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Whose voice counts? Achieving better outcomes in global sexual and reproductive health and rights research

Cristina Mattison ,[1] Elena Ateva,[2] Luc De Bernis,[3] Lorena Binfa,[4] Jama Ali Egal,[5] Karyn Kaufman,[6] Marie Klingberg-Allvin,[7] Elisa Maria Maffioli ,[8] Mary Renfrew,[9] Pragati Sharma[10]

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For numbered affiliations see end of article.

Correspondence to
Dr Cristina Mattison;
cristina.mattison@ki.se

INTRODUCTION

Progress in meeting the Sustainable Development Goals (SDGs) by 2030 has stalled. Despite some advances, indicators related to sexual and reproductive health and rights (SRHR) have worsened.[1 2] COVID-19, war and powerful conservative political movements around the world are reversing decades of improvements. SRHR are at the heart of the SDGs, as they affect the survival and short-term and long-term health and well-being of individuals, with mental health and socioeconomic consequences for women, trans, non-binary people, children, families, communities and populations.[3 4] Knowledge derived from global health research should guide policy, planning and practice. In this paper, we use the Guttmacher-Lancet Commission's definition of SRHR to interrogate the field of global SRHR and investigate who and what gets published, as well as the location and position of authors, and propose an alternative, evidence-based and strengths-based approach to future development.

By applying the Guttmacher-Lancet Commission's definition of SRHR—the 'state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity'[4]—this definition recognises that SRHR is comprehensive, requiring an intersectional approach to tackle difficult and neglected problems. Improving maternal and child survival, health and well-being is the top priority to reach the SDGs. By focusing on SRHR for women, trans and non-binary people, it generates a cascade effect that contributes to gender equality and power and improves overall health and well-being.

The authors are key contributors to global SRHR research with origins from five continents, including low-income, middle-income and high-income countries. We bring transdisciplinary approaches including systematic reviews and bibliometrics, advocacy, human rights, health economics, epidemiology, health professions education, health systems and policy, and clinical expertise in midwifery, nursing, obstetrics, human rights and public health. Using a mixed-methods approach, we began by taking stock of the global SRHR literature, and then identified and analysed the publications with the most impact on health systems, policy, clinical practice and the future direction of research in this field. The following questions underpinned our interrogation of the literature with the highest impact on global SRHR evidence:

1. What are the methodological and content characteristics of the journal articles?
2. Who are the influential authors and where are they located?

SUMMARY BOX

- ⇒ Many indicators related to sexual and reproductive health and rights have worsened, with COVID-19, war and powerful conservative political movements around the world reversing decades of improvements.
- ⇒ Improving sexual and reproductive health and rights generates a cascade effect that contributes to gender equality and power and improves overall health and well-being.
- ⇒ Any solutions to address the problems in global sexual and reproductive health and rights research first require recognition of a fundamental disconnect between who is leading the research and the actual needs of the users of care.
- ⇒ We encourage pursuit of transdisciplinary solution-focused questions and research designs that address the needs of local communities by drawing on the knowledge of diverse interprofessional groups, across geographic regions, who have access to the resources and space that amplify their voices and ways of working.

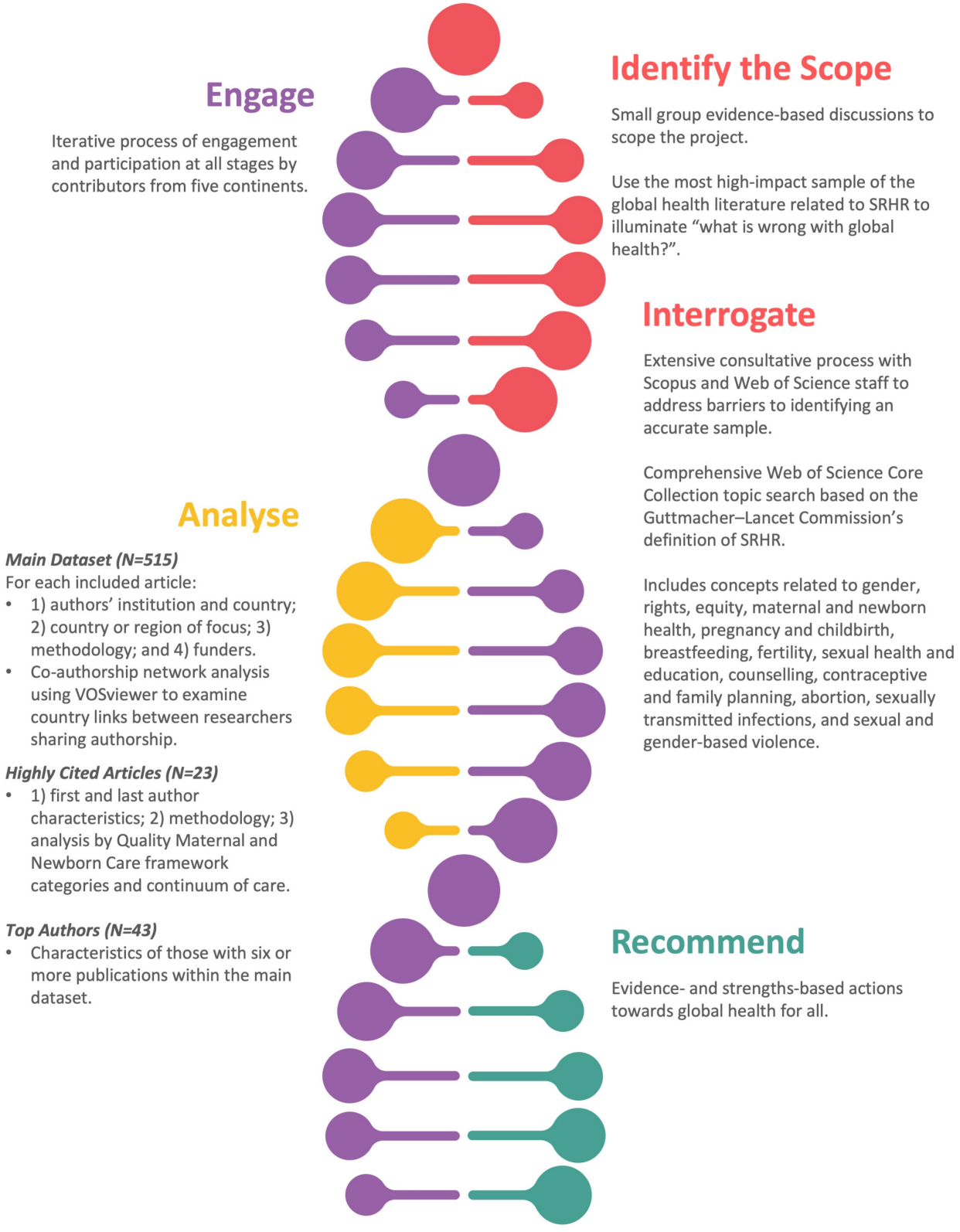

Figure 1 Research process helix. SRHR, sexual and reproductive health and rights.

3. Are there critical methodological and content gaps in the articles? If so, what are they?

Our approach integrated a series of quantitative and qualitative analyses outlined in figure 1. The iterative approach to this research began with a small group to scope the project, followed by engagement with all authors to develop, inform and finalise analyses and interpretation. We interrogated the literature through a mix of descriptive and bibliometric analyses coupled with thematic analyses that led us to generate recommendations.

(sexual or gender)NEAR/0 (health OR care OR rights OR equality OR equity) (Topic) or **reproductive NEAR/0 (health OR care OR rights OR equality OR equity)** (Topic) or **contracept* OR "family planning" OR "family spacing" OR"child spacing" OR "breastfeeding" OR "chestfeeding"** (Topic) or **(maternal NEAR/0 care) OR (maternity NEAR/0care) OR (newborn NEAR/0 care) OR (neonatal NEAR/0 care) OR (infant NEAR/0care)** (Topic) or **(prevent* NEAR/0 HIV/AIDS) OR (treat*NEAR/0 HIV/AIDS) OR (manage* NEAR/0HIV/AIDS)** (Topic) or **(prevent* NEAR/0 infertility) OR (treat*NEAR/0infertility) OR (manage* NEAR/0 infertility)** (Topic) or **(prevent* NEAR/0 "sexually transmitted infection") OR (treat*NEAR/0"sexually transmitted infection") OR (manage* NEAR/0 "sexually transmittedinfection")** (Topic) or **(prevent* NEAR/0 "sexually transmitted disease")OR (treat*NEAR/0 "sexually transmitted disease") OR (manage* NEAR/0 "sexuallytransmitted disease")** (Topic) or **(prevent* NEAR/0 "reproductive tract infection")OR (treat*NEAR/0 "reproductive tract infection") OR (manage* NEAR/0"reproductive tract infection")** (Topic) or **(prevent* NEAR/0 "cervical cancer") OR (treat*NEAR/0 "cervical cancer")OR (manage* NEAR/0 "cervical cancer")** (Topic) or **sex* NEAR/0 health NEAR/0 (education OR information)** (Topic) or **sex* NEAR/0 health NEAR/0 (counselling OR counseling)**(Topic) or **(safe AND abortion) OR "post-abortion care"** (Topic) or **prevent* NEAR/0 (gender OR sexual OR partner OR female) NEAR/0 (violenceOR discrimination OR mutilation)** (Topic) or **treat* NEAR/0 (gender OR sexual OR partner OR female) NEAR/0 (violenceOR discrimination OR mutilation)** (Topic) or **detect* NEAR/0 (gender OR sexual OR partner OR female) NEAR/0 (violenceOR discrimination OR mutilation)** (Topic) or **manage* NEAR/0 (gender OR sexual OR partner) NEAR/0 (violence ORdiscrimination)** (Topic) or **(maternal NEAR/0 health) OR (maternity NEAR/0health) OR (newborn NEAR/0 health) OR (neonatal NEAR/0 health) OR (infantNEAR/0 health)** (Topic) or **(prevent* NEAR/0 "reproductive cancer") OR(treat*NEAR/0 "reproductive cancer") OR (manage* NEAR/0 "reproductive cancer")** (Topic) or **(safe OR quality OR effective OR care) NEAR/2 (pregnan* OR birth ORprenatal OR antenatal OR intrapartum OR postpartum OR postnatal)** (Topic)and **2014** or **2015** or **2016** or **2017** or **2018** or **2019** or **2020** or **2021** or **2022** (Publication Years) and **ReviewArticle** or **Article** (Document Types)

Figure 2 Search string.

We conducted a search in the Web of Science Core Collection using the terms in the SRHR definition to form a detailed search string (see figure 2).[4] We used a combination of citation counts and Web of Science's Journal Citation Reports (eg, using the number of citations to find articles that were in the top 1% when compared with other articles in the same field) as indicators of journals with the most impact within global SRHR. Using that filter, BMJ Global Health, The Lancet and The Lancet Global Health emerged as the top journals. We limited results by year, from January 2014 to November 2022, and to research articles and review articles. The 'analyse results' feature in Web of Science was used to generate Excel data files for the detailed analyses (see figure 2).

As an additional analytic step, files of the full records and cited references were generated for analysis in VOSviewer, a network analysis programme. This provided a picture of co-authorship networks and country linkages among the researchers in the dataset.

Figure 3 displays the findings of systematic literature searches of the Web of Science Core Collection that were completed on 23 November 2022. The broad search yielded 209 359 records. The refined search that focused on the three journals yielded 546 articles, and 31 records were excluded because they did not fit within the definition of SRHR (CM, MR, KK and MK-A), leaving a total of 515 articles for detailed analyses by the team (figure 3).

To understand the methodological characteristics of the articles in the dataset (n=515), we categorised each publication by type: (1) description-focused: research that describes 'what is', that is, measurement and description of the problem/problems; (2) potential

solution-focused: research that uses data to identify/focus on potential solutions and (3) implementation and/or evaluation focused: research that is focused on implementing or testing solutions in applied contexts.

Next, we identified a highly cited subset of 23 articles from the main dataset. This highly cited subset consisted of articles that had ≥250 citations. The author group read the articles and categorised them using the three categories described above and mapped the content to an existing evidence-based and human rights-based framework, the framework for Quality Maternal and Newborn Care (QMNC) (figure 4).[5] The framework represents the optimal approach to ensure access and improve outcomes for all women and newborns. The articles were coded based on the QMNC categories and the continuum of maternal and newborn care. Articles could be coded to more than one category but needed to make a substantive contribution to each. Simply mentioning related concepts did not result in a code.

Finally, we identified the top authors, those with six or more publications, within the main dataset (n=43) to understand their author characteristics.

MAPPING THE RESEARCH IN GLOBAL SRHR

We found the majority (56%) of the articles in the main dataset (n=515) were description-focused, followed by potential solution-focused (25%) and implementation and/or evaluation focused (21%). Within the highly cited subset of articles from the main dataset (n=23), 11 were description-focused and 12 were potential solution-focused. None were implementation and/or evaluation focused. When we mapped the content of these 23 highly cited articles to categories of the QMNC framework, the content of these articles mostly centred on the practice categories. More articles were focused on treatment of pathology, with a total of 17 in the two categories of medical, obstetric and neonatal services (n=12) and first line management of complications (n=8), with fewer examining health and well-being and preventive care (n=9). Largely absent were articles with substantive content on values (n=4) or care providers (n=4). Only one of the articles focused on abortion and none of the articles fully covered health systems issues or the full spectrum of QMNC categories.

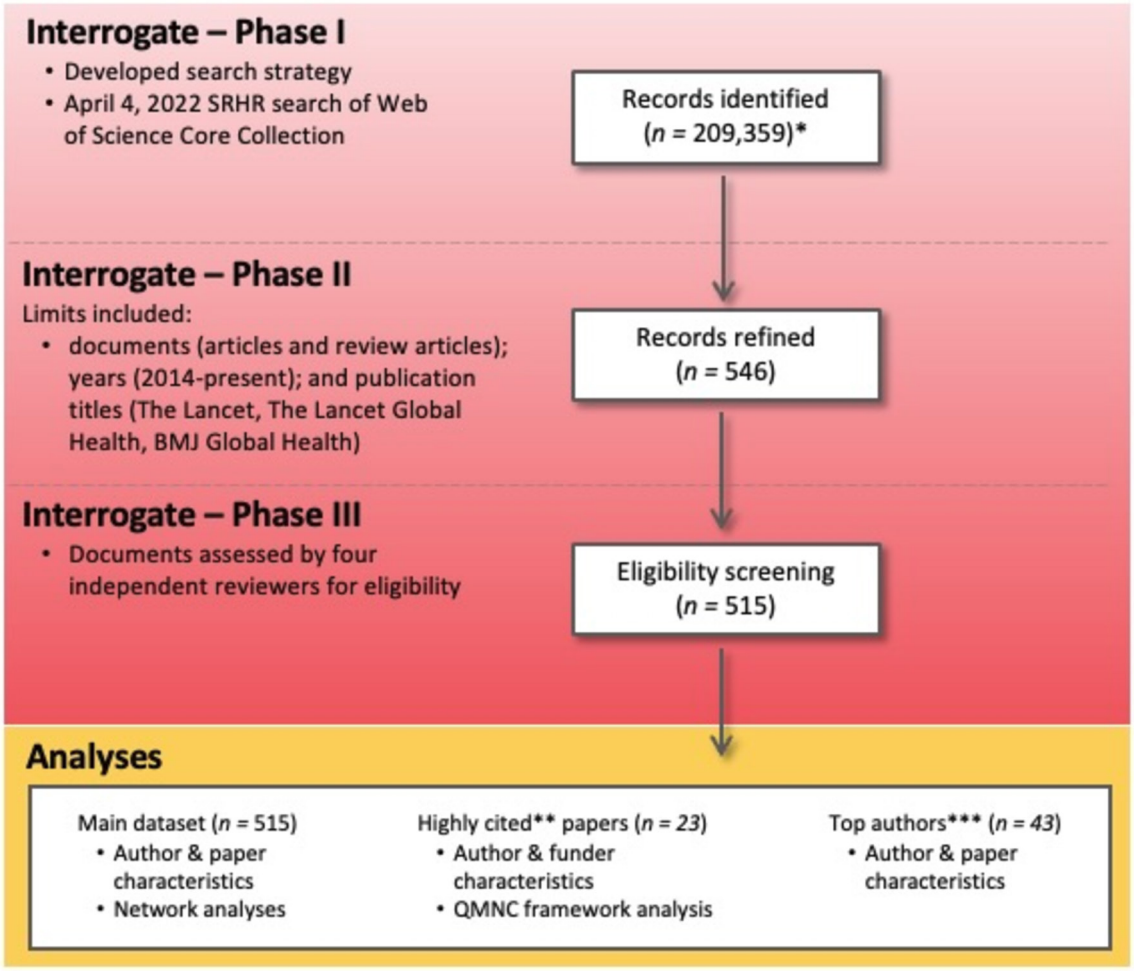

Figure 3 Literature search, article selection and analysis flow diagram. SRHR, sexual and reproductive health and rights. *Language of article analysis was run on records identified in first phase. **Highly cited articles – articles with ≥250 citations. ***Top authors – those with ≥6 publications in the main dataset.

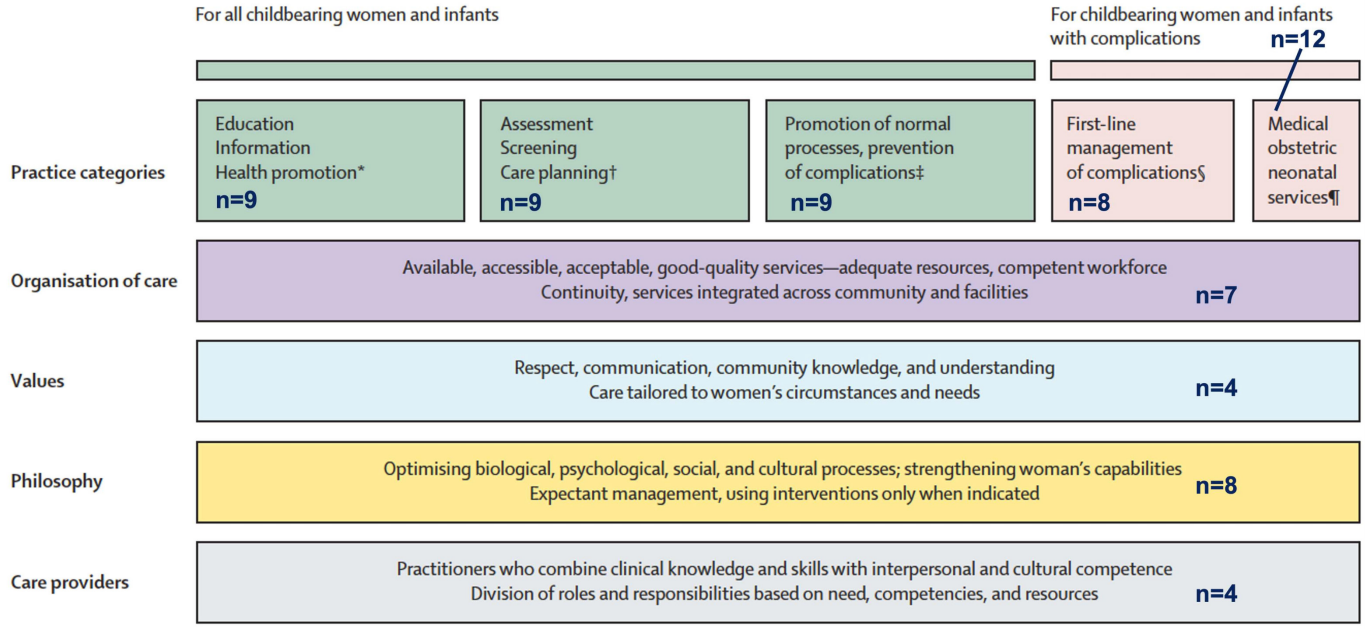

Figure 4 Mapping the 23 highly cited articles to the QMNC framework.[5] QMNC, Quality Maternal and Newborn Care.

Regarding the continuum of care, most of the highly cited articles focused on pregnancy (70%), labour and birth (52%) and the postnatal period (early weeks of life of the child) (61%). Fewer articles examined pre-pregnancy and interpregnancy (22%), early weeks of life (for both mother and child) (30%), infancy and childhood related to conditions of pregnancy and childbirth (beyond the perinatal period) (22%) and longer term maternal or women's health related to pregnancy and childbirth (13%). No articles examined the full continuum of care.

Lastly, we examined the author and funder characteristics of the 23 highly cited articles. The majority of the first (91%) and last authors (83%) of these articles were based at institutions located in high-income countries. Over half of the first authors (61%) and 52% of last authors were medical doctors and most of these had a background in epidemiology. Of all the first and last authors, only one was neither a physician nor an epidemiologist. The data related to the research funders were mixed in terms of what is reported, however, 16 of the 23 highly cited articles credited the Bill & Melinda Gates Foundation as a funder and 19 of the 23 articles listed US-based funding sources.

Who holds the power?

High impact journals in global health have an important role in defining the direction of future research and allocation of funding within the field of SRHR. Importantly, publications in these journals guide global agencies and health system decision makers, who are the key drivers in the development of influential policy, strategy and technical advice.

To better understand who holds the power in generating the global SRHR evidence, we analysed authorship patterns by country within the main dataset (n=515) using a co-authorship network analysis of all the article authors (see figure 5). Co-authorship networks are a tool to examine research collaboration trends. The nodes in the figure represent countries and their size denotes the number of authors from the country. Nodes (countries) are connected when they share the authorship of an article and the closer the nodes are located to each other in the visualisation, the more strongly they are related to each other based on bibliographic coupling. The colours highlight clusters, indicating scientific collaboration networks and countries that have strong relationships to each other. The main cluster in the figure (turquoise) is made up of the USA, the UK, Switzerland (likely authors based at United Nations agencies), India, Canada, Pakistan, Sweden, Bangladesh, Norway, Nepal, South Africa, Cambodia and Sierra Leonne. The analysis highlights a dominance of the USA and the UK, and Switzerland, which have the greatest total link strength in the network. These clusters highlight colonial power structures and country patterns. When we categorised the countries in the network analysis by income using the World Bank Country and Lending Groups, we found that 57% were high-income economies, 24% lower-middle-income economies, 13% upper-middle-income economies and 7% low-income economies.

We analysed the full text of each of the articles in the main dataset (n=515) to understand the country focus of the research, as this often differed from the author's country information. We categorised these publications based on whether the article focused on a study in a specific country (67%) or researched/analysed across countries (eg, reviews, theory, standards, recommendations or commentaries) (33%). Of those that centred on

a specific country, 83% of those articles focused on either lower-middle-income countries (53%) or low-income countries (29%).

To understand the attributes of authors with a strong influence on global SRHR research, we analysed a subset of authors with six or more publications using the 'author information' field in Web of Science. We found that 43 authors represented 384/515 publications (75%). All but 5 of the 43 authors were medical doctors and/or epidemiologists, and all but four were from institutions based in high-income countries. Just over half (57%) of the authors were men.

A final consideration on who holds the power is considering the language of global SRHR research. In the first phase of our literature search, which was not limited by language, we found that 96% (n=205 867) of the articles matching our search string were in English, followed by Spanish 1% (n=2345) and French 1% (n=2332).

EVIDENCE-BASED AND STRENGTHS-BASED ACTIONS FOR BETTER OUTCOMES IN GLOBAL SRHR

Below we propose a series of evidence-based and strengths-based actions to achieve better outcomes in global SRHR research. These actions are anchored in

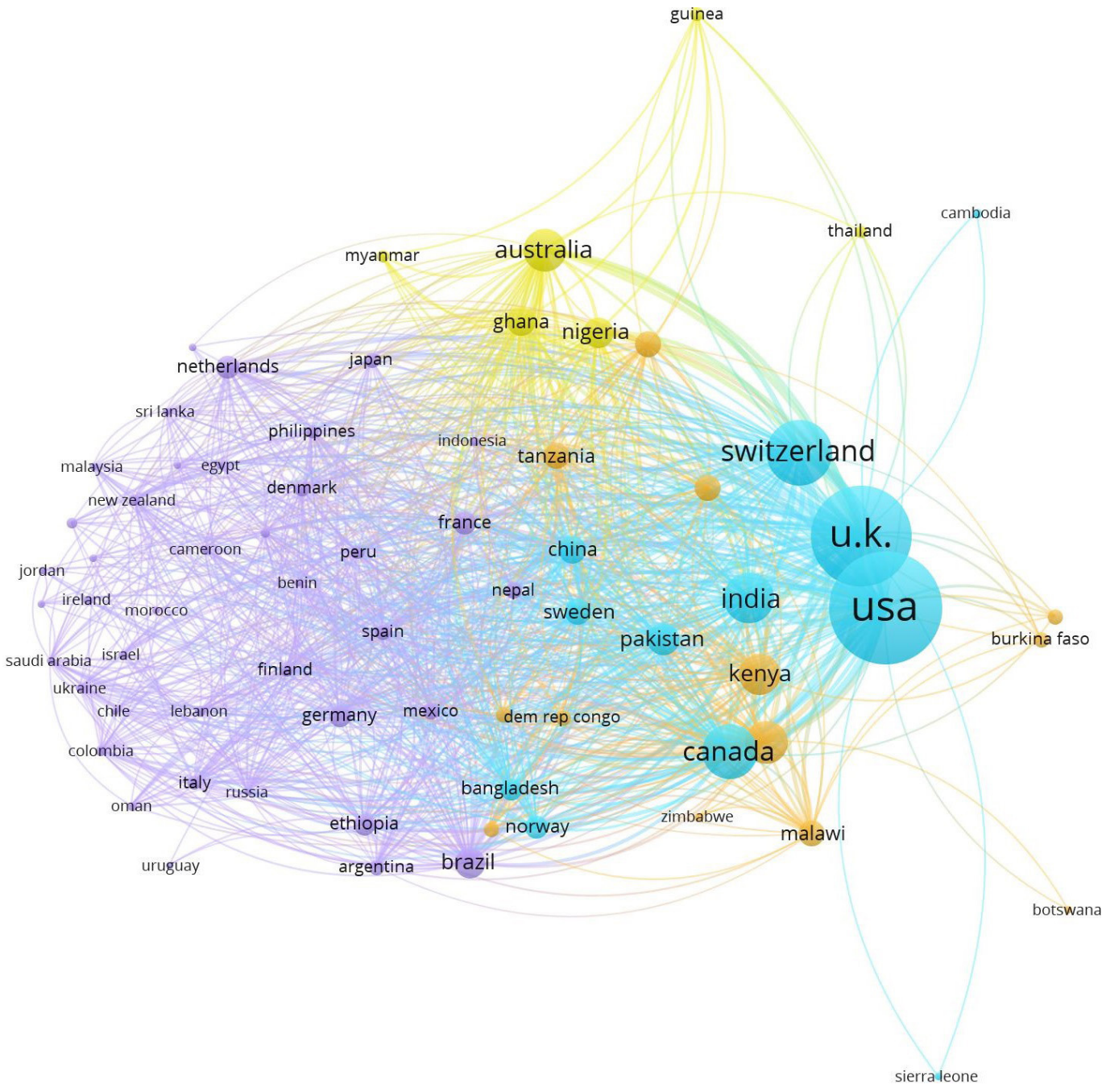

Figure 5 Co-authorship network by country.

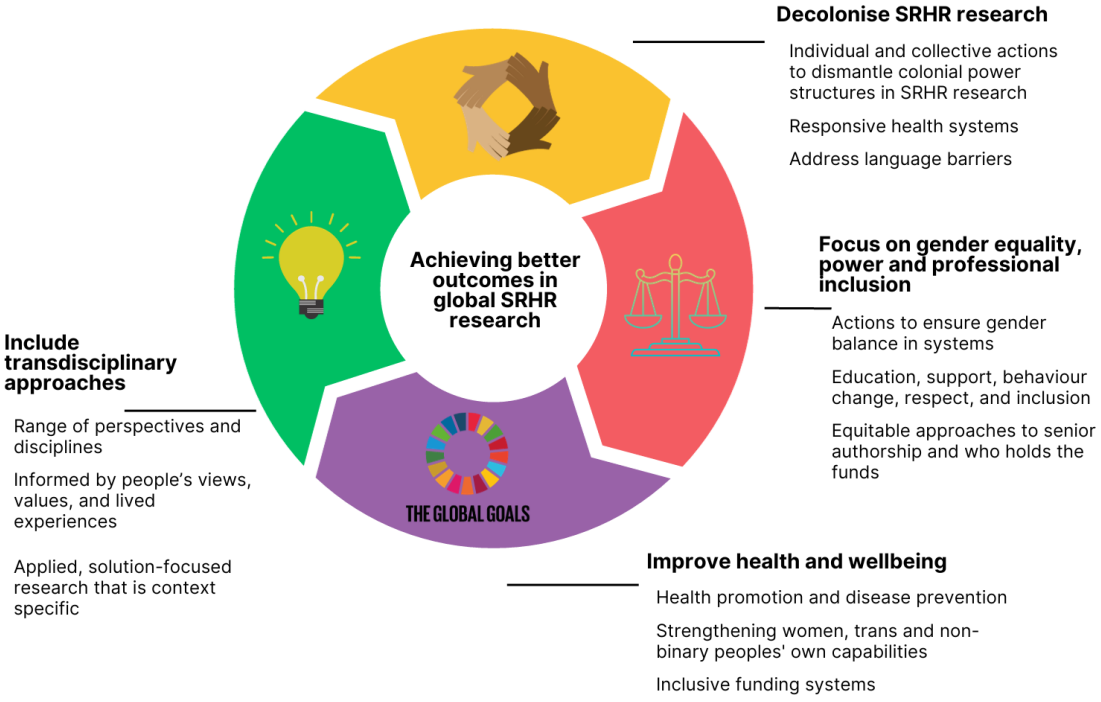

Figure 6 Evidence-based and strengths-based actions to achieve better outcomes in global SRHR research. SRHR, sexual and reproductive health and rights.

four overarching and inter-related solutions: (1) decolonise SRHR research; (2) support gender equality, balance of power and professional inclusion; (3) focus on prevention and improving health and well-being and (4) include transdisciplinary approaches (figure 6).

Decolonise SRHR research

Responsive health systems are needed to better understand and meet the SRHR needs of diverse individuals and communities. Perhaps the most starkly shown examples of the imbalance of power in global SRHR research are the country clusters in the co-authorship network analysis (figure 5), which reflect the legacy of colonial practices and show that colonial power structures remain firmly in place in current research collaborations. The skew in funding and authorship between high-resource and low-resource settings even while studying the problems facing low-resource populations, is equally problematic.[6 7] Our findings on authorship patterns align with previous research on international health research collaborations focused in low-resource settings, showing that researchers from within these settings were less likely to be listed in senior authorship positions on publications (ie, first or last author).[7–9] Our findings may also reflect existing institutional promotion committee practices that place a higher value on first-author and last-author research articles over middle author publications.

It is also important to recognise the dominance of the English language in global SRHR research, which may have the effect of silencing other languages, discouraging researchers to write in their native language and limiting who can access the findings.

Any solutions to address the problems in global SRHR research first require recognition of the fundamental disconnect between who is leading the research and the actual needs of the users of care. Once we acknowledge the pervasiveness of colonial networks and power asymmetries in global health, we can confront its consequences and deliberately reimagine global SRHR research.[10]

Support gender equality, balance of power and professional inclusion

There are power imbalances in global SRHR research that silence key knowledge holders, including women, 2SLGBTQI+, as well as local experts and non-medical professionals.[6 11–13] The dominance of the medical model is perhaps most inappropriate in SRHR. Our analyses show that this skew in professional perspectives influences the direction of global SRHR research and prioritises pathology over prevention focused approaches. More than 90% of the authors with six or more publications in our dataset were medical doctors and/or epidemiologists, however, more than 50% of the health workforce globally are midwives and nurses, more than twice the number of doctors.[14]

Bringing interprofessional approaches to global SRHR research is essential but challenging. One example is midwifery, which has been shown to be critically important to survival, health and well-being of women, trans, non-binary people, girls and children.[15] Midwives are especially valuable in the field of global SRHR research because of their specific knowledge and skills, their work in prevention and support as well as treatment of complications, and their access to local communities

and to women, trans, non-binary people at a formative time in their reproductive lives and throughout the life course. The profession continues to face barriers that are fundamentally rooted in gender inequality and limits midwives' participation and impacts in global SRHR research. In many countries, midwives experience low status, inadequate remuneration, limited professional education both at pre-registration and postgraduate levels, limitations imposed on their full scope of practice, professional disempowerment and lack of voice in decision making.[16 17]

The picture is further complicated by the dominance of funders based in the USA, who are likely to be rooted in their national medically dominated model of SRHR and may not recognise the key contribution made by health professionals outside of medicine. As a consequence, interprofessional approaches including midwifery and nursing are vastly under-represented in global SRHR research.

Focus on prevention and improving health and well-being

The lack of focus on identifying and developing solutions based on individuals' needs and testing these solutions through global SRHR research is striking. Our findings show that the field of global SRHR research is focused on the treatment of pathology, not aimed at health and well-being, and that researchers in this field are not examining the entire continuum of care from a life course perspective, meaning they are not seeing the full journey of the woman/trans/non-binary person and the child. A whole knowledge base about health systems as well as health promotion and disease prevention is missing.

Funders and aid systems play an important role in addressing health and well-being in global health research. The Alma-Ata Declaration of 1978 has not been realised in practice,[18] possibly because the perspectives of researchers and institutions from the USA and UK dominate the field. As an example of funders driving research agendas, the Bill & Melinda Gates Foundation has historically prioritised innovation and health technologies over addressing inequalities in primary healthcare through socioeconomic development and health systems' approaches.[19] Aid programmes reflect the legacies of colonial practices by exporting machines and technologies rather than giving power to context-specific initiatives aimed at health and well-being at the community level.

Include transdisciplinary approaches to global SRHR research

There is another marked imbalance—though perhaps much less visible—that results in a narrow focus when conceptualising and designing research projects, research questions and methodological approaches, and therefore on the solutions proposed.[20] Traditional 'western' research appears to prioritise descriptive quantitative research over different types of knowledge or ways to gather knowledge,[21] resulting in an over representation of quantitative methodologies. Prestigious journals, such as Lancet journals, prioritise positivist epistemology.[22] The Lancet Global Health only recently published its first qualitative research article.[23] When rigid ontological and epistemological assumptions of the biomedical worldview are made, it devalues qualitative and mixed-methods research such as implementation research in the eyes not only of researchers, but also of funders and decision makers. There is an implicit judgement regarding quality attached to this decision, one that does not give space to studies that examine people's views, values or lived experiences. The result is an important lack of learning from studies of, for example, implementation, health systems and health economics, and from studies examining the needs, views and experiences of local populations.

We recognise the important role of quantitative description-focused research on the burden of disease, trends in the prevalence of conditions and the availability of resources; this information can help guide decision making. However, the literature is saturated with this approach and there needs to be a move toward solution-focused and implementation-focused research. Existing tools such as the WHO's Situation Reports measure and monitor issues in global health. It is not clear why description-focused research is taking priority in the most highly cited journals in the field, especially when we have not moved the needle in many SRHR-related indicators.[1 2] Related to this, we find that a majority of the first and last authors are medical doctors and epidemiologists; important as their perspectives are, space must be made for transdisciplinary approaches, including broader methodologies, to identify, test and implement solutions to complex problems in global SRHR.

CONCLUSION

Our interrogation of the global health research in SRHR has shown that there is inequity in the distribution of money, access and professional power. SRHR is a field where we would expect to see the inclusion of women's voices and participation of the full range of health professionals with important knowledge and skills, yet significant barriers exist. While we need a transparent examination of the intersection of systems of oppression within SRHR, of equal or greater value is an examination of the systems of privilege that can create—or act as barriers to—appropriate solutions. This process must include self-reflection to recognise our complicity in reinforcing systems of oppression, and actions to dismantle existing power structures to achieve equity and diversity in global SRHR research.[13 24] We call on the research community to debate these power imbalances in SRHR research and the field of global health more broadly. We advocate for transdisciplinary solution-focused questions by drawing on the knowledge of diverse interprofessional groups, individuals and communities, across geographic regions, who have access to the resources and space that amplify their voices and ways of working.

Author affiliations
[1]Women's and Children's Health, Karolinska Institute, Stockholm, Sweden
[2]The Adrienne Arsht-Rockefeller Foundation Resilience Center, Atlantic Council, Washington, DC, USA
[3]Independent Consultant in International Maternal and Perinatal Health, Bias, France
[4]University of Chile, Santiago de Chile, Chile
[5]College of Medicine and Health Sciences, University of Hargeisa, Hargeisa, Somalia
[6]Family Medicine, McMaster University, Hamilton, Ontario, Canada
[7]Women's and Children's Health, Karolinska Institutet, Stockholm, Sweden
[8]Health Management and Policy, University of Michigan, Ann Arbor, Michigan, USA
[9]School of Health Sciences, University of Dundee, Dundee, UK
[10]Public Health and Policy, London School of Hygiene & Tropical Medicine, London, UK

Twitter Cristina Mattison @MattisonPhD

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ORCID iDs
Cristina Mattison http://orcid.org/0000-0001-7210-0690
Elisa Maria Maffioli http://orcid.org/0000-0003-3303-7945

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