EXPLORING PROGRAMMING AROUND HEALTH EQUITY, HEALTH SYSTEMS STRENGTHENING, AND SOCIAL AND BEHAVIOR CHANGE

(AND THEIR INTERSECTIONS)

FINDINGS FROM A SMALL ONLINE SURVEY

AUGUST 2024

The Health Systems Strengthening Accelerator (Accelerator) is a global health system strengthening initiative, funded by the United States Agency for International Development (USAID), with co-funding from the Bill & Melinda Gates Foundation that supports local partners as they find their own pathways to meaningful and lasting health systems change.

The Accelerator is led by Results for Development (R4D), with support from Health Strategy and Delivery Foundation (HSDF), headquartered in Nigeria, and ICF. Additional global, regional, and local partners will be selected in partnership with USAID/Office of Health Systems and USAID Missions based on demand.

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Disclaimer

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OVERVIEW OF THE ACCELERATOR PROJECT

The Health Systems Strengthening Accelerator is a global initiative funded by the United States Agency for International Development (USAID), with co-funding from the Bill & Melinda Gates Foundation. Its goal is to partner with countries to build resilient, high-performing health systems that respond to persistent and emerging health challenges that disproportionately impact vulnerable populations. The Accelerator contributes to USAID's strategy for achieving improved health equity, quality, and resource optimization by helping countries apply a whole-of-systems lens to intractable health systems issues, connecting local innovation and global knowledge, strengthening local ownership and processes, and building the institutional architecture needed to ensure lasting change.

CROSS-CUTTING CONCEPTS UNDER THE ACCELERATOR

Over the life of the project (2018-2024), the Accelerator team and USAID have been interested in questions around the role of social and behavior change (SBC) within health systems strengthening (HSS) and the intersection of health equity. Such focus aligns to the USAID Vision for Health System Strengthening 2030 and the companion Learning Agenda, which identify SBC and health equity as cross-cutting and critical to strengthening health systems and striving for high performing health systems.

To supplement this body of work, in FY 2023, the Accelerator established a set of research questions to learn more about existing USAID programming approaches around HSS, SBC, and health equity and their potential intersections, as follows:

- **Health Systems Strengthening (HSS):** A health system is defined as consisting of all people, institutions, resources, and activities whose primary purpose is to promote, restore, and maintain health. HSS comprises strategies, responses, and activities designed to sustainably improve country health system performance. USAID's operational definition of HSS draws the boundaries based on the intent of our efforts and resulting patterns of resource allocation.

- **Social and Behavior Change (SBC)** is a systematic, evidence-driven approach to improve and sustain changes in behaviors, norms, and the enabling environment. SBC interventions aim to affect key behaviors and social norms by addressing their individual, social, and structural determinants (factors). SBC is grounded in several disciplines, including systems thinking, strategic communication, marketing, psychology, anthropology, and behavioral economics.

- **Health Equity:** An equitable health system affords every individual a fair opportunity to attain their highest level of health regardless of social or demographic factors, with particular emphasis on underserved, socially exclude, and vulnerable populations (USAID Vision for HSS 2030)

- How do implementers conceptualize and define equity?
- To what extent do projects undertake self-reflection around health equity as a learning and/or programming refinement exercise? What types of rubrics have been used? What has been learned?
- In the context of individual projects, in what ways is a health equity lens informing HSS activities and vice versa? What is "equity" in relation to?
- How (if at all) do projects integrate SBC into HSS activities? Or vice versa, do SBC activities measure changes in HSS and/or health equity related outcomes?
- In what types of situations might a behavioral change goal or metric, and/or social and behavior change approaches help to advance health equity-focused work within a project?

APPROACH FOR THE ONLINE SURVEY

To explore the research questions, a small online survey was undertaken. The survey was designed using Google Forms and shared through multiple channels. Specifically, the survey link was shared via LinkedIn, listservs managed by The Core Group, and the Accelerator's communication channels and newsletters to reach participants actively involved in USAID programming. The survey remained open for about two months before responses were extracted to Excel for analysis. The survey questions are presented in Appendix A.

CHARACTERISTICS OF THE SURVEY RESPONDENTS

Across the 21 survey respondents, the following key characteristics were identified.

- 10 males and 11 females responded to the online survey
- The respondents represent 15 different organizations (2 respondents did not provide the name of their organization)
- 8 respondents indicated they are based in the US
- Outside of the US, there were respondents who indicated they are based in Canada (1), Cote d'Ivoire (1), Ethiopia (2), India (2), Indonesia (1), Malawi (1), Nepal (1), Nigeria (1), South Africa (1), and Turkey (1)
- Respondents were asked to select one technical area describing their work from a list of 13 options. The responses varied with reproductive health and family planning having the most responses (see figure 1)
- Respondents were asked to select one donor that is their organization's primary funder from a list of 8 options. USAID is the primary funder for the organizations the respondents indicated they represent (see figure 2)

FIGURE 1	Primary technical area of work for the respondents

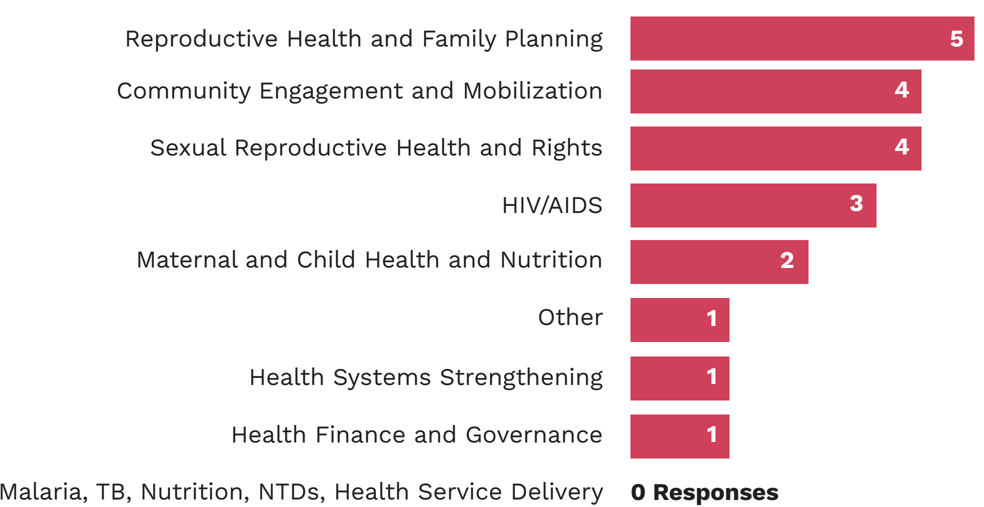
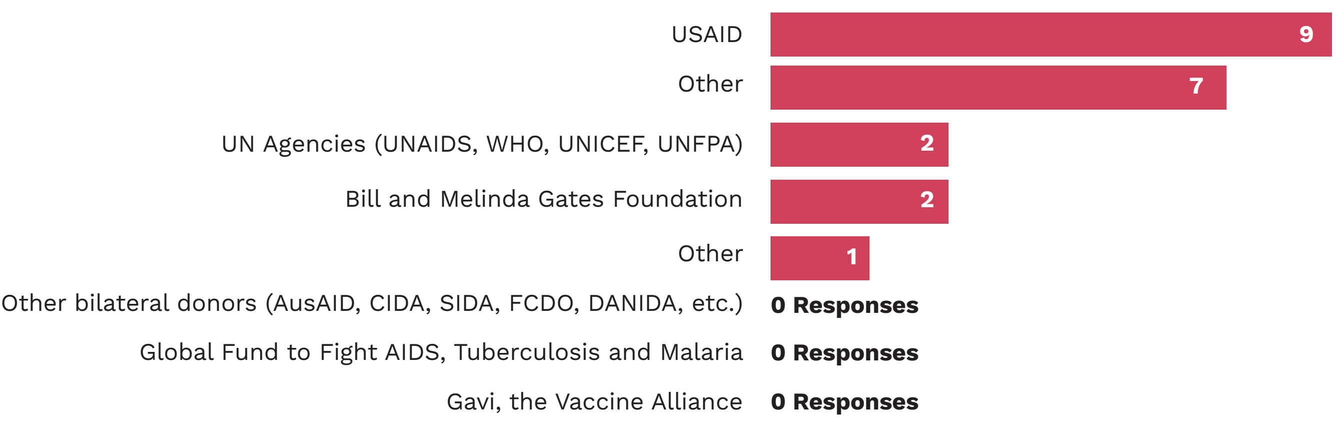


FIGURE 2	Primary donor funding respondents' organiz



FINDINGS FROM THE SURVEY

Integration of the Cross-cutting Concepts

The survey findings provide insights into the integration of health equity, HSS, and SBC into programming. Table 1 presents the respondents' perceptions of their project's integration of these concepts, on a scale from 1 (least) to 10 (greatest).

The following sections explore the interconnected concepts of health equity, HSS, and SBC, highlighting their roles in creating a more inclusive and effective healthcare landscape.

Health Equity: The average ranking for health equity integration (7.90), indicates a common focus on health equity. The distribution of rankings shows that the respondents ranked their projects highly, with most clusters at the higher end of the scale (i.e., 7 and above). 8 respondents ranked their project's integration of health equity at 8, and 5 indicated the highest ranking of 10. Lower rankings were rare, with only a few respondents ranking their focus on health equity at 5 or below. The higher rankings suggest a commitment to incorporating health equity into project activities and address disparities.

Health Systems Strengthening: The average ranking for HSS integration (7.81), reflects a commitment to strengthening health systems across the survey respondents. The rankings are generally high, with most of the respondents' entering rankings of 8, 9, and 10. Lower rankings (i.e., below 6) are less common, showing that while there is some variation, the overall trend leans towards more integration of HSS. This pattern indicates that the respondents' projects prioritize the integration of HSS to build and maintain resilient health systems and improve health outcomes.

Social and Behavior Change: Social and behavior change received the highest average ranking of 9.10 across the three concepts. The distribution of responses is heavily clustered towards the higher end of the scale, with 9 respondents giving a ranking of 10 and 8 respondents indicating a ranking of 9. Only one respondent provided a ranking of 5, and no respondents gave a ranking below this midpoint. These results suggest that respondents' projects recognize the essential role of SBC in influencing health behaviors and outcomes, making it a core component of their strategies.

Program Implementation Across Cross-Cutting Concepts

Table 2 summarizes the number of "Yes" and "No" responses to whether the respondents' project implements specific types of programming in relation to health equity, HSS and SBC.

TABLE 1 The extent respondents feel their project integrates focus on health systems strengthening, social and behavior change, and health equity

On a scale of 1 (least) to 10 (greatest), to what extent does your project integrate focus on ______		Number of responses of each ranking									
	Average Ranking	1	2	3	4	5	6	7	8	9	10
Health Equity	7.90	0	2	0	0	1	0	3	8	2	5
Health Systems Strengthening (HSS)	7.81	0	1	1	1	0	1	2	5	5	5
Social and Behavior Change (SBC)	9.10	0	0	0	0	1	0	0	3	8	9

TABLE 2	Program Implementation in Health Equity, Health Systems Strengthening, and Social and Behavior Change	
	YES	NO
Health Equity: Does your project implement programming to increase health equity in relation to these demographics and opportunities?		
Gender and social norms	21	0
Access to public health services	20	1
Geography / place residence	17	4
Age	16	5
Participation in citizen-led initiatives and advocacy groups	16	5
Socio-economic / employment situation	11	10
Mental Health & Psycho-social or emotional disabilities	11	10
Physical disabilities	10	11
Religion/caste/ethnicity	9	12
Health Systems Strengthening: Does your project implement health system strengthening programming in these areas?		
Manage the adoption of strategies and solutions to operationalize and implement change	18	3
Support to the health workforce, including mobile and community-based service provision	17	4
Health service delivery quality improvement and quality assurances procedures	16	5
Capacity building for Government and Ministry staff at national and subnational levels	15	6
Policy reviews and reform, including financing and universal health coverage (UHC)	11	10
Standardized use of and interoperability of health information systems	11	10
Improve commodity availability and supply chain management	11	10
Empower and engage communities to improve social accountability	11	10
Generate learning and evidence to diagnose problems and formulate solutions	11	10
Social and Behavior Change: Does your project implement social and behavior change (SBC) programming in these areas?		
SBC targeted to specific populations (i.e., women, men, youth, vulnerable groups, etc.)	20	1
SBC in relation to specific health topics (i.e., HIV/AIDS, malaria, nutrition, etc.)	20	1
SBC for civil society actors and advocates	18	3
SBC for health service providers working in facilities and/or via mobile or community-based work	17	4
SBC as part of social accountability (i.e., budget advocacy, community radio, community scorecards, etc.)	17	4
SBC for health facility leadership and management	13	8
SBC for ministry and other government staff	12	9
SBC in relation to efforts to advance universal health coverage (UHC)	12	9
SBC as part of introducing health financing schemes and financial protection initiatives	7	14

The findings suggest varying levels of implementation, showcasing where efforts are concentrated and where additional focus may be needed to enhance the cross-cutting concepts. The first part of Table 2 focuses on health equity across specific demographics. Some of the key points include:

- All respondents report that their project implements programming to increase health equity in relation to gender and social norms, indicating commitment to addressing systemic barriers. The inclusion of programming in this area underscores recognition of the impact of gender and social norms on health disparities and the importance of focusing on these issues to achieve equitable health outcomes.
- All but one respondent reports that their project implements programming to increase health equity in relation to access to public health services. This focus potentially reflects a prioritization of access to services in promoting health equity across various communities.
- Physical disabilities (n = 10) and religion, caste, and ethnicity (n = 9) are less emphasized areas of focus for the respondents, potentially indicating a need for increased focus and resources to integrate programming that can address the unique challenges faced by these populations. By prioritizing these areas, projects can work towards a more inclusive approach, ensuring that health equity initiatives are comprehensive and benefit all demographic groups equitably.

The second part of Table 2 focuses on HSS. Some of the key points include:

- Across the 9 options for HSS programming areas, the most frequently selected was "The adoption of strategies and solutions to operationalize and implement change" (n = 18). Pursuing programming of this type suggests that respondents' projects are initiating and executing new strategies and driving organizational change and implementing innovative solutions.
- A high number of respondents selected "Support to the health workforce, including mobile and community-based service provision" (n = 17), "Health service delivery quality improvement and quality assurances procedures" (n = 16), and "Capacity building for Government and Ministry staff at national and subnational levels" (n = 15). Programming in these areas suggests focus on supporting healthcare professionals and government coordination are common as part of striving to provide quality service delivery and healthcare reach.
- Across the 9 options for HSS programming areas, 5 of the options had 10 "No" responses (out of 21 respondents). These were:
    - Policy reviews and reform, including financing and universal health coverage (UHC)
    - Standardized use and interoperability of health information systems
    - Improving commodity availability and supply chain management
    - Empowering and engaging communities to improve social accountability
    - Generating learning and evidence to diagnose problems and formulate solutions

The response of "No" is seemingly indicating that this type of HSS programming is not undertaken. The reasons for not implementing these types of programming cannot be gleaned from this survey question, but possibly could be in relation to systemic challenges, including insufficient policy frameworks, fragmented health information systems, logistical and supply chain inefficiencies, limited community involvement, and/or inadequate mechanisms for data-driven decision-making. Addressing these weaknesses could be essential for a more resilient health system capable of delivering comprehensive and effective healthcare services.

The third part of Table 2 focuses on SBC. Some of the key points include:

- Twenty respondents (out of 21) indicated their project implements programming in relation to "Specific populations (i.e., women, men, youth, vulnerable groups, etc.)" and "Health topics (i.e., HIV/AIDS, malaria, nutrition, etc.)." The high number of responses suggests recognition of the importance of tailoring SBC efforts to specific populations and specific health areas.
- Only 7 out of 21 respondents reported that their projects implement "SBC in health financing schemes and financial protection initiatives." The low number of "Yes" responses suggests a possible gap in addressing financial barriers to health care which could amplify individuals' financial limitations and prevent them from seeking and receiving necessary health services.
- There is a low number of "Yes" for use of SBC approaches among health facility leaders (13 out of 21) and government staff (12 out of 21). The lack of SBC use here potentially impacts the effectiveness of health interventions, as these health system actors are influential in the healthcare system and play a critical role in shaping health policies and procedures.

Challenges Relating to the Cross-cutting Concepts

Programming around health equity, HSS, and SBC is fundamental for improving health outcomes. However, some challenges exist particularly given diversity in relation to population demographics and socio-economic contexts. This section presents some of the challenges mentioned by the respondents in response to several open-ended questions. Many of the challenges are interconnected with barriers to equitable healthcare access, systemic and structural difficulties within health systems, and the myriads of factors that influence social norms and health practices.

Health Equity: The health equity challenges highlighted by respondents encompass a range of issues affecting diverse groups. Key challenges identified by the respondents as limiting access to care included geographic remoteness, economic disparities, and disabilities, while gender norms were mentioned as sometimes the root cause of barriers for men and women. Several respondents noted that specific demographic groups, including mothers, children, adolescents, sex workers, and prison populations, face unique challenges in obtaining affordable and public healthcare. Further, it was noted by several respondents that fragile settings and short funding cycles inhibit long-term solutions.

Health Systems Strengthening: The challenges for HSS programming mentioned by the respondents ranged from inequitable access to care among marginalized populations, leadership and governance issues, health worker turnover, and systemic problems such as stockouts and lack of infrastructure. Additionally, the respondents commonly reported that financing for community health remains inadequate and further, the unpredictable nature of weak health systems and insufficient training for health workers add to the complexity of addressing these challenges comprehensively.

Social and Behavior Change: The respondents mentioned numerous challenges with SBC programming. Key challenges included an inconsistent understanding of SBC concepts among decision makers, insufficient understanding of the factors influencing behavior change, and failure to design solutions that address behavior change barriers. Several respondents noted that implementers often struggle with incorporating cost-effective digital solutions and ensuring their sustainable deployment. These challenges are exacerbated by sometimes focusing only on either supply or demand rather than a holistic approach. Short programming cycles also hinder meaningful impact as change in behavior requires time monitoring.

Programming Examples Relating to the Cross-cutting Concepts

This section explores programming examples described by the respondents in relation to health equity, HSS, and SBC. Across many of the examples, the commitment to overcome systemic barriers and foster sustainable health improvements across different populations is evident.

Health Equity: Health equity programming involves creating and implementing initiatives that aim to reduce health disparities and ensure that everyone has fair access to health care, regardless of their socioeconomic, social and demographic factors status, race, ethnicity, or other factors. The health equity programming examples highlighted by the respondents relate to several different health equity challenges and their efforts in addressing them. For example, TB prevention programming was described in terms of targeted focus in areas with limited access to TB services while the maternal health programs highlighted the approach of focusing on regions with high maternal and infant mortality rates, low access to MHN care and social inclusion issues. Other health equity programming examples reported by the respondents included knowledge dissemination events to increase access to health services, advocating for community engagement and the integration of marginalized groups in policy development, and developing interventions and clinic-based models of care tailored for various patient groups throughout clinics. In response to a question about if their views and approaches toward health equity have changed over time, most respondents noted that their views and approaches towards health equity have been consistent over time. However, the respondents again mentioned challenges that exist in striving for health equity, notably in relation to persistent social norms and biases.

Health Systems Strengthening: The HSS programming examples described by the respondents included focus on vulnerable populations such as former sex workers and trafficking victims through improved patient-provider relationships and enhancing pharmacy services. Several respondents mentioned the importance of person-centered care as integral to shift provider mindsets and improve care quality.

Regarding whether views and approaches toward HSS have changed, several respondents mentioned that they have shifted to a more strategic and policy-driven approach. Others referenced expanding their focus to include digital health systems shaping beyond consumer engagement, changing from a top-down HSS approach to one that is responsive to the needs of individual providers and clinic teams.

Social and Behavior Change: The respondents described several specific SBC programming examples, including community radio to target health issues and engaging community cadres to improve maternal and neonatal health. In addition, the respondents mentioned the use of advanced health information systems to streamline patient care and data retrieval, social marketing to enhance product availability and demand, integrating SBC indicators into government systems, and using more interactive activities for engagement.

Many respondents noted that over time they gained an increased appreciation for SBC, recognizing its role as a key element in health programming and its potential to generate concrete results. However, the respondents also noted that challenges persist, such as inadequate funding, outdated perceptions of the importance of SBC work, over-reliance on only clinical work, and systemic barriers that go beyond SBC interventions.

Nexus of the Cross-cutting Concepts

Across the survey data, the responses to open-ended question point to the interconnectedness of health equity and HSS. For example, many of the respondents noted the inequity of access to health services among those with disabilities and social exclusions, highlighting how HSS efforts aim to address these disparities by ensuring supply chains for vulnerable groups and balancing specialized care with sustainable, integrated models. Other interconnections that respondents highlighted included how health equity drives HSS priorities by identifying who is left behind and why as part of striving for UHC. This grounds HSS programming in inclusive services, equitable healthcare professional distribution, and robust health information systems with the vision that they contribute to health equity.

Similarly, HSS and SBC are interconnected, as they both aim to enhance health outcomes by addressing systemic and behavioral factors. Examples of this interconnection that can be gleaned from the survey responses include advocating for improved access to care through community leaders, supporting leadership behavior change, and encouraging providers to have empathetic dialogues with clients.

HSS efforts to enhance health infrastructure and service delivery are complemented by SBC initiatives promoting patient adherence to medical advice. The vision described by the respondents is that together, HSS and SBC, create an environment where systemic improvements and behavior changes lead to better health outcomes.

CONCLUSIONS & RECOMMENDATIONS

The survey responses indicate that health equity, HSS, and SBC intersect in numerous ways. Among respondents, there is a recognized need to integrate these cross-cutting concepts as part of ensuring that strengthened health systems support equitable access to care, while informed SBC leads to sustainable and inclusive health improvements for all. The recommendations aim to provide insights on how to address the complex challenges.

HEALTH EQUITY

Expand Programming for Underserved Populations

- To increase health equity, it is important to develop targeted interventions for marginalized groups. Increasing the focus on programming for individuals with physical disabilities and those from diverse religious, caste, and ethnic backgrounds is essential to address existing gaps. By tailoring these efforts, programming can create a more inclusive health system that recognizes and responds to the unique needs of all community members.

Enhance Data Collection and Analysis

- To effectively address health disparities, it is necessary that programming includes thorough processes for collecting and analyzing data. This data should inform targeted interventions and identify and break down systemic barriers. These efforts will enable healthcare systems to be more inclusive and responsive to the needs of all populations, particularly those who are underserved or vulnerable.

HEALTH SYSTEMS STRENGTHENING

Strengthen Policy and Governance

- To create an enabling environment for HSS, it is pivotal to advocate for policy reviews and reforms, including health financing and UHC. These reforms will help build a supportive framework necessary for the effective implementation of HSS initiatives. Additionally, supporting government and ministry staff at both national and subnational levels through targeted capacity strengthening initiatives will enhance their ability to manage and sustain health systems improvements. This approach ensures that the structural and operational aspects of health systems are strengthened to provide better health outcomes for all.

Community Empowerment and Social Accountability

- To enhance social accountability and transparency in health systems, it is recommended to empower and engage communities through initiatives like community scorecards and budget advocacy. Additionally, fostering community participation in health system governance is essential to ensure transparency and responsiveness. These strategies are pivotal for building trust and encouraging active involvement in health-related decision-making processes, ultimately leading to more equitable and effective health outcomes.

SOCIAL AND BEHAVIOR CHANGE

Prioritize SBC in Government Agendas

- To ensure improvement and accountability in SBC initiatives, it is essential to advocate for the inclusion of SBC in government health agendas. Engaging with policymakers to highlight the importance of SBC in achieving health outcomes will foster a supportive policy environment, secure funding, and ensure that SBC strategies are integrated into national health programs.

Increase Funding and Resources for SBC

- To address financial barriers to healthcare access, it is necessary to integrate SBC with health financing schemes and financial protection initiatives. Advocating for increased funding and resource allocation for SBC initiatives will help create a more equitable healthcare system by reducing financial obstacles and promoting effective behavioral changes.

FURTHER RESEARCH AND LEARNING

- The low number of survey respondents must be factored into interpretation of the findings, particularly in consideration of the volume and diversity of people and organizations that are involved in global health programs. That consideration, however, should not take away from the insightful comments a small set of people provided in responding to the survey. Additional work to obtain more responses to the questions in the survey and other similar questions would provide important and useful information. Interest in health equity and SBC and their interconnections to HSS has gained considerable momentum over the last few years. Increased understanding, documentation of lessons, and guidance, particularly from organizations that implement health projects, will be invaluable as part of efforts to improve the effectiveness of health systems and ensure that health interventions are appropriately tailored to the needs of the populations they serve, ultimately improving health outcomes.

APPENDIX A: ONLINE SURVEY QUESTIONS

Global Health Programming: Integrating Health Equity, HSS and SBC

BACKGROUND

This inquiry is organized by the Health Systems Strengthening Accelerator (Accelerator), a six-year (2018-2024) global health systems strengthening (HSS) initiative funded by the US Agency for International Development (USAID) with co-funding from the Bill & Melinda Gates Foundation.

We are seeking inputs from organizations involved in the implementation of USAID-funded health projects. Our aim is to learn more about programming approaches around health equity, HSS, SBC and their potential interconnections.

THANK YOU FOR YOUR INPUT

Providing input will take about 15-20 minutes. Please move through each section and click submit at the end. We are very grateful for your willingness to contribute.

Please feel free to share the link to this form with others who are involved in USAID-funded health projects.

HOW THE FINDINGS FROM THIS SURVEY WILL BE SHARED AND USED

The findings from this inquiry will be summarized in a learning brief that identifies implementation considerations for HSS programming that integrates health equity and SBC.

Please note that your responses are anonymous. Please do not write your name anywhere within the form.

Best Regards.

Susan Pietrzyk, Senior Researcher
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PART 1 RESPONDENT INFORMATION

Q1. What organization do you work for?

Q2. What is your title?

Q3. What country are you based in?

Q4. What sex were you assigned at birth, on your original birth certificate?

1. Female
2. Male

Q5. What is your current gender?

1. Female
2. Male
3. Transgender
4. Don't know
5. Prefer not to answer

Q6. Please indicate the project you spend most of your time working on, including the country (ies) where the work takes place.

Q7. What is the primary technical area of your work (select just one)?

1. HIV/AIDS
2. Malaria
3. Tuberculosis
4. Nutrition
5. WASH
6. Neglected Tropical Diseases
7. Maternal and Child Health and Nutrition
8. Reproductive Health and Family Planning
9. Sexual and Reproductive Health and Rights
10. Community Engagement and Mobilization
11. Health Systems Strengthening
12. Health Finance and Governance
13. Health Service Delivery
14. Other

Q8. Who is the primary donor that funds your organization?

1. USAID
2. Other bilateral donors (AusAID, CIDA, SIDA, FCDO, DANIDA, etc.)
3. United Nations Agencies (UNAIDS, WHO, UNFPA, UNICEF, etc.)
4. Bill and Melinda Gates Foundation
5. Global Fund to Fight AIDS, Tuberculosis and Malaria
6. Gavi, the Vaccine Alliance
7. Other Foundations
8. Other

PART 2 HEALTH EQUITY

In this section of the survey, we are interested to learn more about the health equity challenges and programming approaches in your country and project context. For the purposes of this survey health equity is defined as follows:

Health Equity: An equitable health system affords every individual a fair opportunity to attain their highest level of health regardless of social or demographic factors, with particular emphasis on underserved, socially exclude, and vulnerable populations (USAID Vision for HSS 2030)

Q1. On a scale of 1 (least) to 10 (greatest), to what extent does your project integrate focus on health equity?

1 2 3 4 5 6 7
8 9 10

Q2. Does your project implement programming to increase health equity in relation to these demographics and opportunities?

Q2A. Gender and social norms

1. Yes; 2. No

Q2B. Socio-economic / employment situation

1. Yes; 2. No

Q2C. Geography / place residence

1. Yes; 2. No

Q2D. Age

1. Yes; 2. No

Q2E. Religion/caste/ethnicity

1. Yes; 2. No

Q2F. Physical disabilities

1. Yes; 2. No

Q2G. Mental health and psycho-social or emotional disabilities

1. Yes; 2. No

Q2H. Access to public health services

1. Yes; 2. No

Q2I. Participation in citizen-led initiatives and advocacy groups

1. Yes; 2. No

Q3. Please describe the health equity challenges that are most prominent in your country/project context?

Q4. Can you provide examples of the specific programming that your project has implemented to address the health equity challenges in your country/project context?

Q5. Within your country/project context have the team's views and approaches toward health equity changed? Please explain what change has occurred and what prompted the change.

PART 3 HEALTH SYSTEMS STRENGTHENING

In this section of the survey, we are interested to learn more about the health systems strengthening (HSS) challenges and programming approaches in your country and project context. For the purposes of this survey HSS is defined as follows:

Health Systems Strengthening (HSS): A health system is defined as consisting of all people, institutions, resources, and activities whose primary purpose is to promote, restore, and maintain health. HSS comprises the strategies, responses, and activities that are designed to sustainably improve country health system performance. USAID's operational definition of HSS draws the boundaries based on the intent of our efforts and resulting patterns of resource allocation.

Q1. On a scale of 1 (least) to 10 (greatest), to what extent does your project integrate focus on health systems strengthening (HSS)?

1 2 3 4 5 6 7
8 9 10

Q2. Does your project implement health system strengthening programming in these areas?

Q2A. Capacity building for Government and Ministry staff at national and subnational levels

1. Yes; 2. No

Q2B. Support to the health workforce, including mobile and community-based service provision

1. Yes; 2. No

Q2C. Health service delivery quality improvement and quality assurances procedures

1. Yes; 2. No

Q2D. Policy review and reform, including financing and universal health coverage (UHC)

1. Yes; 2. No

Q2E. Standardized use of and interoperability of health information systems

1. Yes; 2. No

Q2F. Improve commodity availability and supply chain management

1. Yes; 2. No

Q2G. Empower and engage communities to improve social accountability

1. Yes; 2. No

Q2H. Generate learning and evidence to diagnose problems and formulate solutions

1. Yes; 2. No

Q2I. Manage the adoption of strategies and solutions to operationalize and implement change

1. Yes; 2. No

Q3. Please describe the health systems strengthening (HSS) challenges that are most prominent in your country/project context?

Q4. Can you provide examples of the specific programming that your project has implemented to address the health systems strengthening (HSS) challenges in your country/project context?

Q5. Within your country/project context have the team's views and approaches toward health systems strengthening (HSS) changed? Please explain what change has occurred and what prompted the change.

PART 4 SOCIAL AND BEHAVIOR CHANGE

In this section of the survey, we are interested to learn more about the social and behavior change (SBC) challenges and programming approaches in your country and project context. For the purposes of this survey SBC is defined as follows:

Social and Behavior Change (SBC) is a systematic, evidence-driven approach to improve and sustain changes in behaviors, norms, and the enabling environment. SBC interventions aim to affect key behaviors and social norms by addressing their individual, social, and structural determinants (factors). SBC is grounded in several disciplines, including systems thinking, strategic communication, marketing, psychology, anthropology, and behavioral economics.

Q1. On a scale of 1 (least) to 10 (greatest), to what extent does your project integrate focus on social and behavior change (SBC)?

1 2 3 4 5 6 7
8 9 10

Q2. Does your project implement social and behavior change (SBC) programming in these areas?

Q2A. SBC targeted to specific populations (i.e., women, men, youth, vulnerable groups, etc.)

1. Yes; 2. No

Q2B. SBC in relation to specific health topics (i.e., HIV/AIDS, malaria, nutrition, etc.)

1. Yes; 2. No

Q2C. SBC for health service providers working in facilities and/or via mobile or community-based work

1. Yes; 2. No

Q2D. SBC for health facility leadership and management

1. Yes; 2. No

Q2E. SBC for ministry and other government staff

1. Yes; 2. No

Q2F. SBC for civil society actors and advocates

1. Yes; 2. No

Q2G. SBC as part of introducing health financing schemes and financial protection initiatives

1. Yes; 2. No

Q2H. SBC in relation to efforts to advance universal health coverage (UHC)

1. Yes; 2. No

Q2I. SBC as part of social accountability (i.e., budget advocacy, community radio, community scorecards, etc.)

1. Yes; 2. No

Q3. Please describe the social and behavior change (SBC) challenges that are most prominent in your country/project context?

Q4. Can you provide examples of the specific programming that your project has implemented to address the social and behavior change (SBC) challenges in your country/project context?

Q5. Within your country/project context have the team's views and approaches toward social and behavior change (SBC) changed? Please explain what change has occurred and what prompted the change.

PART 5 THE NEXUS OF HEALTH EQUITY-HSS-SBC

In this last section of the survey, we are interested to learn more about any connections that you see between health equity, health systems strengthening (HSS) and social and behavior change (SBC).

Q1. When you think of what a global health project ought to include, do you think that health equity, health systems strengthening (HSS), and social and behavior change (SBC) overlap and are interrelated?

1. Yes
2. No

Q2. What examples come to mind of how health equity and health systems strengthening (HSS) are related?

Q3. What examples come to mind of how health systems strengthening (HSS) and social and behavior change (SBC) are related?

Q4. Please share any additional thoughts you have about how your project approaches health equity, health systems strengthening (HSS), and social and behavior change (SBC).

If you know of colleagues in your country working in the health field who might like to complete this survey, please feel free to forward the link or share your suggestions in the reply below. Also, feel free to contact Susan Pietrzyk (susan.pietrzyk@icf.com) with your suggestions.

THANKS FOR COMPLETING THE SURVEY.

WE GREATLY APPRECIATE YOUR TIME AND YOUR INISGHTS. WE LOOK FORWARD TO SHARING THE RESULTS OF OUR FINDINGS.

Contact Information

USAID

USAID missions and country representatives interested in buying into the Accelerator project should contact Jodi Charles, USAID Agreement Officer's Representative, at jcharles@usaid.gov.

Accelerator

Other interested parties should contact Nathan Blanchet, Accelerator Project Director, at nblanchet@r4d.org.

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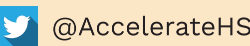
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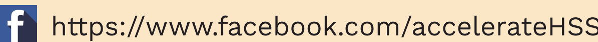
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