Agency-Based Empowerment Interventions: Efforts to Enhance Decision-Making and Action in Health and Development

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Abstract

This paper outlines the critical role of personal agency in influencing health and development outcomes and presents a framework for implementing non-therapeutic cognitive-behavioral interventions that foster agency, especially for women, in resource-poor settings. The United Nations' Sustainable Development Goals (SDGs) has placed "empowerment" at the center of global targets, particularly to improve individuals' health and development. Despite extensive research on individual and community empowerment, there is limited focus on the role of psychological and behavioral approaches directly fostering individual and collective agency in health programs. Fundamental to this process is the understanding that decision-making is an interaction between mental processes and one's current context. Approaches that allow individuals to understand how their beliefs, values, emotions, and thoughts impact their behaviors and can be modulated to increase their personal agency are needed. This model is illustrated through a pilot behavioral intervention with women engaged in sex work in Pune, India, demonstrating substantive benefits.

Introduction

Empowerment is a critical focus of development that is necessary to reach gender equality, improve health, and enhance financial security.[1] While numerous definitions of empowerment exist, a commonly accepted one is an "expansion in one's ability to make strategic life choices in a context where this ability was previously denied to him/her."[2 (p. 19)] Central to empowerment are the interconnected concepts of resources and agency. Resources are the *external* conditions from

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which choices are made and can lead to new ideas of possibility. Agency is the psychological ability to make and act upon decisions and is related to one's *internal* power and the meaning, motivation, and purpose that can underlie an action.[3,4] Despite the considerable literature on empowerment theory and application pointing to the importance of individual agency in health and development outcomes, there is a paucity of proven interventions that directly foster agency.[1,5–10] A focus on individual agency requires new metrics and tools for achieving health and development objectives that can be used to increase the effectiveness of existing interventions.

Although there is growing attention on personal agency in the development sector, there is limited understanding of what types of interventions directly cultivate agency, and few strategies and programs have been rigorously tested and scaled. Most development efforts have focused on external resources by addressing larger structural inequities, such as human rights discrimination, opportunities, functions, and roles, with the hope that improved agency will result. A majority of health interventions have been designed to address the biological determinants of poor health. A missing piece of such efforts is a concomitant focus on fostering individual agency. This view recognizes the need for advancing human resource capacity at the most basic level, through shifting individual mindsets, to cultivate resilient people and communities that can adapt to diverse and changing environments.

This paper suggests that building individual agency, specifically women's agency, should be a primary goal of development interventions. This would have multiplicative effects. First, personal agency remediates the negative, neurobiological effects of stressful life events and circumstances by giving individuals the psychological capacity to overcome adversity. Second, when cultivated within an individual's sociocultural and situational context, this newfound psychological strength can translate into tangible action in health and development. Third, when embedded within existing social networks, the enhanced individual agency can strengthen collective agency. Existing agency-centered approaches in health are reviewed and the need for more comprehensive cognitive-behavioral approaches that build an individual's psychological capacity to overcome adversity are established. In addition, a new framework for agency-based empowerment interventions is presented. This approach is illustrated through a case study of a pilot behavioral intervention of sex workers in Pune, India. It is through a more complete recognition of the interplay of biological, psychological, and social forces that affect individual perception, cognition, decisions, and behaviors, that innovative development solutions can be identified, tested, and applied.

The role of agency in health interventions

A lack of focus on strengthening individual agency is seen throughout health interventions in low-resource settings. This shortcoming is particularly challenging for women as they have an important role in the intergenerational transmission of health, development, and equality given that, both biologically and typically as primary caretakers, women greatly impact the early health and development outcomes of their children. Research has shown that when women are valued, enabled, and empowered as both consumers and providers of health care, gender equality, and wellbeing can be achieved.[11]

At a biological level, personal agency positively impacts how individuals view and respond to stressful life events and circumstances, which is critical as stress has immense negative impacts on health. Stress, adverse experiences, and environmental insecurity are linked with serious neurobiological outcomes, including lower levels of cerebrospinal fluid serotonin concentrations, disturbances in brain growth factors and hormonal regulation, and elevated glucocorticoids, which boost the risk of stress-related disorders including heart disease, diabetes, hypertension, and stroke.[12,13] Individuals with greater personal agency can buffer stress and the resulting negative health impacts due to a wider range of positive psychosocial resources, such as greater self-esteem, perceived social support, and environmental autonomy.[14]

Optimism, gratitude, positive emotions, positive self-worth, and a sense of purpose are all "personal coping resources" that are key to building the personal agency that helps individuals cope with high-stress environments.[14 (p. 312)] Studies have found that optimism is associated with a lower risk of heart failure; high emotional vitality is correlated with a reduced risk of hypertension; and greater purpose in life is linked to a lower risk of stroke.[15–17] Gratitude increases social support and reduces stress and depression; likewise, resilience and positive emotions are correlated with lower rates of depression.[18–20] Scientists have found neural bases for empathy, altruism, pro-social behavior, and mindfulness that lead to sustained positive emotion and recovery from negative life events. Personal agency not only has individual impacts, but intergenerational health impacts. Recent studies have shown that higher agency in mothers is linked with better child health outcomes, such as reduced diarrheal and respiratory disease.[21]

Current efforts to enhance women's agency for improved health outcomes

A primary path being taken to support individual empowerment, including one's agency, is creating structural changes to informal and formal policy, laws, and governance. Efforts to enhance empowerment have included a focus on providing external resources such as: formal education, skills-building training, finance (e.g., microcredit), information communication technologies (ICTs) (e.g., mobile phones), and financial opportunities (e.g., jobs). Enhanced agency is usually not the primary outcome sought from these interventions nor is it directly targeted; however it can result as a byproduct of these efforts.

Education is considered one of the primary mechanisms to enhance agency among women and girls. Greater educational achievements are associated with delays in marriage and lower fertility. Maternal schooling has measurable effects on child health through increased advocacy for the completion of childhood immunizations.[22] Studies have also shown that higher education is associated with a lower prevalence of HIV, fewer children, and improved decision-making regarding health.[23–25] One important caveat related to the role of education on individual agency is that, despite important benefits seen with increasing levels of education, it is a necessary, but insufficient, investment to achieve gender equality or improve women's wellbeing and agency.[26]

Access to ICTs has been shown to increase individuals' capacity to improve health outcomes. Reviews of ICT interventions show these programs could have both positive and/or negative impacts on gender relations. For example, mobile-based SMS tools have improved communication between couples regarding health and positively boosted male participation in women's health areas, though there is some evidence that mobile-based interventions have reinforced domestic disputes and spousal tensions.[27,28] Digital ICTs can be important resources for women and girls' empowerment, but the impacts are dependent on the context. Learning new skills and using digital ICTs are seen to build self-confidence, increase economic power, and enhance communication with peers, yet there is limited evidence that digital ICTs are able to significantly shift women's individual or collective voice enough to influence societal policy.[29]

Access to finance is another common path to support women. A systematic review of the impacts of microcredit on women's health found that participating in microfinance can positively affect women's health literacy, actions, and outcomes in relation to disease management, however, significant gaps in evidence remain.[28] Similar results were noted in a recent review of randomized trials of microcredit in six countries, which found no significant generalizable impacts on household living standards.[30] Programs using a multi-faceted graduation approach (that included microcredit) were shown to have significant positive impacts on consumption, assets, and food security, although there was no change in women's decision-making capacity.[31]

There are a number of notable interventions focused on building collective agency that, as a result, have enhanced individual agency. These include the formation of women's self-help groups

and community action committees. Similarly, Tostan's community empowerment programs in Senegal have led to a significant reduction in genital cutting in these regions.[32] Numerous studies have demonstrated that using women's health awareness groups with participatory learning and action activities have significant impacts on women's health seeking as well as maternal and neonatal mortality.[33]

These interventions, while effective, could benefit from a more direct focus on fostering individual agency. Understanding the cognitive and emotional processes that take place once individuals are exposed to new resources and opportunities allows more directed exploration of how these processes impact individual and collective action. There is often a time lag between an individual's understanding of an issue and when people make decisions and act upon them. These resource-driven intervention efforts are an important foundation for action; however, at the individual level, these efforts are not always sufficient to spur action. Indeed, there is a significant *knowledge-action gap* in the health and development sectors, described as the gap between an individual having knowledge of what they want to do but still not taking action towards that goal that limits the impacts and success of programs.

Addressing the knowledge-action gap

The knowledge-action gap is influenced by an individual's external environment and social relationships at multiple levels, including the intrapersonal/individual level, the interpersonal/primary group level, the community level, the institutional level, and the policy level. In addition, behaviors occur along a continuum and are rarely the function of discreet and linear thoughts or actions. Life stage, competing responsibilities, and existing competencies all contribute to one's capacity to take action at any given time. There are numerous theories that provide insights on factors that contribute to the knowledge-action gap, including social cognitive theory and the theory of planned behavior.[34,35] Another important theoretical approach is the ipsative theory of behavior that specifically focuses on constraints to behavior.[36] This theory posits that the primary constraints to action include (1) ipsative constraints, which include internal factors (i.e., the action is not cognitively accessible to the individual, (e.g., "I do not know that I can change my behavior to improve my health"); (2) subjective constraints, which include beliefs of what is possible (e.g., "I know how, but do not think I can contribute to managing my family's health"); and (3) objective constraints, which include external or situational factors that are considered to inhibit an individual's ability to act (e.g., "My partner does not allow me to manage my family's health").

While many health and development programs have a theoretical basis, few incorporate activities that effectively allow individuals time and space to examine their existing belief systems as a function of their cognitive-behavioral realities. Strengthening an individual's understanding of the critical relationships between how they *think*, how they *feel,* and what they *do* can potentially bridge the knowledge-action gap. From a psychological perspective, these relationships are well established. Drawing from Bandura's work on human agency, it is through cognitive self-guidance that individuals can visualize futures that can be acted on in the present, and through evaluation, modify their courses of action to gain the desired outcomes that can override existing environmental influences.[4]

The capacity to foster agency must also consider the existing conditions related to learned helplessness which directly impedes agency.[37] Learned helplessness suggests that individuals living in resource-poor settings may feel helpless to overcome existing situations due to previous experience that has shown them they do not have the control to do so. Within the context of poverty, the "capacity to aspire" could be considered a twofold process that requires individuals to set goals and know how to reach them by actively challenging conditions they face.[38] Populations living in poverty have faced generations of learned helplessness that reduce their capacity to aspire

because individuals may not have confidence that they can use existing opportunities to contest their present situation. Gender-based biases can exacerbate learned helplessness in women. A person's sense of freedom, political voice, how involved they feel in their ability to shape their lives, as well as participation in social, economic, and legal processes are often born from crucial, subjective psychological factors related to agency that have been missing in both dialog and on-ground interventions in the development and health sectors.[39]

Existing cognitive-behavioral agency-centered interventions

Existing interventions, though smaller in number, have shown that focusing on agency and cognitive-behavioral functioning as primary goals can positively influence health outcomes, both directly and indirectly. Project Choosing Life: Empowerment, Action, Results! (CLEAR) is an evidence-based HIV prevention and health promotion intervention for youth and adults. The program uses a cognitive-behavioral approach that incorporates goal-setting strategies, identity building, role-playing, and personal values reflections to build individual self-efficacy, ultimately leading to a significant reduction in high-risk sexual behaviors.[40] Another example is the randomized control trial from the "GirlFirst" intervention, which found that resilience training with adolescent girls in Bihar, India improved emotional resilience, attitudes surrounding gender equality, and health literacy.[41]

Furthermore, an intervention in the Mumbai slums of India that coupled positive psychology and design thinking resulted in a youth-led campaign on slum sanitation, as well as improvement in happiness, grit, empathy, and gratitude.[42] In that study, the community was able to channel their newfound psychological strength into action that raised health awareness. More recently, results from a World Bank study showed that psychology-based entrepreneur training programs could outperform traditional business trainings and significantly increased economic empowerment. This action-oriented personal initiative training fostered key behaviors associated with a proactive entrepreneurial mindset, such as self-starting behavior, identifying and exploiting new opportunities, goal setting, and overcoming obstacles.[43]

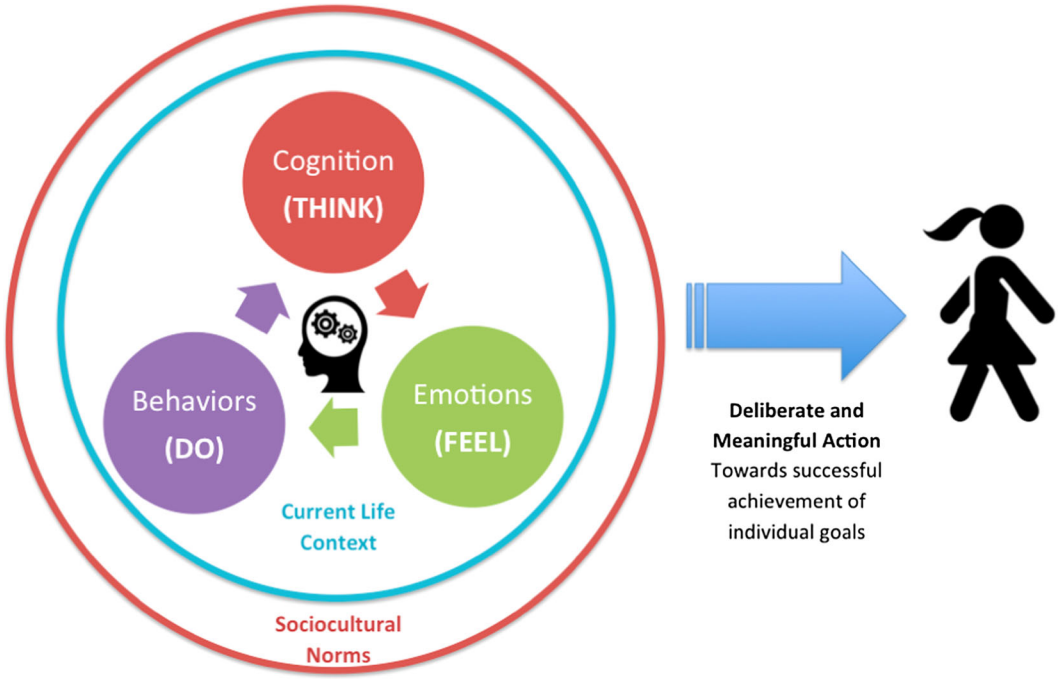
Shankar et al. tested a focused agency-based empowerment training for rural and urban women who were poor in Kenya, which resulted in significant changes in psychological wellbeing, improved relationships, and enhanced health seeking and economic security.[44] A similar customized agency-centered training was tested within a randomized controlled trial of clean energy entrepreneurs in Kenya that showed a doubling of business capacity, a nearly tripling of sales, and enhanced wellbeing of women compared with standard entrepreneurial training.[45] These studies, as well as the pilot case study described later in this paper, inform the basis for the study team's proposed framework on agency-based empowerment.

A Framework for Agency-Based Empowerment for Health and Development

Figure 1 displays how a cognitive-behavioral approach that considers how an individual's thoughts, feelings, and actions can lead to meaningful action when examined within one's specific sociocultural and situational context. This focus can easily complement and enhance existing intervention activities, as it helps participants become more aware of how they are processing new information and incorporating it within their current life constructs. Using a four-pronged cognitive-emotional-behavioral approach that is embedded within existing sociocultural norms while addressing the specific environmental context is suggested (see Fig. 2). This framework recognizes that successful interventions require a deep understanding of the local culture, and that cognitive-behavioral approaches should be anchored within life areas that have meaning to the participants. As personal agency is the primary program goal, practitioners should design spaces that allow individuals to self-define their goals in life areas

Figure 1

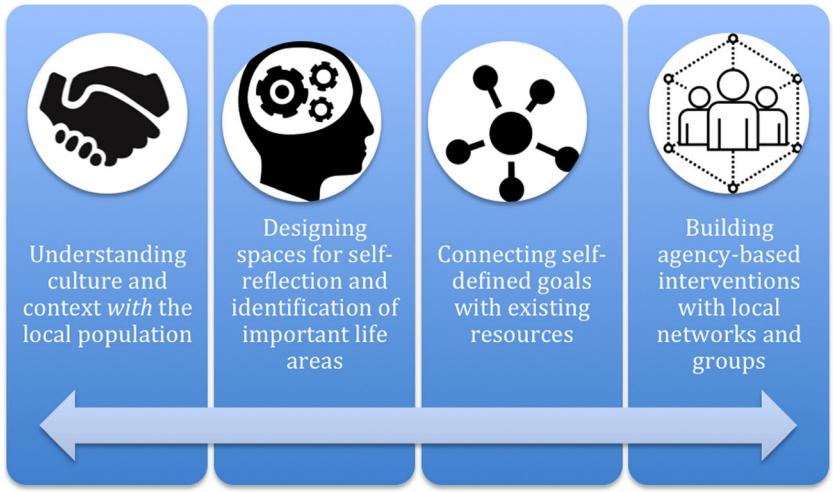
Agency-based empowerment model. Cognition: cognitions involve ideas, beliefs, observations, interpretations, and reasoning. Cognitions, often made apparent through one's self-talk, are beneficial or detrimental depending on their effects on feelings and actions. Emotions: emotion consists of neural circuits and response systems, and a feeling state or process. This is then labeled according to how one experiences physical sensations, such as: fear, sadness, loneliness, panic, satisfaction, anger, worry, contentment, frustration, pleasure, etc. Emotions and the subsequent feeling states influence the thoughts one has and the actions they take. Behaviors: there are a multitude of factors influencing behaviors. Actions can result from deliberate thinking, while other behaviors are governed by automatic factors. The first is a reflective system, whereby what one does is a result of goals that reflect their values and where they are aware of what they are doing. While the automatic system generally accounts for much of behavior, both are considered important when making a change and creating a new habit. Both deliberative and non-deliberative choices and actions can be affected by social factors (such as personal interaction and interaction within, and between, groups) and the large-scale social context, like the location one lives or the specific life stage one is in (pregnancy, old age, etc.)



such as work, relationships, sexuality, spirituality, or financial security and connect those goals with existing resources that support them. Finally, practitioners should build interventions that tap into local social networks to collectively catalyze the community in an experiential learning process that leads to action. This framework prioritizes the use of psychological tools that promote the understanding of self, in addition to the interaction of thoughts, beliefs, emotions, and current behaviors. It is critical that there is cultural adaptation of cognitive-behavioral strategies that have meaning both at the individual and collective level.

Figure 2

Four-pronged method to a cognitive-behavioral agency approach. (1) Before interventions are designed, it is vital to understand and be immersed in the local cultural context. This requires a deep understanding of the specific context through processes that engage the local population, and create opportunities for listening, processing, and collaboration. (2) Encouragement and facilitation of self-reflection. Before interventions are designed, there must be spaces for individuals to reflect on their own personal goals (think) and why they are pursuing those goals (feel). This also includes women identifying key areas of their life in which they have pressing desires, such as: work, health/body, emotional states, relationships, and spirituality. (3) Support individuals in connecting their self-defined goals with the external resources needed to achieve those goals. (4) Building interventions that consider the above 3 points and that leverage the power of local networks and groups to bring the program to life. This connects individual goals with collective action



Challenges to agency-based empowerment approaches

Inherent to an agency-based approach is that the individual's self-awareness and personal desires drive his or her behavior (as opposed to externally derived prescriptive or proscriptive advice), which in turn, drives collective behavior. Therefore, increased agency could potentially lead to actions that are not directly in line with the existing scientific evidence for health and wellbeing. However, it is still a critical step that individuals are bolstering their capacity to aspire and make choices, whether or not those choices are objectively aligned with best practices in development. As individual agency builds, it is crucial to increase access to information on the latest research and context-specific data to allow individuals to make the best choices for themselves.

Another key challenge in agency-based empowerment approaches is measurement. Existing metrics around agency tend to focus on proxy measures. Ideally, agency would be assessed as the concordance between the desired actions and actual behaviors. Available metrics include subjective measures of self-efficacy, empathy, grit, and happiness, among others.[46–50] The challenge in collecting subjective data, particularly data that measures life satisfaction, is that an individual's goals and identity often adapt with objective changes in their environment, making it difficult to isolate a specific measure of agency.[51] These challenges point to important research opportunities as programs and interventions move forward. Recent advances in digital technology, such as the use of cell phone communications, prompts, and machine learning to target messaging, are important avenues to examine for future programs.

The next section describes how a non-governmental organization in India used an agency-based empowerment approach to effectively shift individual mindsets, resulting in enhanced health and wellbeing of participants. This case study illustrates the proposed agency-based empowerment framework and highlights the importance of understanding the sociocultural norms and the local context to create effective adaptations of behavioral trainings and strengthen local capacity.

Case Study: an Agency-Based Intervention for Sex Workers in Pune, India

Saheli Sangh, founded in 1998, is a sex worker's collective that supports more than 4000 women living and working in the red-light area in Pune, India. Most of these women come from various regions of South Asia. They tend to be from poor, low-caste families and are illiterate. Most were sold to the brothel at a young age; however, some women chose to engage in this profession as a means of supporting their families. If sold into the brothel, women incur an initial debt, ranging from US$250–1500, which often increases with time as a result of housing needs and personal costs. Brothel-based sex workers generally give 50% of their daily earnings to the brothel owner. Once entered into this work, women tend to stay in this profession, as social norms make it difficult to return to their home villages. For nearly two decades, Saheli has been instrumental in providing health care services, social and legal aid, education, child care services, financial literacy training, and opportunities for alternative livelihoods to it members. Beginning in 2012, Saheli began carrying out an empowerment training program focused on fostering personal agency and monitored its impacts on women's wellbeing over time.

The behavioral intervention component of this program consisted of a culturally-adapted, context-specific application of a US-based training program developed by the Empowerment Institute in New York. The program was led by Saheli's director, a certified Empowerment trainer, and consisted of a group-based workshop over the course of 8 days, with sessions running 3.5 h/day. The training was adapted by modifying exercises and translating concepts to be better understood by the local population and reflected the existing shared context. Where necessary, content was adjusted to address the specific challenges faced by this population. During the training, individuals engaged in an introspective examination of aspects of their lives, including their thoughts, emotions, values, relationships, health, and finances. Each exercise was designed to accommodate the specific needs, literacy levels, and realities faced by each group of women (e.g., HIV status). The training utilized numerous experiential learning techniques, interactive group sessions, and peer support.

Many of the exercises employed drew from psychoanalysis and positive psychology traditions. Individuals focused on understanding their sources of personal power, their core beliefs, and envisioning future goals. Using a simple cognitive reframing process, individuals learned to facilitate behavior change and create achievable actions towards larger goals. The methodology allowed for highly interactive sessions and resulted in strengthened individual and, subsequently, collective agency. Counseling support was provided for all participants during both the workshop and the follow-up. The workshop was conducted at the Saheli office premises and was one component of the larger program, which tailored its provision of specific support services, such as health care, legal literacy program, alternate livelihood options, child care, and crisis support based on the issues that arose during the training.

To understand outcomes of this integrated agency-based approach, the study team followed 62 women who had participated in the training from 2013 to 2014. At baseline, interviews were conducted to collect sociodemographic data in addition to current life challenges and issues of concern to these women. Follow-up interviews were then conducted at 3, 6, and 12 months. Of the women trained, four women died due to complications of existing illnesses. As an outcome of the training, three of these women died surrounded by friends and family, an occurrence that is seldom experienced in this population. The team followed the remaining 58 women (ages 18 to 48) over a

12-month period after completing training. Peer educators, who were long-time sex workers now helping to support young women, were trained as part of this cohort. An additional 43 women who did not participate in the training were monitored and served as wait-listed controls. Due to the nature of the program activities, blinding study staff to participant treatment status was not feasible. Table 1 outlines differences between these groups.

Table 1

Socio-demographic data and changes experienced by women who participated in the Saheli empowerment intervention compared with the wait-listed controls

Characteristic	**Women participating in the Saheli empowerment training (n=58)**	**Women in the wait listed controls (n=43)**	**P-value***
Mean age	32	32	
Having any formal education (primary school or higher)	9 (16%)	12 (28%)	0.20
Percentage married (or having regular partner)	35 (60%)	21 (49%)	0.34
Serving as Peer educator for Saheli	9 (16%)	0 (0%)	0.01*
Having any children	47 (81%)	31 (72%)	0.41
Hindu religion	46 (79%)	37 (86%)	0.89
HIV positive	24 (41%)	5 (12%)	0.00*
Over the past 12 months:			
Increased uptake and/or adherence to HIV medications (*as a percentage of total HIV positive individuals*)*	13 of 24 (54%)	0 (0%)	0.05*
Less uptake or adherence to HIV medications	1 of 24 (4%)	1 of 5 (20%)	0.32
Improvements in addictions of alcohol or tobacco	5 (9%)	5 (12%)	0.74
Reported improvements in health status	30 (52%)	8 (19%)	0.00*
Reported deterioration in health status	1 (2%)	6 (14%)	0.04*
Reported improvement in economic status *(either through savings or greater earnings)*	31 (53%)	7 (16%)	0.00*
Stated desire to leave	27 (47%)	20 (47%)	0.99
Stated desire to leave and subsequently left sex work (includes all women and peer educators^)	20 (34%)	1 (2%)	0.00*
Total non-peer educators who left sex work	14 (24%)	1 (2%)	0.00*

ART adherence verified through ART clinic records and pill counts

^ Peer educators are women who have been engaged with Saheli outreach, tend to be older and have greater flexibility to leave sex work than other women

*Chi-square or Fisher's exact test as required, statisically significant at $p > 0.05$

At baseline, the intervention group had comparably poorer health and social indicators; they tended to have less formal education (primary school or higher) (28 vs. 16%) and were more likely to be HIV positive (44 vs. 12%). Despite these challenges, field staff reported positive behavior changes in the areas of decision-making, managing emotions, and problem-solving after the agency-based empowerment training. With respect to health indicators, women in the trained group had significant improvements in uptake and adherence to HIV medications and overall improvements in reported health status (52 vs. 19%), which included testing and treatment for tuberculosis and diabetes as well as improved antenatal care (if pregnant). Adherence to medication was confirmed through the local clinic records. These findings contrast the deterioration in health status reported by several participants in the control group. More than 80% of women from both arms reported having addictions to alcohol and tobacco; however, no significant changes were found related to alcohol or tobacco use as a result of this training.

Significant shifts were noted related to economic status, either through enhanced savings or greater earnings, with more than half (53%) of the trained group showing progress, as compared with 16% from the untrained group. In both groups, nearly 50% of women stated their desire and intention to leave sex work for other opportunities or to return to their home village. In the untrained group, only one woman was able to make sufficient efforts to leave this work, yet in the trained group, 20 (35%) women decided and were successful in leaving the sex trade over the course of 12 months. Of these 20 women, 14 not only identified alternative means of livelihood but also were able to successfully clear their debts to the brothel.

Since 2012, more than 200 women have undergone the agency-based empowerment training at Saheli, with the majority demonstrating increased wellbeing, financial security, and improved relationships. In late 2016, a group of 14 brothel owners (all female) asked to undergo this training based on the positive changes they noticed with the women who worked for them. As a result of their participation, two brothel owners decided to end their engagement in this work and returned to their home village. Another ten decided to make a pact to no longer purchase young girls into their brothel. While it is unclear if such a pact will sustain over time, it is apparent that significant shifts in the local culture in the red light district have begun.

Discussion

A critical missing piece of health and development programming is the integration of cognitive-behavioral interventions that directly impact individual agency. Through the proposed four-pronged framework, a greater focus on activities that catalyze deliberate, self-driven, and meaningful thought processes in low-resource settings that are anchored in a greater awareness of individual thoughts, beliefs, emotions, and actions can be created. This greater awareness can then be used to provide targeted support at the individual level.

An important caveat to this approach is that, while there is a focus on positive psychological states as a means of cultivating wellbeing, recognizing and productively dealing with negative emotions is a critical component of the cognitive-behavioral process. The processes outlined here recognize the importance of greater awareness and self-reflection, and that emotion, including negative ones, may be necessary to spur focused action.

Such interventions have immense potential to build human capacity, particularly when grounded in people's own experiences and contexts. Recent research on the use of cognitive-behavioral therapies (CBT), which are generally used for treatment with mental illness and disease frameworks, has demonstrated deep cognitive reflection leading to long-lasting emotional and behavioral changes.[52–54] Cognitive-behavioral approaches have historically been "expert-driven," relying on the practitioners and not the target individuals or groups, to set goals, define interventions, and assess progress. Efforts should be driven through the context of self-defined meaning, so that individuals can begin with what matters to them most and address their current

needs in various areas of life—such as family and jobs.[1] Allowing individuals to self-define these life issues based on what is most meaningful to them is imperative in helping vulnerable populations better foster the personal agency that tackles the biological effects of adversity.

Implications for Behavioral Health

With the explicit focus of the United Nations' SDGs on the overall wellbeing of individuals, of which enhanced agency is a central component, the implications for behavioral health are significant. Designing robust interventions that focus on building agency and actively working to shift mindsets should be a primary component of programs and interventions. It is vital to collect a dynamic knowledge base on how individuals in low-resource settings adapt, respond, and think about shifting scenarios in their personal lives and communities. Recent advances in technology and information exchange allow greater capacity to capture data on human behavior in diverse contexts in development. This can increase the ability to design programs that address human behavior in a meaningful way that is rooted in a population's own sense of meaning. Ultimately, creating processes and systems that foster agency-based empowerment at scale are critical to the future of development, and building the research and knowledge base towards this goal is imperative.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no competing interests.

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