant interest groups and individuals to discuss results due to constraints from the COVID-19 pandemic. As such, there is

opportunity to engage interest groups in the future to further understand the non-academic scope of the topic. The methods of the scoping review are outlined in detail in Chapter 3.

Overall, through Arksey and O'Malley's [111] framework, employing a keyword search of four databases, findings suggest the extent of adolescent engagement in ASRH research is limited, resulting in a lack of comprehensive evidence, consistent challenges with stigma, little information on holistic concepts and a narrow framing of ASRH. This review offers a critical step towards understanding current approaches to adolescent engagement in ASRH research and identifying opportunities to build a strengthened evidence base with adolescent voices at the centre, aligning with calls for change as proposed in the conceptual framework for an imagined future for global health, developed in Chapter 2.

Chapter 4

Chapter 4 consists of a policy review of Canadian policy for foreign aid, specifically analyzing the FIAP. Despite existing analyses and critiques of the FIAP, it is unclear how stakeholder interests, ideas, and institutions influenced the development of the FIAP and subsequently, what these influences indicate about the future of Canadian policy for development assistance, especially in relation to global health funding and ASRH. This study uses document analysis, through the 3i framework to examine the interests, ideas, and institutions that influenced the development of the FIAP. Document analysis is a method of qualitative research that consists of analyzing various documents including

scholarly articles, policies, and institutional reports, commonly employed in multiple-strategy research [42,43,113]. The approach to document analysis in this study drew on that of Dalglish et al. [113] which involves, readying the materials, extracting data, analyzing the data, and distilling findings. The method is an effective approach to examine the historical trajectories that led to the development of policies and processes, and inform new policies, aligned with the research question in this study [42,43,113]. It also offered a comprehensive process to consider both academic literature as well as policy documents and news media. Limitations of the approach include the impact of the researchers' lens in the analysis and limited literature available on the FIAP which could impact the level of detail gathered from the documents to answer the research question. However, the approach was feasible, unobtrusive to human participants, and cost-effective to employ during the COVID-19 pandemic and to gather a wide scope of knowledge on the FIAP. The methods of the study are further outlined in detail in Chapter 4.

Overall, this study aims to examine the interests, ideas, and institutions that influenced the development of the FIAP, and considers these in relation to the to the conceptual framework for an imagined future for global health as proposed by Chidwick et al. [114]. We examine the extent to which the FIAP supports the realization of decentralized, equitable, and context specific approaches to funding in an imagined future for global health. Findings support further research about how Canadian policy can continue to shift towards more effectively supporting projects with greater potential for respectful,

context-specific impact, as called for in the conceptual framework for imagined future for global health.

Chapter 5

Chapter 5 seeks to understand how the FIAP influences ASRH projects through key informant interviews. Drawing on knowledge from the first three studies in the dissertation, this Chapter 5 study applies an approach that draws on both stakeholder analysis and Qualitative Description (QD) to complete key informant interviews [45,48,49,51,115,116]. Stakeholder analysis is a process of systematically gathering and analyzing information to determine stakeholder interests, interrelations, intentions, and roles in policy change [45–50]. QD is a research methodology that aims to describe experiences, events, and perspectives in a factual and authentic way, through concurrent data collection and analysis [54–56,117]. QD studies explore the who, what, and where of events or experiences, based on a constructivist paradigm which notes perspectives are subjective and specific to social, cultural, and historical context while aiming to be inclusive of all perspectives regardless of existing social power hierarchies [54–56]. Aligned with both approaches, this study uses key informant interviews to explore perspectives of the FIAP and its influence on ASRH projects. Strengths of the approach include engaging individuals in a respectful, accessible, and feasible way allowing for an exploration of multiple in-depth perspectives that were captured. Limitations include constraints with ethics review processes that limited the population that was included and having a small sample size. However, the approach contributed to triangulating the data

from previous studies and engaged individuals in a respectful way, as aligned with the overall values and methodological approach of the dissertation. The methods of the study are further outlined in detail in Chapter 5.

Based on eight semi-structured interviews with individuals from Canadian NGOs who work on ASRH projects in Eastern sub-Saharan Africa, findings highlight the role of Canadian organizations, importance of partnerships, influence of the FIAP, and operational and contextual tensions that arise with GAC funding. Despite challenges with engaging a broad scope of stakeholders, this paper contributes to informing future changes to funding in the Canadian development sector that align better with the FIAP and with the priorities of NGOs, communities, and individuals involved in ASRH projects.

Justifying the methodological approach

In addition to justification for using specific methods as outlined above (and in detail in each chapter), it is important to justify the overall methodological approach further in terms of pragmatic decision-making and accounting for positionality.

Pragmatic decision-making

A pragmatic approach to global health research is described as being guided by practical experience rather than only theory. Robson and McCartan [103] note the central idea of the approach is that "the meaning of a concept consists of its practical implications" (p.

28). As such, the methodological approach to this study which consisted of both document and literature review and key informant interviews, was informed by practical opportunities and constraints. First, the COVID-19 pandemic led to limited opportunities to build meaningful relationships as many individuals had shifted to working online and public health stressors were widespread resulting in less capacity to engage in non-essential activities. This resulted in a greater exploration and use of secondary data during the initial years of the project. In addition, and related to the COVID-19 pandemic, my own skills as a researcher based in Canada completing research on ASRH in Eastern sub-Saharan Africa were a primary aspect of decision making. I felt uncomfortable completing aspects of the research over technologies such as Zoom without being in the context of the research. Considering factors such as the COVID-19 pandemic and prioritizing in-context relationship building, much of this research was completed through secondary data analysis (i.e., literature and document review). This provided an opportunity for rigorous and extemporaneous analysis of the existing information on ASRH, the FIAP, and critiques of global health. However, there was limited initial engagement with individuals as study participants. Nevertheless, after exploring much of this secondary literature in the initial years of the degree, I was able to then engage respectfully with Canadian project leaders from NGOs.

Accounting for positionality

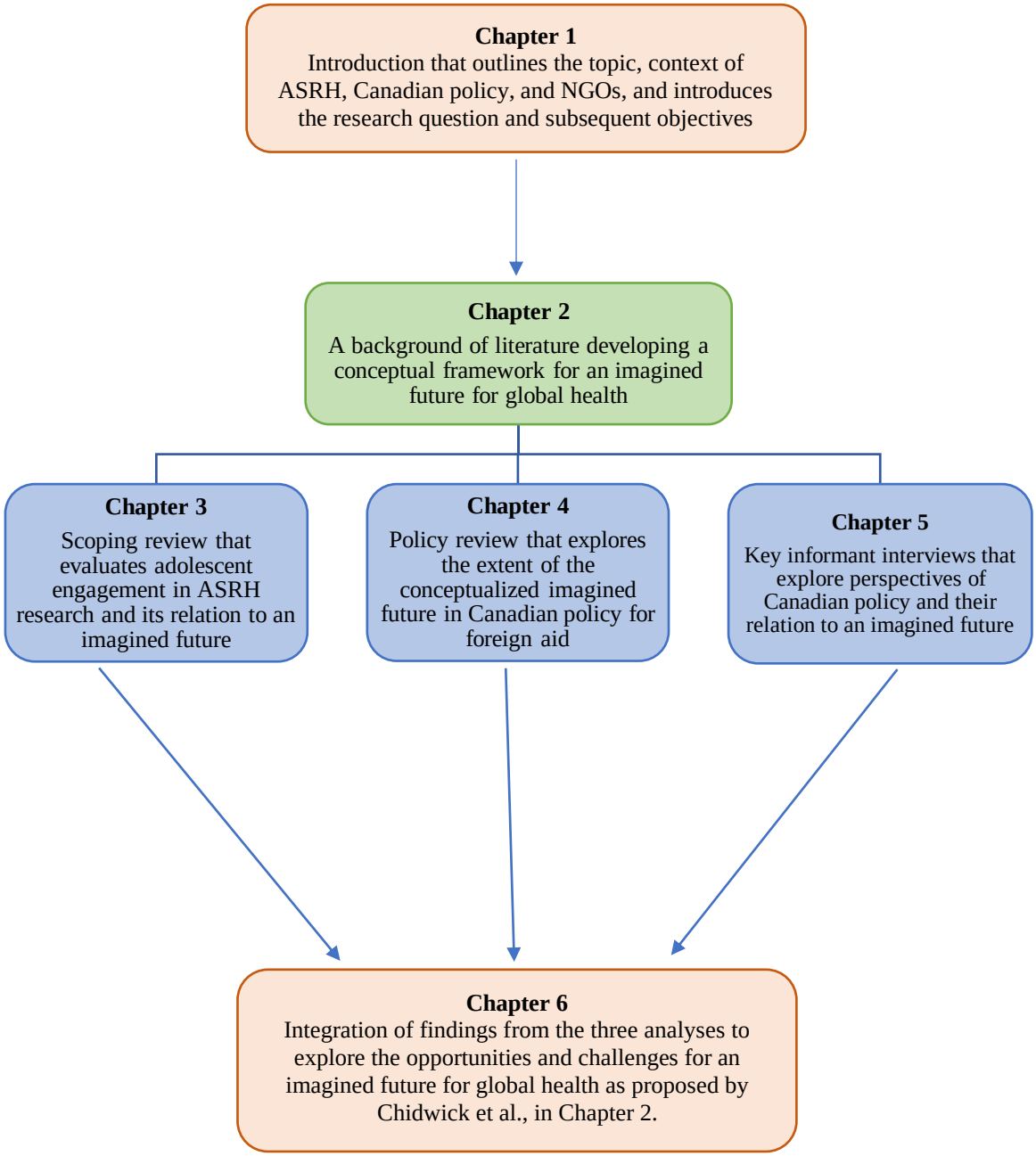
Aligned with the approach of pragmatists, my positionality and values as the lead student researcher were a central aspect of why the methodological approach and specific

methods were chosen. Pragmatists "believe that values play a large role in conducting research and in drawing conclusions from studies, and they see no reason to be concerned about that influence" [103] (p. 28). Similarly, many articles considered in Chapter 2, about the contemporary critiques of the dominant paradigm of global health, emphasize the importance of reflexivity as a step towards an imagined future for global health [16,22,25,100,118–122]. My own positionality as a white, HIC trained doctoral student had an important role in shaping my own lens and priorities in this research. I value dignity, partnership, inclusion, respect, collaboration, and mutual benefit in research. Global health has historically been a field of extractive research where researchers from one context (usually high-income) gather data from human participants in another context (usually low-middle income) with limited consideration of dignity, respect, or partnership. This idea of extraction is related to conceptions of global health as the study of health outside of HICs (discussed in Chapter 2) [6,37,100,102,123–126]. Based on my own experiences previous to the PhD and in completing research outside of Canada, one of my main priorities in this dissertation was to mitigate how extractive this research was by prioritizing the respect and dignity of all individuals involved and by exploring opportunities to interrogate existing written information. As such, I used document and literature reviews to explore secondary data in order to mitigate extraction of information from human participants. This provided an opportunity to explore a large scope of written information over a longer period of time while continuously having the opportunity to reconsider and add to the data. Once I had a widespread and comprehensive scope of knowledge on existing literature and written information related to the topic of study, I

was able to engage individuals in a very specific, thoughtful, and impactful way in Chapter 5.

Aligned with the methodological approach of the thesis overall, the concluding chapter, Chapter 6, synthesizes the ideas presented in preceding chapters to draw conclusions about the opportunities and challenges for an imagined future for global health. Within the rapidly changing discourse and action in global health, this dissertation contributes to a set of new ideas about how to go forward as policy makers, researchers and practitioners in the field, highlighting the opportunity to shift power and control to individuals and communities at the centre of health challenges.

Fig 1. Dissertation structure



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CHAPTER 2. Theorizing an imagined future for global health policy, research, and practice: A conceptual framework

Preface

This chapter examines and consolidates the trajectory of critiques in global health to develop a conceptual framework for one potential imagined future for the field. By identifying and consolidating the claims made in existing literature about global health, the conceptual framework for an imagined future demonstrates the practical opportunities to shift the power in how we do global health and shift the paradigm in which we think about global health. This conceptual framework guides the subsequent chapters of the thesis.

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Theorizing an imagined future for global health research, policy and practice: A conceptual framework

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Abstract

Ongoing global health inequities, such as a lack of access to health resources and services due to structural determinants, have been further exposed and amplified in recent years resulting in a proliferation of literature that critiques both the historical roots and current practices in the field. From this literature, questions have emerged about the future of global health and despite the increasing prominence of critiques, what this literature calls for has not been critically assessed or conceptualized. By tracing a genealogy of contemporary critiques of global health (2020–2023), we use the concept of imagined futures to present one potential imagined future for global health. Findings from the literature indicate calls for two overarching shifts: shifting the paradigm in which we think about global health and shifting power in how we do global health. We conclude by presenting a conceptual framework for this potential imagined future for global health and encourage further research to explore this conceptual framework practically.

Keywords: global health, critiques, imagined futures, policy, research, practice

Introduction

Global health spans research, practice, and education [1]. Developing from the history of tropical medicine, public health, and international health, global health has become a focus of many scholars and practitioners [2–4]. Since the early 1970s, defining global health has been a challenge amongst scholars and practitioners because of its interdisciplinary nature [1,3–10], leading to many claims and biases about what it is and

what it ought to be. Currently a widely accepted definition has been provided by Koplan et al. [2] who state that global health is,

> [A]n area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care. [p. 1995]

Despite wide acceptance, this definition has been critiqued for missing the inclusion of political and historical context, and for ignoring the negative impacts of globalization on health, such as economic insecurity, deregulation, and privatization [3,4].

In 2021, Salm et al. [1] proposed a working definition for global health based on a literature review of existing definitions, which included the explanation presented by Koplan et al. [2]. Salm et al. [1] identify four key themes common across definitions: 1) global health is a "multiplex approach to worldwide health improvement" [p. 8] that is taught and learned through institutions; 2) global health is an ethical initiative guided by values of equity and social justice; 3) global health is a mode of governance yielding power through politics and resource allocation; and 4) global health is a "vague yet versatile concept with historical antecedents and an emergent future" [p. 8]. In particular, Salm et al. [1] note that global health is commonly defined in literature as "an area of research and practice committed to the application of multidisciplinary, multisectoral and culturally sensitive approaches for reducing health disparities that transcend national borders" [p. 12]. In this paper, we acknowledge the complexity in defining global health

and consider it an interdisciplinary field of health-related policy, research, and practice that is guided by the values of equity and justice.

Based on the widely acknowledged definitions of global health, the field is rooted in altruistic endeavors to improve health equity and, some would argue, it has been quite successful in reducing health disparities [11,12]. Through multidisciplinary and multi-sectoral approaches that span national borders, global health has united disciplines, governments, organizations, and communities working to build solutions to both global and local health challenges [11,12]. As a dynamic and evolving field, there is also growing literature and discussion concerning the historical roots and current practices in global health, which have been further amplified by the social movements and inequities exposed by the COVID-19 pandemic [13]. Starting in 2020, the COVID-19 pandemic brought forward existing inequities in global responses to public health challenges [14,15]. The pandemic inequitably impacted already vulnerable groups where existing structural factors of inequity such as colonialism and racism became unequivocally visible [14,15]. Since then, many of these critiques concern the future of the field. Specifically, how global health and its actors need to change to redress past transgressions and move towards greater equity and justice in policy, research, and practice [16,17,26–30,18–25]. These critiques are themselves being critiqued for aggravating inter-group and international antagonisms and undermining opportunities for redistributive changes in the future [31–36]. Despite the increasing prominence of this literature, it has not been critically assessed or conceptualized.

In this literature review, we aim to consolidate and trace the genealogy of critiques of global health as an interdisciplinary field to create one potential conceptualization of an imagined future. With critiques pointing towards change in the field, the question of if we should proceed as scholars, policy makers, and practitioners and, if so, how do we proceed has become a point of discussion. Through this literature review, we construct a conceptual framework for an imagined future for global health, which we then suggest can be used to explore how to proceed towards equity.[2]

We start by outlining the underpinning concept of the review, imagined futures, based on Futures Studies literature. Second, we describe the methodological approach, Foucault's idea of genealogy. Third, we explore a genealogy of critiques that have emerged from the literature and indicate an imagined future for global health. Finally, we present a conceptual framework for an imagined future for global health and draw conclusions to inform further discussion.

Imagined Futures

The theoretical basis for imagined futures is rooted in Future Studies scholarship. Futures Studies is the transdisciplinary study of what is possible and probable in the future, encouraging a mapping of past and present discourses to conceptualize a future [37–44].

[2] This paper is not suggesting that global health is a field that is either good or bad. The goal of the paper is to critically analyze global health which allows us to think about both the good and bad of the field and understand it in a way that builds towards equity and justice. The practice of imagining something different, offers an opportunity for growth.

Futures Studies gained legitimacy in the early 1990s, and it considers alternative futures of society while embracing the multiple interpretations of reality that exist and influence the future [38–40,43,45]. Futures Studies scholars note that if the present is complex, the future is just as complex and unpredictable [39]. As such, Futures Studies does not aim to predict the future but rather to explore and map what could be possible through a number of alternative imaginings [43,45]. The conceptualized future for global is therefore only one possible future for the field amongst many. Scholars encourage and support pluralistic approaches that generally include four key processes: considering critiques and tracing the historical roots of ideas that may emerge in the future, creating new spaces for considering alternative futures through innovation, integrating new voices, and synthesizing new ideas [41,43,45].

Futures Studies also includes a number of key post-positivist approaches to considering futures, namely, critical/postmodern, cultural/interpretive, prospective/participatory, and integrative/holistic [41]. This review works through a cultural/interpretive futures lens, which argues for the recognition and consideration of alternative worldviews and attempts to provide methodologies and images of futures across space and time [38,41,45]. The cultural/interpretive approach developed out of the work of Futures scholars who prioritized the inclusion of non-Western cultures [41,45,46]. The approach offers engagement of multiple perspectives towards imagining something different from present realities.

Two assumptions are important to note. First, Futures Studies makes an ontological assumption that the future exists, and we can use various methods to determine what it may be [45]. Second, Futures Studies assumes that the present is iterative and fragile – a construction of a dominant discourse; whereas the future is something different – potentially constructed by various discourses and a conceptualization of what could be and what is desired [37–39,43,45]. Some scholars discuss how globalization and the dominant economic system homogenizes knowledge and cultures towards science, rationality, and individuality [41,44,45]. Futures Studies offers an opportunity to understand the principles and practices of these current systems and what they could hold for development, imagination, and renewal [41,43].

Futures Studies scholars note that the study is often overlooked in academic discourse; however, with the speed and demand at which shifts are happening in society, there is greater recognition of the approach [41]. Critics also question the feasibility and validity of Futures Studies given the level of uncertainty involved and broad scope of topics [41]. Despite critiques, Futures Studies is an established academic and practical discipline, offering an opportunity to explore possible, alternative, and imagined futures.

The concept of an imagined future for global health

The idea of an imagined future is not new and spans many disciplines, including economics, anthropology, political science, and sociology [44]. An imagined future conceptualizes alternatives to present contexts based on historical and current societal

processes, structures, and discourses [38,39]. Beckert [44] argues that imagined futures are crucial to understanding the development of society. When applied to global health, the concept helps orient multidisciplinary global health scholars and practitioners towards what is possible by grounding the idea of an imagined future in existing learning, literature, and critiques. The concept also allows for health equity to be approached in a way that acknowledges the different areas of global health namely, research, policy, education, and practice.

Many global health practitioners and scholars, including Vincanne Adams, Paul Farmer, Anne-Emanuelle Birn, Seye Abimbola, and Madhukar Pai, have discussed the importance of reimagining global health. Growing since around 2010, literature has highlighted the need to reimagine global health, calling for a critical consideration of the dominant structures shaping the field (e.g., colonialism) and a restructuring towards equity and justice [18,22,30,47–49]. Critiques have been amplified over the past three years as the inequities in global health have been exposed and exacerbated by the COVID-19 pandemic [13,17,24,25,50,51]. For example, Abimbola et al. [13] explain that,

> We are aware that the global health of our dreams and our wish list are unrecognisable from the global health of today. Much will have to change. But change is possible—if we are all willing to deepen our consciousness, listen deeply, listen differently, embrace global solidarity, and fight supremacy in all its forms. We are optimistic and hopeful that these dreams will become reality, since the COVID-19 crisis has made it imperative that humanity builds a more just and equitable world. (p. 9)

Theorizing global health through Futures Studies provides an opportunity to consider the historical roots of global health and conceptualize a potential vision for change.

Methods

Genealogy is a method of writing a "history of the present" [52,53]. This involves considering and using historical materials, structures, and discourse to critically examine the values that shape a practice in present day [52,53]. Genealogies problematize the present by revealing the power relations upon which it depends [52]. By drawing on the concept of genealogy, we aim to make sense of the structures and discourses that have shaped global health in a non-linear way, exploring how we got to where we are through a consideration of intersecting power, actors, and concepts in the field.

The set of literature considered in this review includes the work of critical global health scholars and contemporary critiques. Emerging in a formalized way around 2010, critical global health considers the complex neocolonial underpinnings, biomedicalization, and role of private actors in global health [18,22,23]. Critical global health felt an appropriate starting point of consideration because scholars integrate discussions of reimagining global health by critically examining the actors and structures shaping the field. The lead author (HC) developed an understanding of global health that included a critical view of discourses, structures, and processes guiding what is valued in the field today. From here, the lead author examined critiques developed in the last three years (2020–2023) that focused on the inequities (i.e., lack of access to health services, limited quality of care) exposed by the COVID-19 pandemic, Black Lives Matter movement, and calls to address

structural inequalities in global health organizations[3] [13,21,24,25,50,54]. These critiques are important because they articulate how the structural determinants of global health, such as history and policy, continue to impact the inequities that exist in the field.

References were identified from a set of seminal readings by critical global health scholars and critiques made in the past three years [13,17,57,58,18,19,22,24,25,47,55,56], hand searching reference lists and key journals, searching electronic databases, following alerts from listservs and key journals, and discussions with colleagues (see Appendix 1). To synthesize the literature, we mapped common themes across critiques with a focus on themes that called for shifts or changes in global health in relation to funding, partnerships, information and knowledge production. We then identified points of intersection where we considered the influence of history, discourse, structural power of knowledge, and current events. Based on these common themes – their historical trajectories, connection to contemporary critiques, and where these critiques point towards – we completed a framework analysis of contemporary literature (2020-2023) by clustering key quotes within the overarching themes that emerged. The genealogy presented traces contemporary critiques of global health and conceptualizes one potential vision of an imagined future for global health. In the conclusion, we suggest further research to explore the conceptual framework for an imagined future more practically.

[3] Note, critiques that discussed decolonizing global health university curriculum were excluded as global health curriculum was determined to be out of scope.

Findings

In this section, we outline the main themes identified in the literature and trace the genealogy of each theme. These themes are then considered in relation to contemporary critiques and used to develop the conceptual framework for an imagined future. The critiques that have emerged over the past 10 years and last three years in particular emphasize the role of the local (i.e., the role of the communities and individuals at the centre of a health challenge). Burgess [29] notes that "despite the claims to service social and global justice… global health often feels as though it has long forgotten *who* it is for" (p. 3). Further, Oni Blackstock (quoted in Pai [59]), says, "[t]o achieve global health equity, those who are the most burdened must be centered and should lead efforts to develop and implement policy and programmatic solutions" (p. 5). Language such as "radical transformation" [17] (pp. 1628), "imperative for change" [13] (p. 1), and a call for practitioners to "seize… critiques and set radical agendas for a new global health" [60] (p. 4) demonstrate the significant focus on changes in the global health field. These changes broadly and consistently emphasize greater inclusion and prioritization of local decision makers, increased local knowledge production, and decentralized control of funding (described in the following sections).

Despite the significant discourse calling for shifts in global health, counter-arguments to this discourse have also emerged [25,31,34–36,61,62]. Although minimal, these counter-arguments highlight how discussions to change and decolonize global health are siloed in high-income country (HIC) institutions [32,34] and have been described as somewhat

irrelevant to individuals experiencing health challenges in the so-called Global South [63]. Pandey [63] wrote that, "true progress – to make global health relevant for everybody – requires the Global South to elevate and shape its own normative discourse and agenda, to generate local knowledge for a global world, and to lead in solving its own problems" (no p.). Further, some scholars have cautioned against the overwhelm of critiques in how it could risk delegitimizing the field of global health due to inter-group debate [31,36,62]. Finally, counter-arguments emphasize the impact of historical colonization that has created and/or reinforced structural power dynamics (i.e., caste) within groups of people, making the call to shift to the local complex [35,61].

There is also minimal discussion about what is already working in global health, or what could be preserved. As such, some may argue that the swing of critiques to one side of the pendulum, with a focus on the local, holds practitioners in HICs less accountable regarding what their role is in the suggested changes. However, by tracing the historical trajectory of critiques, there is opportunity to better understand what the role of policy makers, researchers, and practitioners in HICs can be, and foster change towards an imagined future for global health.

There were two overarching themes identified in the literature: shifting the paradigm in which we think about global health and shifting power in how we do global health. These two overarching themes are discussed in relation to their historical trajectory, connection to contemporary critiques, and by identifying where critiques points towards. The

emerging ideas are then further considered within literature calling for practical shifts in global health that were written between 2020 and 2023 to develop a conceptual framework for an imagined future for global health. Note, the use of the term "we" is not intended to imply agreement about this potential future for global health and who/what constitutes the "we" will change across different potential futures for the field.

Shifting the paradigm in which we think about global health

Shifting the paradigm in which we think about global health is a call to rehistoricise and repoliticise the field. That is, to critically acknowledge and work to disrupt the supremacy and structural determinants of the field including colonialism, racism, and capitalism.

Historical trajectory of critiques

The origins of global health are described as rooted in the interests of Western, primarily white, colonial priorities and understandings of medicine [17,20,64]. Colonialism is the "structural domination and a suppression . . . of the heterogeneity of the subjects in question" [65] (p. 18). Many scholars have noted the coloniality of global health [3,12,68,13,17,20,55,58,64,66,67]. This means that the underpinnings of colonialism, such as power, paternalism, and whiteness, continue to be fundamental structural tenants of global health (e.g., through metrics, leadership structures), reproducing a specific social hierarchy at a global scale [3,12,73,55,66–72].

Global health has developed through the colonial and imperial history of global relations [3,12,13,51,67,74,75], transitioning from colonial medicine, tropical medicine, and international health. Imperialism and the slave trade from the 1500s-1800s were prominent in shaping the drive to eradicate disease and prescribe the value of Eurocentric knowledge and European-based medicine on Indigenous populations [3]. In particular during the later 1700s, medicine and public health became established as significant tools in the colonization of people [3,12]. The goal of colonial medicine was to facilitate occupation and colonial expansion by making things "habitable" for European and other colonial settlers while fostering productivity and reinforcing the stratification between the colonizer and colonized [3,12,67]. The history of colonial medicine shows a purposeful undermining of the health of Indigenous populations through assertions of power and assumptions of cultural superiority [67].

In the 1800s, there was a shift to tropical medicine where colonized nations in the "tropics" became laboratories for health research [3,12,67,74]. Perhaps assumed to be altruistic in the approach, productivity, moralizing and civilizing populations, and safeguarding commerce were values at the centre of tropical medicine, which worked to mitigate the spread of diseases such as malaria and cholera [3,57,67,74]. These values continued to assert health as a form of "civilizing" colonized populations, enforcing the assumed hierarchical superiority of Eurocentric culture and, in particular, whiteness [3,67,70,74]. The colonial and imperial underpinnings of tropical medicine also reinforced the "us" versus "them" narrative, where diseases such as cholera were

understood as problems faced only by “uncivilized” populations [67]. Greene et al. [67] note that the “us” versus “them” thinking continues in global health today as the field connotes the idea of disease being “elsewhere”. Tropical medicine also led to the development of research and education institutions in European countries that studied disease in colonized nations [67]. This structure has persisted in global health, as many North American and European universities host global health research institutions, reinforcing ideas of Western benevolence and saviorism where disease and the study of health is needed “elsewhere” [9,17,51,56,75–78].

Imperial and colonial values continued to shape the drive to eradicate disease in the 1900s, when the Rockefeller Foundation (discussed in detail in the next section), led the increase in private organizations and shift to international health. The Rockefeller Foundation implemented programs and research in colonized countries, perpetuating the superiority of Eurocentric knowledge and values to modernize and “civilize” non-Western cultures, from colonial medicine [67,74]. The influence of the Rockefeller Foundation also resulted in a prioritization of biomedical, disease-focused, cost-effective, and efficient health interventions [19,22,67,69,79]. The history of global health that is rooted in imperialism and colonialism also shows the foundation of the field in the global capitalist economy, where health was used as a tool to increase control and productivity [3,12,69,74].

Contemporary critiques

Considering the historical trajectory of how we think about global health, contemporary critiques are apparent. The way we think about global health has been significantly influenced by dominant actors in the field. Foucault [53] discusses the idea that history is shaped by the power of institutions and individuals which renew and reinforce practices that legitimize knowledge. Similarly, Futures Studies scholars emphasize that systems are interconnected and governed by structures of knowledge and power (i.e., politics), thus influencing conceptions of the past and the future [38,39]. Many scholars and practitioners note ongoing colonialism in global health today through a number of processes and relationships such as development assistance, authorship, and metrics that prioritize Eurocentric knowledge [3,9,82–85,17,20,24–26,28,80,81].

In the early 2010s, many scholars and practitioners began articulating and critiquing the field as colonial and further, neocolonial, perpetuating asymmetrical power dynamics between institutions and countries [18,48,67]. More recently, many academic critiques of global health have called for the field to decolonize [16,17,84,86,20,24,25,31,32,54,56,73] and further, to grow towards Indigenization [68,87]. Chaudhuri et al. [25] define decolonializing based on Fanon's definition, stating, "an entire systemic overhaul" is needed and can only be accomplished by the removal of the colonizer or dismantling of structures that preserve power (p. 1). Similarly, Affun-Adegbulu et al. [84] state that decolonization means "decentring Western Eurocentric ways of being, knowing and doing, and embracing the pluriverse" (p. 5). The recognition

of the structural violence and white supremacy embedded in global health, that root back to the colonial starting point of the field, has called for disruption and approaches "to address the complex interdependence between histories of imperialism with health, economic development, governance, and human rights" [24] (p. 1). Although literature on "decolonizing" global health has been critiqued for being colonial in itself [73], being siloed in academic HIC institutions [32], and occurring through the perspective of the colonizer [73], some suggest that making visible the implicit values and history of global health offers a way forward [57]. Affun-Adegbulu et al. [84] emphasize the importance of questioning what decolonization means for historically colonial entities and prioritizing a shift in power through reckoning with historical colonialism that continues to shape relationships between stakeholders in global health.

Where critiques point towards

Critiques point to a paradigm shift through rehistoricising and repoliticising the way global health is understood and practiced towards more just and reflexive practice. Rehistoricising and repoliticising means identifying and acknowledging the implicit values of Eurocentric colonial, racial, and cultural superiority in global health [24,51,60,67,81,88]. Scholars have noted a need to identify and consider the political, economic, historical, and cultural underpinnings of global health that continue to privilege a white, Eurocentric knowledge paradigm in the field [5,57,67,70,72]. There is a call to meaningfully engage global and local structures that drive health inequities, prioritize critical reflection, and interrogate the basis of knowledge and colonial roots of

global health [13,16,90–95,24,51,67,72,73,76,80,89]. A paradigm shift to repoliticise and rehistoricise global health, through learning and acknowledging the violent colonial history of global health, is also noted as a step towards working through a health justice framework in the field [24,30,60,67,81,88]. By repoliticising and rehistoricising global health, scholars suggest there is opportunity to resist dominant forms of thinking about, and thus doing, global health, and shift towards approaches rooted in equity.

Shifting power in how we do global health

Shifting power in how we do global health can be considered in terms of funding (i.e., who funds global health, how funding agendas shape interventions) and knowledge (i.e., how knowledge is produced, what knowledge is valued).

Historical trajectory of critiques

Global health has been discussed as a re-creation of historically colonial international health dynamics with a new name [3,12,69,81]. Before global health, there was colonial medicine and tropical medicine (as discussed), leading to international health [12,64,67,81]. International health focused on cooperation and exchange of resources and power through both nation-states and institutions such as the World Bank and International Monetary Fund [3,12,67,69]. In the early 1900s, the focus of international health was on institution building and disease eradication [3,12,67,69]. Global health decision makers continue to justify a reliance on technical solutions to conquer disease based on early motivation for disease eradication [3,12,67,69].

In the early 1900s, important power structures were formed, namely the Rockefeller Foundation and League of Nations Health Organization (LNHO) (pre-cursor to World Health Organization (WHO)) [3,12]. The LNHO and Rockefeller Foundation were key players in shaping the construction of other supranational institutions, most directed towards disease eradication campaigns [3,12]. The Rockefeller Foundation in particular popularized international health, holding significant power to shape the priorities, ideologies, and practices of the field and fund the development of other international health organizations later in the 1950s [3,12,69,74].

In 1948, the WHO launched and legitimized the role of international health as a supranational, decentralized field, working on broader campaigns with both private organizations and governments [12]. Starting in this postwar era, bilateral and non-governmental health agencies became more prevalent [3,12]. In the 1970s and 1980s, alongside the Alma Ata declaration of "health for all", the prominence of private sector involvement and financial support of health initiatives signalled a transition to "global health" [12]. Global health prioritized a business-oriented approach through private actors in the field [3,12,69]. New financial and non-governmental actors advocated for efficiency of reforms aiming to cut government spending, decentralize, and privatize services and interventions [3,12,69]. For example, organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Bill and Melinda Gates Foundation (BMGF) are both independent financing bodies with power to shape global health

[12,69]. The rise of private organizations in global health also resulted in a significant influence of the randomized control trial and evidence-based medicine movement, which aligns with the prominent business style outputs and accountability in global health [3,12,19,96].

Today, business-oriented models have proliferated alongside philanthrocapitalism [69,97,98]. Philanthrocapitalism mobilizes private wealth and corporate philanthropy that Adams et al. [97] explain is reminiscent of the colonial era in global health. Although similar to the role of the Rockefeller Foundation in the early 1900s, philanthrocapitalist organizations such as the BMGF mobilize private wealth from corporate entities to fund global health interventions in a way that more directly prioritizes business approaches, encouraging a more significant role of private companies, rather than just wealthy elites [3,97,98]. With such significant private funding and investment in global health, philanthrocapitalist organizations have considerable influence in shaping the priorities of health interventions [99]. Thus, the colonial legacy of global health, evident through the role of private actors and promotion of public-private partnerships, points to the power of private organizations to shape what knowledge is valuable (largely framed by the market) and what gets funded (i.e., “magic bullet”, standardized, scalable approaches) [23,29,101–105,49,58,77,79,81,82,97,100].

Contemporary critiques

Critiques of how we do global health, and specifically the role of private actors, can be consolidated by considering knowledge and funding. Many critical global health scholars explain that, as a result of the business-oriented demands of funding agendas, local level knowledge, contextual complexity and community-based approaches to global health have been silenced [3,5,107,61,79,86,98,101,102,105,106]. Most notably, scholars have discussed the silencing of community-based (mostly qualitative) approaches, that take longer to develop and implement and result in data that does not always fit directly into evaluation frameworks from funding organizations [101,106]. Local level knowledge and contextual complexity have been dismissed in favour of standardized approaches, led by private actors, with minimal adaptation to the context of implementation [29,97,100,101,106]. As such, there is a need to interrogate scalable, quantitative methods and metrics producing knowledge that is led by private actors, and prioritize context specific analysis, acknowledge the asymmetries that exist in what is legitimized as data, and support community-based, ethnographic approaches and slow research [18,97,113,101,105,106,108–112]. Prioritizing such approaches does not inherently mean undermining scientific knowledge and technical expertise, as questioned by some scholars, but instead presents an opportunity to value context specificity and diversity of knowledge rather than the superiority of one knowledge set [28,31,72,95,104].

Scholars also discuss the crucial shift needed in funding, from private actors in HICs to localized funding structures such as in-country governments [13,54,116,55,72,81–

83,110,114,115]. Weigel et al. [117] suggest this shift could happen through accompaniment, an approach that means "supporting developing country partners, public and private, until they have capacity to deliver services and improve livelihoods in the long term" [p. 294]. This shift has the potential to mitigate the harmful impacts of business-oriented approaches that are standard amongst private actors in HICs. Shifts in power through funding also involve greater accountability in building "real, long-term, mutually beneficial, and reciprocal collaborations, with people on the ground in the driving seat" [13] (p. 7).

Where critiques point towards

To shift power towards mutually beneficial, long term collaboration, scholars discuss the importance of prioritizing approaches that value decentralized funding along with community leadership and knowledge production in research and practice [18,19,119–121,22,72,91–93,108,110,118]. Adams et al. [106] discuss the idea of "slow research", to resist the norms of speed, innovation, efficiency, and production that currently shape global health research approaches. Slow research approaches value context-specific "local" knowledge, keeping the old things that work in place rather than assuming new is better, spending extended periods of time in a space to understand the context of the phenomenon, and prioritizing community involvement in knowledge production [106]. Along with approaches to research, shifts towards community-led practice that include social, contextual knowledge of a community are also emphasized [29,97]. These shifts include co-leadership and power sharing with a focus on South-South connections,

greater accountability to communities involved, consistent reflexivity of staff in global health organizations, especially when considering privilege, and practicing structural diversity and inclusion [13,24,33,75,83,107,114,120,122,123]. Community based methods, through prioritizing local and contextual knowledge and engaging in mutually accountable partnering through co-leadership and program development, enable power-sharing and ultimately greater equity, sustainability, and impact of global health interventions [29,75,125,126,97,107,112,113,118,119,121,124].

Conceptual Framework

The two overarching themes identified in the literature – shifting the paradigm in which we think about global health and shifting power in how we do global health – highlight one possibility of what a future of global health could look like. The genealogy of critiques presented demonstrate that global health is based in ideologies of colonial superiority that continue to prioritize the values of private, elite actors. The funding agendas of private actors have significant influence in shaping the knowledge and approach in many interventions. How we think about and do global health can be critically considered in terms of who holds power, largely stemming from financial power to determine what gets funded or not.

Questions have grown about the possibility of any future for global health where scholars even ask, “will global health survive its decolonisation?” and emphasize the need for “radical transformation” [17] (p. 1628). Despite questions about the function and value of

the field, recent literature has outlined calls for practical shifts [13,17,106,127,18,21,22,29,58,85,96,97]. As such, we argue that these critiques are pointing towards a version of global health that is more equitable and just – an imagined future. With this growing sense of urgency and rapid expansion of theoretical possibility for change, as outlined in the literature, it is time to explore what is possible in practice in this imagined future [36,128].

Through a framework analysis of contemporary critiques (January 2020-June 2023) focusing on the themes that emerged from the genealogies presented, we developed a conceptual framework for one potential imagined future for global health. By identifying and consolidating the claims made in existing literature, the framework demonstrates the practical opportunities to shift the power in how we do global health and shift the paradigm in which we think about global health. These opportunities include funding, leadership, knowledge production, knowledge history, knowledge justice, and reflexivity (see Table 1, Figure 1). Note, this conceptual framework does not aim to predict or make a value-judgement about global health, but rather conceptualizes one possibility, amongst many, of a future for the field.

Table 1. Conceptual framework

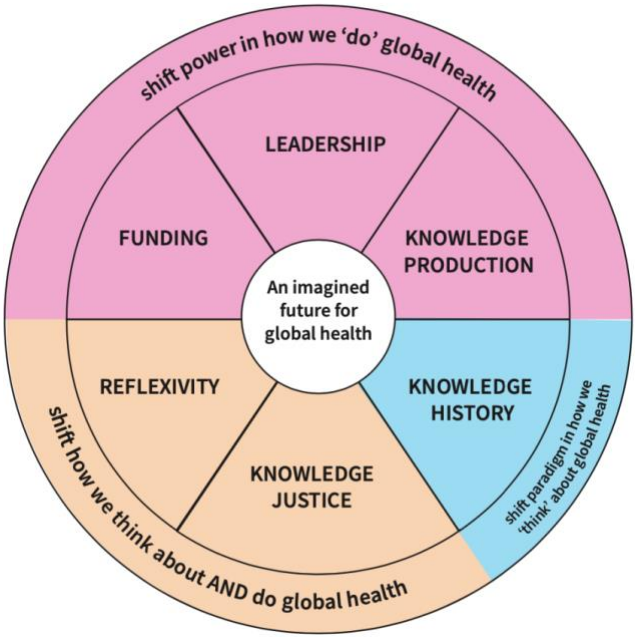
An imagined future for global health		
	Funding	• Redistribution and decentralization of resources to local (i.e., people closest to the work,

Shift power in how we **do** global health		communities of focus while acknowledging context specificity of the "local")[4] • Funder accountability to local • Diversification of decision making to include local (collaboration) • Better align funding with local priorities
	Leadership	• Institutions reorient leadership to local, decentralize decision making power • South-South collaboration • Elevate local/community level knowledge, reflexively consider HIC knowledge
	Knowledge production	• Decentralize knowledge platforms • Increase community engagement, prioritize local, lived experience • Centre Indigenous ways of knowing • Engage diverse groups in decision making towards knowledge production • Increase representation in academic journals
Shift paradigm in how we **think** about global health	**Knowledge history**	• Identify and acknowledge how structures such as colonialism, racism, etc., pose a threat to health equity • Ground analysis in colonialism and its intersections with other structures (i.e., white supremacy) • Institutional reckoning to mitigate harms perpetuated by structures on which they were built
Shift how we **think about and do** global health	**Knowledge justice**	• Diversify what knowledge is considered valuable (ex., outside of metrics) • Shift focus of knowledge and actors in global health to local (disrupt epistemic injustice) • Prioritize reciprocal flows and critique of knowledge • Create new learning platforms and knowledge legitimacy outside of academic English

[4] The authors acknowledge the complexity of "shifting to the local". Contractor & Dasgupta [35] discuss the fact that simply shifting money and power to LMICs, or "the local", and assuming that contexts are neutral/not fraught with internal power structures (i.e., caste) is limited. However, many scholars argue that although it is challenging and not as simple as just "shifting to local", HICs should not remain the centre of power and decision making. As such, this framework suggests a re-centering/redistribution of power where there is greater mutual accountability, collaboration and value on non-Western ways of knowing, leading and funding.

	Reflexivity	• Default to local gaze, instead of Western gaze • Critically consider and reflect on individual and institutional positionality, behaviour, unconscious bias • Recognize basis of lens and framing • Listen deeply, listen differently • Dignity based practice

Fig 1. Summarized conceptual framework for an imagined future for global health



Literature emphasizes that equity and building towards something different in the field is a continuous process and must adopt multi-dimensional, pluralistic and community-centred approaches [73,121,129]. The purpose of the conceptual framework is not to evaluate the merit of this potential imagined future for global health, but rather provide a basis to explore and discuss the extent to which the themes presented in the framework

are being achieved or how they could be achieved in global health policy, research, and practice.

Limitations

There are a number of limitations to note. First, there may be an apparent contradiction in discussing an imagined future before it exists. This is why we have used the work of Futures Studies scholars and conceptualized one potential vision for an imagined future for global health by tracing the genealogy of critiques – to present the possibility of something different, based on present conversations, and then allow for a greater exploration of what this imagined future looks like practically. Second, and aligned with the work of Foucault and Futures Studies scholars, there are many different potential variations of futures that can be imagined [38,39,53]. Futures Studies scholars emphasize that multiple versions of the future exist based on intersecting aspects of connection and identity in our society (i.e., race, class) [39]. This review presents one view of a potential imagined future for global health, specifically in terms of how to think about and do global health, while acknowledging that the possibility of other imagined futures. Third, there is high rate of literature currently being published that focuses on critiques in global health. As such, we endeavored to extemporaneously incorporate emerging literature over the course of completing the review. Fourth, although the breadth of literature included is significant, the framework was developed based on only literature rather than also discussion with stakeholders. We endeavoured to engage with a wide scope of literature and encourage future research that would include problematizing the framework with

stakeholders. Finally, this paper is influenced by the positions of the authors involved and, in particular, the lens of the lead author (HC). HC has included a reflexive statement after the conclusion to articulate her positionality in this work.

Conclusion

This review has presented a genealogy of major critiques in global health discourses, which point towards one potential imagined future for global health. Despite a recognized value of global health in building solutions to health challenges across disciplines and geographies, discourses pointing to an imagined future for global health are rapidly expanding in literature due to the inequities that have been amplified over the last 10 years, but in the last three years in particular. Scholars and practitioners are urging for a shift in how we think about and do global health and despite growing discussion about a potential reimagining of global health in the literature, the extent to which this can be achieved in global health policy, research, and practice remains unknown. Further research is needed to explore perspectives of the conceptual framework for an imagined future from practitioners, policy makers, and researchers to understand the opportunities and challenges of achieving a new vision of global health.

Epilogue: A note on reflexivity

Initially emphasized in qualitative research, reflexivity has grown to be identified as an imperative aspect of research [130–133]. Reflexivity is “the practice of the researcher examining their research practices and critically reflecting on their own role” [p. 1],

through a reflection of the development of the research and how the characteristics of the researcher shape the research [130]. Many articles within the contemporary critiques of the dominant paradigm of global health emphasize the importance of reflexivity, as a step towards an imagined future for global health [13,16,76,80,90,91,93,133,134]. As such, it is important to engage in reflexivity, and acknowledge my lens (HC) as a doctoral researcher from a HIC university institution, to contextualize the discussions in this paper, ultimately aiming to foster greater equity and justice in global health.

As a young, white, Canadian, female doctoral researcher, who has trained at HIC university institutions where Western and Eurocentric values, knowledges and ideologies are dominant, I bring a set of assumptions, biases, knowledge, privilege, and power to doing research, especially in global health. My lens, and thus the development of this paper has also been influenced by my position as a doctoral student. Benedetta Zocchi [135], recently wrote a piece about the complexity of engaging in research as a doctoral student, explaining that she "spent a considerable amount of [her] time questioning what [she] was doing, why [she] was doing it and if [she] was doing it right. In other words, [she] was completely embedded in the system and at the same time constantly looking for ways to rebel against it" [p. 4]. And, although clear on the principles that guide my work including partnership, inclusion, respect, collaboration, and mutual benefit, I have similarly questioned my role, both practically and epistemologically, as a doctoral student throughout the development of my dissertation, and thus, this paper. As a result, the development has been iterative, prioritizing an exploration of what research looks like

given the context (i.e., COVID-19), the emerging conversations in global health (i.e., decolonizing, equity, justice, power), and given my own positionality and privilege as a white woman in this field.

The conceptual framework presented in this paper was not developed solely from my own thinking or that of my committee. It was developed through a comprehensive analysis of academic literature written by scholars who have historically and continue to be racialized, marginalized and/or tokenized in their opportunity to lead in the field, such as Black people, Indigenous people and People of Colour. Although I share the same values of revolutionizing global health that the critiques have pointed towards, this framework is rooted in the invaluable thinking of racialized scholars.

As a young person in global health, I am motivated to explore what is possible in the future, and how we can continue to learn from each other to foster equity in global health research. I want to learn, how do we do global health, given its harmful colonial legacy, and how do we do it well? I think there is a unique opportunity for cross-cultural and multi-disciplinary collaboration and learning in global health, which I hugely value, and believe that by engaging in such learning, we can move towards a more equitable and just practice.

Through a consistent reflexive practice, I see my role as an opportunity to disrupt the current structures through transparent interrogation of the systems and narratives that

perpetuate inequities. Abimbola [136], notes that every narrative places the spectator in a position of power and agency to tell the story, and I see my role as someone with this power and agency, as an opportunity to disrupt. Ultimately, I hope by disrupting the dominant systems and narratives in global health, there will be opportunity to consider how Canadian policy and Canadian organizations, can more respectfully partner with communities at the centre of the challenge towards justice.

Throughout my work, I aim to prioritize reflexivity, interrogating my own lens of research, and transparently naming this lens, in implementing, analysing, and discussing data. The aim of articulating my own positionality is to acknowledge my lens, and situate the context of the discussions presented in this paper, towards understanding the strengths, and limitations, of this lens, and my ongoing work as a global health researcher.

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CHAPTER 3. Exploring adolescent engagement in sexual and reproductive health research in Kenya, Rwanda, Tanzania, and Uganda: a scoping review

Preface

This chapter provides a scope of knowledge on the current approaches to ASRH research in Eastern sub-Saharan Africa. It aims to examine adolescent engagement in ASRH research in four East African countries, Kenya, Rwanda, Tanzania, and Uganda, offering a critical step towards understanding current approaches to adolescent engagement in ASRH research and identifying opportunities to build a strengthened evidence base with adolescent voices at the centre.

This scoping review was completed between December 2020-July 2021. L. Banfield, A. Baumann, D. DiLiberto consulted on the search terms. P. Ogba and I reviewed the literature (title and abstract) and extracted data. I drafted the manuscript and the thesis committee in 2022 (D. DiLiberto, A. Baumann, L. Schwartz) provided feedback for publication. This manuscript has been published open-access in PLOS Global Public Health (https://doi.org/10.1371/journal.pgph.0000208). As such the manuscript falls under the Creative Commons Attribution 4.0 International license allowing for free unrestricted use (see Appendix 3). A post-script is included to contextualize the discussion in the paper with the conceptual framework presented in Chapter 2. The conceptual framework was developed after the scoping review was published.

Exploring adolescent engagement in sexual and reproductive health research in Kenya, Rwanda, Tanzania, and Uganda: a scoping review

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Abstract

Adolescent sexual and reproductive health (ASRH) in East Africa has prioritized research on the barriers to care, communication, and ASRH knowledge, attitudes, and practices. However, there is little research examining the extent to which meaningful adolescent engagement in research is achieved in practice and how this influences the evidence available to inform ASRH services. This review offers a critical step towards understanding current approaches to adolescent engagement in ASRH research and identifying opportunities to build a strengthened evidence base with adolescent voices at the centre. This scoping review is based on Arksey and O'Malley's (2005) framework, employing a keyword search of four databases via OVID: Medline, Global Health, Embase and PsycINFO. Two reviewers screened title, abstract and full text to select articles examining ASRH in Tanzania, Rwanda, Kenya, and Uganda, published between 2000 and 2020. After articles were selected, data was extracted, synthesized, and thematically organized to highlight emerging themes and potential opportunities for further research. The search yielded 1201 results, 34 of which were included in the final review. Results highlight the methods used to gather adolescent perspectives of ASRH (qualitative), the content of those perspectives (knowledge, sources of information, gaps in information and adolescent friendly services), and the overall narratives that frame discussions of ASRH (risky sexual behaviour, stigma, and gender norms). Findings indicate the extent of adolescent engagement in ASRH research is limited, resulting in a lack of comprehensive evidence, consistent challenges with stigma, little information on holistic concepts and a narrow framing of ASRH. In conclusion, there is opportunity for

more meaningful engagement of adolescents in ASRH research. This engagement can be achieved by involving adolescents more comprehensively throughout the research cycle and by expanding the range of ASRH topics explored, as identified by adolescents.

Keywords: sexual and reproductive health, research, adolescents, Kenya, Rwanda, Tanzania, Uganda, global health

Introduction

Adolescents make up over half of the world's population and represent the largest generation in history [1,2]. Defined by the United Nations (UN), as young people aged 10 to 19 years old, adolescence is a key time influencing the trajectory of individual and community health outcomes [1,2]. Of particular interest are adolescent sexual and reproductive health (ASRH) outcomes, as adolescents start engaging in sexual behaviour around the age of 15 years [1,3]. Sexual and reproductive health (SRH) is defined as "a wide range of health issues including family planning; maternal and newborn health care; prevention, diagnosis and treatment of sexually transmitted infections (STIs) … [with] services [aiming to prevent] poor SRH, such as … unintended pregnancies, unsafe abortions, [and] complications caused by STIs" [4,5]. Improving SRH outcomes aligns with Sustainable Development Goals (SDG) 3.7 and 5.6, which aim to ensure universal access to SRH services and rights [4,5].

In Sub-Saharan Africa, which includes East African countries such as Kenya, Rwanda, Tanzania, Uganda, progress on achieving SDG targets remains slow, resulting in a

continuing burden of STIs, unmet contraceptive needs, and inadequate quality of SRH care among adolescents [4,6–13]. As such, the focus of health-specific literature in East Africa has been on SRH interventions, barriers to care amongst adolescents, parent and community communication on SRH, and knowledge, attitudes and practices [6,9,14–28]. This slow progress has been attributed to the complexity of defining ASRH priorities and inadequate research evidence to support relevant policy and program decisions [4,12,29]. Increasing adolescent involvement in research about ASRH has been suggested as a way to build a more responsive and relevant evidence base [2,29–32]. Adolescent participation can contribute to defining ASRH services, polices, and programs that better reflect adolescents needs [2,29–32].

There is little research examining the extent to which meaningful adolescent engagement in ASRH research is achieved in practice and how this influences the evidence generated to inform ASRH programming, education, policies and services [2,29–31]. This review offers a critical step towards understanding current approaches to adolescent engagement in SRH research and identifying opportunities to build a strengthened evidence base with adolescent voices at the centre.

The purpose of this paper is to examine adolescent engagement in ASRH research in four East African countries, Kenya, Rwanda, Tanzania, and Uganda. These four countries were selected based on the Organization for Economic Cooperation and Development (OECD) Development Assistance Committee data on Aid to Health, which highlights that the largest investments in reproductive health in the East African Community (EAC) are

flowing to Tanzania, Uganda, South Sudan, Kenya and Rwanda [33]. However, South Sudan was not included in this analysis given its unstable context and heavy investment in the humanitarian rather than development sector over the last 15 years. In this paper, we will examine, (i) the methods used to gather adolescent perspectives of SRH, (ii) the content of those perspectives and, (iii) the narratives framing discussions of ASRH. The review was guided by the following question: How are adolescents engaged in research on ASRH and what are the perspectives about ASRH in Kenya, Rwanda, Tanzania, and Uganda?

Methods

This scoping review aimed to map the existing literature on ASRH in Kenya, Rwanda, Tanzania, and Uganda, to consider how adolescents have been engaged in research and the related perspectives about ASRH. A scoping review allows for iterative "mapping" of existing literature towards identifying gaps for future research [34–36]. Our approach was informed by Arksey and O'Malley's (33) scoping review framework and the PRISMA-ScR Checklist by Tricco et al. (S1 Appendix) (35). We followed a five-stage process involving, 1) identifying the research question, 2) identifying relevant studies, 3) selecting studies, 4) charting the data, and 5) collating, summarizing and reporting results [34].

Identifying relevant studies

We searched four databases through OVID: Medline, Global Health, Embase and PsycINFO. The search strategy involved the keywords "sexual health" or "reproductive

health" or "sexual and reproductive health" AND Adolescent* or teen* or youth AND "East Africa" or Tanzania or Rwanda or Uganda or Kenya (S2 Appendix). The review included peer-reviewed articles written between 2000 and 2020. All searches are current to February 2021.

The inclusion criteria were studies that, 1) focused on adolescents (aged 10-18, pre-university); 2) were conducted in Tanzania, Rwanda, Uganda, or Kenya; 3) discussed the concept of SRH and specifically adolescent perspectives on, from and of SRH; and, 4) were written in English and published between 2000-2020 to capture the current literature on SRH along with historical perspectives.

The exclusion criteria were, 1) literature on interventions or prevalence of SRH that did not provide adolescent perspectives on, from and of SRH; 2) grey literature; 3) studies that were implemented in countries in East Africa outside of Tanzania, Rwanda, Uganda, and Kenya; and, 4) literature that focused on "last mile populations" or niche communities (i.e., refugees). We did not exclude studies based on study design.

Selecting studies

Two reviewers completed the title, abstract screening, and full text review through Covidence, an online reviewing platform. If there was disagreement on inclusion, reviewers discussed until consensus. The primary author subsequently completed an additional full text review for comprehension.

Charting the Data

Information from selected studies was collated and summarized using the data extraction framework (Table 1).

Table 1. Data extraction framework.

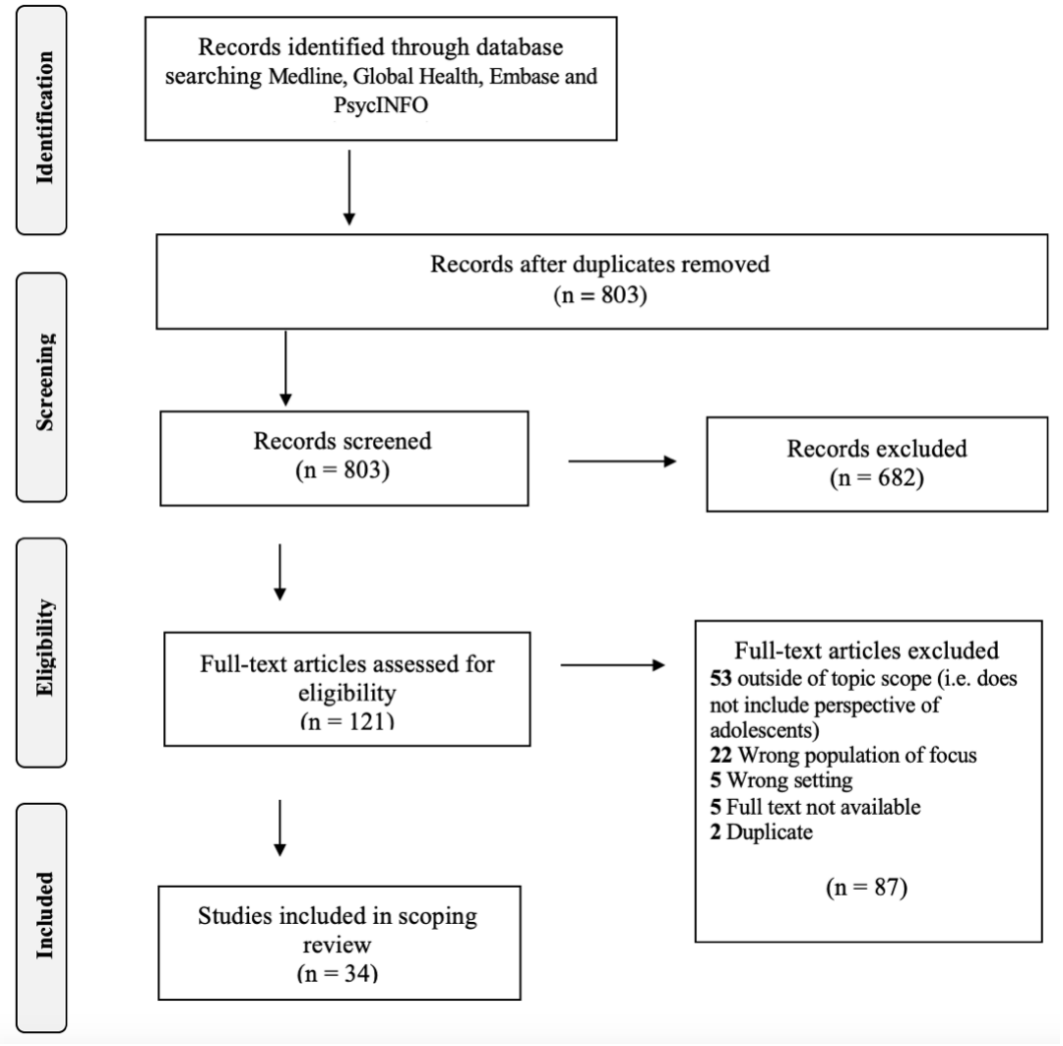
Category	Description
Author	Where is the main author(s) from? Is the lead author from an African or non-African based institution?
Title	What is the title?
Journal & type of publication	Indicate both the journal and type of publication (i.e. peer reviewed article etc.)
Year of publication	What is the year of publication?
Aim/objectives of paper	Describe aim/objective of study
Overview of study	Country of study focus, type of study, intervention examining (if applicable), thematic focus area (identify the problem being studied), main objective/aim of study
Study design and methods	Type of study, methodology, approach, data collection tools, analysis, outcome measures Whose perspectives were included, discussed, and gathered in study? What do those perspectives involve? Were adolescents involved in development of research, collection of data/analysis, used as member checkers?
Overview of results/conclusions	Reported outcomes, summary of key findings, highlight conclusion
Limitations	Describe study limitations

Results

The search yielded 1201 results. Out of those results, 398 were excluded as duplicates and 803 articles were screened (title and abstract). Subsequently, 121 texts were reviewed fully and 34 were included in the final review (see Fig 1, S3 Appendix). Of these studies, 11 were conducted in Uganda [6,14,26,37–44], 12 in Tanzania [22,27,45–54], eight in Kenya [8,55–61], and three in Rwanda [10,11,62]. The results were summarized to

highlight the methods used to gather adolescent perspectives of SRH, the content of those perspectives, and the narratives that frame discussions of ASRH.

Fig. 1. PRISMA flow diagram.



Methods used to gather perspectives

Almost 62% of articles implemented a qualitative study design and used in-depth interviews and focus groups to collect data. Quantitative study designs accounted for

26%, mixed methods for 6% and participatory approaches for almost 6%. Adolescents were included primarily as study participants and were the only participants in 25 articles [6,8,43,44,46–49,51,53,55,56,10,58,60,11,22,26,27,38,39,42]. In eight articles, adolescents were involved as participants alongside community members, teachers, caregivers, religious leaders, and healthcare providers [14,40,45,50,52,54,57,59,62]. One study captured adolescent perspectives without directly involving adolescents [41]. None of the articles indicated that adolescents had contributed to developing the research design or contributed to the analysis of data (i.e., member checkers, verifying data analysis, etc.).

Content of perspectives

The content of adolescent perspectives of SRH can be specified as knowledge, sources of information, gaps in information, and adolescent friendly services.

Knowledge: Thirteen articles examined ASRH knowledge, including concepts such as family planning, contraceptives (i.e., condoms), STIs, puberty and, abstinence [8,10,44,45,50,51,11,22,26,37,39,40,42,43]. Most of these articles quantitatively measured level of SRH knowledge among adolescents and how knowledge translates into behaviour. Based on the findings, a high level of SRH knowledge did not translate into safer sexual behaviour or genuine understanding of SRH [40,44,45,55,58].

Sources of information: Six articles identified the primary sources of SRH information among adolescents as peers, radio, and parents, with some mentioning health centres [8,14,22,39,47,50]. Radio was identified as the most common source of information due to mass media campaigns, accessibility and convenience [22,47]. Adolescents indicated

that parents were a valued and desired source of information even though many parents assumed ASRH was immoral and were hesitant to discuss the topic [14,41,43,45,50,54,59]. Due to this hesitation from parents, adolescents indicated that peers provide a significant amount of SRH information [8,14]. Although health centres were cited as a source of information, the limited confidentiality, lack of adolescent-specific information, and low trust in the care provided, deterred adolescents from seeking SRH information at health centres [22,52,59].

Gaps in information: Adolescents reported misconceptions about aspects of SRH such as contraceptives [38,39,42,43,49,56,60,62]. For example, a number of articles indicated that adolescents believed contraceptives, abortion and family planning were linked to infertility and cancer due to information shared by parents and communities, and due to fear regarding side effects from biomedical treatment [8,22,38,42,43,56,58,60]. The fear of infertility is connected to the high value placed on having children in East Africa [43,53]. Literature noted that adolescents are constrained by cultural and gender norms which equate having children with status and value, creating pressure to prove their fertility, especially among young women [43]. Two articles discussed adolescents wanting to know about diversity in sexual behavior (i.e., curiosity about sex rather than just sexual health) [10,49].

Adolescent friendly services: Seven articles discussed adolescent friendly services [6,8,40,41,50,52,59]. These were defined as non-judgmental, private spaces in which care is free and health practitioners are trained on specific ASRH needs [6,8,50]. Tanzania,

Rwanda, Kenya, and Uganda have all focused on providing adolescent friendly services at existing health clinics to increase the access adolescents have to SRH information and care. However, access is limited due to barriers such as confidentiality and limited knowledge of adolescent-specific SRH (6,8,52,55,56,59). Three articles noted the need to shift towards more adolescent involved development of services to address misconceptions and mistrust in existing services [6,8,50].

Narratives framing discussions of ASRH

Narratives framing discussions of ASRH in the literature were consistent over the 20-year period of the review and included risky behavior, stigma, and gender norms. Twelve articles discussed risky sexual behaviour, that is, adolescents engaging in sexual relations, such as sex without a condom and having multiple sexual partners, leading to negative outcomes (e.g., STIs, unwanted pregnancy) [8,11,58,61,43–45,50,52–55]. Transactional sex and a mistrust in condoms were also noted as risky sexual behaviour [43,44,52–54,61]. Sex for pleasure was considered deviant or risky behaviour among adolescents in Rwanda, where abstinence was framed as "good" sexual behaviour [10].

Some articles noted that high levels of SRH knowledge do not translate into decreased risky sexual behaviour [44,45,55,58]. Other articles highlighted how social and environmental factors such as experiences of poverty, unequal gender norms, substance abuse, and lack of parental support correlate with increased risky sexual behaviour [6,8,10,11,50,54].

Stigma, a social determinant of health specifying what is acceptable or deviant SRH behaviour based on assumptions and stereotypes (i.e., religious beliefs and assumptions of sexual "promiscuity"), was discussed in 11 articles, particularly from healthcare providers, communities and parents [38,40,61,42,43,46,52,53,56–58]. Stigma towards sex outside of marriage, use of contraceptives (especially condoms), early or unintended pregnancy, and abortion were discussed as leading to shaming, social isolation and negative name calling [8,38,42,43,52–54,56,61]. Stigma towards contraceptive use was based on the assumption that contraceptives are only for people who are married or have children, and if used otherwise, result in infertility or increased risky sexual behaviour [8,38,42,43,52,56].

Nine articles discussed how gender norms limit the ability of young women to access SRH care and/or engage in safe sexual behavior (e.g., condom use) [8,10,38,42–44,50,53,55]. This included reference to patriarchal gender norms that prioritize men over women resulting in power imbalances and decreased decision making capacity of women, while reinforcing assumptions that young women are sexually promiscuous [10,38,50].

Discussion

With such a significant population of adolescents in the world and adolescence being a key time of growth and challenge, especially in regards to SRH, it is important to identify how adolescents have been engaged in SRH research in Kenya, Rwanda, Tanzania, and Uganda. Findings indicate the extent of adolescent engagement is limited, resulting in a

lack of comprehensive evidence, consistent challenges with stigma, little information on holistic concepts, and a narrow framing of ASRH.

In the studies reviewed, adolescents were involved as study participants but not in the development or analysis of research projects. Limited engagement through top down, generalized research and programming fails to recognize the intersectional, diverse and context-specific SRH experiences of adolescents in East African countries [2,29,30,63–65]. The value of involving adolescents in SRH research, education and programming development is established [2,29,31,32,50,66–69]. The WHO has called for participatory engagement of adolescents, supporting programs and policies that are "partnership-driven, evidence-informed, gender-responsive, human rights-based, sustainable, people-centered, [and] community-owned" [32]. Participatory action research and community-based participatory research methods have been shown to effectively engage research participants more comprehensively throughout the process of research, resulting in more equitable, context-specific research information and action [30,70–72]. In particular, methods such as photovoice, meaningfully engage adolescents leading to greater peer support, knowledge and insight to inform future SRH education and programming [30,73–75]. It is essential to further engage East African adolescents in SRH research, education and program development in order to create more effective ASRH programs [29,30].

Stigma related to ASRH was noted as a significant challenge for adolescents and stakeholders in the studies reviewed. Stigma from healthcare providers, community

leaders and parents towards contraceptive use ultimately limits the perceived and experienced access adolescents have to adolescent friendly services and SRH information [38,43,52,56,61]. Research on how to reduce stigma towards ASRH has showed that open dialogue and communication with all community stakeholder groups, including adolescents, has been effective [43,52]. Based on learning from HIV experiences, it is possible to address stigma in healthcare facilities by engaging in participatory dialogue and action planning with stakeholder groups [52,76]. A recent study in Burundi also recommended engaging religious leaders, confronting gender-based power imbalances and exploring the underlying drivers of health practitioner stigma as norm-shifting interventions [77]. Engaging adolescents and stakeholders in participatory action research focused on stigma reduction can help to address this pernicious barrier to improve ASRH outcomes [2,10,29,45,50,67,78].

The concepts identified in the literature on Kenya, Rwanda, Tanzania, and Uganda echo the concepts identified in the global SRH literature over the last 20 years, including family planning, contraceptives, STIs, puberty and abstinence [1,2,42–45,50,51,8,10,11,22,26,37,39,40]. Although important, these SRH concepts do not address a wider scope of ASRH perspectives that include sexual desires, masturbation, and sex for pleasure [10,49,79]. These topics have been included in "Comprehensive sexuality education" (CSE) programs implemented in some Sub-Saharan African countries after the 1994 Conference on Population and Development [80]. In East Africa, however, topics such as masturbation, abortion and sexual orientation directly contradict religious beliefs and traditions such as premarital sexual abstinence and patriarchal

gender norms resulting in resistance from communities to include such topics in sex education [80,81]. Research has demonstrated that capturing a wider scope of SRH perspectives among adolescents is important to inform more effective, inclusive and adolescent context-specific research, programming and education [49].

The studies reviewed framed adolescent perspectives of SRH within assumptions of risky behaviour [8,11,58,61,66,67,43–45,50,52–55]. This narrow framing of adolescence as an inherently risky time in an individual's life does not recognize the intersectional experience of adolescents, ultimately limiting how societies support them [29,66,67]. Adolescence is a key time in which intersecting experiences of race, class, gender, and age impact the health of young people. An intersectional lens to ASRH recognizes the social, political and economic power structures that shape individual interactions and health experiences [82]. For example, economic vulnerability and unequal gender norms in East Africa result in transactional sex and limits agency among young women to access SRH services [8,10,82,38,42–44,50,53–55]. Recognizing the intersecting experiences specific to adolescence, rather than framing adolescence as inherently risky, invites an intersectional reframing of adolescence as a time of capacity building and growth towards increased engagement in SRH [2,10,29,45,50,67,78], leading to more targeted, effective ASRH research, programming and education [82].

This study had several limitations. First, literature was only included if written in English, limiting the diversity of perspectives captured. However, the majority of the literature involved authors from institutions based in East Africa in collaboration with institutions

from the United States or Europe. Second, literature was only included if available through university accessible databases. However, the databases provided a wide scope of journals and articles. Finally, the data extraction and analysis of literature was completed only by the primary author (HC). Although we recognize that best practice involves multiple reviewers, the input from contributing authors on conceptualization (LB, HC, PO, DD), data collection (PO, HC), and drafting and editing (HC, DD, AB) added to the rigour of ideas shared.

Conclusion

This scoping review has explored how adolescents have been engaged in SRH research in Kenya, Rwanda, Tanzania, and Uganda by identifying the methods used to gather adolescent perspectives of SRH, content of those perspectives and narratives framing discussions of ASRH. Findings suggest that there is opportunity for more meaningful engagement of adolescents in ASRH research and exploration of more diverse framings and concepts concerning ASRH, as identified by adolescents. Future research should explore how East African countries engage adolescents in the development of ASRH programming.

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Post-script

The aim of the scoping review was to understand current approaches to adolescent engagement in ASRH research in Eastern sub-Saharan Africa. By understanding the current approaches to adolescent engagement in ASRH research in the region of focus, the paper provides a comprehensive overview of the example, ASRH, that is used in this thesis to explore an imagined future for global health as proposed by Chidwick et al. [83] in Chapter 2. This scoping review paper was written before the conceptual framework for an imagined future for global health as proposed by Chidwick et al. [83] was developed. As such, complimentary to the main aim of this scoping review, this post-script offers a brief exploration of how current approaches to adolescent engagement in ASRH research align with the rearrangements to research called for in the conceptual framework for an imagined future for global health.

In general, findings from the scoping review indicate that there is opportunity for more meaningful engagement of adolescents in ASRH research and exploration of more diverse framings and concepts concerning ASRH, as identified by adolescents. These findings suggest opportunity for shifts in ASRH research that are more aligned with an imagined future for global health, particularly in terms of knowledge production, knowledge justice, and reflexivity. However, the values that are beginning to be prioritized and frame ASRH research are aligned with the imagined future offering an opportunity to operationalize such values.

Knowledge production

The conceptual framework for an imagined future calls for shifts in how we do global health, specifically in terms of knowledge production. Knowledge production refers to increasing and prioritizing community engagement and 'local' knowledge production, and engaging diverse groups as decision makers [83]. Dominant approaches to ASRH research programming engage adolescents in a limited way (i.e., only as participants), thus demonstrating minimal alignment with diversifying knowledge production and engaging adolescents as decision makers. However, the value of involving adolescents in SRH research, education and programming development is established [2,29,31,32,50,66–69]. The WHO has called for participatory engagement of adolescents, supporting programs and policies that are "partnership-driven, evidence-informed, gender-responsive, human rights-based, sustainable, people-centered, [and] community-owned" [32]. As such, the emerging discussion about adolescent involvement, identified value of adolescent engagement, and calls for participatory research, suggest that this imagined future, specifically in terms of knowledge production, is a developing aspect of ASRH research.

Knowledge justice and reflexivity

The conceptual framework for an imagined future also calls for shifts in both thinking about and doing global health, specifically in terms of knowledge justice and reflexivity. Knowledge justice refers to calls to diversify what knowledge is considered legitimate and disrupt epistemic injustice. The concepts identified in the literature on Kenya,

Rwanda, Tanzania, and Uganda echo the concepts identified in the global SRH literature over the last 20 years, including family planning, contraceptives, STIs, puberty and abstinence [1,2,42–45,50,51,8,10,11,22,26,37,39,40]. Although important, these SRH concepts do not address a wider scope of ASRH perspectives that include sexual desires, masturbation, and sex for pleasure [10,49,79]. As such, these findings suggest there is opportunity to expand knowledge that informs ASRH programs, indicating an opportunity for further alignment with an imagined future specific to knowledge justice and shifting to adolescents to inform programs going forward.

Reflexivity refers to shifting the dominant gaze of research to prioritize 'local', which in this case refers to adolescents, while critically reflecting on positionality and intersectional identities to account for the complexity of experience. Findings from the review suggest there is opportunity to recognize the intersecting experiences specific to adolescence, rather than frame adolescence as inherently risky, inviting an intersectional reframing of adolescence as a time of capacity building and growth towards increased engagement in SRH [2,10,29,45,50,67,78]. This approach encourages more targeted, effective ASRH research, programming and education [82]. As such, the recognized value in acknowledging and understanding the intersectional experience of adolescence aligns with the rearrangements called for in terms of critically considering positionality, where knowledge is coming from, and tailoring approaches to better account for the complex experiences of adolescents.

In sum, the values emerging in ASRH research including a call to engage adolescents more directly, expand the concepts considered in ASRH programs, and recognize the intersectional capacity of adolescents, suggest alignment with the calls for shifts in the conceptual framework for an imagined future.

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Supporting information

Available upon request.

S1 File. PRISMA-ScR checklist. The 'Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist' was used in this study.
(DOCX)

S2 File. Sample Search Strategy. A text file of the search strategy we used in this scoping review.
(DOCX)

S3 File. Summary of data extracted. A text file of the summarized data extracted.
(DOCX)

CHAPTER 4. Exploring the development of Canada's Feminist International Assistance Policy and its role in the future of global health funding: A policy review

Preface

This chapter explores the development of Canada's Feminist International Assistance Policy (FIAP) and analyzes the development of the policy in relation to the conceptual framework for an imagined future for global health proposed by Chidwick et al., in Chapter 2. An analysis of stakeholder interests, ideas, and institutions that informed the development of the FIAP illuminates ways in which Canadian policy can more effectively support international development projects with greater potential for respectful, context-specific impact in contexts outside of Canada.

This manuscript was completed between April 2021 and June 2023. I reviewed the literature, extracted the data and drafted the manuscript. The thesis committee (D. DiLiberto, L. Schwartz, G. Tuyisenge) provided ongoing feedback on the data extraction and manuscript draft for publication. This manuscript has been prepared for publication to the Canadian Foreign Policy Journal.

Exploring the development of Canada's Feminist International Assistance Policy and its role in the future of global health funding: A policy review

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Abstract

Background: Since 2017, Canada's Feminist International Assistance Policy (FIAP) has framed Canadian funding for foreign aid prioritizing adolescent sexual and reproductive health (ASRH). Analyses have discussed the limitations of the FIAP, but it is unclear what specific interests, ideas, and institutions influenced the development of the policy and subsequently, what these influences indicate about the future of Canadian policy for development assistance, especially in relation to global health funding and ASRH. This study examines the interests, ideas, and institutions that influenced the development of the FIAP, and considers these in relation to the to the conceptual framework for an imagined future for global health as proposed by Chidwick et al.

Methods: This study was conducted through a document review approach using the 3-i framework (interests, ideas, institutions). Data were extracted manually from the FIAP and supporting literature to identify the key interests and ideas of relevant stakeholders and institutions. Data were then considered in relation to the conceptual framework for an imagined future for global health as proposed by Chidwick et al.

Results: Interests of the Canadian government and civil-society organization included gender equality and economic growth. Ideas and values of stakeholders included poverty reduction and "Canadian" values such as compassion. Institutions included previous Canadian policy and current global policy (i.e., the SDGs) along with prominent discourses such as empowering women and girls, and partnerships.

Discussion: Findings suggest that despite engaging in a participatory process to develop the FIAP, equitable representation of the ideas, interests, and institutions that informed

the policy was not achieved. As such, there are opportunities in future Canadian development assistance policy to more significantly prioritize decentralized leadership, local ownership of funding, and context-specific approaches to gender equality – ultimately strengthening the alignment with an imagined future for improved equity and justice in global health.

Introduction

Background

Canada's Feminist International Assistance Policy (FIAP) was introduced in 2017 by the Liberal government, and signalled an intentional shift in Canada's approach to international development assistance. The FIAP prioritizes a gender transformative lens, rather than gender equality or solely women in development, which had been the focus of previous Canadian policy dating back to the 1970s [1–3]. Previous Canadian policies influencing international development assistance include Canada's Women in Development Strategy (WID) and the Policy on Gender Equality (PGE).

In 1976, Canada implemented the WID which shaped subsequent gender equality and feminist approaches to development assistance, including funding to support health programs [2–4]. The WID strategy, led by the Canadian International Development Agency (CIDA), highlighted the need to improve and increase women's participation in development projects funded by the Canadian government [2,4]. After criticism that the WID focused too heavily on women, missing the complex dynamics between men and

women, and paralleling the gender and development approach popularized in the 1990s, CIDA's PGE was implemented in 1999 [2,4]. The PGE [3] aimed to "support the achievement of equality between women and men to ensure sustainable development" (p. ii). Through eight guiding principles, the policy acknowledged and worked to integrate different perspectives, roles, needs, and interests between individuals, defining gender as men and women [3,4]. Gender equality became the overarching guide to economic and social progress, including poverty reduction and basic human needs (i.e., health, and specifically, reproductive health) [3]. However, critiques of the PGE focused on the compartmentalization of gender equality processes from other societal dynamics in the policy, the limited clarity on how to implement gender equality throughout funded projects (not just at the outset), and the promotion of results-based management and technical fixes that limited the value of understanding and addressing systemic aspects of gender inequality [4].

In 2017, the Canadian government launched the FIAP, based on these previous policies and after hearing from a diverse set of global stakeholders through the 2016 International Assistance Review (IAR) [1,5]. The 2016 IAR engaged "Canadian [non-governmental organizations] NGOs, donor and partner governments, youth, people in developing countries, and experts in the field of international assistance" [6] (no p.). Based on feedback from this process, the FIAP was developed with six core action areas, 1) gender equality and the empowerment of women and girls; 2) human dignity; 3) growth that works for everyone; 4) environment and climate action; 5) inclusive governance; and, 6)

peace and security [1]. The policy promotes participation and inclusion of vulnerable groups, highlighting the role of women and girls in poverty reduction [1]. Financially, the FIAP aimed to invest $3.5 billion, in addition to funding from the previous government, into development assistance, which included a specific focus on health, and in particular sexual and reproductive health (SRH) in sub-Saharan Africa [1,2,7–11]. Five years after implementing the policy, the FIAP is still one of the only policies in the world to prioritize feminist approaches through "new" and "innovative" financing and support, with a focus on SRH [1,2,12].

Critiques of the FIAP

Despite engaging a diverse group of stakeholders to develop the FIAP, and presenting a new approach to development aid through prioritizing gender transformative approaches, the FIAP has been critiqued.

First, the FIAP has been critiqued for its unclear definition of feminism and lack of guidance to implement a feminist or gender transformative approach [2,10,12–14]. Second, critiques have noted how the policy simplifies gender to women and girls while depoliticizing the experience of women and girls [12,15]. Similarly critiques discuss that the policy has a significant focus on gender and gender equality with limited acknowledgement and understanding of impactful intersecting structures such as age, race, class etc. [12,15,16]. Third, critiques discuss how the narrative of economic growth in the policy essentializes the role of women in development, without addressing the

systemic and structural causes of gender discrimination [14,16,17]. Finally, critiques argue the FIAP is a reproduction of previous gender and development policies in Canada, promoting the same approach under a different name [2,4].

Rationale

Despite existing analyses, it is unclear how stakeholder interests, ideas, and institutions influenced the development of the FIAP and subsequently, what these influences indicate about the future of Canadian policy for development assistance, especially in relation to global health funding and adolescent SRH (ASRH). Using the 3i framework, this study examines the interests, ideas, and institutions that influenced the development of the FIAP, and considers these in relation to the to the conceptual framework for an imagined future for global health as proposed by Chidwick et al. [18]. We examine the extent to which the FIAP supports the realization of decentralized, equitable, and context specific approaches to funding in an imagined future for global health. This analysis will present the trajectory of the FIAP and advance how Canadian policy can continue to shift towards more effectively supporting projects with greater potential for respectful, context-specific impact in contexts outside of Canada .

Conceptual framework: An imagined future for global health

In this study, the FIAP is analyzed in relation to a previously developed conceptual framework for an imagined future for global health as proposed by Chidwick et al. [18]. In the past few years, there has been growing literature and discussion concerning the

historical roots and current practices in global health [19]. Many of these critiques concern the future of the field and specifically, how global health and its actors need to change to redress past transgressions and move towards greater equity and justice in policy, research, and practice [20,21,30–33,22–29]. Based on scholarship from Futures Studies [34,35], which offers a process to conceptualize multiple different futures, the conceptual framework was developed through an analysis of the history and contemporary critiques of the field. The framework presents one potential alternative to the present context and processes in global health research, policy and practice. The conceptualization of this imagined future does not aim to evaluate or predict the future of global health as a field, but rather explore one possible vision of change as it relates to ASRH policy, research, and practice [19,21,22,25,26,34,36–39]. The framework describes two overarching shifts in this potential future, first, shifting the power in how we do global health and second, shifting the paradigm in which we think about global health. These shifts are practically conceptualized in terms of funding, leadership, knowledge production, knowledge history, knowledge justice, and reflexivity (see Appendix 2).

3i framework

The 3i framework asserts that policy development and choices are influenced by stakeholder interests, ideas, and institutions [40]. The framework is useful for both retrospective and prospective analysis of policy [40] and offers an opportunity to describe the development of the FIAP through a systematic approach considering stakeholder

interests and ideas, and key institutions. This study examines the interests and ideas of the Canadian government and other important stakeholders, and describes the institutions of influence in the FIAP, with a focus on action area 2, human dignity, as it includes health.

The first "i" of the 3i framework, *interests*, refers to the "agendas of societal groups, elected officials, civil servants, researchers, and policy entrepreneurs" [41] (p. 709). To examine the interests of different actors in policy development, key questions include, who benefits and why from the adoption of the policy, and what are the potential losses for stakeholders? [40]. The second "i", *ideas*, refers to "knowledge or beliefs about what is (e.g., research knowledge), views about what ought to be (e.g., values), or combinations of the two" [41] (p. 709). Ideas impact how the problem is defined by different actors and thus what policy options are seen as effective, feasible, and acceptable [40]. Key questions include, are stakeholders drawing on different sources of evidence to advocate for the policy, and is the policy consistent with dominant societal values or culture? [40]. The third "i", *institutions*, refers to, "the formal and informal rules, norms, precedents, and organizational factors that structure political behaviour" [41] (p. 709). Institutions include government structures, discourses, and policy legacies [40,41].

Methods

Study design

A document analysis of government and academic documents was conducted using the 3i framework to identify and describe the interests, ideas, and institutions that influenced the development of the FIAP [40–42]. Document analysis is a method of qualitative research that consists of analyzing various documents including scholarly articles, policies, and institutional reports [43,44]. In this study, documents are defined as publicly available written material including government documents (policies, policy briefs), media and communications documents (news reports, press briefs, government websites), and scholarly work (peer-reviewed academic articles). Document analysis is an effective approach to consider the historical trajectories that led to the development of policies and processes, and inform new policies, aligned with the research question in this study [43,44]. The approach also offered a comprehensive process to consider both academic literature as well as policy documents and news media that was feasible, unobtrusive to human participants, and cost-effective to employ during the COVID-19 pandemic. The approach to document analysis in this study was based on that of Dalglish et al. [45] which involves, readying the materials, extracting data, analyzing the data, and distilling findings.

Document identification

Documents were identified through database searches (Scopus, SAGE, Google Scholar, OVID), manually searching references from key policy papers, government websites, and

grey literature, and speaking with colleagues. Search terms included "Canada's Feminist International Assistance Policy", "development", "Canadian foreign policy", and "Canada's Feminist Assistance Policy and adolescent sexual and reproductive health". Documents included were, 1) the FIAP and relevant government announcements for the FIAP; 2) publicly available policy documents that directly influenced the development of the FIAP – the 2016 IAR, the associated IAR discussion paper, and Canada's 1999 PGE; and, 3) scholarly literature discussing the FIAP dating back to its development in 2016, and/or the policy trajectories that influenced the FIAP.

Data extraction

Data were extracted manually from the FIAP and supporting literature to identify the key interests and ideas of relevant stakeholders, along with overarching institutions, using the data extraction framework outlined in Table 1. The data extraction framework was developed from the key questions of the 3i framework raised in the literature [40,41], along with recommendations from Dalglish et al. [45]. The data extraction framework aimed to identify the key interests, ideas, and institutions (i.e., who is involved, what is the document saying in regards to the interests, ideas, institutions etc.) that influenced the development of the FIAP.

Table 1. Data extraction framework

	Description in relation to FIAP Action Area 2: Human Dignity
Interests	• Whose perspective is the document written from? • What stakeholders are discussed/described as being involved? How were their interests captured?

	• Are direct interests from stakeholders described? If yes, what are those interests?
Ideas	• What sources of evidence are identified and discussed as informing the FIAP? • Who (individuals, organizations etc.) is identified as influential in developing the FIAP? • Are values that informed the FIAP explicitly discussed? What are these values?
Institutions	• Are other policies discussed in influencing the FIAP? What are these policies? • What other underlying discourses are named? What underlying rules/norms are discussed?

Analysis

Data was then analyzed and discussed in relation to the conceptual framework for an imagined future for global health, outlined in Table 2 and Appendix 2. The key questions for data analysis were developed by considering the literature on the 3i framework [40,41] while integrating a critical lens from the conceptual framework for an imagined future.

Table 2. Key questions for data analysis

	Description in relation to FIAP Action Area 2: Human Dignity	**Description in relation to an imagined future**
Interests	• Who are the powerful stakeholders involved? What are the key government interests? • What are other possible stakeholder interests (e.g., researchers, funded organizations in Canada and Eastern Africa)? Do they hold power to shape the policy? • Who wins and who loses with adoption of the policy? Who benefits from the dominant interests that guide the policy? Who is harmed?	How do the interests/ideas/institutions align and/or misalign with the conceptual framework for an imagined future for global health?
Ideas	• What sources of evidence were drawn upon to build the policy (e.g., evidence about role of women and girls in poverty reduction, evidence on understanding ASRH etc.)?	

	• What stakeholders were prioritized to provide evidence? • What values is the policy congruent with? Who/what holds the power to prioritize these values?	
Institutions	• What is the policy legacy of the FIAP (reactions to preceding policies)? • What are the formal and informal rules, norms, and government structures that influenced the FIAP? • What are key underlying discourses that can be interpreted from the policy?	

Results

The search of documents resulted in 29 government documents, other media from NGOs, and scholarly work (outlined in Table 3). Most of the documents (n=22), were academic, peer-reviewed articles discussing and critiquing the FIAP. As such, academic scholars have interpreted many of the interests, ideas, and institutions that influenced the development of the FIAP. Government documents such as the FIAP, IAR, and earlier policies, directly and indirectly, note interests, ideas, and institutions.

Table 3. Documents included

Document type	Description	Number included
Government documents	Policies; Policy briefs and government discussion papers	5
Other media	NGO websites[5]	2
Scholarly work	Peer-reviewed academic articles; Commentaries published in academic journals; Reports	22

[5] While many NGO websites note the FIAP, two shared commentaries on the policy that fit with the inclusion criteria of the paper.

Interests

Interests refer to the agendas of stakeholders in the development of the policy [40,41]. Results indicate who the main stakeholders are and their interests.

Main stakeholders and how their views were captured:

The main stakeholders noted in the literature include the Canadian government, civil society organizations (CSOs), the Canadian public, leaders from the Global South [1,2,5,12,14,17,46–48], and "voices of the poor" [5] (no p.). Stakeholder perspectives were gathered through the 2016 IAR, which involved the Canadian government engaging various stakeholders through surveys, interviews, and public forums to collaboratively set Canada's funding priorities [5,49]. Government documents indicate that the IAR was a participatory process that directly informed the FIAP from the perspective of organizations and leaders in the development sector [1,5,49]. Academic articles note the power of the Canadian government, specifically Global Affairs Canada (GAC, formerly CIDA), to inform the priorities of the FIAP despite collaboration with other stakeholders [10,12,46,50,51]. Academic analyses also identify key interests of the Canadian government as informed by previous gender equality policy, global agendas such as the Sustainable Development Goals (SDGs), and the values of the political party in power (i.e., Liberal values such as feminism that appealed to the party's voting base) [2–4,15,48,52].

Stakeholder interests:

The FIAP directly outlines government interests through several "we believe" statements [1]. For example,

> We believe that empowering women and girls is the best way to achieve positive economic and social outcomes…We believe that the inherent human dignity of all people should be respected and that everyone should have equal access to health care…irrespective of their gender… We believe in economic growth that benefits everyone—and believe that when women and girls are given equal opportunities to succeed, they can transform their local economies and generate growth that benefits their entire communities and countries. [1] (p. 8)

Government interests in the FIAP, as indicated through "we believe" statements, include positive economic and social outcomes, dignity, and growth for everyone (with a focus on women and girls) [1]. Academic analyses further emphasize government interests in economic growth, poverty reduction, empowerment of women and girls, and specifically SRH, in the FIAP [2,10,53,54]. Additional stakeholder interests were defined in the FIAP through a description of statements that GAC "heard" through the IAR [1,5,49]. This included stakeholder interests in support for scaling up SRH interventions, considering children and youth more directly, and ensuring there are appropriate mechanisms for youth to participate in the development agenda [5].

Ideas

Ideas refer to the knowledge, beliefs, values, and discourses that shaped the development of the FIAP [40,41]. More specifically, documents, directly and indirectly, note the sources of evidence and values that informed the FIAP.

Sources of evidence:

A few sources of evidence are noted in academic, NGO and government documents. These include, the IAR [5,13,49,50,55], previous gender and development policy in Canada [2,4,10,13,16,48,56], and global development agendas [5,15,17,46]. The FIAP directly notes the 2030 Agenda for Sustainable Development (otherwise known as the SDGs), the IAR, existing work by CSOs, and encourages further collaboration with researchers to continue to build evidence in support of a feminist approach [1].

Ideas from the evidence:

Government documents emphasize poverty reduction through gender equality as a key idea informing the FIAP [1,5]. Specifically, the FIAP prioritizes empowering women and girls, particularly to access the economic market and SRH services, such as safe abortion, family planning, and contraceptives [1,5,12,49]. Academic articles further note the dominance of poverty reduction and economic growth through gender equality as a pervasive idea in the FIAP, while also discussing the simplification of gender to only women and girls in the policy [2,10,12,16,51]. For example, academic analyses critically discuss the vague definition of gender in the FIAP which results in assumptions of gender as a binary between men and women, homogenizes women and girls, and perpetuates harmful power dynamics by essentializing the role of women and girls (i.e., as victims) in many societies [2,12,15,50].

Values:

Government documents, based on results from the IAR, and academic analyses of the FIAP, indicate that a wide range of values and perspectives were included in the policy [1,5,49]. Significant values in the policy that are directly noted, interpreted by academic scholars, and celebrated by NGOs, include empowerment of women and girls, economic participation, and poverty reduction [1,2,5,10,12,49,51,55]. Academic articles also discuss Canadian government values as significantly influential in developing the FIAP [2,10,13,17,50,57]. These government values are noted by academics as specific to the political party in power, in this case, the Liberal party [2,9,46,48,51,58]. For example, Brown [48] writes that values such as internationalism and feminism while targeting women voters, informed the Liberal party's development of the FIAP. Similarly, the IAR notes "Canadian" values that informed the FIAP, that is, Canadians having a moral imperative to contribute to development assistance, Canadians as compassionate people who want to contribute, and the idea that development assistance is good for both Canada and the world [5,49]. In addition, government documents, particularly the IAR and the FIAP, emphasize the value of innovation and measurement by "encouraging greater experimentation and scaling-up of new solutions to development challenges" [1] (p. 72). Academic articles further discuss this focus on quantitative targets in FIAP, noting how the policy promotes public-private partnerships to encourage innovation and greater impact [1,2,5,10,48].

Institutions

Institutions refer to the rules, norms, discourses, and past policies that shaped the FIAP [40,41]. Academic articles and government documents note past policies and global agendas and indirectly allude to underlying discourses of influence.

Past policies and global agendas:

Many academic articles refer to other feminist foreign policies, for example, Sweden's Feminist Foreign Policy (FFP), as influential in developing the FIAP [10,12,13,15,57]. A feminist approach, noted in other international policies, elevates gender equality in development practice, encouraging transformational challenge and renegotiation of power hierarchies [1,10,12]. Similarly, the FIAP describes a feminist approach as recognizing "that promotion of gender equality and the empowerment of women and girls require[s] the transformation of social norms and power relations" [1] (p. 9).

In addition to other feminist foreign policies, global agendas, in particular the SDGs, also referred to as the 2030 Agenda for Sustainable Development, and Millennium Development Goals (MDGs), are discussed as influential in many academic and government articles. Five documents discuss the SDGs [1,5,13,46,49] and three note the MDGs [5,17,49] as influential in the development of the FIAP. The SDGs set out 17 global goals for peace, prosperity, and health, one of which aims to improve the health and well-being of women and girls, specific to SRH [52]. These significant global agendas are discussed in many documents in conjunction with previous Canadian policies

for international assistance, namely, the WID (1970s) and the PGE (1999) [2,4,10,13,15,16,48,59]. Tiessen [2,4], explains that the trajectory of Canadian policy for development assistance has been consistent for the past 50 years. From the WID strategy to the PGE, documents discuss gender equality (previously discussed as the involvement of women only), as a priority among stakeholders, which has been exemplified by the focus in the FIAP [2,4,10,13,15,16,48,59].

Underlying discourses:

Two main discourses are discussed in both government documents and academic articles that influenced the FIAP, first, gender equality and empowering women and girls, and second, partnerships.

The FIAP promotes poverty reduction through an approach that prioritizes women and girls towards gender equality [1]. Based on previous policies, articles indicate gender equality is both a national and global discourse [2,4,10,13,15,16,48,59]. Many academic articles critique this discourse of gender equality, evident through the language used in the FIAP (i.e., empowerment, women and girls, engaging boys and men etc.) [2,10,12,15–17,59]. Critiques note the lack of intersectionality in how the FIAP promotes gender equality which in turn results in a perpetuation of the gender binary and an increased burden on women and girls to be "empowered" to work in the economic market [2,10,12,14–17,59]. Despite critiques, government documents often refer directly to

gender equality and empowering women and girls, demonstrating the pervasiveness of the discourse to reduce poverty and increase health [1,5,49].

In addition to the discourse of gender equality and empowerment, partnerships were also discussed as influential in both government and academic documents [1,5,10,17,46,56]. Partnerships are noted as a key priority in the FIAP to encourage collaboration amongst global actors towards innovation and building more effective development and global health interventions [1,5,49,52,56,60]. Academic articles contextualize Canada's commitment to global partnerships by discussing the history of collaboration with organizations such as the United Nations Population Fund, which focuses on global population and reproductive health [17,46,56]. In the FIAP, the SDGs are also noted as key to informing the priority of multi-stakeholder partnerships among both public and private actors [1]. Specific to improving SRH, the FIAP directly states the importance of partnerships with women's organizations abroad to increase access to SRH information and services [1,9].

Discussion

Results show the interrelated interests, ideas, and institutions that influenced the development of the FIAP. These interrelated concepts were critically analyzed to identify the extent to which the FIAP aligns with renewed approaches to funding and leading ASRH projects, as called for in an imagined future for global health. Findings suggest that despite engaging in a participatory process to develop the FIAP, some of the ideas,

interests, and institutions that influenced the policy are more powerful than others. As such, there are opportunities in future Canadian development assistance policy to more significantly prioritize decentralized leadership, local ownership of funding, and context-specific approaches to gender equality – ultimately strengthening the alignment with an imagined future for global health. In this section, I first discuss how the FIAP aligns with the conceptual framework for an imagined future for global health, and then consider the opportunity for greater alignment towards both new and renewed approaches to funding.

3i alignment with an imagined future for global health

Results of this analysis indicate that many of the interests, ideas, and institutions that shaped the development of the FIAP align with the conceptual framework for an imagined future for global health proposed by Chidwick et al. [18]. In particular, the participatory process to develop the FIAP, which included many different stakeholders, the values that informed the policy, and the focus on partnerships, gender equality, and empowerment, demonstrate strong connections to an imagined future for global health.

Interests: Results specify that the FIAP was developed through a participatory, consultative process with NGOs, and local stakeholders (i.e., the 2016 IAR) [1,2,5,12,49]. As such, the FIAP is seemingly based on the interests of those at the centre of the challenge, local stakeholders, which has led to a focus on ASRH as the policy draws attention to the opportunity for more effective funding and partnership specific to women, girls, and SRH [1]. An acknowledged strength of the FIAP is the participatory

engagement of stakeholders, and resulting identified interests that informed the FIAP, which was conducted through an innovative feminist approach [2,9,55]. Through an approach that was explicitly named as feminist, the development of the FIAP engaged a diverse range of stakeholders and considered their interests in ASRH, prioritizing the lived and local experience of communities that will ultimately receive the funding for knowledge production and decentralizing the interests that informed the decision-making in the FIAP (funding, leadership).

Ideas: Results show that some formative ideas of the FIAP, including feminism, participation, empowerment, and gender equality, align with the conceptual framework for an imagined future. As a result of these ideas, the FIAP promotes decentralized leadership, funding, and knowledge production, by prioritizing women as leaders and local women's organizations as development partners [1,9]. The ideas in the FIAP support diversified decision-making and aim to disrupt the structural and systemic barriers to gender equality, with women as agents of development, rather than objects of development [1,10]. These ideas align with a similar shift in foreign policy from countries like South Africa, Germany, Norway, Sweden and Mexico that are pro-gender justice and equality [61,62]. These ideas in the FIAP also mark a more explicit and publicly embraced shift to support health services such as safe abortion that were previously limited by the Conservative government's maternal health focused foreign policy [17,48]. In addition, promoting the role of local women's organizations as key recipients of funding demonstrates a potential redistribution and decentralization of resources to local

communities, aligned with calls for funding shifts in an imagined future for global health [18]. Calls to engage and empower voices at the centre of the challenge, in this case, adolescents, are also relevant in the changes encouraged specific to ASRH, where scholars and practitioners have begun to prioritize meaningful engagement of adolescents in ASRH projects and research [63].

Institutions: The results discuss underlying policies and global agendas, including the SDGs, feminist foreign policies in other countries, and previous gender and development policy in Canada, along with the discourses of empowerment and partnerships, as informing the development of the FIAP. While other countries such as Mexico, Norway, and South Africa emphasize a pro-gender justice approach implicitly, Canada is one of the only countries, along with France and Sweden, to explicitly state a feminist approach to foreign aid with gender equality at the centre of the approach [12,55,61,62]. These policies and discourses ultimately aim to support local communities, along with women and girls, to lead prosperous, healthy lives through engaging with the economic market and elevating the role of women in the market [1,2,10,12,13,15,52]. As such, the basis of the policies and discourses that informed the FIAP – empower women and girls towards poverty reduction and better health – aligns with the ideas of decentralizing leadership, decision making and knowledge production, called for in an imagined future for global health. Engaging diverse groups of individuals, prioritizing local and lived experience, and reorienting decision-making to those at the centre of a given challenge, are encouraged in an imagined future, and evident in institutions in which the FIAP is based.

Overall, many actors including NGOs and academics have celebrated the FIAP and its focus on an approach that was named feminist and focused on gender equality [55,64]. Results indicate that the interests, ideas, and institutions that influenced the development of the FIAP have led to an innovative policy that has expanded the opportunity for the Canadian government to support gender equality, feminist and human-rights-based approaches to development and ASRH.

3i misalignment with an imagined future for global health

Despite the alignment of the FIAP and its development with an imagined future for global health, existing power asymmetries between stakeholders, and subsequent interests, ideas, and institutions, limit the opportunity of the FIAP to decentralize leadership, funding, and knowledge production in the way it is encouraged. In theory, the FIAP strongly aligns with an imagined future, although opportunities for further alignment are evident through critical analysis.

Interests: Despite the participatory engagement of stakeholders to gather interests, results suggest that the Canadian government held the most power in shaping the interests of the FIAP [5,10,12,46,47,50,51]. Interests of the Canadian government, including gender equality, poverty reduction, and increased access to SRH, align with mainstream global values and interests outlined in previous development assistance policy in Canada and global agendas (i.e., the SDGs) [2,4,10,13,15–17,48,56]. Bouka [50], notes that although

multiple stakeholders were engaged in developing the FIAP, more sustained, meaningful engagement of diverse stakeholders was needed, and continues to be needed, for effective funding and implementation. Thus, although the FIAP was developed through a participatory process, existing power dynamics between stakeholders and the priorities of included stakeholders, significantly shaped the priorities emphasized in the policy [12,16,54,65], and the subsequent structure of funding and support for these priorities.

In particular, the existing global focus on maternal and child health by the Canadian government and global stakeholders dating back to the 1970s led to the emergence of ASRH as a priority for funding [2,17,47]. This shift was in conjunction with the empowerment narrative that is promoted in the FIAP which misses the prescriptiveness, and perhaps coerciveness and paternalism, of some ASRH policy as a method of potential population control [17]. Priorities of the Canadian government have also shaped the push for innovative, "gender transformative financing" in the FIAP, with little clarity on how this gender transformative financing can be operationalized, particularly with NGOs [1,2,9,10]. The prioritized interests of the Canadian government limit the alignment of the FIAP's development with an imagined future as decentralized leadership and the push for localized funding and knowledge production is continually led and prescribed by the Canadian government, rather than local stakeholders.

Ideas: Similar to asymmetrical power between stakeholders that informed the interests of the FIAP, certain ideas are more pervasive and powerful than others. Results show that

poverty reduction and gender equality, by empowering women and girls, are key ideas that informed the FIAP [1,5]. These ideas date back to Canada's initial involvement in development assistance and are critiqued, by academics, for simplifying the complexity of gender, in approaches to poverty reduction, as only engaging women and girls [2,10,12,16,51]. Despite some mention of an "intersectional" approach to gender equality, gender in the FIAP is conceptualized as women and girls with some mention of men and boys – reinforcing the socially constructed gender binary [1,2,12,15,50]. In reality, gender is much more expansive and diverse, and many scholars argue for the critical integration of intersectionality to mitigate harmful power dynamics, which the FIAP does not [15,16,50]. In addition to pervasive ideas of gender equality as only engaging women and girls, results show that the FIAP is based on both Canadian government and seemingly inherent "Canadian" values [2,5,9,46,48,49,51,58].

Canadian values of compassion and morality and Canadian government values of feminism that the FIAP is based on, and also promotes, show underlying paternalism and an assumed understanding of feminism in the policy. For example, the influence of a singular idea of (Western) feminism and the idea of empowerment, through engaging women in the economic market that is promoted in the FIAP, has led to a discourse that essentializes the systemic, intersectional challenges that women in sub-Saharan Africa, for example, experience (i.e., intersections of gender, power, socioeconomic factors), and infantilizes these challenges by only conceptualizing women and girls based on the challenges/needs they experience, not as whole people [2,12]. Canadian and Canadian

government values assume that the FIAP is inherently an "ethical" and "good" policy because it was developed through a feminist approach [66], while missing the potential paternalism, limited context-specificity and thus lack of localized leadership and knowledge that informed the policy. For the FIAP to truly be "ethical" there is opportunity to expand ideas of feminism, justice and human rights so they extend beyond the scope of Western liberal assumptions [66].

In sum, findings from the literature suggest that the ideas of feminism and gender equality are integrated in the policy through a single, and perhaps biased, vision limiting the impact of such priorities. For example, Bardall [51] explains that while the FIAP "made a significant commitment to supporting women's groups and local organizations that support gender equality and women's empowerment, the majority of funding continues to flow to implementers with essentially non-gendered or gender-mainstreamed perspectives on development" (no p.). Scholars argue that there is opportunity to embrace the fluidity of ideas such as feminism and gender equality by acknowledging and appreciating the context-specificity of such concepts [12,14,67]. Specifically, what feminism means in Canada is not equivalent to what it could mean outside of Canada in countries of implementation and thus, Canadian policy needs to embrace the idea of multiple definitions of feminism[6] [12], especially in ASRH work. For example, Coates & Allotey

[6] The FIAP does not directly define feminism although scholars argue that despite not being defined it is assumed in the policy through a Western lens by pushing the narrative of "empowerment of women and girls" [9,50,51]. A vague definition of feminism could be effective if the FIAP specifically acknowledged thereafter that a multitude of definitions of feminism exist and encouraged context specific approaches (rather than assuming a Western definition and funding based on this bias).

[68] discuss gender transformative approaches to SRHR arguing for policies to be designed in a way that prioritizes autonomy and agency amongst women, girls and gender diverse individuals to access resources. Similarly, Tiessen [2] explains that,

> A fully gender-inclusive policy must address such variables as cultural norms, discrimination, political processes and institutionalized gender inequality, and examine how and where they intersect. Policy implementation must include input and advice from local organizations that are aware of marginalization, as well as from individuals who have lived the experience of inequality and understand its local context. (p. 1)

Despite a commitment to gender equality and feminism, the ideas informing the FIAP need to be more concretely committed to through an inclusive and intersectional approach.

Institutions: The institutions that informed the FIAP, such as previous policies and global agendas, as noted in the results [1,2,4,5,13,46,49], largely align with the conceptual framework for an imagined future. However, the power of global agendas to promote a generalized approach to development, rather than approaches that prioritize context specificity is important to acknowledge. For example, the FIAP has a focus on ASRH, which aligns with previous policies and the SDGs, although there is limited discussion on how ASRH is understood differently based on context. Similarly, the promotion of partnerships, which results indicate was key in the FIAP development, should also be situated in the inequities that have historically and continue to exist between different stakeholders. Black [47] discusses the idea of partnership as mutually beneficial, transparent, equity-focused, recipient-focused and collaborative work between country actors, and explains that the FIAP prioritized Canada's development goals over "partner"

country goals, questioning whether true partnership is achievable in foreign policy. In other words, funders have more power in partnerships than implementing organizations and local stakeholders [19,25,69,70]. Further, Robinson [66] notes that "ethical foreign policy that is feminist is about seeing global actors as constituted and sustained through relationships in specific times and places, and tracing how power, in its various forms, makes those relationships – in various, ever-changing contexts – oppressive or enabling" (p. 23). As such, there is a continued opportunity to acknowledge power dynamics and invest in more sustained, bottom-up ways of partnership and gathering information [50], to better align with the calls for shifts in leadership, funding, and reflexivity, outlined in the conceptual framework for an imagined future for global health.

Opportunities for future

Given the extent of alignment discussed, there is an opportunity to further refine aspects of the FIAP to better align with the contexts in which funding is directed and/or provide opportunity for flexibility within implementation countries. Table 4, which is based on the conceptual framework for an imagined future for global health (Appendix 2), presents the opportunities for further alignment towards greater equity and justice in Canadian development assistance for global health, specific to ASRH.

While outlining opportunities for shifts in the FIAP, it is important to acknowledge the complexity of foreign policy and existing related processes in Canada that set a precedent (i.e., Canada Revenue Agency procedures for funding projects abroad). In addition, it

could be argued that it is out of scope for a national government to devise a development assistance policy that is responsive to the context of its recipient countries. However, by framing the FIAP in relation to an imagined future for global health, practical and accessible shifts are possible in how context responsiveness could be further supported in a national policy. Clearly articulating the possibility for context responsiveness in development assistance might encourage NGOs to more effectively navigate both Canadian government and context-specific priorities.

Table 4. FIAP opportunities for alignment with an imagined future for global health

Aspect of an imagined future	Opportunities for shift
Funding	• Greater direct alignment of Canadian funding priorities with local context of ASRH (i.e., consider the context-specific ideas on ASRH, gender, feminism, transformative financing), and/or greater flexibility in the FIAP to account for contextual specificity of ASRH, similar to work modelled by the Equality Fund [71] • Shift ownership of funding to local communities that are implementing projects
Knowledge production	• Decentralize knowledge platforms informing government policy for foreign aid specific to ASRH (i.e., engage adolescents) • Include a wider scope of values to inform the knowledge the policy is based on • Continue to engage expertise and knowledge of those with lived and institutional experience (i.e., bottom-up development) [2,50]
Knowledge history	• Reflect on the influence of historical power structures such as colonialism in which Canadian policy for foreign aid is (indirectly) based, and views of ASRH are impacted by • Prioritize acknowledging and working to mitigate power relations (i.e., shifting leadership, knowledge production, funding to local ownership/context) in policy

Knowledge justice	• Expand the definition of gender, gender equality and feminism to embrace the multiple, context-based and complex ideas of such concepts • Explore opportunities to diversify metrics and measurements of impact that are valued in current FIAP • Create more inclusive and clearer processes for implementation of policy, guided by transnational perspectives obtained through consultative processes [9]
Reflexivity	• Critically consider the institutional biases that have influenced the policy and work to mitigate this gaze by reviewing processes for measuring impact, distributing funding, reporting etc.

Overall, the discussion indicates that the conceptualized imagined future for global health has been achieved to an extent, although there is continued opportunity for clarity on what alignment looks like practically.

Limitations

There are a few important limitations to note. First is the lack of existing literature written on the FIAP, especially grey literature. Literature discussing the FIAP is confined to a small group of Canadian, academic, scholars and as such is largely written from a Canadian perspective. Despite this bias, the review includes a wide scope of both academic critiques and government documents relevant to the FIAP with the aim of sharing a wide and comprehensive scope of discussion on the policy. Second, the FIAP, despite promoting transparency, is a vague and somewhat unclear document to navigate. In response HC, the lead author, discussed the policy with scholars, colleagues, and practitioners from universities, government-affiliated organizations, and GAC to better understand the policy and its development, in addition to the literature included. Finally,

HC was trained in development studies before engaging in global health work. As such, her perspective is perhaps more critical than not of international development policy, especially of Canada's role abroad. She has worked to mitigate this bias through reflexive practice throughout this review, along with engaging in a rigorous process of writing and editing that involved critical feedback from co-authors.

Conclusion

The FIAP promotes a gender transformative approach that encourages a disruption of structural and systemic barriers to gender equality, with women as leaders, towards poverty reduction. Findings suggest that the policy appears to align with the conceptual framework for an imagined future for global health, that is, centering the voices of women and girls in approaches to reduce poverty and improve access to health services, specifically in terms of SRH, and shifting power to communities at the centre of the challenge. However, findings also indicate several opportunities for shifts in Canadian policy for foreign aid that support and promote contextualized, community-led and gender-expansive approaches to ASRH projects. As such, further research on how the FIAP shapes ASRH projects in practice and the subsequent alignment with the conceptualized imagined future would be beneficial to learn about how to respond to and make rearrangements towards shifts in global health funding.

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CHAPTER 5. Exploring the impact of Canada's Feminist International Assistance Policy on adolescent sexual and reproductive health projects

Preface

This chapter explores how Canada's Feminist International Assistance Policy (FIAP) influences adolescent sexual and reproductive health (ASRH) projects in Eastern sub-Saharan Africa. It aims to explore stakeholder perspectives of the topic and then consider these perspectives in relation to the conceptual framework for an imagined future for global health, as proposed by Chidwick et al. in Chapter 2 of this dissertation. This study offers a potential path of action, from the perspective of the implementing actors, to shift the practice of funding and supporting ASRH projects.

This manuscript was completed between February and June 2023. I developed the research protocol, completed interviews with participants, analyzed the data and drafted the manuscript. The thesis committee (D. DiLiberto, L. Schwartz, G. Tuyisenge) provided ongoing feedback on the research process, data analysis and manuscript draft for publication. This manuscript has been prepared for publication.

Exploring stakeholder perspectives of Canada's Feminist International Assistance Policy (FIAP) and how these perspectives align with an imagined future for global health

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Abstract

Background: Ongoing global health inequities, such as a lack of access to health resources and services due to structural determinants, have been further exposed and amplified in recent years resulting in a proliferation of literature that critiques both the historical roots and current practices in the global health field. From this literature, questions have emerged about the future of global health and Canada's role in this future. However, there is little research exploring the role of Canadian policy for global health funding and the experience of stakeholders that currently implement projects with Canadian funding. This study explores stakeholder perspectives of how Canada's Feminist International Assistance Policy (FIAP) influences adolescents sexual and reproductive health (ASRH) projects and how these perspectives align with calls for change in global health as proposed by Chidwick et al. in the conceptual framework for an imagined future for global health.

Methods: This study was conducted from March to May 2023 through eight interviews with key informants who were working on ASRH projects, funded through Global Affairs Canada (GAC). The study approach included stakeholder analysis and qualitative description (QD).

Results: Results highlight the role of Canadian organizations in ASRH projects, importance of partnerships, influence of the FIAP, operational and contextual tensions and contradictions that arise from implementing FIAP values in ASRH projects outside of Canada, along with stakeholder views on moving forward in global health policy and practice.

Discussion: Findings indicate that the language of the FIAP is aligned with calls for change in global health although there is opportunity for further action towards operationalizing this change in GAC funding structures and policy. Specifically, findings highlight opportunity to create more flexible funding processes, expand monitoring and evaluation approaches to include qualitative and feminist ways of measuring impact, promote rights-based and dignity-based approaches to ASRH, and increase timelines for projects in order to facilitate greater consultation and partnership building with communities involved. In conclusion, the FIAP creates an impactful foundation for change towards equity and justice in ASRH projects, although Canadian funding structures and processes need to continue to re-imagine how they support organizations and projects to action these changes.

Introduction

More than half of the global population is comprised of adolescents, defined by the United Nations (UN) as young people aged 10 to 19 years [1,2]. This period of development is pivotal in shaping both individual and community health outcomes [1,2]. Adolescents may start engaging in sexual behaviour around the age of 15 years making their sexual and reproductive health (SRH) an important issue for both their immediate and long-term health outcomes [1,3]. SRH is defined as,

> A wide range of health issues including family planning; maternal and newborn health care; prevention, diagnosis and treatment of sexually transmitted infections (STIs) … [with] services [aiming to prevent] poor SRH, such as … unintended pregnancies, unsafe abortions, [and] complications caused by STIs. [4,5]

Improving SRH outcomes aligns with Sustainable Development Goals (SDG) 3.7 and 5.6, which aim to ensure universal access to SRH services and rights [4,5]. In sub-Saharan Africa, and Eastern sub-Saharan Africa in particular, progress on achieving SDG targets remains slow, resulting in a continuing burden of STIs, unmet contraceptive needs, and inadequate quality of SRH care among adolescents [4,6–13]. As such, adolescent SRH (ASRH) has become the focus of many foreign governments through development assistance.

Over the last six years, Canadian international development assistance has increasingly prioritized ASRH. In 2017, the Canadian government announced the Feminist International Assistance Policy (FIAP), which guides Canadian funding for development abroad [14]. The FIAP encourages a specific focus on gender equality and human dignity, including SRH [14]. After implementing the FIAP, the government announced $650 million over three years to address gaps in SRH globally, where 95% of all financial support for development initiatives would target and integrate gender equality and empowerment of women and girls by 2022 [14–17]. In 2019 and a further part of Canada's FIAP, the Liberal government announced a "10-Year Commitment to Global Health and Rights" investing an additional $1.4 billion each year (for 10 years) to further support the health and rights of women and girls globally [15]. This included an commitment of $700 million each year specifically for SRH [15].

Global Affairs Canada (GAC) under the leadership of the current government, leads the implementation of the FIAP by distributing funds to relevant projects [18,19]. Significant to this distribution of funds are organizations, as the FIAP promotes multi-sectoral approaches by engaging global and local civil society, multinational organizations, women's rights organizations, and non-traditional donors [14]. Over the past decades, these various non-governmental organizations (NGOs) have grown into one of the most significant groups of actors influencing development and health globally [20–22]. Since 2018, GAC has focused its funding on projects that adopt a feminist and sustainable approach to improve the health, rights, and well-being of adolescent girls, women, and children [23]. Based on this approach, GAC has funded many ASRH projects with a specific focus in Eastern sub-Saharan Africa [14,23,24]

Study Purpose & Rationale

Several studies have examined the FIAP including stakeholder perceptions of feminism within the policy and challenges with its implementation [17,25–31]. These studies, along with GAC, have established NGOs as important and prominent actors in implementing FIAP funded projects [32], specifically for ASRH. However, there has been limited exploration of how the FIAP practically impacts ASRH projects that are implemented by NGOs, and further, what this impact indicates about the future of ASRH and global health generally. This study aims to understand how the FIAP influences ASRH projects and examine how this aligns with the conceptual framework for an imagined future for global health, as proposed by Chidwick et al. [33] in Chapter 2 of this dissertation.

This study examines the influence of the FIAP through GAC processes at different stages of the project (i.e., development, implementation, and evaluation) and in different aspects of the project (i.e., project values, approaches to ASRH and partnerships, integration of gender, project accountability and reporting structures). Exploring how the FIAP influences projects and work by NGOs is not a new discussion as evidenced by scholarship in the development sector which has examined the FIAP's influence in how organizations are addressing gender equality targets [34].

Research Questions & Study Objectives

The research question for this study asks, *how does the FIAP influence ASRH projects in Eastern sub-Saharan Africa and how do these perspectives relate to an imagined future for global health?* The study objectives include the following:

1. To describe key informant perspectives about how the FIAP influences ASRH projects in Eastern sub-Saharan Africa.
2. To examine how the FIAP and its connection to ASRH projects aligns with the conceptual framework for an imagined future for global health, as proposed by Chidwick et al. [33] in Chapter 2 of this dissertation.

Conceptual framework: An imagined future for global health

In this study, the FIAP is analyzed in relation to a previously developed conceptual framework for an imagined future for global health as proposed by Chidwick et al. [33] in

Chapter 2 of this dissertation. In the past few years, there has been growing literature and discussion concerning the historical roots and current practices in global health [35]. Many of these critiques concern the future of the field and specifically, how global health and its actors need to change to redress past transgressions and move towards greater equity and justice in policy, research, and practice [36–49]. Based on scholarship from Futures Studies [50,51], which offers a process to conceptualize multiple different futures, the conceptual framework was developed through an analysis of the history and contemporary critiques of the field. The framework presents one potential alternative to the present context and processes in global health research, policy and practice. The conceptualization of this imagined future does not aim to evaluate or predict the future of global health as a field, but rather explore one possible vision of change as it relates to ASRH policy, research, and practice [35,37,42,45,46,51–55]. The framework describes two overarching shifts in this potential future, first, shifting the power in how we do global health and second, shifting the paradigm in which we think about global health. These shifts are practically conceptualized in terms of funding, leadership, knowledge production, knowledge history, knowledge justice, and reflexivity (see Appendix 2).

Implications & Benefits

By understanding how the FIAP influences ASRH projects, this paper aims to inform future funding and related practices by the Canadian government to strengthen alignment with the priorities of the FIAP, NGOs, communities, and individuals involved in ASRH projects. This study offers a potential path of action, from the perspective of the

implementing actors, to shift the practice of funding and supporting ASRH projects. As such, this study contributes to the information available to practitioners, researchers, funders, and policy makers to foster more equitable global health practice.

Methods

Key informant interviews were conducted to investigate stakeholder perspectives about the FIAP and how the policy influences ASRH projects in Eastern sub-Saharan Africa. Both qualitative description (QD) and stakeholder analysis recommend the use of semi-structured interviews for focused data collection [56–61].

Stakeholder analysis is a process of systematically gathering and analyzing information to determine stakeholder interests, interrelations, intentions, and roles in policy change [58–60,62–64]. What, or who, constitutes a stakeholder has been widely discussed in literature on the approach [58–61,64–66]. In general, a stakeholder can be defined as individuals, groups or organizations that share common interests and holds interest in the outcomes of certain decisions or objectives [58,59,61,64]. Stakeholder analysis offered an effective structure to engage and recruit key informants from NGOs which are part of a specific stakeholder group described by Schiller et al. [61] as civil society organizations (CSOs). According to Schiller et al. [61], CSOs include NGOs, faith-based organizations, and "Indigenous/ethnic groups" (p. 5). The Canadian government has identified NGOs specifically, as essential actors in implementing the FIAP. However, there is limited

information about the perspectives of key informants within NGOs on the FIAP and its influence on ASRH projects.

Ethics and informed consent

This study was reviewed and approved by the Hamilton Integrated Research Ethics Board (HiREB #13761). A letter of information and consent was shared with participants prior to the interview to gather written consent (see Appendix 6 and 7). Oral consent was also gathered from participants prior to the start of the interview. All participation was voluntary. Participants were made aware that interviews would be conducted confidentially and information would be immediately de-identified upon completion of the interview to maintain privacy. Participants were also made aware that there were no foreseeable consequences to any future GAC funding.

Sampling and recruitment

To identify key informants from NGOs working on ASRH projects funded through the FIAP, the lead student investigator (HC) met with a colleague from the Canadian Partnership for Women and Children's Health (CanWaCH). CanWaCH is an organization that aims to collate the knowledge and expertise of Canadian NGOs to advance the health and rights of women, children, and adolescents globally [67]. CanWaCH works to exchange knowledge, measure results of projects implemented by Canadian development actors, and engage stakeholders [67]. To this end, CanWaCH has developed a "Project Explorer" database outlining all GAC funded projects [68]. As such, lead student

investigator completed an initial search of key informants through the CanWaCH Project Explorer database. Key informants were included in the study if they were individuals in Canada leading ASRH projects implemented in Eastern sub-Saharan Africa, that were at least 90% funded by GAC from 2018 onwards. These individuals were connected to the country-based implementing organizations so could speak to the wide scope of FIAP influence.

After this list of potential key informants was developed, the lead student investigator worked with her colleague at CanWaCH to gather contact information for each individual. Based on recommended procedures for stakeholder analysis and QD [59,61,66,69], key informants were then purposively recruited via email (see Appendix 8). It was made clear in the initial email to key informants that CanWaCH would not be involved in the interviews and participating in an interview would in no way impact partnership with CanWaCH or the funding received from GAC.

Data collection

Of the eleven key informants that fit the inclusion criteria and were purposively recruited, eight individuals participated in interviews between March and May 2023. A framework of questions for the interview guide was informed by stakeholder analysis tools [58,59,61] and qualitative interview methodology [70,71] (see Appendix 9). Content for the interview questions was developed from the study research question, objectives, and previous analyses of the FIAP and ASRH research by Chidwick et al. [72,73] (included in

Chapters 3 and Chapter 4 of this dissertation). The interview guide consisted of 13 pre-determined open-ended questions and additional probing questions. Questions asked about the key informant's work and role at the organization, details on the ASRH project of focus and how it was developed and implemented, and their perspective on the FIAP and its connection to the ASRH project. This structure intended to encourage a conversational style.

The lead student investigator conducted the interviews in English over the Zoom platform. Interviews took about 50 to 60 minutes, where all participation was voluntary and confidential. Recommended practices for conducting ethical remote interviews, including the use of the Zoom platform specifically, flexibility with possible technical and connectivity challenges, and sharing the privacy policy from Zoom with participants in the informed consent process, were consulted and continually considered throughout the process [74–76]. Interviews were recorded, de-identified and transcribed to ensure confidentiality and effective data analysis. All information from the study was stored in electronic encrypted and password-protected folders.

Analytic Strategy

Key informant interviews were analyzed through a QD approach using content analysis. QD is a research methodology that aims to describe experiences, events, and perspectives in a factual and authentic way, through concurrent data collection and analysis [69,77–79]. QD studies explore the who, what, and where of events or experiences, based on a

constructivist paradigm which notes perspectives are subjective and specific to social, cultural, and historical context while aiming to be inclusive of all perspectives regardless of existing social power hierarchies [69,77,78]. Aligned with Sandelowski's view of QD, this study emphasizes the value of participant's perspectives as viable end-products [69,78]. QD has also been noted as especially effective in health research, providing an opportunity for factual responses from participants and description of those responses to understand the impact of processes and policy [77]. In this study, QD offered an opportunity to describe key informant perspectives of the FIAP which have not been previously captured.

Data analysis was completed concurrently with data collection so, interview transcripts and documents were analysed together to describe the phenomena of interest with limited integration of external theory or interpretation [69,77–81]. Data was explored inductively to identify and describe recurring themes, concepts, and patterns [69,77,78,82]. Recordings from participant interviews were immediately de-identified using a study key and transcribed by the lead student investigator. Transcripts were then coded through the NVivo 12 software, enabling transparency, flexibility, and trustworthiness of the data [83].

A codebook was developed inductively from interview data. Codes are action-oriented words or labels used to describe parts of interview text, reflecting recurring themes or topics [77,81]. The study codebook was developed through a process of line-by-line

coding and clustering of emerging patterns. Line-by-line coding is the process of identifying words and sentences that appear to capture thoughts on concepts, allowing for open, inductive themes to emerge [77,80]. One member of the research team (HC) line-by-line coded six interview transcripts and another member of the team (LS) coded two transcripts. After this, the team discussed the line-by-line coding and codes were grouped into categories and clustered into larger sections based on their area of focus. Codes were further synthesized and refined, and emerging themes were noted. Themes from the codebook were reviewed for consistency against a set of government documents such as a Call for Proposals, Results-Based Management Framework and Gender Analysis Framework (see Appendix 4). This provisional codebook and an overview of emerging themes was also shared, via email, with interview participants who indicated interest in providing feedback on the codebook during the interview. Based on feedback from participants stating they were content with the codebook and continuing discussions with the research team, the codebook was revised as needed. Relevant data was re-coded to ensure consistency and quality of the analysis. After inductive analysis of the data and identification of themes, results were explored in relation to the conceptual framework for an imagined future for global health proposed by Chidwick et al. [33] in Chapter 2 of this dissertation.

Memoing by the lead student investigator was completed throughout the process of study development and data collection to ensure researcher reflexivity and capture the lead student investigator's stance and process for considering data [77,84]. Reflective memos

also assisted in ensuring the integrity of participant perspectives, as researcher perspectives and biases were identified and the analysis was then be able to stay grounded in the data [77,79,84].

Results

The findings presented below are organized into five main sections: an overview of key informants and their ASRH projects; the significance of partnerships in ASRH projects; the influence of the FIAP; tensions between the FIAP, GAC structures and context of implementation; and what participants described as push for change. These sections align with the flow of questions presented in the interview guide which aimed to understand how ASRH projects are developed and implemented, perspectives of the FIAP, and how ASRH projects can be better supported in the future.

Key informants & ASRH projects

Eight key informants were involved in the study, five who used she/her pronouns and three who used he/him pronouns. Majority of participants (n=6) were Program Managers or Program Officers at their organizations, with a specific focus on SRHR. One participant was a Gender Equality Advisor at their organization, and one participant was the SRHR Director. Participants described their role at Canadian organizations and in the SRHR projects as leading on management and coordination of projects from Canada through collaborative, non-hierarchical and accompanying approaches (see Table 1). Participants noted in particular that they lead on communication and compliance with

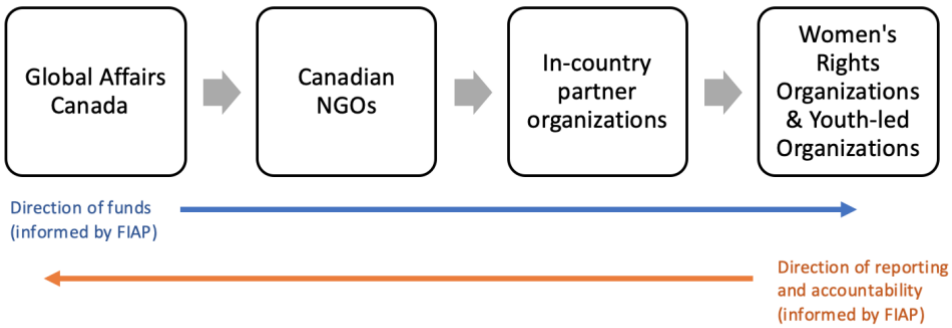
GAC and emphasized their role as the intermediary between GAC and partner organizations, to *"soften the blow from... GAC compliance"* (Study Participant[7]). GAC funding was described as distributed mostly to in-country partners that are responsible for the implementation of the ASRH projects. Figure 1 outlines the structure of funding, identifying where individuals from Canadian organizations are involved (also see Appendix 5).

Table 1. Overview of key informants and ASRH projects

Org. ID	Time-frame	Project Goal	GAC Funding
1	2020-25	Help adolescent girls and young women access better SRH care	< $20mil
2a	2021-27	Improve access to high quality, gender sensitive SRH services for adolescent girls and young women	< $20mil
2b	2021-27	Improve access to high quality, gender sensitive SRH services for adolescent girls and young women	< $20mil
3	2021-26	Help adolescents access better SRH care	> $20mil
4	2022-2027	Support adolescents and existing NGOs provide services to access SRH care	> $20mil
5	2021-28	Improve SRHR of adolescent girls, particularly girls who have dropped out of school	> $20mil
6	2019-2024	Improve access to SRH services for adolescents	< $20mil
7	2021-2028	Improve access to ASRH care	> $20mil

[7] Participant quotes are referenced using a generic indicator "Study Participant". Information has not been disaggregated based on participant ID's (i.e., Study Participant 1) in order to ensure privacy and confidentiality. Due to the small number of participants in the study, participant privacy was a significant priority. Disaggregating participants by their ID could lead to identification if patterns of language, through the quotes shared, are familiar or recognizable. As such, a generic indicator has been used throughout. We aimed to include as many participant voices as possible.

Fig 1. Structure of funding and reporting



Projects were implemented in seven Eastern sub-Saharan Africa countries including, Malawi, Mozambique, Uganda, Democratic Republic of the Congo, Burundi, Kenya, and Zambia. Many projects were implemented in more than one of these countries. Projects were usually structured through a three to four pillar model that included elements such as health systems strengthening, access to care and SRH information, quality of care, and advocacy. Some organizations had existing approaches to SRHR that were noted as *"very progressive… inclusive, [and] intersectional"* (Study Participant), whereas other organizations discussed their SRHR focus as newer (within the last 2-3 years). Participants also discussed prioritizing projects that focused on the four neglected, or "under-funded", areas of SRHR, which include family planning and contraceptives, advocacy, safe abortion and comprehensive sexuality education (CSE).

Partnerships

In the development stage of projects, participants described consultation with partners as an important part of the process. Partners included in-country NGOs, international NGOs, women's rights organizations (WROs) and youth led organizations (YLOs). In-country and international NGOs were usually larger organizations whereas WROs and YLOs were smaller organizations. In the implementation stage of projects, participants discussed partner organizations as the primary implementers. One participant noted the importance of prioritizing partner organizations stating, *"we always have to think about our partners, the people that we're working with, and so… it's a balance of where we want to go and who we can support"* (Study Participant). Evaluation was largely described as being led by partners, with Canadian organizations as a support actor, but many participants noted GAC compliance requirements were difficult to navigate, especially for YLOs and WROs as many smaller, grassroots organizations do not have the capacity to meet the strict GAC auditing and reporting requirements. Opportunities for more partner led, participatory evaluation approaches such as outcome harvesting (where outcomes are not pre-determined and are developed with end-users), were noted by different participants although limitations were also noted. These limitations which included differing values in the project than those in-country are discussed in greater detail in the section below about tensions.

> *"there is an initiative to, to go beyond the traditional, you know, baseline, midline, end-line, quantitative survey, and sort of qualitative focus group approach to include some outcome mapping, maybe a little bit of outcome harvesting"* (Study Participant)

> *"when we're talking about our feminist monitoring, evaluation, accountability, learning processes, we want our partners to be in the driver's seat, we want them to really be able to, like, say, here are our priorities, here's what we're working on it. Um, but we acknowledge that there's limitations there. You know, some of our partners are really uncomfortable with the idea of abortion. So… there is a tight balancing act"* (Study Participant)

In general, a range of participants described project partnerships as both the project's main strength and main challenge or weakness. For example, for one participant project strengths included the *"dynamic consortium [that] everybody contributes to it differently"* (Study Participant) and for another, the "*dedicated and knowledgeable staff who are really trained and are committed to providing care at whatever time"* (Study Participant). Challenges with partnerships included the quality of consultations in proposal development due to short submission timelines (6-8 weeks) along with difficulty coordinating and communicating with many partner organizations. For example, a few participants described extensive requirements from GAC to track spending and budgets across the project along with detailed reports which were time consuming.

Different participants also described operational challenges with the process of engaging adolescents as collaborators and partners. These challenges included navigating parental consent while respecting adolescent privacy, the ethics of safely engaging adolescents, and mitigating how much safeguards become barrier to engaging adolescents.

> *"every time you talk about participation of children and youth, you all of a sudden become so sensitive, so careful, that nothing happens…So you're too cautious to engage the community, and at the end of the day to do it in a perfect way you are basically missing the point of doing it at all"* (Study Participant)

> *"it's a bit tricky working with adolescents because of parental consent, because of ethics…the constraints of those Call for Proposals and the timelines makes it really difficult to engage meaningfully with young people at the, at the proposal development stage. Once we get to, once a project has been accepted, there's a bit more time and space to engage young people."* (Study Participant)

Influence of the FIAP

Participants described that the FIAP significantly influences ASRH projects through funding and determining project priorities. For example, one participant stated that their organization has to *"go where the money is"* (Study Participant) and develop projects based on the current government priorities (i.e., SRHR). Other participants noted that the FIAP *"certainly shapes [the] trajectory or it creates the opportunity to take on topics that [are] considered neglected"* (Study Participant) and, *"…why [the project] was funded or approved is because, you know, whatever we put forward was bound to be in alignment with FIAP and other GAC priorities"* (Study Participant). Further a participant noted that *"…the Call for Proposals outlined what the intermediate outcomes had to be. So it was like, certainly there is a major focus from the donor around what the project was supposed to look like. Obviously, there's room to adapt within that…"* (Study Participant). The FIAP was also described as informing the Call for Proposals, which in turn shapes how the project is designed, what the priorities of the projects are, and its outcome measures.

Similarly, different participants noted that aspects of the FIAP such as gender transformation and a focus on the four neglected areas of SRHR shaped ASRH projects. For example,

> *"the whole project approach is very much geared towards being gender transformative….what are the types of interventions? How is it being evaluated? It's very much like cross, cross-cutting and throughout everything"* (Study Participant).

> *"we answer to a call to applications… For the past, maybe two, three years, it's a lot related to the neglected field… so there's safe abortion and post abortion service, complete education, a complete sexual education..."* (Study Participant).

In addition to the FIAP, participants noted that existing organizational values, experiences and approaches to SRHR that prioritized feminist approaches, and comprehensive SRHR were important in shaping projects.

Tensions

When discussing the FIAP, majority of key informants shared the positive impacts of the policy conjunctionally with its limitations. Thus, two significant tensions of the FIAP and its implementation through ASRH projects emerged from key informant perspectives. First, the tension of the FIAP as an important policy although difficult to implement within GAC processes and structure – the "operational" tension. Second, the tension of the FIAP as a progressive and gender transformative policy although not aligned with context-specific ideas of ASRH – the "contextual" tension.

Operational

The first tension draws on the incongruity between the policy goals of the FIAP and the funding requirements from GAC. The FIAP is described as *"a huge step forward in an approach to international cooperation by the Canadian government… relatively speaking, very, very progressive"* (Study Participant). On the other hand, GAC processes are described as *"strict"* and prohibitive, limiting the potential to operationalize the FIAP. For example, participants said,

> *"…to a certain extent, [the FIAP] was sort of, in some ways, putting the cart before the horse, because…GAC was not ready to action a lot of what this policy demands, right, it wasn't prepared. It's great, though…the impetus... So even as the operationalizing of the policy needed to catch up and has been catching up, it's still not there, but has been catching up."* (Study Participant)

> *"I think for us the problem is not the FIAP. The problem is like the machine – the government, in terms of their structure, their ways of reporting, their ways of, you know, functioning and working and their requests and how they request it, and just the way they disperse the money or not..."* (Study Participant)

> *"…it's great that the FIAP exists, it's great that we have a focus on SRHR, that we have a focus on contested areas and neglected areas of SRHR. But the ways of working at GAC are prohibitive, and like extremely limiting in terms of what we can do, right, like, ideally, we would have really participatory processes that put youth in the driver's seat that, you know, recognized youth agency and their, you know, evolving capacities as young people to make important decisions about their sexual health…But in terms of like engaging [youth] on the kind of like operational side…if you want youth led organizations to meaningfully participate in these types of projects, you need to understand that grassroots women's rights organizations, youth led organizations do not have the structures typically, to really be able to produce solid financial reporting, be ready for an audit, provide all the reporting that you require."* (Study Participant)

This operational tension is also related to challenges that participants describe, namely, with timelines. For example, one participant described a timeline of 5 years being too little to implement a project in a respectful, context-specific way as the opportunity to build partnerships and trust is not included in the timeframe.

Contextual

The second tension draws on the misalignment between the content of the FIAP and the context where ASRH projects are being implemented. Participants described contradictions of the FIAP in promoting empowerment and capacity building but then also prescribing a set of feminist values or certain idea of what SRHR is, leading to questions about the role of Canadian organizations in ASRH projects. For example, participants said,

> *"So when you bring it down to like, what you need to do as a country, that contradiction, that, in our logic, in our template of development, it makes sense to tell them this is the best thing to do. But at the same time we are talking about their empowerment. Like, if I am talking about your empowerment and saying to you this is the right way to do, how you are involved? ...Is that empowerment or a temporary kind of supply of information and services? So when we work in the sector, it's, it's even specific to this project, it's very difficult to accept both scenario. Neither we can accept that women are humiliated and harassed, and whatnot in a country context, whereas, taking a feminist international assistance policy and pushing them to do it. Both are wrong"* (Study Participant)

> *"…community priorities often conflict with FIAP. It is not a straight solution like oh, so let's only do the community things. We even don't know what the community wants, engaging them earlier, is easier said than done"* (Study Participant)

> *"Like when we talk about abortion and LGBTQ plus rights. That's, that's a whole other story. And then again, we don't want to impose our views."* (Study Participant)

Projects implemented in some East African countries were noted to have legal frameworks that somewhat aligned with the FIAP, making it easier or less risky to implement project aspects (i.e., inclusion of LBGTQ communities, CSE). Contrarily, in other East African countries, FIAP values were described as conflicting with national legal frameworks and/or cultural values, making it more prescriptive and sometimes dangerous to implement.

To address this contextual tension, participants noted the importance of moving forward with awareness and with humility in building trusting and respectful partnerships with organizations and communities. Different participants said,

> *"…building it in and being cognizant of local realities and perspectives of like the need to build that trust. And kind of the generational time frames of, of the change. So it's like it's important that things don't feel like they're being, being imposed in any way, and so, be designed with that in mind where it's, it's not, it's not prescriptive of what needs to be implemented, but rather it's a two way conversation"* (Study Participant)

> *"You know, some of our partners are really uncomfortable with the idea of abortion, to them, it's like the end of a human life…So, you know, like, it's really, there is a tight balancing act where, you know, we don't want to say like, 'Well, you're wrong about this', I think where we land is that we take a rights based approach, and that people have rights, over their bodies, over their lives. And that's where we come back to so we can accept that, you know, there's different values that exist within different people and organizations, but at the end of the day, if people want to work on an SRHR project funded by GAC, with Org X, we want everyone to, to understand that we take a rights based approach to it. So*

> *they can have their personal views. And also respect that other people have human rights that are worthy of being upheld, and promoted and supported."* (Study Participant)

Push for change

When participants were asked about what policy makers and funding organizations should prioritize in supporting ASRH projects, participants did not mention changes to the FIAP. Rather, most participants named opportunities for an operational push for change amongst government processes for funding. First, participants emphasized the importance of flexible timelines and funding throughout projects by stating,

> *"So my specific recommendation, if I made it that to the Government of Canada is that you have to allow flexible funding… give some flexibility of the funding"* (Study Participant)

> *"… longer project cycles or opportunities for longer project cycles… and, yeah having those flexible, flexible pools of funding"* (Study Participant)

Similarly participants discussed the importance of longer timeframes to submit Calls for Proposals.

> *"What can we do in three weeks, really, and then we have to go there and then do consultations. And there's a limit to what we can do. But…if we had like something like six months, or like a year, and then it would, the projects themselves would be so much better, will be more detail would be more innovative"* (Study Participant)

Second, participants called for GAC to be bold and take more risks in supporting innovation in SRHR.

> *"…invest in progressive SRHR. It's worth it. It's the way forward that empowers diverse groups of adolescent girls and young women the most. It really speaks to their needs, in their context"* (Study Participant)

> *"…be bold, they're always like, we want to innovate… well, innovation comes with risk. So [GAC has] to be willing that in our reporting, the project might have failed"* (Study Participant)

Third, participants described accountability and security as important for policy makers and government actors to prioritize when funding progressive SRHR. This was especially noted in contexts where FIAP values such as supporting diverse sexual orientations and gender identities do not align with the in-country values which puts individuals who work on FIAP funded projects at risk.

> *"…security, is very, very, very important… So I'm talking about youth here, but it could be also activists, if you're being active, like activist on abortion, for example, it might be at some point you need to be extracted from the country, you know?"* (Study Participant)

> *"It's like SOGI [sexual orientation and gender identity] issues in Uganda… that's a real head scratcher for me at the moment… we really want to support Ugandan civil society, who are in a really difficult place right now. And we want to, like amplify their messages, in terms of saying that the proposed legislation in Uganda is very problematic…the challenges, though, for Org X in Uganda is that if they go around saying this stuff that they put their staff and their partners at risk, and so there's significant security restraints and considerations to take."* (Study Participant)

Finally, participants noted the importance of GAC ceding power and control while emphasizing reflection and listening in how GAC funds ASRH projects and what this funding means.

> *"I think also, to not be afraid to cede a little bit of control and power. Right. That's, I think, it's sort of, that's even taking a step further back. Right. Don't be afraid, don't be afraid. Friends in compliance at GAC, and I know they are undergoing this major sort of overhaul, whatever, we'll see how major it is, but don't be afraid… So I think that would be an important thing for policymakers and*

> *decision makers to at least think about for five seconds. What does it mean? What reparations mean? What reparations mean vis a vie aid?"* (Study Participant)

The Women's Voice and Leadership (WVL) funding call was also discussed by a few participants as an effective approach to funding going forward. Participants discussed WVL funded projects as having more flexibility in funding and reporting so that partnerships with grassroots organizations, WROs, and YLOs are more feasible and effective.

Discussion

Findings suggest that the FIAP influences ASRH projects in Eastern sub-Saharan Africa in impactful and positive ways although there are contradictions and tensions that arise. These tensions indicate opportunity for changes to funding and related processes by GAC to more effectively support ASRH practice that upholds feminist and multi-sectoral approaches promoted in the FIAP and that meaningfully aligns with the conceptual framework for an imagined future for global health as proposed by Chidwick et al. [33] in Chapter 2 of this thesis (see Appendix 2). Findings are discussed in relation to the key areas of the conceptual framework for an imagined future – funding, leadership, knowledge (production, history, justice), and reflexivity.

Funding

Although informed by the FIAP and its progressive focus on SRHR, GAC funding was described as strict and prohibitive. Specifically, the funding structure of the FIAP through

GAC was described as a barrier to operationalizing feminist, sustainable approaches to ASRH. The conceptual framework for an imagined future calls for a redistribution and decentralization of resources and funding to the "local", which refers to the people closest to the work [33]. In addition, the conceptual framework outlines funder accountability to the local grantees along with greater alignment between funding and local priorities [33]. Findings suggest that these calls to decentralize and redistribute funding to the local are not currently being met in ASRH projects given the restrictive nature of GAC funding and inaccessibility of GAC financial reporting and auditing for grassroots organizations. Current Canadian funding for organizations is led by "direction and control" provisions from Canada's Income Tax Act which requires Canadian organizations to provide oversight and operational control of funds [85]. The Canadian Council for International Cooperation (CCIC) [85] notes that this structure limits the ability of partner organizations to adapt to their context due to unnecessary bureaucratic burdens and constrained decision making for partners due to power dynamics. As such, alternative funding structures and oversight processes have been suggested to emphasize flexible funding and reporting to allow for adaptation of approaches to local contexts and needs [85,86]. As noted by participants, the WVL Program is a step forward in flexible funding, despite its challenges [86]. In particular, the WVL Program funds WROs directly, working to mitigate some of the challenges of direction and control from Canadian organizations as financial and technical intermediaries. In order to meaningfully operationalize feminist, sustainable approaches to ASRH, as called for in the FIAP and which align with the conceptual framework for an imagined future, GAC is encouraged to

shift funding structures to foster flexibility, adaptation, and context-specificity through local leadership.

Leadership

Results indicate that collaborative, non-hierarchal partnerships along with cross-context learning were priorities and strengths of ASRH projects that align with feminist, multi-sectoral approaches, encouraged in the FIAP. However, the operational tension of the GAC "machine" (i.e., reporting requirements, timelines etc.) limited how meaningful and collaborative these partnerships were. Although collaboration is promoted in the FIAP, GAC processes lack support for alternative approaches to consultation and partnership. The 2023 Auditor General's Report also presented potential constraints to partnerships by further encouraging a tightening of reporting and regulatory processes to better show the impact of Canadian funding [87]. The conceptual framework for an imagined future outlines shifts in leadership such as reorienting decision making to the local and decentralizing power while also encouraging South-South collaboration [33]. Findings suggest that there is opportunity to shift structures of leadership, and thus reporting, to be more feminist and flexible, and extend project timelines to strengthen the ability of Canadian organizations to build sustainable and impactful relationships with partner organizations. This aligns with growing initiatives amongst NGOs to redefine measures of success and reorient who has agency to tell the story of impact and how this story is told in development and global health projects [88,89]. For example, initiatives such as the Pledge for Change 2030 and CSO Partnership for Development Effectiveness

advocate for equitable partnerships, accountability and authentic storytelling in development and global health which supports opportunities to decentralize leadership and ultimately, more effectively align with the FIAP [89,90].

Further analysis of the results in terms of partnerships, prompts additional consideration about the role of power in leadership and project structures. Although many participants described their relationships with partner organizations as non-hierarchical, the operational tensions that arise suggest that GAC holds structural power, limiting the opportunity to meaningfully operationalize feminist approaches, as encouraged in the FIAP. Structural power is power to shape and determine how things are done – power that is less visible [91,92]. For example, GAC holds structural power to shape the behaviours and processes of NGOs through aspects such as a Call for Proposals and reporting compliance guidelines. This power is also directional, where accountability is from the partner/Canadian organizations to the Canadian government. The conceptual framework for an imagined future calls for "funder accountability to the local" [33]. This idea has been supported in other disciplines such as Global Development studies where scholar Shama Dossa describes directional accountability through processes such as reporting as a mode of surveillance [93]. Dossa [93] further asks, "What if we trust instead of surveil?" indicating a potential way forward in shifting power from GAC to partner organizations and creating opportunities for mutual accountability which more strongly aligns with the FIAP.

Knowledge

The contextual tension that arose from results indicates misalignment of implementing the FIAP through ASRH projects with aspects of an imagined future, namely, knowledge production, knowledge history and knowledge justice. Results indicate that community priorities sometimes conflict with the FIAP. For example, participants described conflicting views with partner organizations for some SRHR concepts such as abortion, while also acknowledging that it was wrong to impose certain (Western) views. The knowledge production, history and justice aspects of an imagined future call for decentralizing knowledge platforms, prioritizing local and lived experience, and identifying how structures such as colonialism impact what knowledge is valued towards diversifying these values [33]. Recently, a few scholars have begun to advocate for dignity-based practice [94,95], providing a potential path forward to work within these contextual tensions. Dignity-based practice recognizes that communities at the centre of the challenge are best positioned to define their own needs [95]. Abimbola [94] further notes that "We [in global health] mustn't give in to the notion that the global South must come to the global North's table to be seen as knowers" (p. 2). Similarly, and as noted by some participants, rights-based approaches that enable individuals and particularly women and girls to actively take part in SRH decisions [96], also provide a path forward for how to balance differing contextual values.

Findings about the contextual tension between the knowledge promoted in the FIAP and in-country knowledge and values, also prompts a discussion about a duty of care. Health

care providers in Canada hold an ethical and legal duty to provide care [97,98]. This includes providing both information and access to safe, compassionate, competent and ethical healthcare [97,98]. Considering a duty of care when implementing the FIAP, leads to the question of, if funding from GAC is received, is there a duty of care to employ human-rights based approaches to SRHR regardless of contextual views? And further, if there is a duty of care, what responsibility does GAC have to protect the security of individuals engaging in SRHR services such as abortion that could put the service providers and patients at risk? Currently, the Canadian government follows the Voices at Risk guidelines to protect human rights defenders abroad [99]. The guidelines establish that the Canadian government supports individuals who defend human rights and aim to ensure they are able to do their work in a safe environment [99]. As such, GAC evidently has a responsibility to protect individuals who advocate for human rights in contexts where FIAP values such as feminist approaches and diverse sexual and gender identities, are not supported. Going forward, given the likelihood of conflicting views, flexible processes for consultation, a commitment to rights-based, dignity-based care, and a commitment to support the security of individuals working in this area, through existing Voices at Risk guidelines, should be prioritized. By prioritizing such processes, greater alignment with the conceptual framework for an imagined future, particularly in terms of knowledge, is possible.

Reflexivity

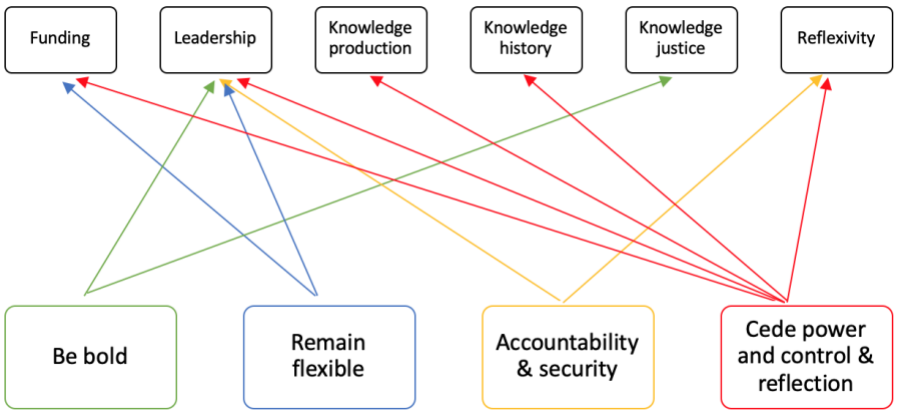
Humility and processes to build trust with partner organizations and communities were also highlighted as a way forward through operational and contextual tensions that arise when implementing ASRH projects through the FIAP. Humility and building trust are values that align with calls for reflexivity in the conceptual framework for an imagined future [33]. For example, participants called GAC to cede power and control while supporting organizations in building trust and respectful partnership. Reflexivity in the conceptual framework for an imagined future advocates for critically considering and reflecting on both individual and institutional positionality, recognizing lens and framing, and listening deeply and differently [33]. Feminist and dignity-based approaches similarly advocate for reflexive practice through participatory methods such as photovoice and body-mapping that integrate intersectionality and reconceptualize what knowledge is seen as legitimate (i.e., epistemic justice) [95,100]. Evidently, there is continued opportunity re-imagine GAC processes to foster a flexible structure of consultation that supports humility, building trust, and reflexive practice and thus greater alignment with the FIAP.

Considering the push for change and an imagined future

Findings indicate that there is discussion within NGOs to shift processes towards thinking and doing global health differently. Key informants note opportunities for operational changes from the Canadian government to more effectively support ASRH projects. Figure 2 explores these opportunities for shifts in relation to the conceptual framework for an imagined future [33]. Opportunities suggested by participants significantly align

with calls for shifts in leadership from HIC institutions to local, along with increased reflexivity amongst institutions and HIC individuals to mitigate harmful power dynamics. The call for GAC to cede power and control and integrate greater reflection aligns with most aspects of an imagined future. Based on the alignment of the FIAP with the conceptual framework for an imagine future, these shifts from GAC would strengthen the potential for feminist, sustainable approaches to ASRH.

Fig 2. Alignment of an imagined future with participant future directions



Limitations

Important limitations to note include, first, challenges with completing this study during the COVID-19 pandemic. The pandemic affected the capacity of organizations to engage, and ability of the lead student investigator to build trust with organizations before interviews began remotely. Relationships and rapport with organizations involved were developed gradually and through existing connections with CanWaCH, to maximize the opportunity for meaningful interviews. Flexibility in the timeline, recruitment, and remote

interview approach was also prioritized to accommodate for the changing capacity of organizations. This resulted in most interviews being rescheduled due to participant capacity. Second, the scope of NGOs involved in this study is limited based on the inclusion criteria and ability of the student researcher to engage organizations in multiple foreign countries (i.e., processes of ethics approval, relationship building abroad etc., was limited). To ensure feasibility of the study, key informants from NGOs in Canada were involved in interviews. Although the perspectives from country-based NGOs were minimal, Canadian organizations work directly with country-based organizations and were able to engage meaningfully with the interview questions while reflecting on how the FIAP shapes ASRH projects in general. In addition, data from interviews was triangulated with data from the relevant government documents (see Appendix 4), which enhanced the rigour and quality of the discussion from this study, ultimately aiming to influence the Canadian development sector's approach to ASRH projects. Further research with country-based NGOs is encouraged in future study.

Conclusion

This study has explored key informant perspectives on how the FIAP influences ASRH projects in Eastern sub-Saharan Africa and their subsequent alignment with the conceptual framework for an imagined future for global health as proposed by Chidwick et al. in Chapter 2 of this dissertation. Findings suggest that the language of the FIAP is aligned with an imagined future for global health although there is opportunity for further action towards operationalizing shifts in GAC funding structures and policy. Specifically,

findings highlight opportunity to create more flexible funding processes, expand monitoring and evaluation approaches to include qualitative and feminist ways of measuring impact, promote rights-based and dignity-based approaches to ASRH, and increase timelines for projects in order to facilitate greater consultation and partnership building with communities involved. Future research should explore alternative, flexible processes for funding that foster feminist, participatory and locally-led approaches to ASRH in Eastern sub-Saharan Africa.

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CHAPTER 6. Conclusion

This concluding chapter aims to discuss the principal findings from the four original research studies (Chapters 2-5) in relation to the overall research question, *What are the challenges and opportunities for moving towards an imagined future for global health research, policy, and practice as it relates to adolescent sexual and reproductive health (ASRH) in Eastern sub-Saharan Africa?* Guided by four specific objectives that correspond with each chapter, this thesis offers an examination of what is possible for the future of how we think about and do global health, specific to ASRH. Chapter 2 developed a conceptual framework for an imagined future for global health based upon literature from academic scholars critiquing the current structures and processes in global health. Chapters 3, 4, and 5 explored this possible future in global health research, policy and practice as it relates to ASRH in Eastern sub-Saharan Africa. This concluding chapter offers both a summary and synthesis of findings and their implications for research, policy, and practice going forward, along with a reflection on the process of completing this research.

Principal findings

Chapter 2 (*Theorizing an imagined future for global health research, policy and practice: A conceptual framework*) presented a conceptual framework for an imagined future for global health. Based on scholarship from Futures Studies [1,2], which offers a process to conceptualize multiple different futures, the conceptual framework was developed

through an analysis of the history and contemporary critiques of the field. The framework presents one potential alternative to the present context and processes in global health research, policy and practice. I, HC, developed the conceptual framework alongside the supervisory committee. To situate my own lens in this framework, it is important to note that I am a white scholar who has studied and trained at HIC institutions. Throughout the development of the conceptual framework, I endeavoured to reflexively consider my own positionality and critically interrogate assumptions and discomforts that arose. The framework was not simply developed from my own thinking or that of my committee. It was developed through a comprehensive analysis of academic literature written by scholars who have historically and continue to be racialized, marginalized and/or tokenized in their opportunity to lead in the field, such as Black people, Indigenous people and People of Colour. Although I share the same values of revolutionizing global health that the critiques have pointed towards, this framework is rooted in the invaluable thinking of racialized scholars.

The conceptual framework for an imagined future does not aim to evaluate or predict the future of global health as a field, but rather explore one possible vision of change as it relates to ASRH policy, research, and practice [1,3–11]. The conceptual framework describes two overarching shifts in this potential future: first, shifting the power in how we do global health, and second, shifting the paradigm in which we think about global health. These shifts are practically conceptualized in terms of funding, leadership, knowledge production, knowledge history, knowledge justice, and reflexivity (see

Appendix 2). This conceptual framework for an imagined future for global health was used to explore ASRH research, policy and practice in the subsequent chapters of the dissertation.

Chapter 3 (*Exploring adolescent engagement in sexual and reproductive health research in Kenya, Rwanda, Tanzania, and Uganda: A scoping review*) presented a review of literature that sought to examine adolescent engagement in ASRH research in four East African countries. The review offered a critical step towards understanding current approaches to adolescent engagement in SRH research and identifying opportunities to build a strengthened evidence base with adolescent voices at the centre. This review also provided a comprehensive overview of the key focus area explored throughout the dissertation – ASRH. Findings suggest that the extent of adolescent engagement in ASRH research is limited, resulting in a lack of comprehensive evidence, consistent challenges with stigma, little information on holistic concepts and a narrow framing of ASRH. As such, we found that there is opportunity for more meaningful engagement of adolescents in ASRH research, as aligned with calls to decentralize knowledge production and leadership within the conceptual framework for an imagined future for global health.

Chapter 4 (*Exploring the development of Canada's Feminist International Assistance Policy and its role in the future of global health funding: A policy review*) explored Canadian policy for ASRH – Canada's Feminist International Assistance Policy (FIAP). The study provided an opportunity to critically explore the development of the FIAP

through the 3i framework. Findings suggest that despite engaging in a participatory process to develop the FIAP, some of the ideas, interests, and institutions that influenced the policy are more powerful than others. As such, there are opportunities in future Canadian development assistance policy to more significantly prioritize decentralized leadership, local ownership of funding, and context-specific approaches to gender equality – ultimately strengthening the alignment with the conceptual framework for an imagined future for global health.

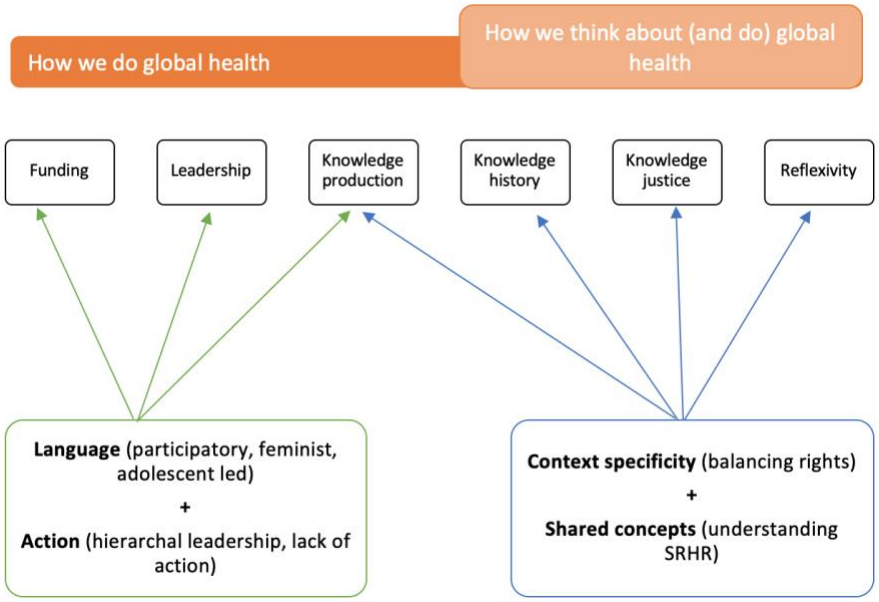
Through the generous time and insights shared by key informants from Canadian NGOs, Chapter 5 (*Exploring stakeholder perspectives of Canada's Feminist International Assistance Policy (FIAP) and how these perspectives align with an imagined future for global health*) explored the role of the FIAP in ASRH projects and how this aligned with the conceptual framework for an imagined future for global health. We learned from participants about the role of Canadian organizations in SRH projects, complex dynamics of Global Affairs Canada (GAC) funding, importance of partnerships, operational and contextual tensions and contradictions that arise from implementing FIAP values in SRH projects outside of Canada, along with stakeholder views on moving forward in global health policy and practice. Findings indicate that the language of the FIAP is aligned with the conceptual framework for an imagined future for global health although there is opportunity for further action towards operationalizing shifts in GAC funding structures and processes. Overall, this study contributed to understanding possible ways forward for

government funding to align better with the priorities of NGOs, communities, and individuals involved in ASRH projects.

Opportunities and challenges for an imagined future

The conceptual framework for an imagined future for global health was developed in Chapter 2 of the dissertation through consolidating and analyzing the contemporary critiques of global health. Based on the overall research question, the following section first explores the opportunities and challenges for this imagined future that emerged from the original research presented in Chapters 3-5. These challenges and opportunities are discussed through two overarching themes – 1) language and action which relates to the funding, leadership and knowledge production aspects of the conceptual framework for an imagined future; and 2) context specificity and shared concepts which relate to the knowledge history, knowledge justice, knowledge production and reflexivity aspects of the conceptual framework for an imagined future (see Fig. 1). These overarching themes remain general as to intentionally limit the creation of a "roadmap" for going forward. Based on the learning from this thesis, it is evident that the practical aspects involved in future global health research, policy, and practice should be developed with the communities at the centre of the challenge. Second, this section interrogates and further discusses the conceptual framework for an imagined future to better understand its value and critiques.

Fig. 1. Challenges and opportunities for an imagined future



Language and action

There are both opportunities and challenges that relate to shifting funding, decentralizing leadership and changing how knowledge is produced in global health.

These opportunities and challenges are thematically organized into the concept of language and action. Throughout this thesis, there is recognition that change is needed, and ASRH research, policy and practice uses this language of change, although change is difficult to action within existing structures that support ASRH research, policy and practice (i.e., funding, global goals etc.).

The language of change towards an imagined future is present in ASRH research, policy, and practice which establishes a strong foundation for action towards the conceptual

framework for an imagined future, especially in terms of shifting funding, knowledge production and leadership to the local. This language, as discussed in Chapter 3, 4, and 5, includes concepts such as feminism and equal participation and encourages feminist, sustainable, participatory, and sex-positive approaches to ASRH research, policy and practice. Chapter 3 demonstrated that there is a continued language that supports the idea of adolescent voices at the centre of ASRH research practices and that the value of engaging adolescents has been established [12–20]. Chapter 4 demonstrated that the language in the FIAP emphasizes feminist, sustainable, gender-transformative approaches to ASRH programs [21]. Subsequently Chapter 5 demonstrated through interviews with key informants that the language of feminist, sustainable, de-centralized, localized and non-hierarchal approaches is present in their work although there are challenges with its operationalization within GAC funding timelines and processes [22].

The conceptual framework and results demonstrated in this thesis appears to be in alignment with language used by GAC and their new initiatives for development assistance. GAC has recently begun to prioritize a “localization” agenda, defined as shifting power, resources, and decision making to local civil society organizations [23]. In 2022, GAC completed an evaluation of localization in civil society organizations and identified opportunities to shift resources and power to foster more context-specific and accessible approaches to projects, information and reporting [23,24]. GAC has also launched a Grants and Contributions Transformation Initiative to mitigate some of the challenges expressed by key informants in Chapter 5 such as reporting timelines and

financial compliance [25]. The initiative aims to minimize the burden of funding compliance for partners and make information easier to share [25]. Paired with the localization agenda [23], this initiative evidences a basis of support for shifts towards what is called for in the conceptual framework for an imagined future. Overall, there is language in ASRH research, policy, and practice, further supported by GAC initiatives, that aligns with shifting the way we do global health, as outlined in the conceptual framework for an imagined future.

Although there is language that supports action for change, the existing structures of ASRH research, policy for funding, and programs limit the potential operationalization of change. Chapter 4 demonstrated the asymmetrical power relations between stakeholders that informed the development of the FIAP which limited the ability for stakeholders to action feminist approaches. Similarly in Chapter 5, key informants described that the existing role of GAC funding structures and monitoring processes make it difficult to operationalize values of the FIAP. We also learned from key informants that ethics boards and institutional processes, although aim to safeguard work with adolescents, create barriers to engaging them in research and projects. Rao [24] explored similar challenges amongst organizations in their work to localize funding and programming. Challenges to action a localization agenda include funding and compliance burdens and the project-based funding model that constrains funding to specific projects rather than flexible funding to organizations generally [24].

The GAC focus on localization has been consistent since 2020, as discussed above. In May 2023, GAC released a new Call for Proposals focused on health systems strengthening [26]. Similar to the 2019 Health and Rights Call for Proposals [27], which was part of the funding key informants shared about in Chapter 5, the new funding envelope focuses on neglected areas of sexual and reproductive health and rights (SRHR) in sub-Saharan Africa where the Call for Proposals outlines the expected project outcomes such as "improved gender responsive" health services [26]. However, the emphasis on localization in the 2023 Call was significant, encouraging direct leadership from partner organizations [26]. Despite this greater emphasis on localization, the available information about the 2023 Call indicates that similar funding and reporting structures that key informants discussed as restrictive will guide the funding. As such, despite language that supports action towards an imagined future, there are continuous challenges in building structures to operationalize this future.

Context specificity and shared concepts

Opportunities and challenges towards greater reflexivity, reckoning with knowledge histories in global health, shifting knowledge production and promoting knowledge justice were also evident throughout the original research studies presented in this dissertation. Findings from the dissertation indicate that there is a desire to shift towards reflexivity, knowledge justice, and local knowledge production although challenges were also evident in terms of negotiating meaning and defining approaches.

Findings from the original research studies suggest that there is a desire for change amongst practitioners and scholars to shift the way of thinking and doing global health, and specifically ASRH. For example, in the development of the FIAP, as discussed in Chapter 4, a participatory process was employed to engage individuals from all over the world to inform policy priorities. We also heard from key informants in Chapter 5 that there is a strong desire to push for change which includes calls for GAC to cede power and control and shift towards flexible funding and feminist monitoring, evaluation, accountability and learning processes. Key informants also shared desire to reflexively consider the role of Canadian organizations and funding, stating, "*I think that would be an important thing for policymakers and decision makers to at least think about for five seconds. What does it mean? What reparations mean? What reparations mean vis a vie aid?*" (Study Participant). Based on the existing language towards participatory, feminist approaches as discussed in Chapter 4, along with action amongst practitioners to pursue these changes such as implementing feminist monitoring and evaluation processes, as noted in Chapter 5, shifts towards a more reflexive, context-specific, historically aware future in ASRH are evidently desired.

Despite a desire to shift ways of thinking about and doing global health, findings also pointed towards contradictions and tensions, specifically in terms of defining concepts such as SRHR and balancing context-specific approaches and ideologies with feminist rights. The conceptual framework for an imagined future, developed in Chapter 2, calls for increased local knowledge production, greater acknowledgement of knowledge

histories, and knowledge justice which aims to shift the production of knowledge to the community experiencing the challenge and disrupt assumptions that Western knowledge is superior [28]. However, many concepts promoted through feminist and participatory approaches that are encouraged in Canadian government policy by NGOs and in ASRH research, such as SRHR, are based in Western knowledge and Western conceptions of feminism. For example, we learned from the scoping review on ASRH research (Chapter 3), the values promoted in the FIAP outlined in Chapter 4, and from key informants implementing ASRH projects in Chapter 5, that modern contraceptives should be prioritized in ASRH. However, modern contraception as an SRHR approach is imbued in a violent colonial history of practices such as unethical sterilization [29,30]. Although such an approach is valuable and impactful, the promotion of modern contraceptives may not be context specific. As such, there is opportunity to expand on definitions of SRHR through increased flexibility in knowledge production, funding and leadership to navigate context-specific norms and values. Further there is opportunity to continue to interrogate harmful histories of knowledge and explore how complex, pluralistic and context-specific meaning of concepts such as SRHR can be understood in ways that may not always align with Canadian values. This does not mean creating a binary between Western ideals and context-specific ideals, rather this tension points towards an opportunity to prioritize reflexive discussions about context specificity and SRHR approaches.

Similar to the complexity of defining aspects such as SRHR while integrating context-specific meaning, balancing context-specific approaches to ASRH and approaches

encouraged through a (Western) feminist lens is challenging. This complexity indicates a tension in prescribing the implementation of certain feminist ideas that are rights-based, although sometimes not aligned with the context. The framework for an imagined future emphasizes ideas such as decentralized and local knowledge production and leadership from the community. As evidenced through the original research chapters, current discourses on ASRH research, policy and practice, all encourage rights-based, feminist practice and programs that prioritize gender equality, inclusion of intersectional identities (i.e., sexual orientation and gender identity focus), and access to services such as abortion. However these ideas may not always align with the priorities in context. Thus, is it appropriate to prescribe ASRH approaches that are rights-based although might not be context specific (i.e., abortion)? As a study participant in Chapter 5 explained, it would be wrong to prescribe ideas and approaches, and it would also be wrong to not encourage and promote rights-based ideas and approaches. Therefore, what does localizing knowledge and leadership mean when the norms of the local context could be harmful to some groups? Key informants in Chapter 5 emphasized flexible funding to allow for meaningful partnership and the ability to develop a process of true collaboration. Further learning should prioritize understanding collaborative processes that allow for navigation of complex and non-universal ideas such as rights. As Smith et al. [31] describe,

> …no single approach will allow us to dismantle systems of power that undermine the realisation of global health. Driven by the concerns and priorities of people most affected by the failures of global health, reformists and revolutionaries, and pragmatists and idealists, all have a role in imagining that another world is possible, and pushing together until we get there. (p. 1)

Summary

Findings from this dissertation suggest that in the language and goals of global health research, policy and practice, ASRH work is aligned with the conceptual framework for an imagined future that includes shifts towards decentralized funding, leadership and epistemic justice. This is evidenced through the chapters of the dissertation in terms of the language and aims of ASRH research, Canadian policy for ASRH, specifically the FIAP, and the processes and goals of NGOs implementing ASRH projects in Eastern sub-Saharan Africa. Despite great achievements in realizing and articulating the opportunity for an imagined future, this conversation is largely still just a conversation. Although there is promotion and understanding of partnership, decentralized leadership, reflexivity, shifting knowledge production etc., there is also limited opportunity to meaningfully action change due to the current structures and processes of global health funding, leadership and knowledge production.

Findings also suggest that the answers to the current challenges in global health are not only located in traditional academic or Western-based institutions, rather, the answers are with the people and communities who face and have faced the current challenges, in addition to the work of scholars and practitioners outside of these communities. Thus, we cannot keep relying on the same systems, processes, structures to bring us towards a future that is different. As Audre Lorde states, “the master’s tools will never dismantle the master’s house” [32]. Instead, there is opportunity to prioritize and value thinking and

action that is different from current norms. Central to this shift is listening and revolutionizing the role of HIC institutions.

Reviewing an imagined future

As discussed, the conceptual framework for an imagined future was developed from academic literature written by scholars critiquing global health research, policy and practice. Although it is a comprehensive framework and has been applied throughout the dissertation, there are several complex aspects of the framework that are important to interrogate.

First, the conceptual framework was developed from academic literature and has not been validated by practitioners through an academic evaluation process (i.e., formal feedback through a survey or interviews). An academic or formal evaluation of the framework was determined to be out of the scope of this doctoral research and is encouraged for future research. Although not formally validated, the process of validation happened ad hoc through informal conversations with organizations, individuals from GAC, and academics. Over the course of my doctoral degree, I also attended various conferences, most of which had a significant focus on localization, decolonization, and "reimagining", highlighting ideas such as amplifying grassroots voices, anti-racism, collaboration amongst stakeholders, decentralizing leadership, and equity. Similarly, the FIAP, examined in Chapter 4, promotes parallel ideas to those presented in the conceptual framework through language such as feminist, participatory, multi-sectoral leadership

[21]. As such, based on the current narratives noted through these conversations, conferences, and through the FIAP itself the conceptual framework for an imagined future aligns with current discourses and emerging ideas. Future research, as discussed below, is encouraged to engage various stakeholders to further explore the framework.

Second, some could argue that the scope of the literature used to develop the framework is biased and too critical of global health. In short, I agree; the literature included is critical and could be interpreted as biased. However, much of the literature written in the past 10 years has been critical of the field, and in the past three years especially has overwhelmingly emphasized the role of the 'local' (i.e., the role of the communities and individuals at the centre of the challenge). Despite a proliferation of this literature critiquing the field, at the time the conceptual framework was developed, the academic literature had yet to be consolidated. Although some scholars have encouraged less inter-group critique [33], other scholars have emphasized the importance of critique for change in the field towards equity and justice [34]. Thus, although critical, the literature that informed the development of the framework was and continues to be important to understand, to move forward in the field.

Third, and as discussed in previous sections, the framework calls for reorienting and decentralizing leadership to the 'local'. However, some could argue that this does not account for the potentially harmful leadership structure that could exist in contexts of implementation. For example, during the Chapter 5 interviews with key informants, some

individuals were working on projects implemented in Uganda. Recently, Uganda passed a bill criminalizing same-sex conduct and further discriminating against individuals identifying as part of the LGBTQ community [35]. Key informants expressed the challenge of navigating projects that had aspects which focused on sexual orientation and gender issues in a context where LGBTQ populations are criminalized. This tension was discussed previously in Chapter 5, although important to note in relation to the conceptual framework is the notion that the aim of the framework is not to create a prescriptive outcome for what the future of global health could be and who/what is in a leadership position. Rather, the conceptual framework offers a consolidation of ideas to inform a process for leadership (along with funding, knowledge production, knowledge justice etc.) that is centred in equity and justice. This is similar to the concept of "accounting for reasonableness" in healthcare priority setting processes which is the idea of agreeing on a fair process rather than trying to reach consensus on principles or outcomes [36,37]. Scholars note that the process of "accounting for reasonableness" should be inclusive, reasonable, consistent, transparent, based on trust, and decision makers should be accountable and responsive [37]. The conceptual framework for an imagined future offers a consolidation of ideas to inform such a process in global health.

Similarly, there is opportunity to interrogate the set of ideas that are presented in the conceptual framework for an imagined future in general. The framework presents different ideas (i.e., leadership, funding, knowledge production, reflexivity etc.) to inform the process of shifting how we think about and do global health. One could ask, are the

ideas presented the most impactful or relevant for global health moving forward? Are they relevant in all contexts? Interrogating these ideas is similar to critiques of principles or principlism in bioethics. Critics argue that principles are sometimes dangerous to rely on in fields such as bioethics as there is no universal moral theory in which principles can be developed from for universal application [38]. Similar critiques could be shared about the ideas presented in the conceptual framework in how they cannot be applied universally. However, as noted in Chapter 2, the framework is based in Futures Studies and as such acknowledges the multiplicity of potential futures in global health while presenting one possible future. Thus, it is possible that some aspects of the framework will not be relevant to contexts and the ideas presented may not even be possible to implement given context specific leadership, funding etc. Yet, there is still worth in exploring the conceptual framework in order to understand what one possible future could look like and how aspects of this future may already be happening (or not).

Finally, the current presentation of the framework, as a table, could be interpreted as a linear and colonial articulation of the process to shift how we think about and do global health. When applied, the framework could create an assumingly rigid boundary of what to do and what not to do. Although we have endeavoured to use language that is more process/ideas-oriented so it does not become a prescriptive roadmap, the framework is oriented towards a colonial structure of doing, with a specific focus on the role of HIC institutions. As such, it is important to acknowledge that the framework could itself reinforce some of the ideas it is encouraging to shift. However, and as previously

discussed, using the framework with an understanding that it is only one possible imagined future creates an opportunity to explore what is possible and build ideas towards further equity and justice in the field.

Reflections on an imagined future as a PhD student

The process of exploring an imagined future for global health was both a hopeful and discouraging one. I came out of exploring the research question with many more questions – will doing global health differently actually happen in the colonial (harmful) system in which it is based? What does foreign policy look like when it embraces fluidity, multiple versions of a concept and prioritizes context? Is a different future possible within the current hegemonic systems (i.e., capitalism)? Despite the multitude of questions that arose from the writing of this thesis, many were answered throughout and I learned that the opportunity to imagine something different is generative towards something different and new to emerge. Further, I learned that we will not break free of our current structures without being brave enough to imagine and action something different. Particularly important throughout my own learning has been reflection.

The following reflection aims to highlight some of the tensions and contradictions that arose throughout this PhD based on its structure along with my own positionality and gaze. I argue that in order to action the ideas presented in the conceptual framework for an imagined future for global health, there needs to be greater courage amongst

institutions to support doctoral students in exploring alternative forms of research methodologies, community partnerships, reflexive process, and future goals.

Tensions & contradictions

The overarching contradiction that emerged throughout my experience in this doctoral program was the idea of completing a PhD on approaches towards greater equity and justice in global health when the process of doing a PhD was based in hierarchy and supremacy of Western knowledge structures and power. In short, the structure and process of completing this degree was in direct tension with the topic of the PhD. I was simultaneously trying to disrupt the inequitable system of doing research while also benefiting from the system. Affun-Adegbulu et al. [39] discuss this tension as a "power-paradox" explaining that "in order to be heard one needs to pass through the initiation rites of…PhD studies – and this tension between using the traditional position of the university as a gateway for people to join the elite does not sit easily with the international expectations of decolonial change" (pp. 5). Although the dissertation focused on conceptualizing ways to do things differently, I completed the research in the same way that has been traditionally prioritized. For example, elements of the study, such as the interviews in Chapter 5, were extractive and I am biased to value a certain kind of academic knowledge based on how I would be evaluated. I integrated these reflections through a positionality statement in Chapter 2, which included work by Benedetta Zocchi [40]. Zocchi [40] explained that she "spent a considerable amount of [her] time questioning what [she] was doing, why [she] was doing it and if [she] was

doing it right. In other words, [she] was completely embedded in the system and at the same time constantly looking for ways to rebel against it" [p. 4]. I similarly felt as though I was embedded in a system but thinking about ideas that were rebellious against it.

Another tension that arose was based on the experience of critiquing the very field I study – global health. Initial discussions about the topic and approach to developing the conceptual framework for an imagined future included encouragement to be cognizant of how critical I was being about global health and highlight what could be salvaged in the field. I appreciated these discussions as they brought forward important thinking around how to problematize global health in a meaningful way and challenged me to expand outside of my lens and bias. Although, I also saw critique and being critical of global health as an opportunity to explore a path forwards. Recently, scholars have engaged in debate around what is important in terms of critique within global health [33,34]. Horton [33] encouraged global health scholars to identify the opponents outside of the field encouraging collective action rather than debate and critique within the field. When I read Horton's article, it reminded me of early conversations of being "too critical" of global health and missing the "real opponent" outside of the field. However, many scholars began a discussion on Twitter critiquing Horton's piece and arguing that we can do both – we, as global health scholars, can recognize both opponents within and outside of the field and healthy debate throughout is important for growth. In other words, healthy debate, differing ideas of moving forward, and thinking about things in many different ways can lead to something different.

Finally, based on my own positionality and gaze as a young, white woman, the process of exploring an imagined future in a field as pragmatic as global health was uncomfortable and resulted in tensions. For example, in developing the conceptual framework through a narrative literature review, presented in Chapter 2, the white/western gaze and its discomfort, for myself and for the people I worked with, was prioritized. This meant that discussing ideas such as the harmful history of colonialism and push for reflexivity were discouraged in the initial discussions of the framework. The value of reflexivity, unlearning and sitting with discomfort grew in support throughout the development of the dissertation, but in the initial stages of the PhD, was not embraced. Similarly, tensions arose with my role as a student and what the framework for an imagined future called for. I saw that my role as a student was to construct an argument and defend the ideas I presented through academic, evidenced-based knowledge which, contradicted the idea of expanding and localizing knowledge production and epistemic justice presented in the conceptual framework for an imagined future. As a result, I engaged in exploring something different by conducting research and writing in a way that is largely abstract and tailored for academics, ultimately limiting the accessibility of the knowledge I learned and have shared in this thesis. I recently heard Dr. Robtel Neajai Pailey [41] give a keynote talk on reimaging development and found comfort in her encouragement to do things differently – writing through story, writing through reflection and resisting the "academic straightjacket" of writing for publication.

Opportunities moving forward

My reflections on the tensions and contradictions of the experience in completing this degree have led to further reflections on how to move forward. I see many opportunities amongst students, individuals supporting students, and institutions to further a shift in global health research, policy and practice towards greater equity and justice. For me, these include first, encouraging alternative research methodologies that centre meaningful relationship building and community-engagement. Second and similarly, holding community partnerships as the utmost priority and continuously encouraging students to reflect on if their research is engaging in extractive practices or if there is mutual and equitable benefit. Third, support for reflexivity amongst students and committees through discussions about power, privilege, positionality is needed in order to imagine ways to do research as doctoral students differently. Finally, I see significant opportunity in shifting the language we use to communicate with each other in academic spaces. Mid-way through my degree, a member of committee reached out after providing some feedback on a piece of my work. She expressed that the language she had used to provide feedback could perhaps be perceived as limiting to a young scholar who identified as a woman. I was struck by the integrity of this feedback, and it led me to reflect on the unconscious way in which I use language and phrases. My own privilege allows for certain (academic, English) language to be familiar but for many, language has been a violent weapon of exclusion and oppression. I see opportunity for doctoral students and supervisors to heighten their awareness of language in order to encourage exploration, confidence, courage, integrity, and critical discussions.

Strengths and limitations

The main strength of this dissertation is the breadth of literature included resulting in contemporary applicability to the academic global health field. The original research chapters draw on a wide scope of literature and most significantly literature that has been written since 2017 on both the FIAP and critiques of global health in which there is limited consolidation and critical analysis. Contributions from key informants in the Chapter 5 qualitative study also strengthen the discussion of the dissertation. Key informants included practitioners from Canadian organizations that provide oversight and guidance to local organizations on ASRH projects funded by the Canadian government. These "in between" practitioners, who are sometimes overlooked, shared valuable insights about the process of developing and implementing ASRH projects and how these processes can shift towards greater equity and justice. Given their employment with Canadian organizations, there was also potentially greater openness to sharing what could change in global health funding processes due to more horizontal power dynamics between the interviewer (HC) and the key informants. Despite these strengths, challenges due to practical aspects such as the COVID-19 pandemic also resulted in limitations to the dissertation.

In the first two and half years of my doctoral work, the COVID-19 pandemic hindered my ability to meaningfully build relationships with individuals and resulted in many shifts to the dissertation topic and approach. Despite engaging with contemporary critiques in a

comprehensive way, not all voices are represented due to practical constraints such as limited opportunity for networking and relationship building which resulted in an inability to feasibly conduct field research and seek ethics approval from more than one country in Eastern sub-Saharan Africa. Based on the changing nature of the pandemic and changing capacity of individuals, the aim of the dissertation shifted to include a greater focus on secondary data and existing literature. As a result, this thesis includes a strong breadth of analysis, through different methodologies, of existing literature.

Second, it is important to acknowledge that this dissertation is significantly representative of one group of voices – scholars, with only some input from practitioners. Many critiques of global health call for shifts to bring different voices and knowledge to the table of decision making and cede power and control of Western, Eurocentric voices, and this was incorporated into the imagined future based on these calls. However, due to practical constraints, this dissertation furthers the discussion of changes in global health amongst mainly "Global North" actors. Although practitioners were engaged virtually and majority of the scholarly literature included is from individuals who are from the so-called "Global South", future research is encouraged to engage with communities at the centre of ASRH challenges in Eastern sub-Saharan Africa to gather perspectives in how HIC institutions can move forward towards equity and justice in leadership, funding and knowledge.

Finally, this dissertation includes a growing body of knowledge on shifts in the global health field towards equity and justice. The literature being published on this topic is continuing to develop and topics such as shifting the way we think about and do global health are the forefront of many scholars, practitioners, policy-makers and institutions. Thus, I endeavoured to extemporaneously gather information to inform both the framework for an imagined future and discussion of key informant perspectives and the FIAP.

Implications and moving forward

This dissertation has explored the challenges and opportunities for moving towards an imagined future for global health research, policy, and practice as it relates to ASRH in Eastern sub-Saharan Africa. The four original research studies present findings valuable to policy-makers, practitioners, and scholars from HIC institutions. There are three main implications and areas of focus that I encourage for future research and practice.

First, this dissertation offers a conceptual framework for an imagined future, encouraging HIC institutions to shift funding, leadership and knowledge production to the local while integrating knowledge histories, reflexivity, and justice into their work. Despite the value in this framework, it needs to be further developed in collaboration with practitioners who are at the centre of ASRH challenges. Future research should prioritize the inclusion of diverse voices outside of HIC academic scholarship to further develop the practical directions for the future in global health.

This dissertation has also brought forward some key tensions and contradictions in the push for change in policy and practice. Although complex, these tensions and contradictions in negotiating meaning, creating structures to support progressive policy, and facilitating processes to balance rights and context-specificity, are important in pushing for change in the field. Exploring these tensions has led to questions for further research including, what does a process of balancing localization and decentralized leadership, and context-specific approaches that may not uphold rights in the same way as Canadian policy does, look like? How do we shift the structure of funding to provide space for context-specificity and flexibility? What is the role of the Canadian government in creating processes that disrupt harmful power dynamics in global health funding for research and practice?

Finally, this thesis overall indicates opportunity for greater collaboration in building a reflexive process for HIC institutions to navigate the complex power dynamics in global health, specifically ASRH research, practice and policy. The FIAP provides a strong basis for both present and future shifts that centre equity and justice although further action is needed to operationalize structures in funding for ASRH projects, policy, and research that prioritize flexibility, context-specificity and integrity of feminist, participatory approaches.

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Appendices

Appendix 1 – Key literature listservs and journals

The key literature listservs and journals that were used to gather literature to develop the conceptual framework for an imagined future include:

- Google Scholar – received weekly search results listserv for authors "Abimbola" and "Pai" and terms "critical global health" and "decolonizing global health"
- PLoS Global Public Health – received monthly emails on new article publications
- Lancet Global Health – received weekly emails on new article publications
- Lancet Adolescent Health – received monthly emails on new article publications
- BMJ Global Health – received weekly emails on new article publications

Appendix 2 – Conceptual Framework

An imagined future for global health		
Shift power in how we **do** global health	**Funding**	• Redistribution and decentralization of resources to local (i.e., people closest to the work, communities of focus while acknowledging context specificity of the "local") • Funder accountability to local • Diversification of decision making to include local (collaboration) • Better align funding with local priorities
	Leadership	• Institutions reorient leadership to local, decentralize decision making power • South-South collaboration • Elevate local/community level knowledge, reflexively consider HIC knowledge
	Knowledge production	• Decentralize knowledge platforms • Increase community engagement, prioritize local, lived experience • Centre Indigenous ways of knowing • Engage diverse groups in decision making towards knowledge production • Increase representation in academic journals
Shift paradigm in how we **think**	**Knowledge history**	• Identify and acknowledge how structures such as colonialism, racism, etc., pose a threat to health equity

about global health		• Ground analysis in colonialism and its intersections with other structures (i.e., white supremacy) • Institutional reckoning to mitigate harms perpetuated by structures on which they were built
Shift how we **think about and do** global health	**Knowledge justice**	• Diversify what knowledge is considered valuable (ex., outside of metrics) • Shift focus of knowledge and actors in global health to local (disrupt epistemic injustice) • Prioritize reciprocal flows and critique of knowledge • Create new learning platforms and knowledge legitimacy outside of academic English
	Reflexivity	• Default to local gaze, instead of Western gaze • Critically consider and reflect on individual and institutional positionality, behaviour, unconscious bias • Recognize basis of lens and framing • Listen deeply, listen differently • Dignity based practice

Appendix 3 – Confirmation of permission to distribute PLOS article

From: **PLOS Global Public Health** globalpubhealth@plos.org
Subject: RE: Copyright inquiry for Chidwick et al PLOS GPH publication
Date: July 31, 2023 at 2:59 PM
To: chidwihw@mcmaster.ca

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---------- Original Message ----------
From: Hanna Chidwick [chidwihw@mcmaster.ca]
Sent: 7/18/2023, 12:54 PM
To: globalpubhealth@plos.org
Subject: Copyright inquiry for Chidwick et al PLOS GPH publication

[CAUTION: External Email.]
Hi there,

I hope this note finds you well.

I co-authored an article that was published in PLOS Global Public Health in October 2022 (https://doi.org/10.1371/journal.pgph.0000208). I am requesting permission to re-publish the article in my PhD thesis at McMaster University. Would you kindly review and sign the attached letter?

With gratitude,
Hanna

Appendix 4 – Relevant Government Documents

Methods to gather documents: Document analysis is a method of qualitative research that consists of analyzing various documents including scholarly articles, policies, and institutional reports [1–3]. Document analysis of government documents was employed to verify the codebook of themes that was inductively developed from key informant interviews. Documents were defined as publicly available written material, which included information notes on SRH evaluation, government calls for proposals on ASRH, and government/NGO reports on ASRH and funding.

Documents were identified through manual electronic searches and with support from government-affiliated organizations and interview participants. An electronic search of documents was completed via Canadian government webpages and affiliate NGO websites (e.g., CanWaCH, Equality Fund). Documents were included if they were, 1) publicly available and, 2) discussed relevant GAC Call(s) for Proposals with a focus on ASRH (i.e., the Health and Rights Pall for proposals), government guidance on developing and/or evaluating ASRH projects, and/or GAC SRH key performance indicators or evaluation specific to SRH. Documents were gathered on an ongoing basis from May 2022-May 2023 by the lead student investigator and used in conjunction with the interview data.

Table of relevant government documents:

Document	Area(s) of relevance
Health and Rights Call for Proposals	Development, funding, partnerships
Health and Rights Call – Questions and Answers	Development, implementation, evaluation, funding, partnerships
Gender-based Analysis Plus	Development, evaluation (reporting)
Gender Equality and Empowerment Measurement Tool	Development, evaluation (reporting)
FIAP Indicators	Development, funding, partnerships, evaluation (reporting)
FIAP Toolkit	Development, funding, partnerships, evaluation (reporting)
Canada's Policy for Civil Society Partnerships for International Assistance – A Feminist Approach	Development, funding, partnerships
Development innovation overview	Development, funding, partnerships
Accountability Framework for Canada's 10-Year Commitment to Global Health and Rights (available upon request)	Evaluation (reporting)
GAC Results-Based Management Framework	Evaluation (reporting)
Technical Guidance Note on Developing Monitoring and Evaluation Plans for Global Health & Rights Programs	Evaluation (reporting)
SRHR Key Performance Indicators	Evaluation (reporting)

SRHR KPI Methodological Notes	Evaluation (reporting)

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Appendix 5 – Overview of the Funding Process

Appendix 6 – HiREB Approval

Hamilton Integrated Research Ethics Board

Date: Feb-13-2023

Local Principal Investigator: Dr. Lisa Schwartz

Participating HiREB Centre(s): McMaster University

Project ID: 13761

Project Title: Exploring the impact of Canada's Feminist International Assistance Policy on adolescent sexual and reproductive health projects

Review Type: Delegated

Date of Final Approval: Feb-13-2023

Ethics Expiry Date: Feb-13-2024

The Hamilton Integrated Research Ethics Board (HiREB) Panel A has reviewed and approved the above-mentioned study.

The following documents have been approved:

Document Name	Document Date	Document Version
Chidwick_data collection form_9 Nov 2022	Nov-10-2022	1
Chidwick_Email recruitment draft_11 Jan 2023_clean	Jan-11-2023	2
Chidwick_Study key_17 Jan 2023	Jan-17-2023	3
Chidwick_Interview guide_17 Jan 2023_clean	Jan-17-2023	3
Chidwick_Consent form_ 31 Jan 2023_clean	Jan-31-2023	4
Chidwick_Study protocol_31 Jan 2023_clean	Jan-31-2023	4

The following documents have been acknowledged:

Document Name	Document Date	Document Version
tcps2_core_certificate-Schwartz 2021	Nov-08-2022	1

While HiREB has reviewed and approved this application, the research must be conducted in accordance with applicable regulations and institutional and/or public health requirements.

We are pleased to issue final approval for the above-named study until the expiry date noted above. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

REB members involved in the research project do not participate in the review, discussion or decision.

The Hamilton Integrated Research Ethics Board (HiREB) provides ethical review and ongoing ethical oversight on behalf of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton, the Faculty of Health Sciences at McMaster University and Niagara Health. HiREB operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans (TCPS 2); The International Conference on Harmonisation of Good Clinical Practices Guideline (ICH GCP); Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural

Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations. For studies conducted at St. Joseph's Healthcare Hamilton, HiREB complies with the Health Ethics Guide of the Catholic Alliance of Canada. HiREB is qualified through the Clinical Trials Ontario (CTO) REB Qualification Program and is registered with the U.S. Department of Health and Human Services (DHHS) Office for Human Research Protection (OHRP).

Sincerely,

Dr. Mark Inman, MD, PhD
Chair, Hamilton Integrated Research Ethics Board

Hamilton Integrated Research Ethics Board (HiREB)
293 Wellington St. N., Suite 120 Hamilton, ON L8L 8E7
Telephone: 905-521-2100, Ext. 42013
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Appendix 7 – Letter of Information and Consent

PARTICIPANT INFORMATION SHEET

Title of Study: Exploring the impact of Canada's Feminist International Assistance Policy on adolescent sexual and reproductive health projects

Locally Responsible Investigator and Principal Investigator, Department/Hospital/Institution:
Dr. Lisa Schwartz, Health Research Methods, Evidence and Impact, Faculty of Health Sciences
McMaster University, Hamilton, ON L8S 4K1
schwar@mcmaster.ca

Co-Investigator(s), Department/Hospital/Institution:
Hanna Chidwick, Global Health, Faculty of Health Sciences
McMaster University, Hamilton, ON L8S 4K1
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Dr. Deborah DiLiberto, Global Health, Faculty of Health Sciences
McMaster University, Hamilton, ON L8S 4K1
diliberd@mcmaster.ca

Dr. Germaine Tuyisenge, Co-program Director, MSc in Sexual and Reproductive Health Policy and Programming, London School of Hygiene and Tropical Medicine, London, UK
tuyisenge.germaine@gmail.com

Funding source: *none*

This is a student research project conducted under the supervision of Dr. L. Schwartz and Dr. D. DiLiberto. The study will help the student learn more about the topic area and develop skills in research design, collection and analysis of data, and writing a research paper.

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision. Feel free to discuss it with your colleagues, community and/or Hanna.

WHY IS THIS RESEARCH BEING DONE?
There is limited information on how Canada's Feminist International Assistance Policy (FIAP) practically impacts adolescent sexual and reproductive health (ASRH) from the perspective of key stakeholders at Canadian non-governmental organizations (NGOs). As such, we are exploring the perspectives of key stakeholders from Canadian NGOs on the FIAP to inform potential policy changes that better support NGOs and their work on ASRH.

WHAT IS THE PURPOSE OF THIS STUDY?
The purpose of this study is to learn about and understand the key stakeholder perspectives from NGOs on the FIAP and how the policy shapes ASRH projects.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?
If you volunteer to participate in this study, we will ask you to participate in one virtual semi-structured interview conducted by the lead student investigator. The interview will take 40-70 minutes to complete. Interviews will be conducted over Zoom. You will be asked to comment on questions that relate to the following:

1. What was the process of building the ASRH project of focus? How was the project developed/implemented/evaluated? Who was involved?
2. Are you familiar with Canada's Feminist International Assistance Policy? If yes, what do you understand the policy as?
3. What do you think shapes ASRH projects? Does the FIAP influence ASRH projects? If so, how?
4. What do you think is the most important for funding organizations and policy makers to keep in mind with regards to supporting ASRH projects?

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
There is a possibility that participants, when discussing ASRH projects, could feel the information is sensitive and difficult to talk about. There are also some risks associated with confidentiality. Although all data will be de-identified to ensure privacy, given the focus of the study and the small sample size, some participants may be identifiable based on the information they share, which could lead to unintended negative consequences at their organization of employment. The study team is committed to protecting the privacy and confidentiality of participants in this study although we are often identifiable through the stories we tell. Please keep this in mind when deciding what to share.

All participation will be voluntary and participants have the right to end the interview or choose not to answer any of the questions. If you choose to take part in this study, you will be told about any new information which might affect your willingness to continue to participate in this research.

All efforts will be made to maintain confidentiality and privacy. All data will be de-identified prior to analysis and only the immediate research team will have access to full transcripts after all direct and indirect identifiers have been removed (e.g., your name, names of others, name of organization in which you work with and other organizations with which you are associated etc.). If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published. If information cannot be sufficiently de-identified (i.e., the themes of the data could lead to identification), we will seek your permission before it is shared. If there are any concerns with sufficient de-identification, the lead student investigator will verify with participants about use of the information.

HOW MANY PEOPLE WILL BE IN THIS STUDY?
We anticipate a minimum of 6 staff from various organizations will be involved.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?
We cannot promise any personal benefits to you from your participation in this study. However, we anticipate this study will benefit the information available to global health practitioners, researchers, and policy makers, to foster more equitable global health practice. Your participation may help inform how Canadian foreign aid can respond to and make rearrangements towards achieving greater equity and justice in its approach to policy and funding ASRH projects.

IF I DO NOT WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?
It is important for you to know that you can choose not to take part in the study. There are no alternatives to participate, but if you prefer to provide a response in writing we will take that into consideration.

WHAT INFORMATION WILL BE KEPT PRIVATE?
We will be gathering your name, affiliated organization, email address and telephone number. This data will not be shared with anyone except with your consent or as required by law. All personal information such as your name, organization, role at the organization, address, phone number, will be removed from the data and will be replaced with a number. A list linking the number with your name will be kept in a secure place, separate from your file. The data, with identifying information removed, will be securely stored in a locked office or electronic file on a password protected OneDrive account. Interviews will be recorded, so the Zoom/audio recordings of the interviews will be viewed only by members of the research team and they will be destroyed after 5 years. As a participant, you have the right to review/edit the recordings upon request via email to chidwihw@mcmaster.ca.

Note, it is possible that representatives of HiREB, this institution, and affiliated sites may consult your original (identifiable) research data to check that the information collected for the study is correct and follows proper laws and guidelines.

This study will use Zoom to collect data. A link to Zoom's privacy policy is available here: https://explore.zoom.us/en/privacy/. While the Hamilton Integrated Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers. If you are concerned about this, we would be happy to make alternative arrangements for you to participate, perhaps via telephone or another web-based service. Please talk to the researcher if you have any concerns.

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your specific consent to the disclosure. If direct quotes are used, all identifying information will be replaced with generic codes (i.e., Study Participant). If quotes cannot be sufficiently de-identified (i.e., the themes of the quote could lead to identification), we will seek your permission before it is shared. No information will be released to any other party for any reason.

CAN PARTICIPATION IN THE STUDY END EARLY?
If you volunteer to be in this study, you may withdraw at any time. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

If you wish to withdraw your data from the study after the interview, this can be done up until 30 June 2023 by emailing Hanna Chidwick, chidwihw@mcmaster.ca.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this study.

WILL THERE BE ANY COSTS?
Your participation in this research project will not involve any additional costs to you.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?

If you have any questions about the research now or later, or if you think you have a research-related injury, please contact the locally responsible investigator (*Dr. Lisa Schwartz,*

schwar@mcmaster.ca ***or*** *Hanna Chidwick, chidwihw@mcmaster.ca).*

CONSENT STATEMENT

By signing this form, I do not give up any of my legal rights.

Participant:

I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

Name	Signature	Date

Person obtaining consent:

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

Name, Role in Study	Signature	Date

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905.521.2100 x 42013

Appendix 8 – Email Recruitment
Email subject: Research study about perspectives on adolescent sexual and reproductive health projects, invitation to participate

Dear [NAME],

My name is Hanna and I am a Global Health PhD Candidate at McMaster University in Canada. I received your contact information from Imaeyen Okon at CanWaCH. I am reaching out about _____ 's (organization name) project on adolescent sexual and reproductive health (ASRH), _____ (project name). I am currently working on a research study about ASRH projects that are funded by the Canadian government. The study aims to understand stakeholder perspectives on the Feminist International Assistance Policy and how the policy shapes ASRH projects. In the end, we hope to inform how the Canadian government can more effectively support equitable and just approaches to ASRH projects.

A key component of this project is interviews with project leaders of ASRH projects at Canadian organizations. Each project leader will be invited for one interview, lasting 40-70 minutes. These interviews will be conducted confidentially over Zoom. Would you be interested in meeting for an interview?

Please note that your identifying information will be kept confidential and that your participation is strictly voluntary. Participating in this study will not be connected to your work with CanWaCH and we foresee no negative impacts to your funding from Global Affairs Canada.

Attached is a document with detailed information about the research study [attach research information and letter of consent]. I am more than happy to provide further clarification on any questions via email or connect over Zoom to chat further. If permission from the director of your organization is needed, I would be happy to speak with them as well.

If you are interested in participating or have any questions, please respond to this email from Hanna and she will get in touch with next steps.

Many thanks,
Hanna, on behalf of the research team

Appendix 9 – Interview Guide

Total time required: 40-70 minutes
Breaks: As many as necessary

Introduction
Hello, thank you for taking the time to speak to me today. I am a PhD student in the Global Health department at McMaster. I am conducting a study that explores stakeholder perspectives of Canada's Feminist International Assistance Policy (FIAP) and how the policy shapes adolescent sexual and reproductive health (ASRH) projects. Through today's interview I am hoping to learn about your perspective on the FIAP, how it shapes ASRH projects and your thoughts on how the Canadian government can better fund and support organizations implementing projects aligned with local community goals.

Would it be ok if I recorded the interview? The recording will be confidential and not shared with anyone, I will be storing notes from our conversation today in a secure place so they cannot be lost or accidentally made public. I will also be removing any identifying information from the data, so the analysis will be completed with your privacy and confidentiality as a priority.

(if consented too …). This interview will consist of a few semi-structured questions, so I may ask follow up questions throughout. You may choose not to answer any of the questions. We can take breaks whenever you'd like and if you'd like to end the interview at any point, that is okay as well.

Do you have any questions before we begin?

I will be starting the recorder now. Please let me know if at any point you would like me to turn off the recorder during the interview.

Introductory questions
1. To begin, could you introduce yourself and describe your role at the organization?
    a. What gender do you identify as and what are your preferred gender pronouns?
    b. What organization are you from?
    c. About how many people work at your organization? Where do most staff work from?
    d. What are your day-to-day activities at the organization?
2. Could you describe your experience with ASRH projects at the organization?
    a. How long have you been with the organization?
    b. What ASRH projects are you involved in?
    c. Where are they located?
3. What is your role on the ASRH project(s)?

General questions
1. Can you tell me more about your organization's focus on ASRH?
2. How long has the organization been working in this area?
3. Generally, who funds the ASRH projects?
4. Can you tell me more about the project funded by Global Affairs Canada, _____ (name of specific project in discussion)?
    a. How is the funding distributed in the project?

b. What was the process of building the ASRH project funded by GAC?
    i. How was the project developed?
        1. Who led the development? Who else was involved?
        2. Were adolescents involved? If so, could you tell me a bit about your experience collaborating with them? How were they involved?
        3. How were the priorities of the project set? Who set them?
        4. Did the call for proposals influence the project? If so, how?
    ii. How is the project being implemented and evaluated?
        1. Who led/is leading the implementation and evaluation phase? Who else was involved (ex., Ministry of Health, Ministry of Gender, religious organizations, other NGOs, schools)?
        2. Were adolescents involved? If so, how?
        3. How is the project being evaluated? What are the measurements of impact?

Stakeholder analysis

1. Are you familiar with Canada's Feminist International Assistance Policy (FIAP)?
    a. If so, how did you hear of it?
    b. What do you understand as the goals of the FIAP?

If participants are not familiar with the FIAP, I will share the following and ask, the FIAP is a policy that frames Canada's funding for ASRH projects and emphasizes a feminist approach by targeting gender equality and empowerment of women and girls. Do you recognize any aspects of the FIAP in your work?

2. Can you tell me a bit about how the FIAP is relevant to your work?
    a. If the FIAP is not relevant, why not?

3. Is there an existing, similar policy to the FIAP within the implementation country of this project? How does this policy align or not with the FIAP?
    a. How has FIAP funding provided opportunities to do things that are aligned with country priorities (i.e., focus on gender, feminist approaches, poverty reduction)?
    b. Are there any differences between FIAP priorities and in-country priorities (i.e., around gender goals, feminist approaches, poverty reduction)?

4. In your opinion, what has shaped this ASRH project?
    a. Do organizational values/community goals/funding expectations/international or national government policies shape ASRH projects? If so, how?
    b. Has the FIAP, or aims of the FIAP, influenced or shaped this project? If so, how or in what ways?
        i. Has the FIAP influenced this project at certain stages, for example, at the development, implementation, or evaluation stage? If so, how?

5. What do you think are the main strengths and limitations of this ASRH project?

6. What do you think is the most important for funding organizations and policy makers to keep in mind with regards to supporting ASRH projects?
    a. How can funding organizations and policy makers better support ASRH projects?

Final comments

1. Is there anyone else from your organization that you would recommend I interview for this study?
2. Are there any GAC reports or similar project documents you would be open to sharing with me for this research?
3. Would you be interested in providing feedback on the data analysis codebook once it is provisionally developed from the interviews?
4. Is there anything else you would like to say about what we've talked about today?

Debriefing

Thank you very much for your time. If you'd like to get in touch with me after this interview, please do not hesitate to send an email. Would it be okay for us to contact you for clarification in the future? I have learned a lot today, thank you so much for sharing about your work and insights.