EVIDENCE TO SUPPORT DONOR AND GOVERNMENT DECISION-MAKING

Intentionally Incorporating the Social Determinants of Health into Social and Behavior Change Programming for Family Planning

A Technical Report

USAID
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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

Acknowledgments

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Table of Contents

Acronyms

FP/RH	Family planning and reproductive health
HIP	High impact practices
SBC	Social and behavior change
SDOH	Social determinants of health
USAID	United States Agency for International Development
WHO	World Health Organization

Purpose

The field of social and behavior change (SBC) recognizes that factors beyond the biomedical model of health affect health and well-being at individual, household, community, and societal levels. However, to date, SBC interventions in family planning and reproductive health (FP/RH) have primarily focused on identifying and shifting behaviors in individuals, groups, and communities; therefore, SBC programs too often overlook the root causes of health disparities related to FP/RH and how SBC approaches can and should be used to address them.[*,1]

The purposes of this brief are to (1) synthesize what is known about addressing the social determinants of health (SDOH) inequities in FP/RH; (2) propose considerations for future SBC programming to address the SDOH inequities in FP/RH based on the existing evidence; and (3) identify implementation research gaps that should be explored to support the use of SBC to address inequities in FP/RH that result from the SDOH.

This document provides evidence to guide strategic decision-making among donors and governments in support of SBC initiatives to reduce inequities in FP/RH. Though the brief focuses on examples from the field of FP/RH, its content is broadly applicable to SBC across all health and development areas. Breakthrough ACTION developed this brief alongside a programmatic tool with practical guidance for SBC practitioners. This resource contributes to work under the "supporting social change in family planning" priority in the Global Shared Agenda for SBC in Family Planning. Social change includes normative dimensions, policy and structural factors, and social accountability approaches enabling communities to hold health providers, services, and governments accountable for their performance.

* *While relevant programs have paid increased attention to normative dimensions (e.g., Social Norms Learning Collaborative and the Passages Project), policy, structural factors, and social accountability approaches have been explored to a far lesser extent.*

Background

In the late 20th century, practitioners and scholars in the field of health promotion recognized that individual health behaviors are influenced by the context in which people live. Therefore, they suggested combined public health approaches that address individual as well as macro-level social and structural determinants of health.[5] A number of models and frameworks have been developed to help expand on this approach, including the World Health Organization Commission on Social Determinants of Health Framework,[6] the Healthy People 2030 Framework,[7] and Frieden's Health Impact Pyramid.[8] SDOH impact several FP/RH indicators, including unintended pregnancy; women from disadvantaged circumstances are both more likely to experience an unintended pregnancy and face more severe consequences as a result when compared to more advantaged women.[9] Further, youth experiencing social inequity have a higher unmet need for contraception due to economic, cultural, social, religious, logistical, and legal constraints that limit their access to safe, affordable contraceptives.[10]

Key Terms

Equity in health "implies that ideally, everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided."[2]

Health equity is the principle or goal that motivates efforts to eliminate disparities in health between groups of people who are economically or socially worse-off versus their better-off counterparts, such as different racial/ethnic or socioeconomic groups or groups defined by disability status, sexual orientation, or gender identity. Those striving to improve health equity make special efforts to improve the health of those who are economically or socially disadvantaged.[3]

Inequity has a "moral and ethical dimension" and refers to differences which are unnecessary, avoidable, unfair, and unjust.[2]

Social determinants of health are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems."[4]

Unequal and harmful gender norms impact the health behaviors and outcomes of all individuals—including men, boys, and non-binary people of all ages—by limiting access to comprehensive FP/RH services and care.

Most effective SBC frameworks and process models already aim to include and review many social determinants affecting FP/RH and other health behaviors.[11–15] Despite these and other efforts to call attention to the deep structural barriers that impede health, the field of SBC is often drawn back to focus on the individual and must do more to address these determinants where possible.

Addressing The Social Determinants of Health to Improve Equity in Family Planning: Considerations and Promising Practices

Breakthrough ACTION conducted a rapid literature review to synthesize key considerations and promising practices for designing SBC interventions that address the SDOH to reduce inequities in FP/RH. Many of the considerations, however, are broadly applicable beyond the fields of family planning and SBC. Several promising approaches for reducing inequities in FP/RH programming have been documented, though more evidence is needed. The following synthesis of available evidence to date, however, can be used to inform future policy, funding, and programming decisions.

Broad Considerations

As funders and decision-makers continue to incorporate an equity lens into their programming and effectively address policy and structural factors, several considerations may help guide planning. The FP/RH community must start by looking beyond access to reproductive health services and identify gaps in areas such as poverty, education, childcare, housing, business, law, media, community planning, transportation, and agriculture. The current evidence suggests the following to guide thinking in this area:

Require SBC programs to provide evidence of meaningful partnership with communities in all aspects of SBC program design, implementation, and evaluation to ensure that project activities are driven by community needs and values. FP/RH program funders and decision-makers must ensure that the organizations they fund systematically and intentionally apply ethical thinking and actions in their work, guided by community needs and values and the

goal of reducing health disparities. This process must entail understanding community power structures, so as not to exacerbate inequalities, and forming meaningful and equitable partnerships with the communities in which they work. This involves taking an asset-based approach and sharing decision-making authority with community partners throughout the lifecycle of a project.[1,16] Incorporating values that expand the design of interventions, such as inclusiveness, openness, reasonableness, responsiveness, and responsibleness, may allow for greater consideration of the complexity involved.

Explore long-term, multi-sectoral and co-funded partnerships to address the social determinants of FP/RH inequities more effectively. Addressing the social determinants of FP/RH inequities will require more time, resources, and multi-sectoral collaboration relative to interventions that address the individual and interpersonal predictors of health. Donors, government decision-makers, and the SBC practitioners they fund must collaborate with sectors beyond health to identify how their programs, practices, and policies affect the health of individuals, families, and communities. They will also need to formulate complementary goals and roles and maximize opportunities for collaboration among country, district, and community-level actors. Action on the SDOH must involve government, civil society, and local communities, business, global fora, international agencies, and all key sectors of society.[17] Funders and decision-makers can also consider cross-sector co-financing, which increases the chance that structural interventions are prioritized and implemented effectively.[18] Through cross-sectoral coordination, structural approaches could be prioritized when a commitment to cooperation exists and evidence of impact across sectors is measured through robust data collection.[18]

Prioritize SBC interventions that address the structural and intermediary determinants of FP/RH outcomes. Structural and intermediary determinants contribute to intersectional marginalization and inequitable health outcomes. For example, a review of 59 studies in Nepal found that several structural determinants facilitated the use of maternity services, including household wealth, higher educational status of women and their husbands, and accessible health facilities. Intermediary variables such as delayed care-seeking, distance to facilities, and poor roads also played a role. While many of the programs reviewed were effective at improving overall coverage of services, advantaged groups benefited more.[19] Local-level governments and SBC practitioners need to actively address structural and intermediary determinants while designing health and other sectoral policies. Combining demand-side interventions with those on the supply-side ensures close coordination so that everyone has access to quality services.

Ensure FP/RH programs provide equitable coverage of FP/RH products and services. Equitable distribution and coverage of interventions are essential considerations for reducing inequities. An analysis across 36 low- and middle-income countries found that most interventions had higher coverage among the wealthy in most countries, with a handful of

exceptions. Interventions delivered at community level are usually more equitably distributed than those primarily delivered in fixed facilities.[20] Policymakers and SBC practitioners must learn from the successes of community-based interventions to scale and adapt these strategies towards reducing inequalities in the coverage of the coverage of SBC interventions, health facility-based, and culturally-driven interventions. Further, the dimensions of service accessibility—approachability, acceptability, availability and accommodation, affordability, and appropriateness—influence one another and must be considered to ascertain whether and how service accessibility varies between subgroups.[21] For example, an unmarried woman may not be counseled on contraceptive options if her provider assumes that she will not be sexually active until she is married. Promoting positive provider behaviors to improve the client-provider interaction and quality of care can in turn support voluntary FP use and equitable access to FP/RH services.[9]

Require gender integration throughout the project life cycle. Structured gender inequality and its forms are interconnected, meaning that "changing one aspect of gender inequality can have unintentional effects on other forms of gender inequality," and gender norms may not progress towards equality in a linear fashion over time.[22] For example, "adolescent girls' and women's economic participation is hampered by gender norms related to early marriage and child bearing and raising roles."[10] SBC interventions should aim to reduce gender inequality through gender transformative interventions, while being mindful of power dynamics.

Incorporate a life-course perspective into FP/RH program strategies and portfolios. As individuals' and couples' contraceptive needs change over time, so do the strength and weight of the determinants of contraceptive use. For example, the social factors that shape vulnerability for an adolescent woman are likely different than that for an older, married woman. Funders and decision-makers should consider how FP/RH needs may vary across the life course and ensure that funded FP/RH programs are addressing the social determinants of contraceptive use across the lifespan, as well as the potential for the accumulation of injustices[23] that may impact a person's ability to use the contraceptive method of their choice. If a woman has lived in chronically stressful conditions, as had the generations before her, with life experiences that exacerbated her vulnerability, she may neither have the same amount of support to consider using a contraceptive method nor the agency to seek FP/RH services.

Encourage community-based participatory approaches to address community-level determinants of FP/RH outcomes. Community characteristics can influence unmet need and birth spacing behaviors. Analyses from 44 Demographic and Health Surveys demonstrate that community-level factors—including gender norms, poverty/wealth, employment, health knowledge, and media exposure—

lead to social pressure that influences unmet need and birth spacing behaviors.[24] To address these determinants and improve equity, practitioners should consider community-based participatory approaches that build from the strengths and resources of the community and offer "meaningful opportunities to work in partnership," including equitable engagement, decision-making, and co-design of interventions between practitioners and community members.[25] A human-centered design approach that incorporates a true co-design process and active participation of end users is but one method to prioritize.[26]

Strengthen national and global health equity surveillance systems to monitor FP/RH and other health inequities. Measurement is vital to evaluate action and raise public awareness. Governments and international organizations should set up national and global health equity surveillance systems for routine monitoring of health inequity and the SDOH. They also should evaluate the health equity impact of policy and action. This requires a stronger focus on social determinants in public health research overall.[17] Further, the SBC community should include a spectrum of factors rather than any single measure to assess inequities and to monitor unintended intervention effects that may increase inequities and/or overly advantage some over others.[27] While equity can be complex and multifaceted, reducing equity into discrete parts for measurement purposes is a necessity for health impact assessments.[28] Further exploration into how such measures may be applied within SBC programs focused on reproductive health is needed.

Use an intersectional gender lens to analyze and address the SDOH that disadvantage specific subgroups. The literature frequently referenced specific considerations for addressing the SDOH that negatively and disproportionately affect the health of women and girls, particularly those experiencing poverty. Gender inequality is a result of power relations that structure how societies are organized, laws are set, and economies function.[29] For example, the intersection of gender norms, economic and educational inequality, and other social determinants lead to poorer health outcomes for adolescent girls, who, compared to boys, tend to receive less education and information about sexuality and reproduction, have poorer access to health services, and be at higher risk of unsafe sex. A study analyzing trends across 74 countries found that each extra year of education expected for girls is linked to a four to seven percentage point increase in modern contraceptive use.[30] Partnerships across sectors (i.e., education or agriculture), therefore, are essential to

address the SDOH, like years of education, that impact contraceptive uptake among adolescents and create and sustain positive change.[22]

Reproductive health and employment are inextricably linked for women, as planned and unplanned pregnancies and childbearing impact a woman's ability to pursue economic opportunities. Case studies from Brazil, Paraguay, Uruguay, South Africa, the Philippines, and Vietnam demonstrate that investments in education and FP/RH with subsequent investment in social protection and labor institutions have increased the supply of better jobs resulting in more women entering the labor force.[31] Therefore, policies that address FP/RH needs, strengthen labor market institutions, and provide social protection can allow women greater control over their fertility, including the healthy timing and spacing of births. Advocacy for such government policies may be another avenue to pursue to create a more enabling environment for free and informed choice.

To ensure interventions are reaching those most in need, donors and decision-makers should ensure SBC programs consider social determinants through a lens of intersectionality and examine how various forms of discrimination based on race, gender, sexuality, class, and other social identities overlap to create and reinforce unequal power dynamics and FP/RH outcomes between subgroups. A 2021 High Impact Practices in Family Planning paper identifies three categories of characteristics that may be associated with inequitable FP/RH outcomes (see Table 1).

Table 1

Categories of characteristics potentially related to inequitable family planning outcomes

Economic	Wealth, poverty, income stability, employment, occupation
Social	Age, race, ethnicity, caste, sex assigned at birth, gender identity, sexual orientation, religion, nationality, language, education, disability, social and gender norms
Environmental	Geographic location (urban/rural, distance from health services), humanitarian setting

Source: *Reproduced from High Impact Practices in Family Planning (HIP). (2021). Creating equitable access to high-quality family planning information and services: A strategic planning guide. Washington, DC.* https://www.fphighimpactpractices.org/guides/creating-equitable-access-to-high-quality-family-planning-information-and-services/

Promising SBC Approaches and Tools in FP/RH

The examples below, documented largely from peer reviewed literature, are a starting point for further exploration into the range of potential SBC interventions and considerations to inform future programming decisions, particularly related to FP/RH outcomes.

Client-centered care: Several approaches have been identified to improve FP/RH services and ensure client-centered care including mobile outreach services; offering the widest possible choice of contraceptive methods; ensuring affordable, quality care; integrating services for maximum efficiency; and focusing on mobile populations including migrants and refugees.[10] SBC practitioners may coordinate with Ministries of Health and other service delivery partners in support of these strategies and leverage them to further generate awareness of and demand for FP, ensure equity in uptake, and build confidence among clients in quality services.

FP/RH service vouchers: Research shows that vouchers increase access and use of long-acting contraceptive methods among women with the lowest levels of education and in the poorest wealth quintile; they reduce financial barriers and generate demand for FP/RH services.[32] Program implementers may explore further use of this approach to reduce inequities in FP/RH. SBC practitioners can leverage voucher programs led by service delivery partners to increase demand for FP/RH services.

Social accountability: Social accountability approaches can be effective at encouraging monitoring and oversight of public and private sector performance and responsiveness through collective action. While some of the evidence around impact is mixed, a meta-analysis demonstrated that, when done strategically, social accountability approaches can impact health outcomes.[33] For example, a social accountability intervention in Uganda improved FP/RH outcomes by incorporating rights and entitlement awareness into FP/RH outreach and health education.[34] A recent study in Ghana and Tanzania validated measures of service users' attitudes and behaviors in a social accountability process to improve contraceptive services, which may inform further efforts towards measurement of intermediate outcomes.[35] Further exploration into creative approaches that encourage social accountability is worth pursuing. Through community and other social mobilization efforts, SBC may be used to hold governments accountable for the implementation of policies at national and/or local levels that address FP/RH directly as well as the social determinants that shape FP use.

Diagnosing inequity and determining barriers to use: Health Policy Plus developed an approach for diagnosing inequity in FP/RH programs that allows users to easily transform Demographic and Health Survey data to identify inequities across countries and subnational geographies.[36] SBC practitioners may use this data for a more granular segmentation to ensure FP/RH services reach underserved populations.

Additional resources for identifying inequity in FP/RH include:

- Creating equitable access to high-quality family planning information and services: A Strategic Planning Guide[16]
- Health Equity Assessment Toolkit[37]
- Reproductive Empowerment Scale[38]
- Reproductive Autonomy Scale[39]
- PMA DataLab[40] and reproductive empowerment tool[41]
- Client poverty status measurement process[42]
- Service Provision Assessment Questionnaires[43]

Once subgroups experiencing inequities in FP/RH have been identified, one should seek to address the barriers (e.g., lack of access; restrictive policies and stigma; and social, cultural, or gender norms) leading to inequities.[16] Further use of these tools could support coordination and among both SBC and service delivery initiatives.

Implementation Knowledge Gaps

The above considerations and promising approaches, based on existing literature and evidence, should be considered a *starting place* for designing SBC strategies to reduce inequities in FP/RH. More research is needed in the following areas to better understand how the SDOH impact FP/RH outcomes and how SBC strategies are best placed to address them.

- How should SBC strategies be used to improve equity within FP/RH?[9] (e.g., advocacy for policy change, influencing public conversation and norms, and contributing to/supporting collective action, among others)
- How can we foster a better understanding of the mechanisms by which social determinants and lifestyle factors affect ability to achieve fertility intentions in different contexts?[30]
- How can we ensure that underserved groups, especially those with restricted access to services due to distance and/or ability to pay for transport or services, are reached?
- How are inequities related to FP/RH defined and assessed? What methods and indicators are appropriate for assessing inequity in contraceptive provision and access to information, and how can equity analyses take into account preferences, choice, and voluntarism more directly?[44]
- How might complexity-aware methods be used to assess changes in equity/the SDOH resulting from SBC interventions?
- How best can we measure the interrelationships between various social determinants and health to inform SBC interventions in FP/RH programmatic interventions?[45]

Conclusion

This review of evidence on the effects of incorporating the SDOH into SBC programs serves to synthesize evidence-informed considerations for reducing FP/RH inequities through SBC programs. The information covered can help generate interest in the urgent need to more intentionally address the SDOH that shape FP/RH outcomes. Ideally, donors, governments, policymakers, civil society, researchers, and program implementers will align around the existing evidence base to justify greater attention and investment in this area. Addressing the SDOH within an SBC program is not linear and will likely be, at times, a complicated and time-consuming process. Further thinking is needed to shape actionable short-, medium-, and long-term goals for social change that benefit those who remain underserved. The evidence and considerations presented here will hopefully inspire decision-makers to address the SDOH and, in doing so, reduce inequities in FP.

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